

Anal intercourse among females in the UK

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This thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy. The candidate has already achieved 180 credits for assessment of taught modules within the blended learning PhD programme

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I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere.

Abstract

The prevalence of receptive anal intercourse among women is increasing; however, public health discourse and education have not evolved proportionally to address this trend. While anal intercourse is well-documented as a risk factor for sexually transmitted infections (STIs) and anal malignancies, its association with anorectal disorders remains underexplored. Women may be particularly susceptible to these disorders due to anatomical differences compared to men. This thesis investigates the perspectives, attitudes, and clinical practices of healthcare professionals who treat female patients with anorectal disorders, aiming to establish an evidence-based understanding of the relationship between anal intercourse and anorectal health, and develop guidance on appropriate sexual history taking in the clinical setting.

The research begins with a systematic synthesis of existing literature on the motivations and experiences of women who engage in anal intercourse, providing crucial context for understanding the female perspective on this sexual practice. Following PRISMA guidelines, databases including PubMed, EMBASE, PsycINFO, and CINAHL were searched for peer-reviewed studies published in English from 2010 to 2023. Thematic synthesis, guided by the approach developed by Thomas & Harden, highlighted the normalization of anal intercourse among many women, despite persistent societal stigma that hinders open discussions—particularly within clinical settings when health issues arise.

The empirical component employs a mixed-methods design, integrating survey data with semi-structured interviews, to examine healthcare professionals' attitudes toward women with anorectal disorders. A structured online survey was distributed to healthcare professionals in general surgery to assess their attitudes, knowledge, and practices concerning sexual history-taking. Quantitative data were analysed using descriptive and inferential statistics, including chi-square tests to examine associations between demographics and clinical behaviours.

Complementing this, semi-structured interviews were conducted with a purposive sample of practitioners to explore institutional, interpersonal, and cultural

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influences on discussions of anal intercourse. Thematic analysis of interview data—facilitated by NVivo—identified key barriers, including provider discomfort, perceived patient resistance, and systemic limitations such as time constraints and lack of training. The study underscores the urgent need for enhanced clinician training, structured protocols for sexual history-taking, and targeted public health initiatives.

Policy recommendations are proposed for the NHS and relevant stakeholders. These include standardised sexual history protocols, the use of chaperones and structured questionnaires, extended consultation times in specialist clinics, and training on managing sensitive sexual health issues, including safeguarding. Public health recommendations involve updating NHS resources to include information on anorectal disorders and expanding sex education curricula to incorporate anal intercourse.

Finally, the thesis contributes to health policy and health economics by highlighting gaps in clinical efficiency and patient outcomes, and it outlines areas for future research, including the economic impact of delayed diagnosis and treatment of anorectal conditions related to anal intercourse.

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Author's Declaration

I declare that this thesis is the result of my own original work and has not been submitted for the award of a higher degree at any other institution. I provide the following additional notes regarding the content of this thesis:

- **Chapter 4**, *The perception of anal intercourse among women*, was published in **BMJ Public Health** under the title "*Perceptions and experiences of receptive anal intercourse among women: a systematic review and thematic analysis*". The published version was adjusted to meet the journal's word count requirements, however, the core analysis remains largely unchanged. I collaborated with colleagues N. Husnoo and V. Dev in conducting the analysis for this systematic review.
- The core findings from **Chapter 5**, Healthcare Perspectives on Anal Sex: Findings from a Nationwide Survey, has also been published under the title "*What do colorectal specialists think about female participation in anal intercourse? An online survey of UK coloproctologists*" to **Techniques in Coloproctology**. This publication is an abbreviated version of the empirical study presented in this chapter and represents work developed in collaboration with researcher L. Hunt.

Word count

Word Count: 32,894*

*Consistent with Lancaster University's Postgraduate Research Regulations, this word count includes the main text of the thesis, data and text incorporated into tables and figures. It excludes material preceding the main text of the thesis and material following the main text of the thesis (i.e., the appendices and the list of references).

Chapter 1: Introduction

1.1 Introduction to the problem

This thesis addresses receptive anal sex among women in the UK. Anal sex, defined as the insertion of a penis or other objects into the anus, is a sexual practice that has been observed across various cultures and historical periods. In common culture, however, it is usually thought to be practiced among men who have sex with men. Therefore, research relating to anal intercourse is primarily focused on men who have sex with men (MSM) and on sex workers, commonly in relation to sexually transmitted diseases.

Women also engage in receptive anal intercourse, a practice that has increasingly become normalized within the heterosexual population, particularly through representations in mainstream media (Faustino, 2020). Historical accounts of anal intercourse date back to as early as 300 AD, as described by McBride and Fortenberry (McBride & Fortenberry, 2010). While anal sex was once considered illegal in many jurisdictions, it has since been decriminalized in several countries (Ciacci & Sansone, 2023). Furthermore, cultural attitudes have shifted to the extent that anal intercourse is now perceived as a “trendy” sexual practice (McBride & Fortenberry, 2010). Like other sexual behaviours, anal intercourse carries potential health implications. However, the medical community has not fully adapted to addressing this increasingly prevalent practice among women.

Anal intercourse is considered a risky sexual behaviour, because of its association with alcohol and drug use (Hutton et al., 2012), multiple sex partners (Leichliter et al., 2007b), and lack of condom use (Hatch-Maillette et al., 2017). Higher rates of sexually transmitted diseases (STDs) and anal malignancy have previously been identified (Daling et al., 1987; Frisch et al., 2003). The absence of native secretions normally present in the vagina, increased traumatic abrasions and less frequent use of condoms, increase these risks (Benson et al., 2015). Anorectal disorders, including, anal pain, bleeding, anal fissures/tears, and incontinence are also associated with anal intercourse (Gana & Hunt, 2022). Voeller argues that passing

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stools has the same impact as anal penetration, suggesting that only coercive anal sex can lead to anal trauma (Voeller, 1991). However, it is well established in medical literature that chronic constipation and passing hard stools is a cause of anal trauma and anorectal disorders, counteracting their argument (NHS, 2021; Sugerman, 2014).

Higher rates of incontinence, and anal sphincter injury, have been demonstrated in females engaging in anal intercourse compared to women who do not engage (Markland et al., 2016)(Zahra et al., 2021). Compared to men, females are at a higher risk of anorectal disorders, due to their less robust anal sphincter muscles (Williams et al., 2001), and the diminishing effects of hormonal changes, pregnancy and childbirth on the pelvic floor muscles supporting the anal canal. Despite the increasing portrayal in mainstream media, the negative effects of anal intercourse on females are not openly discussed. Research on anal intercourse in females is sparse and the disproportionately higher health implications on females is seldom discussed. Historically, gender disparity has existed in health research, with underfunding and underrepresentation of women (Holdcroft, 2007; Winchester, 2021). The dearth of information of anal intercourse and anorectal disease in females is another example of this.

Effective clinical management of anorectal disorders requires an understanding of any underlying risk factors, and an important tool is a thorough sexual history taking. In the absence of this, patients are likely to present repeatedly with the same symptoms. Anorectal disorders, including anal fissures, incontinence, and associated pain and bleeding, impose significant economic burdens on patients, the National Health Service (NHS), and society at large. Expenses for medical consultations, diagnostic tests, treatments, and medications are some of the direct costs. The NHS bears considerable expenses in diagnosing and treating these conditions, for instance, managing a chronic anal fissure with glyceryl trinitrate (GTN) was estimated to cost the NHS approximately £616 per patient, while lateral internal sphincterotomy (LIS) was about £840 per patient, based on National published resource costs at 1999/2000 prices (Christie & Guest, 2002).

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Incontinence in adults accounts for approximately 2% of the total annual healthcare budget in the UK (NICE, 2007).

Indirect costs affecting patients and society include loss of productivity due to missed work, reduced work capacity, and the need for caregiving support. Faecal incontinence can lead to significant social and employment challenges, affecting quality of life and economic productivity (NICE, 2007). Quality of life can also be affected, pain and incontinence can lead to social isolation, mental health issues, and decreased overall well-being, which indirectly affect societal productivity and healthcare utilization. Therefore, addressing these conditions through effective treatment and mitigating risk factors is essential to mitigate these impacts. Sexual history taking is mandatory in genitourinary medicine (GUM) clinics (Brook et al., 2020), but this is less commonly practiced in general practice and surgical clinics where anorectal disorders are seen.

Several issues have been highlighted as acting as a barrier to healthcare practitioners discussing sexual health in clinics. One is inadequate training in assessing and managing issues relating to sexual health (Wimberly et al., 2006). Moreover, taking a sexual history may raise issues that non-sexual health doctors and nurses may not feel equipped to deal with. In addition, sexual topics appear to be considered taboo and create “embarrassment” for patients and healthcare practitioners. The burden of work in GP practices and NHS hospitals is also thought to cause a limitation in time to fully explore issues affecting patients including their sexual health. Gott and colleagues through semi-structured interviews highlighted several personal characteristics that clinicians felt were deterrents to proactively discussing sexual health issues. Opposite gender, older age, ethnicity (black and other minor ethnic groups), and sexuality were the core barriers identified to deter open conversations on sexual health (Gott et al., 2004).

Discussing sexual health in clinical settings remains a challenge, as both patients and clinicians may find these conversations uncomfortable. Nevertheless, the absence of open discourse hinders the identification of potential medical concerns and limits opportunities to improve patients' quality of life. This issue is particularly relevant in surgical practice, where conditions such as anal cancer,

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sexually transmitted infections (STIs), and anorectal disorders are linked to anal intercourse. Despite its established role as a risk factor, clinicians often fail to address anal sex openly, thereby neglecting crucial aspects of patient care. A study by Dames et al. (2021) highlights some of the negative consequences of healthcare professionals avoiding discussions about sexual health in surgical clinics, particularly in perioperative settings (Dames et al., 2021). One possible reason for this reluctance is the influence of societal taboos surrounding anal sex. However, given its increasing prevalence, failing to engage in open conversations with patients can lead to missed diagnoses, ineffective treatment, and inadequate guidance on preventive measures.

In developing this research, the author first sought to understand anal intercourse from women's perspective, examining their motivations, experiences, and reasons for engaging in this practice. In doing this, the researcher is able to gain valuable insights from the population of interest, shaping the way they developed their research design and assessed the outcomes, ultimately enriching the research data. The researcher approaches this by completing a systematic review and thematic synthesis of the perception of anal intercourse among women.

Subsequently, this research investigates how healthcare practitioners address anal intercourse in clinical settings. Given its association with anorectal disorders, it is reasonable to expect that clinicians take comprehensive sexual histories when assessing affected patients. However, this is not standard practice. Thus, this research seeks to examine the attitudes of healthcare professionals working in general surgery toward sexual history-taking, identifying barriers that may impede thorough assessments. The findings provide valuable insights to inform health policies and improve clinical practice. The researcher approaches this by completing a mixed methods study.

There is clearly a stigma associated with discussing anal intercourse, for patients, healthcare staff and society. Individual values and preconceptions may affect our ability to have these conversations openly. It is important to note that the aim is not to further stigmatise individuals who enjoy participating in anal intercourse,

but to provide evidenced based knowledge that will empower women to make their own choices.

1.2 Aims and objectives

The aim of this research was to develop guidance to inform appropriate sexual history taking in the clinical setting, particularly concerning anorectal disorders in females. To inform the development of this guidance, evidence will be gathered on the attitudes of healthcare practitioners (HCP) to sexual history taking in females who present with anorectal disorders. This will enable the researchers to identify current practices and identify the barriers to appropriate history taking, in order to implement change.

Objectives

1. Determine what proportion of HCPs take a sexual history in females presenting with anorectal disorders.
2. Determine attitudes of HCPs to sexual history taking in females presenting with anorectal disorders and factors that may exist as hindrances to appropriate sexual history taking.

Research question

1. What are the current attitudes and practices of healthcare practitioners towards female patients with anorectal disorders who engage in anal intercourse?

1.3 Organisation of the thesis

This thesis is presented in seven chapters. The next chapter describes the theoretical foundation and methodology. Following on from that, the researcher presents an introduction to the prevalence of receptive anal sex among women

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and the health implications. It then dives into a systematic review of existing qualitative literature on the perception of anal sex among women. Understanding the reasons why women engage in anal sex is beneficial for the healthcare community, as they play a key role in managing its potential consequences. A search identified 3,561 unduplicated records, twenty of which were included in the analysis. The results of the thematic synthesis highlighted not only why women engaged in anal sex but also their experiences and societal perceptions.

Chapters five and six present a mixed-methods study conducted among healthcare practitioners in the UK. The primary objective was to develop guidance on appropriate sexual history-taking in clinical practice, with a particular focus on anorectal disorders in female patients. To inform this guidance, the study examined healthcare practitioners' (HCPs) attitudes towards sexual history-taking in women presenting with anorectal disorders. Chapter five employed a quantitative approach, gathering data through questionnaires distributed to clinicians working in general and colorectal surgery. While there was a general recognition of the importance of inquiring about anal sex, such discussions were not routinely integrated into clinical practice. The most frequently cited barriers to addressing this topic included concerns about patient discomfort and fears of being perceived as inappropriate or judgmental. Notably, female clinicians reported less discomfort in taking a sexual history compared to their male counterparts ($\chi^2 (2) = 12.12, p = 0.002$). Additionally, clinicians who identified as homosexual expressed greater ease in discussing sexual history compared to those in other sexualities ($\chi^2 (8) = 18.3, p = 0.01$).

Chapter six builds upon these findings through qualitative analysis, exploring in greater depth the challenges healthcare practitioners encounter when discussing anal sex with women presenting with anorectal disorders. Semi-structured interviews with 19 clinicians identified five key themes, including expert perspectives on the relationship between anal sex and anorectal disorders. The findings indicate that clinicians selectively inquire about anal sex based on assumptions related to a patient's age and appearance. Furthermore, discomfort and personal biases emerged as significant barriers to addressing this topic.

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Systemic factors, such as privacy constraints and time limitations, were also identified as obstacles to comprehensive discussions on sexual health. Finally, participants emphasized the need for enhanced training and public health initiatives to raise awareness of receptive anal sex among women and its potential health implications.

The thesis concludes in a seventh chapter which combines the findings of the empirical studies in chapter five and six, outlines the policy implications of these findings and identifying priorities for future research.

Chapter 2: Methodology

2.1 Research Design

This study employed a mixed-methods approach to comprehensively explore receptive anal sex among women in the UK, integrating both qualitative and quantitative methodologies. The research was conducted in two phases: (1) a systematic review and thematic synthesis of existing literature to understand women's perceptions of anal intercourse, and (2) an empirical study investigating the attitudes and practices of healthcare professionals regarding sexual history-taking in clinical settings. The mixed-methods approach was chosen to capture both broad trends and in-depth insights, ensuring a robust analysis of the subject matter.

2.2 Epistemological position

This research proposal is grounded in the post-positivist research paradigm. Post-positivism is based on the fundamental belief that a researcher can objectively observe and measure phenomena through careful observation. There is a conviction that reality is objective, although unlike positivism, reality is probable and not absolute or infallible (Bunniss & Kelly, 2010). Knowledge gained within this paradigm is gathered through observation, measurement, and analysis. The post-positivist understands that neutrality and human detachment are not possible within research involving other humans (Guba, 1990).

Research conducted within the post-positivist paradigm utilises both quantitative and qualitative methodology, therefore this was applicable to the researcher's intention of pursuing a mixed methods study. Mixed methods research produces a more comprehensive understanding of a phenomenon compared to single method studies (Cohen et al., 2018). This approach allowed for a combination of quantitative rigor with qualitative depth, ensuring that the study addressed both measurable trends and the nuanced experiences of participants. By considering multiple views, the credibility and usefulness of results are increased.

2.3 Methods

Phase 1: Systematic Review and Thematic Synthesis

To explore the perceptions of anal intercourse among women, a systematic review of existing literature was conducted following PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. Databases, PubMed, EMBASE, PsycINFO and CINAHL were searched using predefined keywords related to anal sex, women's experiences, and perceptions. Inclusion criteria included peer-reviewed studies published in English between 2010 to 2023.

A thematic synthesis was performed on the selected studies, following the approach outlined by Thomas & Harden. This involved three stages: line-by-line coding of the findings from the included studies, development of descriptive themes through the grouping of related codes, and generation of analytical themes to provide higher-order interpretations across the evidence base. This synthesis provided valuable insights into the motivations, experiences, and concerns of women engaging in receptive anal intercourse.

Phase 2: Empirical Study on Healthcare Professionals

The second phase of the research investigated how healthcare professionals working in general surgery address anal intercourse in clinical settings, particularly in relation to sexual history-taking. A mixed-methods approach was used, consisting of:

Quantitative Survey

A structured online survey was distributed to healthcare professionals working within general surgery. The survey assessed awareness and attitudes toward taking a comprehensive sexual history, perceived barriers to discussing anal intercourse with patients and confidence levels in addressing sexual health concerns related to anal intercourse.

The survey data was analysed using descriptive and inferential statistical methods. Frequencies and percentages were calculated for categorical variables, while chi-square tests were used to explore associations between demographic factors and attitudes toward sexual history-taking.

Qualitative Semi-Structured Interviews

To gain a deeper understanding of the factors influencing sexual history-taking, semi-structured interviews were conducted with a purposive sample of healthcare professionals. The interviews explored themes such as experiences and comfort levels discussing anal intercourse with patients, institutional and cultural barriers to comprehensive sexual history-taking and recommendations for improving clinical practice and training.

Data was analysed using Braun and Clarke's thematic analysis framework, facilitated by NVivo software (Clarke & Braun, 2017). Thematic analysis was conducted iteratively, sequentially, and inductively, allowing themes to develop progressively throughout the research process

The key stages to thematic analysis were: (1) data familiarization; (2) line-by-line coding; (3) organising and aggregating these codes to develop descriptive themes that reflect the original data content; (4) developing analytical themes that goes beyond the original content. Transcripts were coded, and emerging themes were categorized to provide a richer understanding of healthcare professionals' perspectives.

Context

For the purpose of this research, the terms "female" or "woman" are defined as one born and assigned at birth to the female sex by a doctor, having been born with XX chromosomes and female genitalia.

2.4 Ethical Considerations

Ethical approval was sought and received from both the Faculty of Health and Medicine Research Ethics Committee (FHMREC) at Lancaster University and the NHS Research and Ethics Committee (REC). Informed consent was obtained from

all participants, ensuring their anonymity and confidentiality. For the survey and interviews, participants were informed about the voluntary nature of the study and their right to withdraw at any stage without repercussions. The systematic review was conducted using publicly available data, ensuring compliance with ethical research practices.

2.5 Positionality and reflexivity

As the primary researcher, I bring a unique perspective to this study, combining my background as a PhD student and a medical doctor with specialized training in colorectal surgery. My clinical work frequently involves caring for women who experience the adverse consequences of anal intercourse, including various anorectal disorders. This professional experience has deepened my understanding of the physical and emotional impact of these conditions but also necessitated a careful reflection on how it might shape my approach to this review.

Throughout the review process, I remained mindful of my positioning and the potential biases that could arise from my clinical exposure to the negative outcomes associated with anal intercourse. I acknowledged that my perspective might inadvertently emphasize risks or challenges while underrepresenting other nuanced or positive aspects of women's experiences. To address this, I actively sought to approach the literature with an open and balanced mindset, ensuring that my interpretations were guided by the evidence and not solely by my clinical encounters.

Efforts were made to maintain objectivity and rigor by adhering to established systematic review methodologies, including transparent study selection and comprehensive analysis of diverse perspectives from global contexts.

Furthermore, I utilised a second reviewer throughout the review process, to promote transparency, minimise biases and enhance credibility. I also critically reflected on the language and framing used in this review to avoid reinforcing stigma or bias, recognizing the importance of presenting women's experiences authentically and empathetically.

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Furthermore, to ensure the validity and reliability of the research, I implemented triangulation by using a mixed-methods design, which provided cross-validation of findings through different data sources and pilot testing of the survey and interview guides with a small group of healthcare professionals to refine questions and improve clarity.

This reflexive practice was integral to my goal of providing a comprehensive and balanced synthesis of the literature while respecting the complexity and sensitivity of this topic.

2.6 Conclusion

The findings from the systematic review and thematic synthesis informed the empirical study, ensuring that the research built upon existing knowledge. Quantitative survey results were used to identify general trends, while qualitative interviews provided contextual insights, allowing for a comprehensive understanding of the subject. This methodology ensured a rigorous exploration of both women's perspectives on anal intercourse and healthcare professionals' attitudes toward discussing it in clinical practice. The mixed-methods approach facilitated a nuanced understanding of the topic, with the ultimate goal of informing health policies and improving clinical guidelines for sexual history-taking.

Chapter 3: Prevalence and health implications of anal intercourse among women

3.1 The prevalence of anal intercourse among women

There is a paucity of research on receptive anal sex among women, particularly in the UK. The National Survey of Sexual Attitudes and Lifestyles (Natsal) serves as the most comprehensive resource for sexual health data in the UK, offering detailed insights based on probability samples of the population. Natsal employs a methodology that includes randomly selecting addresses, followed by a visit from a trained fieldworker who randomly selects and invites one household member to participate in a structured interview. This process combines computer-assisted face-to-face interviews with self-completed questionnaires. To date, four nationwide surveys have been conducted.

Natsal-1 collected data from 18,876 individuals aged 16-59 between 1990 and 1991. Natsal-2 surveyed 12,110 people aged 16-44 between 1999 and 2001, while Natsal-3 involved 15,162 adults aged 16-74 between 2010 and 2012. A study by Lewis et al compared data from Natsal 1, 2, and 3, revealing a significant increase in the prevalence of anal sex among women aged 16-24. The findings showed that 12.5% of women in this age group reported engaging in anal sex in 1990-1991, rising to 18.3% in 1999-2001, and 28.5% in 2010-2012 (Lewis et al., 2017).

The recently completed Natsal 4 study focuses on sexual behaviour during the COVID-19 pandemic but does not provide comparable data to previous Natsal surveys on anal sex (University of Glasgow, 2024). However, it suggests a decline in risky sexual behaviour following the first COVID-19 lockdown (Mitchell et al., 2023). Data currently available from Natsal 4, sheds light on anal sex engagement within the past four weeks and not on lifetime prevalence. The results showed that 8% of women reported recent anal sex, 66% had not engaged in it, and 26% chose not to disclose their response (University of Glasgow, 2024).

Chapter 3: Prevalence and health implications of anal intercourse among women

Research from the USA highlights an upward trend in anal sex among women over the past three decades. Satterwhite et al. (2007) analysed data from urban sexually transmitted infection (STI) clinics between 1993 and 2000, finding an increase in reported anal sex among women aged 15–39, rising from 9% to 22% (Satterwhite et al., 2007). Similarly, Aral et al. (2005) compared sexual practice trends among 18–39-year-olds between 1995 and 2004, reporting a rise in anal sex prevalence from 4.3% in 1995 to 8.3% in 2004 (Aral et al., 2005). Gindi et al. (2007), examining medical records of young people aged 12–25 attending STI clinics, found anal sex exposure increased from 2% in 1994 to 6% in 2004 (Gindi et al., 2008).

Gorbach et al. (2009), in a cross-sectional survey of heterosexual adults aged 18–26 attending public STI clinics between 2001 and 2004, reported that 32% of both heterosexual men and women had engaged in anal sex (Gorbach et al., 2009). Reynolds et al. (2010) analysed data from women aged 12–66 accessing HIV prevention services in 2004, identifying that 21.8% had engaged in anal sex (Reynolds et al., 2010). Houston et al. (2007), in a survey of 350 females aged 12–18 conducted between 2001 and 2006, found that 15.6% had participated in anal sex (Houston et al., 2007).

Javanbakht et al. (2010), in a cross-sectional survey of heterosexual adults (mean age: 30 years) attending STI clinics between 2006 and 2007, reported that 10% of women had engaged in anal sex in the 90 days prior to their clinic visit (Javanbakht et al., 2010). Similarly, Mackesy-Amiti et al. (2010) surveyed female drug users aged 18–75 between 2005 and 2008, finding that 15% reported anal sex (Mackesy-Amiti et al., 2010). Leichter et al. (2007) conducted a secondary analysis of data from the National Survey of Family Growth (NSFG) for 2002–2003, identifying that 30% of women aged 15–44 had ever engaged in anal sex (Leichter et al., 2007a). Chandra et al. (2011), using more up-to-date NSFG data from 2006–2008, reported an increase to 36% (Chandra et al., 2011). NSFG data from 2011–2015, analysed by Habel et al, showed similar prevalence rates of anal sex 33.3% among women (Habel et al., 2018).

Scheidell et al. (2020) analysed data from the National Longitudinal Study of Adolescent to Adult Health for 2007–2008 and found that 40% of women aged 24–

34 reported engaging in anal sex after age 18 (J. D. Scheidell et al., 2020). Hess et al. (2016), using data from the National HIV Behavioural Surveillance (NHBS) annual survey in 2013, found that 30% of women aged 18–60 had reported engaging in anal sex in the past year (K. L. Hess et al., 2016).

Similar prevalence rates are reported in the other parts of the world. Meuwly et al 2021, in a 2017 national survey, found that 28% of women have engaged in anal sex in Switzerland (Meuwly et al., 2021). Stulhofer and Bacak 2011, from a 2010 cross-sectional probability survey in Croatia, identified a 29.8% prevalence rate of anal sex among women (Stulhofer & Baćak, 2011). Morhasson-Bello et al 2019, performed a systematic review of published articles on anal sex in sub-Saharan Africa and reported a 4.3–37.8% prevalence of anal sex among adolescents and adults (Morhason-Bello et al., 2019).

3.2 The consequences of anal sex

Compared to vaginal intercourse, penile-AI has been reported to carry a higher risk of sexually transmitted infections (STIs) and anal malignancy (Frisch et al., 2003; Javanbakht et al., 2010). The absence of cervicovaginal secretions and susceptibility to traumatic abrasions are some of the factors considered to increase the risk of STIs (Benson et al., 2015). Additionally, several publications have reported lower rates of condom use during anal sex compared to vaginal intercourse (Gorbach et al., 2009; K. L. Hess et al., 2016; Houston et al., 2007; Leichliter et al., 2007b; Mackesy-Amiti et al., 2010).

Anorectal disorders, which include, anal fissures (tears), anal bleeding, incontinence, and anal sphincter injury, are also associated with anal sex (Gana & Hunt, 2022). Women are at greater risk of these conditions due to anatomical and physiological factors. Compared to men, women have shorter and less robust anal sphincters (Reginelli et al., 2012b; Williams et al., 2001). Hormonal changes, pregnancy, and childbirth further increase the vulnerability of pelvic floor muscles, which support the anal canal, making women more susceptible to anorectal disorders (Frudinger et al., 1999).

Several studies have explored the association between anal sex and faecal incontinence in women. Hemaly and Mousa, in a review article, discuss how anal intercourse-related lacerations to the anal sphincter can result in faecal incontinence (Hemaly & Mousa, 2020). Markland and colleagues (2016) carried out a national cross-sectional survey of 4,170 adults and identified higher rates of faecal incontinence among female participants engaging in AI (9.9 vs. 7.4%, $p=0.05$) compared with those not engaging in AI (Markland et al., 2016). Similarly, Geynisman-Tan et al. (2018) analysed data from a cross-sectional survey of 1,003 women and reported a higher prevalence of faecal incontinence among those who engaged in AI within the previous month compared to those who did not (28.3% vs. 14.4%; $P = 0.01$)(Geynisman-Tan et al., 2018).

Similar associations have been made with the other anorectal disorders. In a national survey of sexual health behaviour, women reported significantly more pain during anal sex (72%) than men (15%) (Debby Herbenick et al., 2015). Gaither et al 2024, in a cross-sectional survey between July 2022 and March 2023, identified an increase in the reported rates of anal fissures in individuals who engaged in receptive anal sex (Gaither et al., 2024). Nzimbala et al identified that traumatic anal sex was an aetiological factor for chronic anal fissures in 13% of participants (Nzimbala et al., 2009). Goddard et al 2021, also found that anal sex was independently associated with anal tears (Goddard et al., 2021).

Anorectal disorders are stigmatizing (Butcher, 2020; Tol et al., 2019) and affect women of all ages. Women may not be fully informed about the potential risks of engaging in AI, challenging their ability to make fully informed choices.

3.3 The stigma surrounding anal intercourse and its impact on healthcare

Sexual health is an essential aspect of overall well-being, yet stigma surrounding certain sexual behaviours can create barriers to effective healthcare (Kingsberg et al., 2019). Society associates anal sex more commonly with men who have sex with men (MSM), and, like other sexual behaviours in this group, it is subject to both social and medical stigmatization, which may affect willingness to seek

Chapter 3: Prevalence and health implications of anal intercourse among women

medical advice and treatment when necessary (Hussein & Ferguson, 2019). Additionally, biases among healthcare providers may influence the quality of care they receive (Gopal et al., 2021).

Women who engage in anal sex may experience significant stigma, both from society and within the medical field. Cultural and social norms often associate anal sex with taboo or deviant behaviour, reinforcing negative perceptions (Hirst et al., 2023a). As a result, women who develop clinical problems due to anal sex—such as fissures, or incontinence—may feel embarrassed or ashamed to disclose their sexual practices to healthcare providers. Fear of judgment, moral disapproval, or even discrimination can lead to reluctance in seeking timely medical intervention, potentially exacerbating health complications.

Furthermore, misinformation and lack of comprehensive sexual education contribute to this stigma. Limited information is available on the NHS website on anal sex and associated risks, mainly focusing on STIs, neglecting anorectal disorders (NHS, 2022). Many women may not be adequately informed about the risks associated with anal sex or the preventive measures they can take. Consequently, when medical issues arise, they may not feel comfortable discussing their concerns, leading to delayed diagnosis and treatment.

Healthcare professionals are not immune to societal biases, and some may hold stigmatizing attitudes toward women who engage in anal sex. This stigma can manifest in several ways, including discomfort in discussing the topic, making judgmental remarks, or failing to provide appropriate medical advice and care. Some clinicians may unconsciously associate anal sex primarily with men who have sex with men, leading to a lack of preparedness in addressing concerns related to women. This gap in understanding and approachability may further alienate female patients, discouraging them from disclosing relevant information about their sexual health.

Reluctance to engage in open, nonjudgmental conversations limits the effectiveness of medical care and reinforces the cycle of stigma. Addressing this issue requires a combination of education, policy changes, and a commitment to

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fostering a more inclusive and nonjudgmental healthcare environment. Therefore, this study aimed to establish an evidence base for best practices in sexual history taking in clinical settings, specifically concerning anorectal disorders in females. To achieve this, it will examine healthcare practitioners' (HCPs) attitudes toward discussing sexual history with female patients presenting with such conditions.

Chapter 4: The perception of anal intercourse among women: a systematic review and thematic analysis

This chapter sets out to systematically review the literature on the perception of anal intercourse among women. It was structured in a journal article format for publication.

The results of twenty studies sourced from PubMed, EMBASE, PsycINFO and CINAHL following a predefined search strategy were thematically synthesised using the thematic synthesis approach developed by Thomas & Harden, involving line-by-line coding, development of descriptive themes, and generation of analytical themes. Three categories of themes are presented; why women engage in anal intercourse (AI), the experiences of women who have engaged in AI and how AI is viewed by women in society.

This synthesis provided valuable insights into the motivations, experiences, and concerns of women engaging in receptive anal intercourse. The discussion underscores that women participate in AI for diverse reasons, some of which do not necessarily reflect agency. AI was commonly expressed as painful, reflecting the local trauma most women experience in their anal canal. Finally, it suggests, that the stigma surrounding AI may not necessarily lessen engagement in AI but limits women's ability to openly discuss AI.

4.1 Introduction

Female participation in receptive penile-anal intercourse has increasingly become normalized, influenced by its portrayal as trendy within popular culture and its growing visibility in the media (Faustino, 2020). The prevalence of receptive anal intercourse (AI) among women appears to have increased, with rates in the USA and Europe reported to range between 28.5% and 44% (Chandra et al., 2011; Kristen L. Hess et al., 2016; Lewis et al., 2017; Stulhofer & Baćak, 2011). This trend may represent a genuine rise in participation or simply greater openness and willingness to discuss sexual practices.

Chapter 4: The perception of anal intercourse among women in the UK: a systematic review and thematic analysis

Once considered taboo and extreme, anal intercourse has undergone a cultural shift over recent decades. Mainstream film and television now frequently depict anal sex, serving not only as a reflection of societal changes but also as an influential factor in its adoption (Faustino, 2020; Rosewarne, 2015). Despite the prevalence of anal intercourse, there is a paucity of public health education on anal intercourse (Hebert et al., 2017).

The psycho-social aspects of anal intercourse are likely complex and variable among individuals. Collecting well-grounded information on this is likely to be fraught with challenges, given the historical stigma surrounding anal intercourse. Some studies have investigated anal sex behaviours among both sexes and cite varying reasons women engage in anal sex, including pleasure, curiosity, pleasing the male partner and coercion (Fahs & Gonzalez, 2014; Reynolds et al., 2015). Men appear more likely to describe having a pleasurable experience whereas women appear to engage due to pressure and describe a more painful experience during heterosexual anal intercourse (Marston & Lewis, 2014). Emily et al. reports up to 25% of women who engage in anal sex, have been coerced or pressured at least once (Emily et al., 2009).

Furthermore, the scientific and healthcare communities require a deeper understanding of women's perspectives on anal intercourse, which remains insufficiently explored. The aim of this review was to systematically synthesise and analyse existing literature that investigates the perception of anal intercourse among females. In this context, perception is defined as “the way in which anal intercourse is viewed, perceived, regarded, or experienced by females”, inclusive of all females who may or may not have engaged in anal intercourse. This would provide an evidence-base which explore the views and experiences of anal intercourse among women who are particularly at risk of anorectal disease.

Research relating to anal intercourse is primarily focused on men who have sex with men (MSM) and on sex workers, commonly in relation to sexually transmitted diseases. Research on anal intercourse in females is sparse and the disproportionately higher health implications on females is seldom discussed. Historically, gender disparity has existed in health research, with underfunding and

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underrepresentation of women (Holdcroft, 2007; Winchester, 2021). The dearth of information of anal intercourse in females is another example of this.

To the researcher's knowledge this is the first systematic review on the perception of anal intercourse among females. The objective was to identify patterns within primary data and aggregate existing evidence on the perception of anal intercourse among women.

This study will set out to answer the following review question: What is the perception of anal intercourse among women?

The framework used to devise the search strategy was **SPIDER**:

Sample (S): Women across various settings and socio-economic groups.

Phenomenon of Interest (PI): Women engaging in anal intercourse

Design (D): Systematic review and thematic synthesis of all available literature looking at the perception of anal intercourse.

Evaluation (E): Perception, views, or experiences of anal intercourse of all females

Research Type (R): Qualitative and the qualitative findings of mixed method studies.

4.2 Methods

4.2.1 Standards

This systematic review was reported according to the Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) statement (Tong et al., 2012). After developing the review question, the PROSPERO database was searched to identify any identical or similar review questions, none were identified. This protocol was registered on the PROSPERO database, with the registration number CRD42023390284. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart as recommended by ENTREQ guidelines for reporting qualitative systematic reviews was used to demonstrate the selection processes and results.

4.2.2 Study design & eligibility criteria

Qualitative studies are best posed to answer the review question, they are better suited to explore attitudes and behaviour in-depth, and as such provides a better understanding on perception and experiences, therefore qualitative studies and the qualitative findings of mixed method studies were included. Only articles that were peer-reviewed were included. The increasing portrayal of anal intercourse on mainstream media is likely to reflect an increase in individuals being more willing to discuss anal intercourse (Faustino, 2020; Rosewarne, 2015). More so, more recently published data will provide more relevant information on the perception and experiences of the current generation of women. A search strategy spanning January 2010 till December 2023, was therefore considered most likely to yield results relevant to the review question. This review was not limited to geographical location or socioeconomic status, the perception of all females regardless of background were considered relevant to this study. Furthermore, despite the increasing participation and discussion of anal intercourse, following an initial scoping search, it was evident that there is a paucity of studies reporting on the perception of anal intercourse among females and restricting the search to location or socioeconomic status would not yield a significant number of results.

Given the qualitative nature of this review, articles not published in English would be at risk of losing their essence or meaning if translated by individuals who are not native speakers of the respective languages. Therefore, as the reviewers are English speakers, only articles published in English were included. Full-text articles will provide data on the different dimensions of female perception where anal intercourse is concerned and rich context, therefore only articles available in full text were included. Table 1 summarises the inclusion and exclusion criteria.

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Table 1 Eligibility criteria

Inclusion criteria
• Qualitative or mixed-methods studies reporting on the perception, views or experiences of females receiving anal intercourse.
• Articles published between January 2010 and December 2023.
• Articles published in English language.
• Full text articles published in a peer-review journal.
Exclusion criteria
• Abstracts, editorial comments, or other non-full text articles.
• Studies only reporting on males engaging in anal intercourse.
• Studies only reporting quantitative data.
• Articles not published in English.

4.2.3 Search strategy & study selection

A combination of controlled vocabulary and Medical Subject Headings (MeSH) terms were put together using Boolean operators as below.

perspective OR views OR perception OR experience OR feelings AND

female* OR "Women"[Mesh] AND

anal OR "anal sex" OR "anoreceptive intercourse" OR "anal intercourse" OR
"Coitus"[Mesh]

The databases searched were PubMed, EMBASE, PsycINFO and CINAHL.

Furthermore, the search strategy was limited to "full text articles", "peer reviewed", "from 2010 to 2023" and "in English only", by applying search filters.

After removing the duplicates, the two reviewers (TG and NH) independently screened article titles and abstracts for eligible studies, guided by the inclusion and exclusion criteria. The Rayyan system was utilised to facilitate this. The studies which the two reviewers agreed on were subjected to full text reviews. All discrepancies were resolved by consensus between the two reviewers.

4.2.4 Quality appraisal

Articles meeting the inclusion criteria were assessed for quality by two independent reviewers (TG and VD) using the Critical Appraisal Skills Programme (CASP) qualitative studies checklist (CASP, 2018). The 10 criteria in the CASP checklist assesses three main quality issues, the validity of the study, the nature and description of the results and the value of the results.

Quality assessment was performed for descriptive purposes only, no studies were excluded based on their critical appraisal scores, as the researcher agrees with the view that many qualitative studies do not always report all critical details of their procedure and methodology and should therefore not be excluded on that basis (Sandelowski et al., 2007). A complete absence of any data to support the results or conclusion of a study on the other hand would warrant exclusion.

4.2.5 Data extraction

Data extraction was a hybrid process involving extraction of descriptive variables using Microsoft Excel and extraction of key findings using NVivo software.

Microsoft Excel was used to extract the following study characteristics; Study details (Authors, Year published, Title, Year of study), Participant details (Setting, Sample size, Sample selection, Age group, Country, Socio-economic group), and Design details (Study type, Study aim, Method of recruitment, Method of data collection, Data extract tool, Analytic approach). In the second phase of data extraction, the results/findings section of each article was entered verbatim into the NVivo software, where they were read several times, coded, and themes developed using the thematic synthesis approach described below.

4.2.6 Data analysis and synthesis

The thematic synthesis framework developed by Thomas and Harden (Thomas & Harden, 2008) was utilised to inductively synthesize key themes from all included studies. The step-by-step process included 1. Line-by-line coding of the results section focusing on direct quotes from female participants, relevant to the review

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question 2. Organising and aggregating these codes to develop descriptive themes that reflect the original data content 3. Development of analytical themes which goes beyond the original content.

The primary researcher (TG) developed the initial codes, which were reviewed by the second reviewer (NH) independently. Any discrepancies in coding were resolved through discussion between the two reviewers. The two reviewers then identified similar patterns within the codes and grouped them to generate “descriptive themes” consistent with the thematic synthesis approach developed by Thomas & Harden.

In the final step, the primary reviewer used their understanding of the review question to tease out analytic themes that reflect the views, motivations or experiences women had about anal intercourse. This step ‘goes beyond’ the primary reported data by synthesising findings across studies and interpreting its meaning in relation to the review questions (Thomas & Harden, 2008). This process identified patterns within all eligible studies and provided an overall account on the perception of anal intercourse among women.

4.3 Results

4.3.1 Study selection and characteristics

A total of 4,092 references were generated following the initial search. After removal of 531 duplicates, 3,561 titles and abstracts were screened. Following screening, 3,526 references were excluded as they did not meet the inclusion criteria. Thirty-five full-text articles were retrieved, and their eligibility was determined independently two reviewers (TG & NH). Twenty articles met the inclusion criteria. The details of the selection process are shown in the PRISMA flowchart in figure 1. The descriptive variables of all 20 included studies are summarised in table 2.

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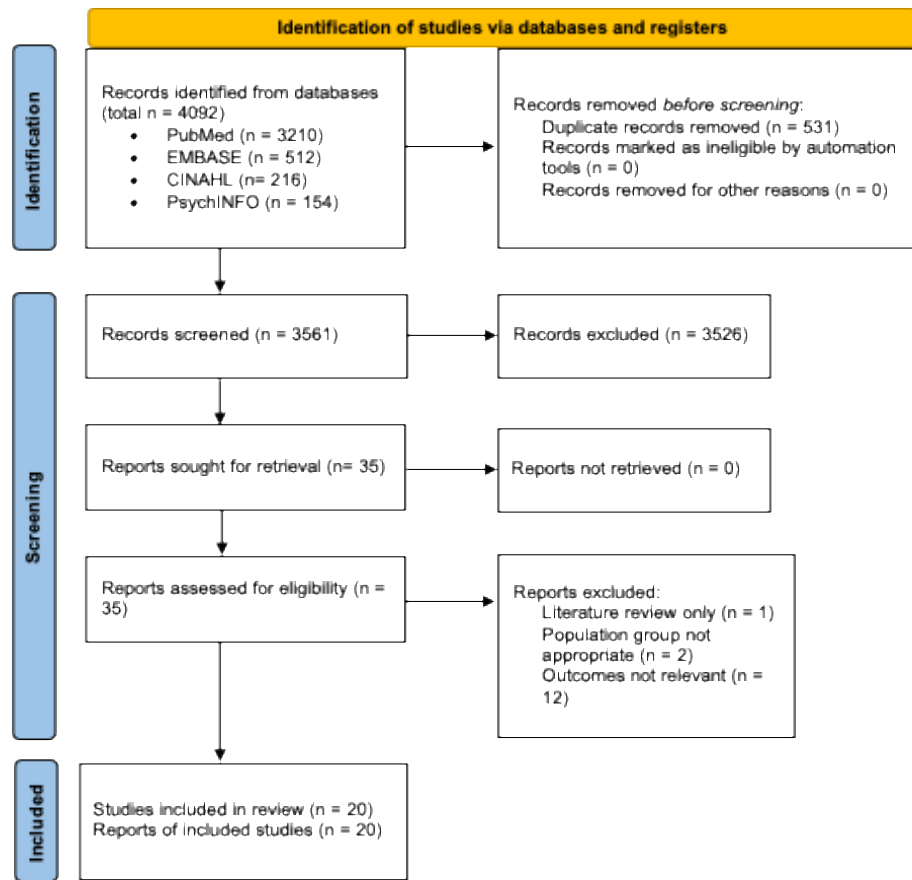


Figure 1: PRISMA flowchart

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Table 2: Characteristics of included studies

Authors, year & country	Setting	Sample size	Age group (years)	Socio-economic status	Incentives	Study design	Selection characteristics	Study aim	Recruitment method	Data collection method	Data extract tool	Analytic approach	Theoretical framework	Ethical approval
Carter et al 2010, USA (Carter et al., 2010)	Interviews	42 (17 males and 25 females)	18 to 25	Mixed	\$25	Mixed methods	self-identification as Puerto Rican or black, 18-25, not being pregnant, having been born on the U.S. mainland or in Puerto Rico, being fluent in English, heterosexuals, recent heterosexual partner	survey findings about the prevalence and predictors of anal sex, as well a qualitative finding of the study population's experience with anal sex	street outreach, word of mouth or referrals, and fliers or newspaper advertisement	Audio recording	Not stated	Thematic analysis	None	Yes
Štulhofer et al 2013, Croatia (Stulhofer & Ajdukovic, 2013)	Online survey & 9 interviews that predetermined themes	9 interviews + 68 questionnaires (68 females)	18 to 60	Mixed	None	Mixed methods	None	the study provided a detailed qualitative analysis of a multitude of women's experiences of pain and pleasure associated with anal intercourse, together with symbolic meanings attached to these experiences.	recruited informally, through the female researcher's informal social network of friends and acquaintances + online questionnaire with open ended questions	Online questionnaire	Not stated	Thematic analysis	None	Yes
Roye et al 2013, USA (Roye et al., 2013)	Interviews	15 (12 females + 3 males)	15 to 22	Mixed	None	Mixed methods	ages 15 to 22; self-identifying as African American, Caribbean Black, African, or Latino; and history of vaginal, anal, or oral intercourse	to obtain young people's own narratives about their experiences with HAI, both the choice to have HAI and HAI refusals, to provide an age-specific and more fleshed-out understanding of this dynamic, and other key dimensions of this increasingly frequent high-risk behaviour, so that a fuller picture of HAI among young people can begin to emerge.	recruited through flyers in a college and an adolescent clinic	Audio recording	Not stated	Grounded theory	None	Yes

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Authors, year & country	Setting	Sample size	Age group (years)	Socio-economic status	Incentives	Study design	Selection characteristics	Study aim	Recruitment method	Data collection method	Data extract tool	Analytic approach	Theoretical framework	Ethical approval
Fahs & Gonzalez 2014, USA (Fahs & Gonzalez, 2014)	Interviews	20	18 to 59	Mixed	\$20	Qualitative	women in the age group of 18–59	To narrate what anal sex means to 20 American women with diverse backgrounds	through local entertainment and arts listings distributed free to the community as well as the volunteer's section of the local online section of Craigslist.	Audio recording	Not stated	Thematic analysis	Poststructuralist feminist analysis	None
Marston & Lewis 2014, UK (Marston & Lewis, 2014)	Focus group discussions & Interviews	130 (37 females and 34 males interviewed, rest in FGD)	16 to 18	Mixed	None	Mixed methods	16- to 18-year-old of mixed background	looks in detail at anal practices among young people aged 18 and under, develops hypotheses for further study and makes suggestions for sexual health promotion	directly approaching people in schools/colleges; youth work services targeting young people not in education or training; youth organisations; a supported housing project for young people living independently from their families; and informal networks	Audio recording	Not stated	Thematic analysis	None	Yes
Massad et al 2014, Palestine (Massad et al., 2014)	Focus group discussions & interviews	83 (42 males and 41 females)	16 to 24	Mixed	None	Qualitative	young adults from all regions	to provide insights into the perceived prevalence and patterns of sexual behaviour among Palestinian young men and women	Via NGOs, further details not given	Audio recording of FGD, Written notes for interviews	NVivo	Thematic analysis	None	Yes
Reynolds et al 2015, USA (Reynolds et al., 2015)	Focus group discussions	32	24 to 56	Low	\$50 cash	Qualitative	having had anal intercourse with a man, past experience of illicit drug use	to examine why heterosexual women, engage in anal intercourse and to examine women's perception of risk related to anal intercourse and women's emotional and physical experiences during the encounter itself.	recruited through an outpatient drug treatment program and a community-based HIV and sexually transmitted infections (STI) testing program	Audio recording	Dedoose software	Grounded theory	Exploratory	None
Stahlman et al 2015, USA (Stahlman et al., 2015)	Interviews	40	>18	Unknown	\$30	Qualitative	women 18 years or older, reporting AI in the past 90 days,	1) to report women's reasons for engaging in unprotected AI; (2) to describe the contextual	women attending public STD clinics in Los Angeles County, California,	Audio recording	ATLAS	Thematic analysis	Theory of gender and power	Yes

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Authors, year & country	Setting	Sample size	Age group (years)	Socio-economic status	Incentives	Study design	Selection characteristics	Study aim	Recruitment method	Data collection method	Data extract tool	Analytic approach	Theoretical framework	Ethical approval
							and being tested for rectal STI	factors surrounding AI, such as feelings about AI and perceptions of control during AI, use of alcohol/substances, condoms, and lubrication, and how these vary by current rectal STI status; and (3) to assess women's knowledge and concerns about rectal infections.	recruited by provider referral					
Wamoyi et al 2015, Tanzania (Wamoyi et al., 2015)	Focus group discussions & Interviews	81 interviews, however no. of females not stated	15 to 49	Low	None	Qualitative	men and women from the general population; women working in food and recreational facilities (FRFs); female sex workers (FSWs) working in brothels and streets; male truck drivers; and fishermen working on Lake Victoria. Sex workers [15-19], women working in FRFs [20-24], truck drivers [25,26] and fishermen [27,28] are known to be key populations at increased risk of HIV and other STIs.	A better understanding of how people talk about the practice of HAS would offer useful insights, contribute on better measures of the practice, and inform development of interventions to make the practice safer.	-truck drivers from four truck stops along a major highway in Morogoro region via snowballing -fishermen from fishing communities on the shores of Lake Victoria via snowballing -Women employed in FRFs in Mwanza city were recruited via consultation with the facility -FSWs in Dar es Salaam via owners of the brothels & snowball sampling -Participants from the general population in Morogoro and Tanga regions were randomly recruited at hamlet level after community meetings.	Audio recording	NVIVO	Grounded theory	None	Yes
Duby et al 2016, South Africa, Zimbabwe & Uganda (Duby et al., 2016)	Interviews	88	20 to 40	Low	None	Qualitative	pre-selected for participation to ensure that at least 10% had reported engaging in penile-	In order to understand the potential contribution that heterosexual penile-anal intercourse makes to HIV transmission to women, it	not clearly stated	Audio recording	NVIVO	Thematic analysis	Sexual scripting theory	Yes

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Authors, year & country	Setting	Sample size	Age group (years)	Socio-economic status	Incentives	Study design	Selection characteristics	Study aim	Recruitment method	Data collection method	Data extract tool	Analytic approach	Theoretical framework	Ethical approval
							anal intercourse whilst enrolled in the clinical trial, and approximately 10% had acquired HIV.	is critical to identify motivations for engaging in it, the behavioural and social contexts, and the dynamics of gendered power and sexual scripting surrounding its practice						
Mazeingia et al 2017, Ethiopia (Mazeingia et al., 2017b)	Interviews	18	18 to 39	Low	\$13 + \$4 for recruitment	Qualitative	FSW self-reporting penile anal intercourse	to explore anal sexual experience of female sex workers; and how they understand risk of HIV transmission through anal sex	initially through agents, then snowballing	Audio recording	Open Code	Thematic analysis	None	Yes
Shayo et al 2017, Tanzania (Shayo et al., 2017)	Focus group discussions & Interviews	903 men & women (number in the qualitative aspect not specified)	15 to 84	Low	None	Mixed methods	>15-year-olds, Commercial sex workers (CSWs) and barmaids, and some adults (males, females, pregnant mothers) and youths were conveniently recruited for the qualitative aspect	to determine the prevalence and risk factors associated with female anal sex in the context of HIV transmission in selected districts of Tanzania	not clearly stated	Verbatim	Not stated	Thematic analysis	None	Yes
McBride 2019, USA (McBride, 2019)	Focus group discussions	33	18 to 30	Mixed	Refreshments and \$10 gift card at the end of the session	Qualitative	English-speaking, self-identified heterosexual women, no requirement for previous anal intercourse	to describe attitudes toward receptive PAI and non-intercourse anal sex behaviours among a sample of women ages 18 to 30 year, to describe motivational factors influencing both PAI and nonintercourse anal sex behaviours.	Via flyers posted in university campus, metropolitan area, and social media	Audio recording & notes	Manual	Thematic analysis	None	Yes
Benson et al 2019, USA (Benson et al., 2019)	Interviews	20	18 to 50	High	\$50 gift card	Qualitative	English speaking, heterosexual, recent history of AI (<3months)	to explore not only women's own attitudes toward HAI, but also their normative beliefs toward	via posted advertisements in local print and online newspapers, on Craigslist, and on a University of	Audio recording	Dedoose software	Thematic analysis	Theory of Planned Behaviour	Yes

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Authors, year & country	Setting	Sample size	Age group (years)	Socio-economic status	Incentives	Study design	Selection characteristics	Study aim	Recruitment method	Data collection method	Data extract tool	Analytic approach	Theoretical framework	Ethical approval
								HAI and their perceived control over engaging in these activities in their sexual encounters.	Washington research recruitment website.					
Herbenick et al 2019, USA (Herbenick et al., 2019)	Online survey	75 (no. of women not stated)	14 to 60	Unknown	None	Mixed methods	Individuals were sampled from KnowledgePanelVR, a probability-based online panel designed to be nationally representative of non-institutionalized, English-speaking Americans.	(1) to assess the proportions of American adolescents and adults (aged 14 to 60) who report that someone did something during sex that made them feel scared and (2) to examine the kinds of sexual experiences reported as scary.	Adults were recruited directly from KnowledgePanel, whereas adolescents were recruited through their parents.	Online questionnaire	Dedoose software	Inductive content analysis	None	Yes
McHome et al 2020, Tanzania (McHome et al., 2020)	Interviews	18	27 to 57	Low	None	Mixed methods	Women from microfinance loan groups	to understand different forms of intimate partner violence from women's own perspectives	Directly approaching microfinance groups within three defined neighbourhoods	Audio recording	NVIVO	Thematic analysis	None	Yes
Nassimi et al 2021, Iran (Nassimi et al., 2021)	Interviews	20 (4 women addressing AI)	<50	Mixed	None	Qualitative	married housewives under the age of 50 years, in Qom City, Iran from January 2017 to April 2018.	the present study aimed to explain the factors affecting the sexual health of housewives in Qom City, Iran.	not clearly stated	Audio recording	Not stated	Content analysis method	None	None
Faustino and Gavey 2022, New Zealand (Faustino & Gavey, 2022)	Interviews	23 (5 males and 18 females)	18 to 64	Unknown	None	Qualitative	People 18 years of age and older, fluent in English, and based in Auckland	What is the nature of women's experiences of unwanted, coercive anal sex with men? What do their stories tell us about the coercive tactics at play? And what are the gendered dynamics underpinning those experiences?	through flyers posted on university notice boards and distributed in various locations in central parts of the city, through notices and information about the study sent to community contacts and professional colleagues to disseminate among their networks, and through social media.	Audio recording	Not stated	Framework analysis	None	Yes

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Authors, year & country	Setting	Sample size	Age group (years)	Socio-economic status	Incentives	Study design	Selection characteristics	Study aim	Recruitment method	Data collection method	Data extract tool	Analytic approach	Theoretical framework	Ethical approval
Morhason-Bello et al 2023, Nigeria (Morhason-Bello et al., 2023)	Focus group discussions & Interviews	128 (65 females and 63 males)	18 to 45	Mixed	None	Qualitative	18 - 45-year-olds & brothel based FSW in Southwest and Ibadan Southeast Local Government Areas (LGAs) of Oyo State, Nigeria	explored knowledge, perceptions, local terminologies, motivations, and beliefs as well as risks associated with different types of sexual behaviours, with specific attention to heterosexual oral and anal sex	recruited in the community from tertiary educational establishments, vocational centers, youth clubs, markets, artisanal groups, and other institutions/facilities in both LGAs to provide a wide perspective on the research topic.	Audio recording	NVIVO	Thematic analysis	Sexual scripting theory	Yes
Hirst et al 2023, UK, (Hirst et al., 2023b)	Focus group discussions & Interviews	20 (16 females and 4 males)	19 to 56	Mixed	None	Qualitative	adults and young people who had an interest in the topic due to (i) their profession as a sexual health or education practitioner, or artist/performer, or (ii) their potential, as young people, to be the recipients of advice or education from professionals, as well as relevance to their own sexual practices	to explore concerns regarding anal sex participation and sociologically deconstruct understandings of anal sex activity	not clearly stated	Audio recording	Not stated	Thematic analysis	None	Yes

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Altogether, the studies included more than 555 female participants, across 12 countries. Most studies were conducted in the USA (8 studies). **Figure 2** highlights the included countries. The included participants were from diverse socio-economic class, with age groups ranging from 14 to 84 years. The majority of studies used individual interviews or focus groups for data collection, while two studies were based on open questions in a survey. Thematic analysis and grounded theory analysis were the most commonly used analytical approaches. All the included studies were of a satisfactory quality and provided value to this systematic review. Quality appraisal outcomes are summarised in **Table 3**.

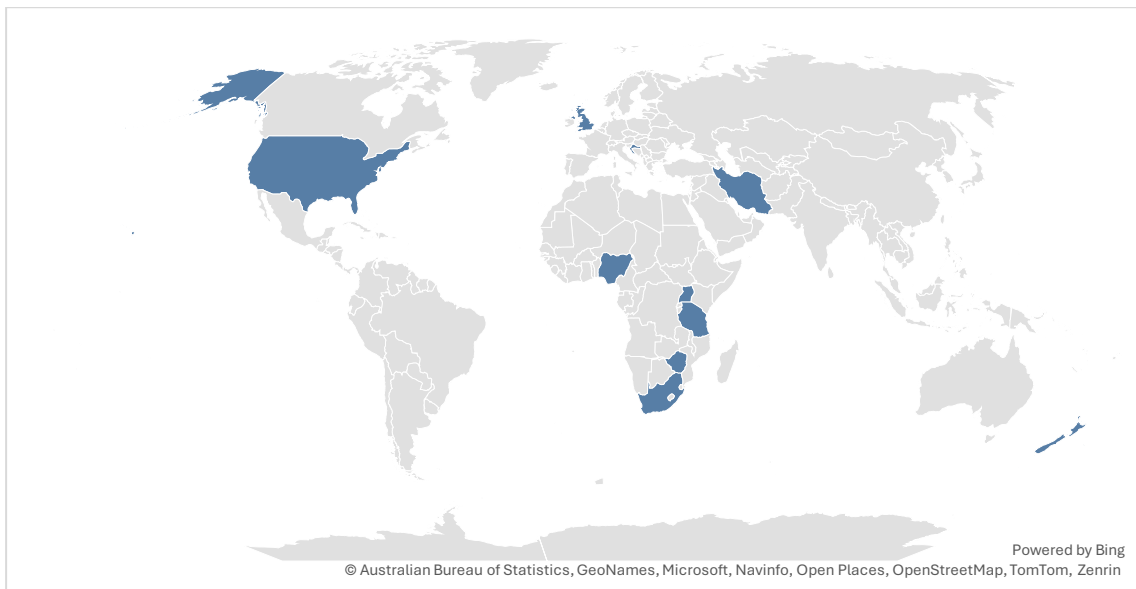


Figure 2: World map highlighting included countries

USA (8 articles), Tanzania (3 articles), England (2 articles), Palestine (1 article), Ethiopia (1 article), Croatia (1 article), Nigeria (1 article), Iran (1 article), New Zealand (1 article) and South African, Zimbabwe & Uganda (1 article)

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Table 3: Quality appraisal of included articles

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Carter et al 2010, USA	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Yes	Valuable
Stulhofer et al 2013, Croatia	Yes	Yes	Yes	Can't tell	Yes	No	Yes	Yes	Yes	Valuable
Roye et al 2013, USA	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable
Fahs & Gonzalez 2014, USA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Very valuable
Marston & Lewis 2014, UK	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Massad et al 2014, Palestine	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Very valuable
Reynolds et al 2015, USA	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Very valuable
Stahlman et al 2015, USA	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Very valuable
Wamoyi et al 2015, Tanzania	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable
Duby et al 2016, South Africa, Zimbabwe & Uganda	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable
Mazeingia et al 2017, Ethiopia	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Very valuable
Shayo et al 2017, Tanzania	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
McBride 2019, USA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Very valuable
Benson et al 2019, USA	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Very valuable
Herbenick et al 2019, USA	Yes	Yes	Can't tell	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Valuable
Mchome et al 2020, Tanzania	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Very valuable
Nassimi et al 2021, Iran	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell	No	Yes	Valuable
Faustino and Gavey 2022, New Zealand	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Morhason-Bello et al 2023, Nigeria	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Very valuable
Hirst et al 2023, UK	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Valuable

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The analysis identified three categories of analytical themes:

1. Why do women engage in anal intercourse?
2. What are the experiences of women who have engaged in anal intercourse?
3. How is anal intercourse viewed by women in society?

A summary of each theme and each paper's contribution to the themes and sub-themes is given in **figures 3, 4, 5, 6, 7** and **8**. It is important to note that the themes highlighted overlap and are interconnected. For example, the experience that women who have engaged in anal intercourse have, plays a role in their reasons for engaging in anal intercourse.

4.3.2 Theme one: Why women engage in anal intercourse

Six sub-themes emerged to explain the reasoning behind participation in anal intercourse.

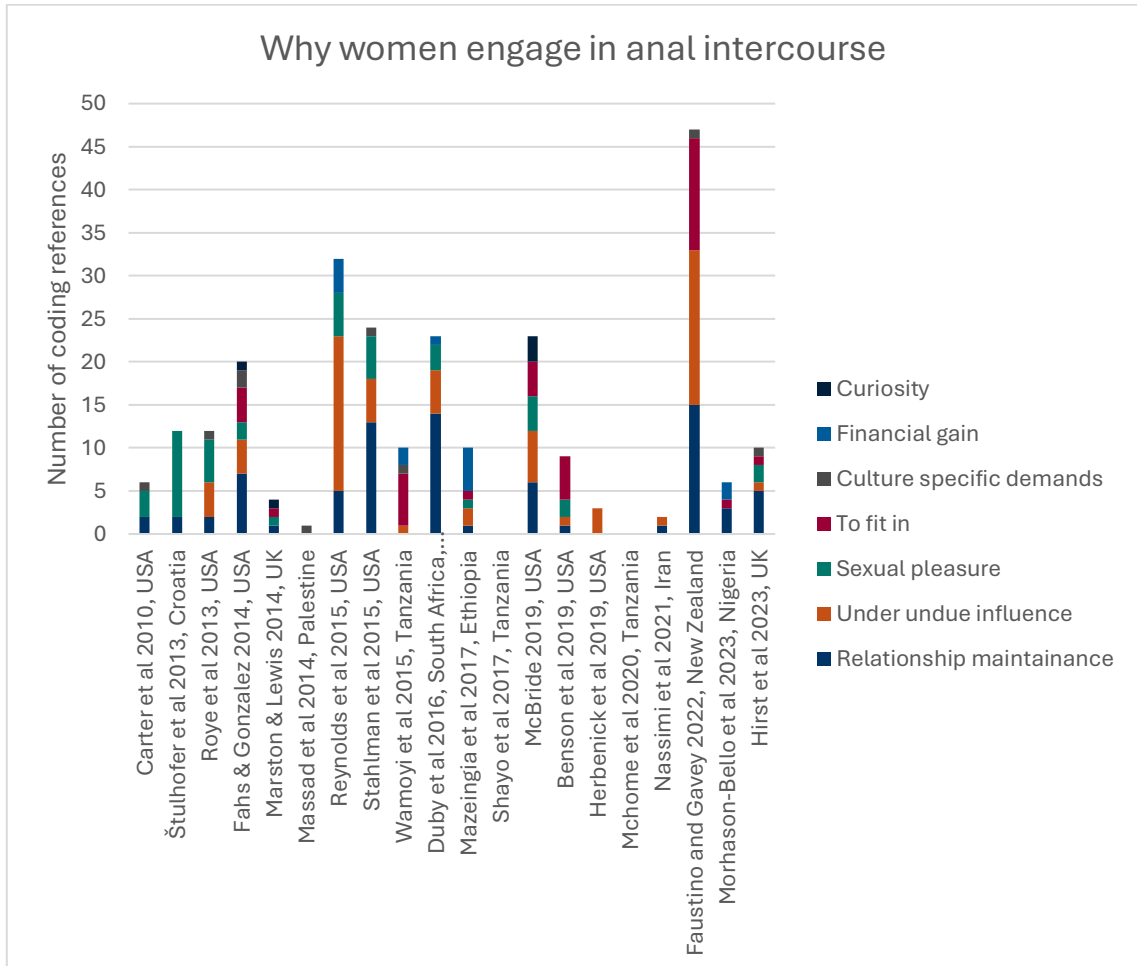


Figure 3: Why women engage in anal intercourse (graphical representation)

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Figure 4: Why women engage in anal intercourse (mind map)

4.3.2.1 Sub-theme one: Relationship maintenance

Relationship maintenance was a dominant sub-theme in fifteen out of twenty articles (Benson et al., 2019; Carter et al., 2010; Duby et al., 2016; Fahs & Gonzalez, 2014; Faustino & Gavey, 2022; Hirst et al., 2023b; Marston & Lewis, 2014; Mazeingia et al., 2017b; McBride, 2019; Morhason-Bello et al., 2023; Nassimi et al., 2021; Reynolds et al., 2015; Roye et al., 2013; Stahlman et al., 2015; Stulhofer & Ajdukovic, 2013). In various forms, the participants in these articles describe pleasing the male partner in a bid to maintain their interests in the relationship as a primary reason for engaging in anal intercourse.

There was a belief among some participants that addressing their partners sexual needs, including that of anal intercourse, would ensure relationship security and protect against infidelity. In some instances, anal intercourse was also described

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as a “...*sacrifice*...” that had to be made for their male partners, (Benson et al., 2019) or an opportunity to prove their devotion to the relationship.

Anal intercourse was also considered a reward, for or by male partners. Some men are thought to feel deserving of anal intercourse, and some women, after establishing a relationship with a new partner, feel anal intercourse is a gift that they can give to their partner, irrespective of previous negative experiences. It was an opportunity to achieve a new level of intimacy.

An example is seen here.

“My partner really wanted it, so it’s good to experiment and explore. I think if you’re in a solid trusting relationship, then it’s okay. I would never do that with a stranger or anything. It’s really painful for me. It’s been a long time with him, and I still try for him and I would try again but still, I just can’t get over that pain.” (23-year-old female, USA) (Fahs & Gonzalez, 2014)

Much like a reward reserved for the “*deserving*”, some accounts from the south and east of Africa, suggest some women feel anal intercourse is far more pleasurable than vaginal intercourse for their male partners especially after birth, and therefore offer anal intercourse for their partner’s pleasure (Duby et al., 2016). Some women also engage in anal intercourse to maintain vaginal elasticity for future penile-vaginal encounters to come (Duby et al., 2016).

To avoid losing their relationship and in a bid to keep their partners happy, some women felt they had to engage in anal intercourse during their menstrual periods, despite the displeasure they experienced (Reynolds et al., 2015; Stahlman et al., 2015). Fahs & Gonzalez (2014) found that in some instances anal intercourse began with hesitation from women, but they eventually succumb to the needs and wants of their partner. This emphasises the idea that these women placed the needs of their male partners above their own, even when they felt discomfort. An example is;

“I don’t like anal sex. It’s not pleasurable for me. Sometimes I do actually cry because it’s a weird feeling and you tear up because of the pressure. Usually, I do it if I’m on my period and he wants to be pleased so, okay, it’s ‘whatever.’ He’ll ask

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and ask it will be like okay, okay, okay. It's very intense and he knows that he's hurting me because I'm so tense." (30-year-old female, USA)(Fahs & Gonzalez, 2014)

In other cases, the reasons for engaging in anal intercourse was not fully explained, it was simply an obligation that had to be fulfilled, a sense of personal duty to please their partners (Fahs & Gonzalez, 2014; Faustino & Gavey, 2022; Stahlman et al., 2015).

4.3.2.2 Sub-theme two: Under undue influence

Thirteen articles cited coercive tactics employed by men as the underlying motivation for female participation in anal intercourse (Benson et al., 2019; DUBY et al., 2016; Fahs & Gonzalez, 2014; Faustino & Gavey, 2022; Herbenick et al., 2019; Hirst et al., 2023b; Mazeingia et al., 2017b; McBride, 2019; Nassimi et al., 2021; Reynolds et al., 2015; Roye et al., 2013; Stahlman et al., 2015; Wamoyi et al., 2015). These coercive tactics came in various forms, including, verbal coercion e.g., nagging, deception or even threats, physical coercion, i.e., unwanted physical manipulation that participants considered consensual and rape. Some women described how their initial resistance to engage in anal intercourse, was eventually converted to acceptance, due to persistence from their partners, e.g.,

Because he was like, "Can we do it, can we do it, can we do it?" (childish voice) And eventually you're like, fuck, like, okay. It's like a child nagging their mum for a chocolate bar or something, like, like just fuck off, we'll do it so that you can stop nagging me. (24-year-old female, New Zealand)(Faustino & Gavey, 2022)

The use of drugs and alcohol to subdue female participants also featured as another coercive tactic, e.g.,

Every time I have had anal sex it was because I was either extremely drunk or extremely loaded; every time I have had anal sex I was on drugs. (female participant, FGD, USA) (Reynolds et al., 2015)

Reynolds and colleagues explored how substances are often used when participating in anal intercourse, and how these substances influence their choice

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to engage (Reynolds et al., 2015). They found that in their cohort of women, anal intercourse was more likely to occur under the influence of drugs. Drugs were used to achieve a higher level of sexual satisfaction and desire. For example,

“When we do drugs, most drugs we take, we know there’s going to be sex involved... It’s going to be like whether it’s right away (claps hands together), or, like, you know, the minute you do it (claps hands together) –BAM!–your clothes are already off or in the process of getting off. We know what’s coming. Or you made the trip, and you go into a motel and you bring all your stuff and you get high and then you are going to have sex. Hours of sex. Hours, hours, hours, yeah.” (female participant, FGD, USA) (Reynolds et al., 2015)

This highlights the complexities of anal intercourse and the lengths some may go, such as participating in substance abuse, in order to participate in anal intercourse. On the other hand, some women described their participation as only occurring because they lost “certain boundaries and morals” and were disinhibited (Reynolds et al., 2015). Suggesting they wouldn’t necessarily engage in anal intercourse without drug use.

4.3.2.3 Sub-theme three: For personal sexual pleasure.

Anal intercourse was referenced as pleasurable in twelve articles (Benson et al., 2019; Carter et al., 2010; Duby et al., 2016; Fahs & Gonzalez, 2014; Hirst et al., 2023b; Marston & Lewis, 2014; Mazeingia et al., 2017b; McBride, 2019; Reynolds et al., 2015; Roye et al., 2013; Stahlman et al., 2015; Stulhofer & Ajdukovic, 2013). However, there were only a handful of quotes across all of these articles describing pleasure as a motivating factor.

Women enjoyed anal intercourse either because it gave them genuine pleasure, or because they found the associated pain pleasurable, or because it made them feel adventurous. The unconventionality of AI was what appealed to some women, participating in something “new and taboo” was what they found intriguing (McBride, 2019). Another important factor in deriving pleasure from AI for some, was the opportunity to give their partners pleasure, *“they liked it, because he liked it” (Fahs & Gonzalez, 2014).*

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The description of sexual pleasure is one of the few positive associations some women have with anal intercourse, and this was seen more commonly in women who had agency, were in long-term established relationships, had significant experience and those who considered pain to be part of pleasure, e.g.,

“I’m actually a big pain person so I like the pain, just how it felt. It hit certain different points and stuff and it was something different to try. I liked it a lot.” (24-year-old female, USA)(Fahs & Gonzalez, 2014)

4.3.2.4 Sub-theme four: To fit in.

Anal intercourse was portrayed as trendy in nine articles (Benson et al., 2019; Fahs & Gonzalez, 2014; Faustino & Gavey, 2022; Hirst et al., 2023b; Marston & Lewis, 2014; Mazeingia et al., 2017b; McBride, 2019; Morhason-Bello et al., 2023; Wamoyi et al., 2015). Women felt pressured to engage in anal intercourse due to internal pressures (i.e., what they felt society expected of them) and external pressures.

This example describes some of the internal pressures women may feel,

When I look back on my first sexual experiences it wasn’t, it wasn’t always brought up, it wasn’t always tried. It was, it was considered still maybe a bit of a taboo, I don’t know. (...) But then as I’ve noticed going through all my partners, yeah it’s gotten, it’s become more and more expected and considered like normal. It’s very, very normalized to the point where I’m, I’m weird not to. (38-year-old female, New Zealand)(Faustino & Gavey, 2022)

Fahs & Gonzalez (2014) identified that some women decided to have anal intercourse after hearing stories shared by other women, who described it as a new and enjoyable experience, hence building on curiosity and a need to fit in and follow the trend. One woman described anal intercourse as something that is ‘hip’ and ‘in’ (Fahs & Gonzalez, 2014).

External pressures came in the form of peer influence, pornographic influences, and the media. The normalisation of anal intercourse was perceived as a source of pressure to engage in anal intercourse by some participants.

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The realisation that anal intercourse was an option for heterosexual couples influenced participation in some cases. One participant remarked *“it had never even like occurred to me”* and not seen it as *“a thing outside of like homosexual relationships”* (Faustino & Gavey, 2022). Pornography appears to have also created a sense of idolisation of anal intercourse, leading to very different expectations to what actually occurs. Faustino & Gavey (2022) found that many women felt that pornography frames their perspectives of sex and anal intercourse. It describes how several men want to engage in anal intercourse because of something they have seen in pornography and idolise it, as it appears unique. An example of this is

“I don’t think guys in the 1600s would constantly [be] hassling their wives to have anal sex. I don’t think that that’s true, because, not than I can ever tell, what was the history of anal sex. But without that constant reinforcement of pornography, the normalizing of anal sex and all those other things, I don’t think that I don’t think that guys would be so insistent nowadays to do that.”

4.3.2.5 Sub-theme five: For culture specific demands

Less striking and more particular to certain religious, societal, and cultural beliefs, maintaining a “virginity” status and preventing pregnancy were additional reasons women engaged in anal intercourse. The relevant references were from articles from the USA (Carter et al., 2010; Fahs & Gonzalez, 2014; Roye et al., 2013; Stahlman et al., 2015), UK (Hirst et al., 2023b), Palestine (Massad et al., 2014), New Zealand (Faustino & Gavey, 2022), and Tanzania (Wamoyi et al., 2015).

The concept of female vaginal virginity and its importance varies across different societies and historical periods. Historically a woman's virginity was seen as a valuable commodity that she was expected to preserve until marriage (Carpenter, 2001). Although those views have evolved in certain societies over time, even in western countries, some women still value their virginity status as a “gift” saved for a loved one. An example is seen here,

...Arab girls... before marriage have a tendency to practice anal sex so that they may preserve their virginity. Their intention is to be found virgins when they marry, [FGD, females, general population, 25-49 years, Tanzania].(Wamoyi et al., 2015)

4.3.2.6 Sub-theme six: For financial gain

Five articles referenced financial gain as a motivating factor for some women who engaged in anal intercourse, however, it is important to note that they were mainly studies recruiting female sex workers (FSW) and/or illicit drug users (Duby et al., 2016; Mazeingia et al., 2017b; Morhason-Bello et al., 2023; Reynolds et al., 2015; Wamoyi et al., 2015).

When I engaged in anal intercourse for the first time, I hadn't slept for days... it was a matter of life or survival to engage in anal intercourse. If I did not accept those offers, what other options do I have? I have no other means of income other than sex work; moreover, I had no family to live with. If I did not do sex work business today, tomorrow I will have nothing to pay for something I need to buy like food, drink and so on. Since I will have nothing to eat and drink tomorrow, I need to go to sex working site for doing business and sleep with men for money. Once I went for sex work, I should accept offers for anal intercourse too... (FSW, Ethiopia)(Mazeingia et al., 2017a)

Mazeingia et al. (2017a) found that female sex workers were offered much more money for anal intercourse than vaginal sex which allowed them to have a better income to pay for essentials such as food. They only “*accepted offers for anal intercourse from men....to get money to survive*”. Wamoyi et al. (2015) had similar findings. One woman stated that “*oh, in the anus you get much more money*”, demonstrating a clear reason why these women choose to engage in anal intercourse.

FSW often engaged in anal intercourse for financial gain, however, in some instances this was coerced, and some FSW felt powerless to reject the proposition. Similarly, there were accounts from illicit drug users of coercion while under the influence.

4.3.2.7 Sub-theme seven: Out of curiosity

Women also engaged in anal intercourse to fulfil their own curiosity as referenced in three articles from the USA (Fahs & Gonzalez, 2014; Marston & Lewis, 2014; McBride, 2019). Fahs & Gonzalez (2014) outlined that some women had an initial

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interest in anal intercourse and wanted to 'try it' but then found that they did not enjoy it. They highlight the desire to explore and experiment sexual behaviours in order to discover preferences.

"I've tried anal sex only once and it wasn't for me. I was with my first boyfriend, and I was young, so we were all about experimenting and we'd try anything just for the sake of it. I just wasn't into it. He didn't seem to care. I wasn't getting aroused by it at all. It was just painful." (26-year-old female, USA) (Fahs & Gonzalez, 2014)

The disappointment experienced by some, may have been as a result of unrealistic expectations and fantasy as a result of external factors such as pornography, but also could have been as a result of a lack of preparedness

"I had thought it would be this great thing but once we actually tried it, I realized how awful it really was! He didn't use enough lube, and we were fumbling around trying to make it sexy while I was all tense and embarrassed. He lost his erection in the middle." (26-year-old female, USA)(Fahs & Gonzalez, 2014)

Women engage in anal intercourse for a complex interplay of reasons. Most of which shed a negative light on anal intercourse including, e.g., coercion and fitting in with society. Sexual pleasure and curiosity highlight a degree of female sexual agency on the other hand. However, despite a perceived evolution of sexual practices in society, women still appear to take on the responsibility of maintaining their relationships by participating in sexual acts that they may not find pleasurable.

4.3.3 Theme two: Experiences of women who have engaged in anal intercourse

Sixteen out of twenty articles described the experiences of women who engaged in anal intercourse (Benson et al., 2019; Carter et al., 2010; Duby et al., 2016; Fahs & Gonzalez, 2014; Faustino & Gavey, 2022; Herbenick et al., 2019; Marston & Lewis, 2014; Mazeingia et al., 2017b; McBride, 2019; Morhason-Bello et al., 2023; Nassimi et al., 2021; Reynolds et al., 2015; Roye et al., 2013; Stahlman et al., 2015;

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Stulhofer & Ajdukovic, 2013; Wamoyi et al., 2015). Pain was a consistent sub-theme in all of these articles. For the vast majority this was associated with displeasure, however, for a few it was considered pleasurable.

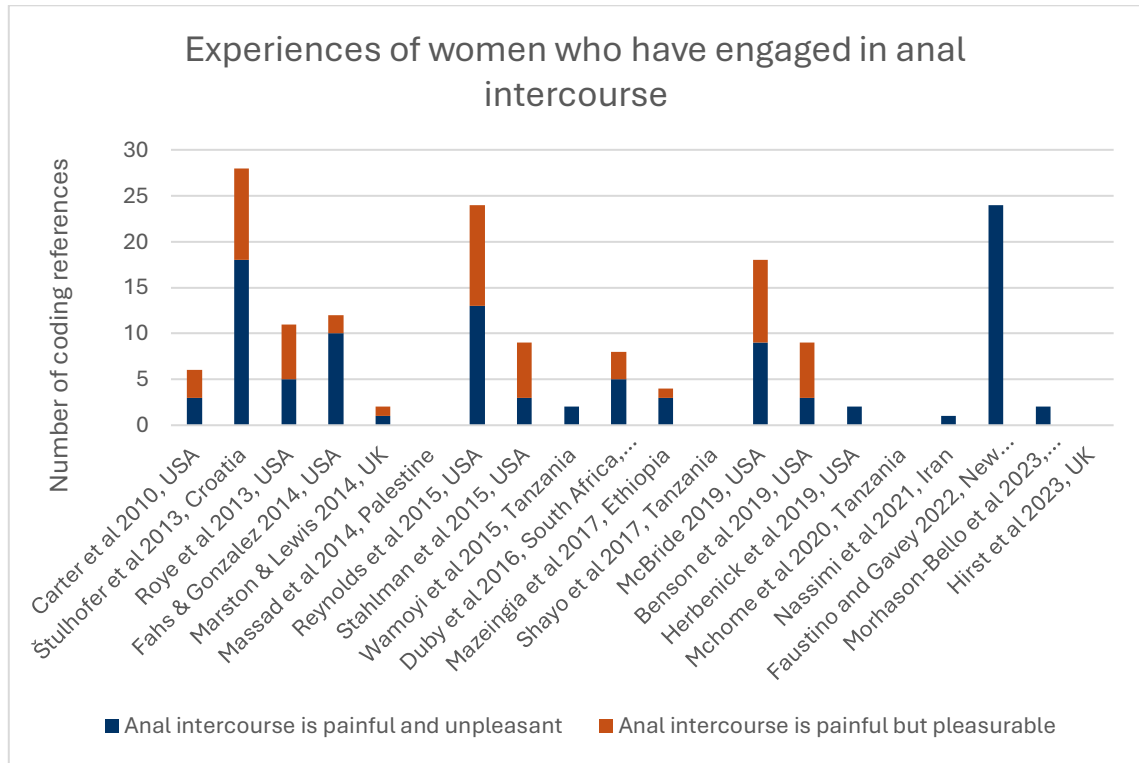


Figure 5: Experiences of women who have engaged in anal intercourse (graphical representation)

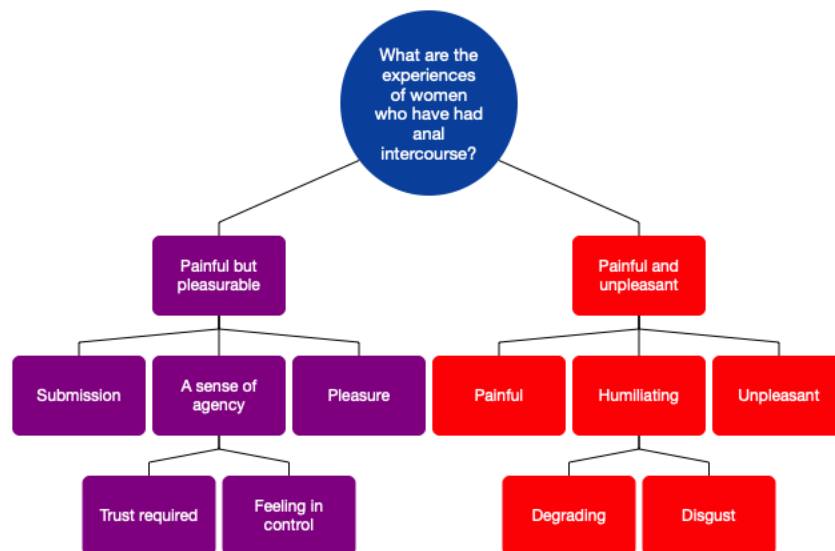


Figure 6: Experiences of women who have engaged in anal intercourse (mind map)

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4.3.3.1 Sub-theme one: Anal intercourse is painful and unpleasant

Verbal and non-verbal coercion played a large part in the pain experienced by women. However, in several cases where anal intercourse did not appear to be coerced, it was still considered painful. It was interesting to find that in this cohort of participants, they persisted in engaging in anal intercourse over time with either the same or a different partner, despite discomfort to themselves.

There are suggestions that the intensity of the pain experienced reduced over time with repeated practice, however, this was not universal. Preparedness and adequate lubrication have been suggested as the key to more tolerable or even enjoyable anal intercourse; however, this does not necessarily eliminate pain and local trauma. An example is seen here.

Even if he [man] will apply oil, it will help him to enter [his penis] easily but you [woman] will still get bruises and tear your anus, [female participant, FGD, 24-49 years, Tanzania](Wamoyi et al., 2015).

The physical effect of this pain is described by some participants as tears, bleeding, inability to defecate, being “...turned inside out...”(Reynolds et al., 2015), etc. There were also some accounts of failed anal intercourse attempts due to severe pain experienced.

In some cases, anal intercourse went beyond unpleasantness, some women reported feeling powerless, used, and humiliated during anal intercourse. The pain described transcended the physical aspect, emotionally they were distressed. There was a sense they were subjected to masculine entitled dominance and had no choice in the matter. In majority if these cases coercive tactics were used.

4.3.3b Sub-theme two: Anal intercourse is painful but pleasurable

Majority of references to pleasure were in association with pain and in enjoying pain as part of their sexual habits. This was discussed previously in 4.3.2.3.

Agency was an important aspect of the experience for a small number of participants. A partner whom they could trust as well as a sense of control over all

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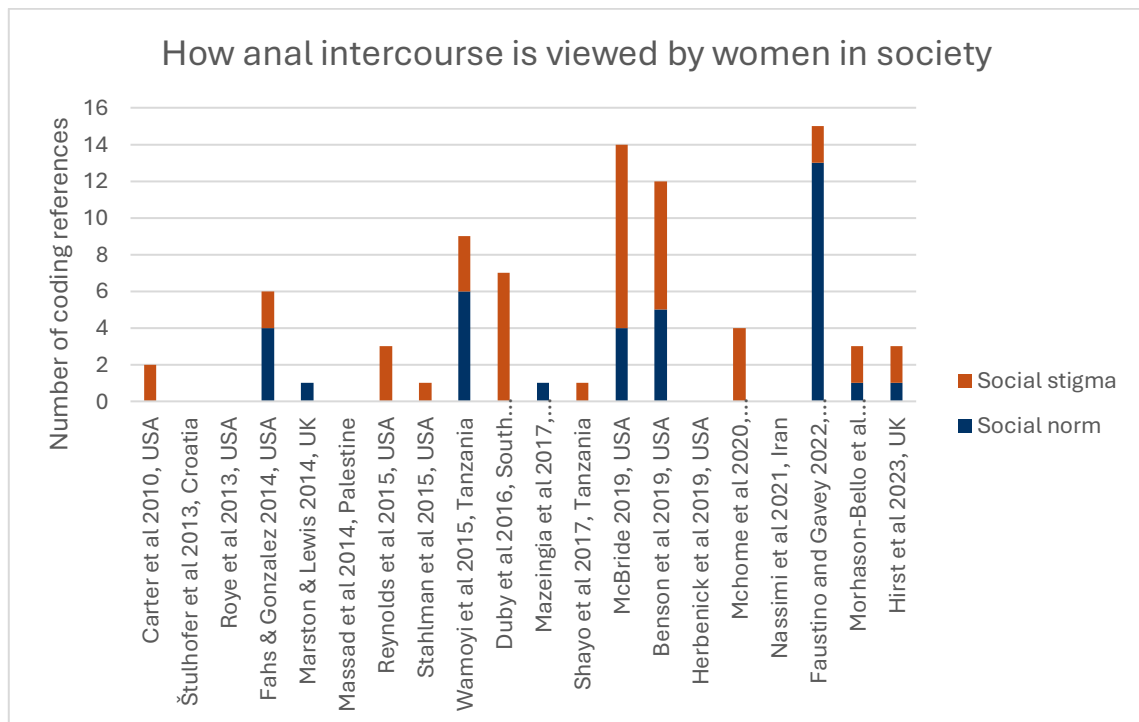
aspects of the anal intercourse encounter was a pre-requisite. Women who enjoyed anal intercourse, had a sense of perceived power, and felt they could stop the act when they wanted.

Also, it is about the relationship and my partner’s domination in this act. It is my trust in him and my total surrender—and the way they mix with pain, discomfort, but also pleasure—that make this experience so extraordinary. [female participant, 28 years, Croatia](Stulhofer & Ajdukovic, 2013)

Sexual pleasure motivated subsequent anal intercourse encounters for some women, unlike others who did not enjoy the experience and opted never to repeat it.

4.3.4 Theme three: How anal intercourse is viewed by women in society

A mix of societal views were expressed by women across all articles, the perception that society viewed anal sex negatively despite increasing portrayal as a social norm was apparent.



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Figure 7: How anal intercourse is viewed by women in society (graphical representation)

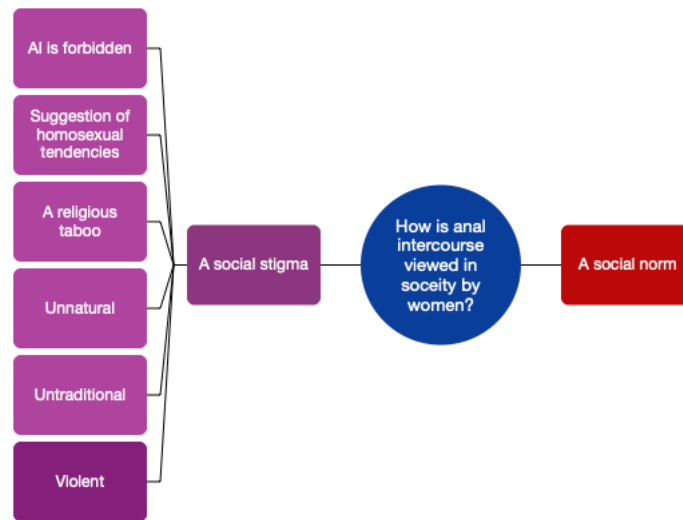


Figure 8: How anal intercourse is viewed by women in society (mind map)

4.3.4.1 Sub-theme one: Anal intercourse is a social norm

Anal intercourse emerged as a social norm in nine out of twenty articles.

Mainstream media (e.g., television, magazines, etc.) and social media portray anal intercourse as trendy. McBride (2019) outlined anal intercourse as a common sexual practice that is now viewed as a social norm. One participant remarked on how “celebrities are talking about it and music is talking about it, so now it’s becoming a little bit opener.” Pornography also plays a big role in influencing anal intercourse. Faustino & Gavey (2022) found that women had certain perceptions of anal intercourse through pornography and fellow peers, “I heard that one of my friends had done it.”

These common sources of informal sexual education contribute to the normalisation of anal intercourse. In addition, discussion amongst peers appears to highlight anal intercourse as a common experience and leaves some women feeling narrow-minded and prudish for not engaging.

“Everyone’s having anal sex, everyone’s enjoying anal sex apparently,” concluding that “then even if you want to say no when someone asks you, those things are going to creep in your head and you’re probably going to give in very easily.” (23-year-old female, New Zealand)

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The normalisation of anal intercourse as part of the sexual repertoire appears to create a narrative that leaves women feeling left out for not being a part of it and men feeling entitled to access to anal intercourse with their female partners.

4.3.4.2 Sub-theme two: Anal intercourse is stigmatised

Anal intercourse was described as stigmatised, even within the most recently published literature. The belief that anal intercourse is untraditional and unnatural in certain societies leads to it being perceived as a religious and cultural taboo, discouraging open discussion and participation.

Majority of women felt that society disapproves of anal intercourse and women who engage in anal intercourse. They felt that society viewed such women as having poor moral standards. However, the decision on whether or not to participate in anal intercourse did not appear to be influenced by those views. Instead, it influenced how comfortable they were discussing their experiences or intention to engage in anal intercourse.

“I think a lot of people claim that they don’t do it [referring to PAI] or don’t like it, but they really do, because it’s still like a taboo.” (19-year-old female, USA)(McBride, 2019)

Furthermore, the anus was considered by some as a dirty place, and therefore, the act of anal intercourse frowned on as dirty.

As with other sexual activities, there was a double standard for men versus women, men are praised for the anal intercourse conquests, while women feel “slut shamed”.

“If a guy speaks about anal sex, everyone is, like, ‘Oh man, it’s so great.’ Whereas if a girl says, ‘Oh I’ve had anal sex’ and is proud about it, she gets labelled a slut.” (19-year-old female, USA) (McBride, 2019)

4.4 Discussion

This comprehensive systematic review of studies published in the last decade provides evidence of the perception of anal intercourse among women. The motivations, experiences, and views of anal intercourse among women are diverse and complex.

Relationship maintenance was the most important motivating factor for engagement in anal intercourse. Women's desires to keep their partners happy and satisfied has been highlighted in other forms of sexual practice as well, including penile-vaginal intercourse (Kelly et al., 2017). Participants often placed their partner's happiness above theirs, therefore, despite the consistently reported pain and unpleasantness, continued to engage in anal intercourse. Chasing an emotional connection and intimacy is an important factor for women in their relationships, which is sometimes sought through sexual practices which may or may not be pleasurable (Fahs, 2014). Sexual scripting theory suggests men have greater power in heterosexual relationships (Gagnon & Simon, 1973; Wiederman, 2005), the effects of which are seen not only seen in penile-vaginal intercourse, but also in anal intercourse. Women appear to play a more submissive role, agreeing to anal intercourse for the benefit of their male partners, ignoring their discomfort or consequences to themselves (Sanchez et al., 2012). Recent insights into sexual scripting are still concordant with traditional scripts, women seek commitment and monogamy in their relationships (Masters, 2012), therefore, the possibility of securing this by satisfying their partners anal sex requests, may outweigh their own sexual desires.

Undue influence was another salient factor. Verbal coercion from male partners often came in the form of repeated requests, however, physical coercion was also common, e.g., male partners inserting their penis into the anus without prior discussion or consent. Although many of the participants did not describe their unwanted encounters as non-consensual, it did appear non-consensual. These accounts of undue influence can be considered a manifestation of male sexual entitlement. Marston and Lewis report on how their 16-18-year-old British male

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participants considered coercion to be a part of anal intercourse, and their expectation that women eventually accept this coerced anal intercourse for varying reasons, including the assumption that they secretly want it despite their reluctance (Marston & Lewis, 2014). They describe a sense of masculine sexual entitlement other authors have similarly described. This is perhaps what is reflected in this sub-theme of undue influence. Jozkowski and Peterson provide a different perspective, some of their male participants used coercive tactics because they knew women hated anal intercourse and coercion insured against refusal (Jozkowski & Peterson, 2013).

Illicit drugs and alcohol also featured as a gateway to anal intercourse. Although a significant proportion of the evidence for this sub-theme emerged from a study distinctly recruiting women with illicit drug history (Reynolds et al., 2015), other studies recruiting from the general population (Faustino & Gavey, 2022; Roye et al., 2013; Stahlman et al., 2015). Several studies have highlighted the association between substance use and risky sexual behaviours (Bellis et al., 2008; Howard & Wang, 2006; Khadr et al., 2016). Lowered inhibitions and impaired judgement create opportunities for women to be exploited. It is possible that some women willingly engage in substance use to make them more relaxed and receptive to AI, however, it may also be a source of coercive unwanted AI.

Pregnancy prevention, maintenance of technical virginity and curiosity were less commonly cited sub-themes. There is an argument that the notion of female virginity stems from patriarchal values and the control of women's sexuality (Olamijuwon & Odimegwu, 2022), despite societal growth towards individual autonomy, gender equality, and the recognition that one's worth is not tied to their sexual history. It was therefore interesting to see in recent times, that these patriarchal values still exist.

A positive motivation for anal intercourse that emerged was sexual pleasure. Women who enjoyed anal intercourse did so either with or without pain, most commonly with trusted partners. The importance of agency is highlighted here, as they were closely related. However, out of 523 quotes, only 43 quotes from participants suggested sexual pleasure. This may truly suggest only a handful of

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women have found sexual pleasure/satisfaction from anal intercourse but may also be as a result of a lack of focus on positive AI experiences. Literature on anal sex is mainly in relation to the health consequences (Fahs & Gonzalez, 2014), therefore positive experiences, may as a result be under reported.

The experiences revealed by women who had engaged in anal intercourse were largely negative. Anal intercourse was painful for the vast majority. The quantitative aspect of the study by Stulhofer and Ajdukovic (Stulhofer & Ajdukovic, 2013) identified that 73.4% of their participants found anal intercourse to be painful. Hensel and colleagues found that up to 35% of women had experienced pleasure from anal stimulation, but not beyond the depth of a fingertip/knuckle (Hensel et al., 2022). The pain frequently reported may reflect local trauma in the anal canal, which not only increases the risk of STI transmission if unprotected but also that of anorectal disorders (Shayo et al., 2017).

There are arguments that the pain experienced by women during anal intercourse is as a result of lack of preparedness, whether psychological or physical (including generous lubricant use). However, there were several accounts from women with previous experience of anal intercourse who were prepared, that still found it painful (Stulhofer & Ajdukovic, 2013; Wamoyi et al., 2015). It is important that women have the awareness that anal intercourse can be painful, and it may not necessarily be due to a lack of preparedness. Moreso, the physical manifestation of this pain, such as anal tears and bleeding, may have implications with repeated engagement. The medical risks, violence and coercion seen in several instances highlight the power dynamics women may endure in their relationships. A significant percentage of young women reported feeling pressured into engaging in anal sex, which can have negative psychological effects, including feelings of regret, shame, or decreased self-esteem.

Although there is still a stigma related to heterosexual anal intercourse (Faustino, 2020), it has increasingly become a sexual norm. Representations of anal intercourse in popular culture (Storey, 2021) as trendy contribute to the belief that participants are "...not normal..." or "...weird not to" engage in this sexual practice. The stigma surrounding anal intercourse instead has a negative impact on open

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discussion of anal intercourse. Uneasiness to discuss anal intercourse openly may come from the fear of being judged (Benson et al., 2019; McBride et al., 2017) but also appears to hinder women sharing their honest experiences. This issue extends into establishments responsible for sexual health education and for managing sexual health and the consequences of poor sexual health. Given, the recent prevalence of anal intercourse, the paucity of public health information on anal intercourse as well as the disinclination of health practitioners to discuss anal intercourse with their patients raises a public health concern (Gana & Hunt, 2022). Social stigma does not stop women from engaging in heterosexual anal intercourse, it only deters open discussion and therefore limits their access to the right information. Benson and colleagues describe how this stigma also discourages discussion with healthcare providers (Benson et al., 2019). This forms basis for a wider discussion given the negative physical and mental effects anal intercourse has on some women. Coercion is a form of domestic abuse and has been highlighted as a factor in anal intercourse for some women. Health services should ideally provide a safe space for addressing domestic abuse (Maras, 2023). However, healthcare practitioners cannot carry out their duty of care when their patients do not feel comfortable discussing these matters.

4.4.1 Strengths and limitations

This is the first systematic review to synthesise evidence on the perception of anal intercourse among women, using accounts from women from various countries. This is the most robust evidence base available till date, however, its qualitative nature limits generalisability. Furthermore, the stated aims of the included studies are heterogenous and although they provide relevant data for the stated aim, the researcher recognises that the individual interview questions affect the nature of responses received. Therefore, extracted quotes may be far removed from the initial meaning.

4.4.2 Conclusion

Social stigma limits women's ability to openly discuss anal intercourse but does not lessen engagement in the act itself. This is one of the most important issues

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highlighted in this article. Stigma has been shown to affect the health outcomes and attitudes to anal intercourse is no exception. As anal intercourse becomes a part of normal sexual repertoire, efforts must be made within education and healthcare to normalise open discussion. The health issues caused by anal intercourse, including, increased STI risks, anal cancer, and anorectal disorders, should be met with balanced health information on the issue.

Furthermore, the literature demonstrates women engage in anal intercourse for a variety of reasons, most of which do not signify agency. It is imperative the medical profession engage with this issue, collect objective data on outcomes and provide women with the information they require to make their own decisions.

4.5 Systematic review implications and gaps in literature

This systematic review aimed to explore women's perspectives on anal sex, including their motivations for engagement and the nature of their experiences. The findings revealed that most women engaged in anal sex primarily to satisfy their male partners, often driven by the desire to maintain their relationships and ensure their partners' fidelity. Overall, negative experiences were more commonly reported than positive ones, with many participants describing anal sex as painful. Even among those who reported some level of pleasure, pain remained a recurring theme. From a medical perspective, anal pain is indicative of trauma, and repeated trauma may contribute to the development of anorectal disorders. Beyond the dominant findings reported in this systematic review, some areas further uncovered were the associated health risks, and the stigma surrounding open conversations about anal sex, which in effect can lead to inadequate healthcare access when required.

Several participants describe experiencing significant pain during anal intercourse. A 38-year-old lady noted “tearing” and “bleeding” during anal sex, at the same time normalizing the pain as something women have to endure (Faustino & Gavey, 2022). Another participant stated, “*There is more friction and more pain during anal intercourse than during vaginal sex since the anus is fragile and has a thin*

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wall.”(Mazeingia et al., 2017b). Such statements underscore the physical trauma, including tears, abrasions, and discomfort that many women endure.

Another prominent concern across some studies is the heightened risk of sexually transmitted infections (STIs), including HIV. Two participants expressed their experiences and fears, stating *“HIV can be transmitted through anal intercourse more than through vaginal intercourse”* due to increased mucosal breaks/tears, and the other remarking, *“There is a danger of acquiring HIV infection because the place where the penis is inserted is much tighter, so during the process, the anus is torn, or the penis can get bruises”*, highlighting direct blood exposure as posing an increased probability of infection transmission (Mazeingia et al., 2017b).

Some women reported fears of long-term medical consequences due to anal sex, such as faecal incontinence. A participant shared, *“I don’t want to have a leaking buttock, and I’m not ready for the use of a diaper for the rest of my life.”* (Morhason-Bello et al., 2019). Another woman described how repeated anal sex led to difficulties in bowel control, stating, *“The faeces will be coming out uncontrollably. When you laugh or do anything, it is a must that the faeces will come out.”*(Wamoyi et al., 2015). Another participant recounted her difficult experience *“Unfortunately, I have physical problems caused by anal intercourse, such as faecal incontinence and anal abnormalities, and this causes me further reluctant to my husband.”*(Nassimi et al., 2021). These concerns from participants highlight the risk of anal sphincter damage and its irreversible impact on quality of life through lived experiences or their knowledge of others suffering long-term consequences.

The accounts presented in these studies highlight some of the health implications associated with anal sex, including pain, increased infection susceptibility and long-term bowel dysfunction. The normalization of pain and the lack of medical support in some regions further exacerbate these risks. This emphasizes the importance of informed sexual health education and medical care to address these concerns and ensure the well-being of women engaging in anal sex.

Anal intercourse has clearly become a part of normal sexual repertoire. The paucity of adequate sexual health information is continuously met by uninformed

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blogs and websites encouraging participation without caution. Sexual health must therefore be addressed at several levels. Potential implementation strategies include adding anal sex to sexual health education curriculum in schools, ensuring accurate information on anal sex is made available on public health websites, including risks beyond STIs, and sign-posting available help for women who may feel coerced and/or are experiencing intimate partner violence and for healthcare practitioners to play their part in normalising discussions on anal sex particularly when clinical situations warrant sexual history taking and when patients present with anal symptoms.

What the empirical study attempts to address is the part healthcare practitioners play in sexual health discussions within clinical settings. To address this, the researcher employs a mixed methods approach combining a quantitative and qualitative study on healthcare practices and attitudes towards female patients who present with anorectal disorder.

The quantitative aspect involved an online survey distributed to healthcare professionals working within general surgery. The survey assessed awareness and attitudes toward taking a comprehensive sexual history, perceived barriers to discussing anal intercourse with patients and confidence levels in addressing sexual health concerns related to anal intercourse.

The qualitative aspect involved interviews of healthcare professionals also working within general surgery. The interviews explored themes such as experiences and comfort levels discussing anal intercourse with patients, institutional and cultural barriers to comprehensive sexual history-taking and recommendations for improving clinical practice and training.

This mixed methods study provides evidence on the current attitudes and practices of healthcare practitioners towards female patients with anorectal disorders who engage in anal intercourse, thereby, creating an evidence-based platform for developing guidance on appropriate sexual history taking within general surgery.

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This chapter presents the first part of the mixed methods study. It outlines the design, data collection, analysis and results of the quantitative aspect of the study, it then concludes with a discussion and highlights of the main findings as well as how it relates to the research question.

5.1 Introduction

Receptive anal intercourse among women has emerged as a sexual norm, with participation rates ranging between 30% to 44% in the USA (Chandra et al., 2011; Kristen L. Hess et al., 2016; Jami et al., 2007) and around 28.5% in the UK (Lewis et al., 2017). Women have congenitally shorter and less robust anal sphincters compared to men (Reginelli et al., 2012b), and this vulnerability is further exacerbated by aging, pregnancy, and childbirth, engaging in anal intercourse may pose greater adverse consequences for them compared to men.

Effective clinical management of anorectal disorders requires an understanding of any underlying risk factors, and an important tool is a thorough sexual history taking. In the absence of this, patients are likely to present repeatedly with the same symptoms. Sexual history taking is mandatory in genitourinary medicine (GUM) clinics (Brook et al., 2020), but this is less commonly practiced in colorectal clinics where anorectal disorders are seen.

Several issues have been highlighted as acting as a barrier to healthcare practitioners discussing sexual health in clinics. One is inadequate training in assessing and managing issues relating to sexual health (Wimberly et al., 2006). Moreso, taking a sexual history may raise issues that non-sexual health doctors and nurses may not feel equipped to deal with. In addition, sexual topics appear to be considered taboo and may create “embarrassment” for patients and clinicians. The burden of work in GP practices and NHS hospitals is also thought to cause a

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limitation in time to fully explore issues affecting patients including their sexual health (Barnhoorn et al., 2022; BMA, 2025). Gott and colleagues through semi-structured interviews highlighted several personal characteristics that general practitioners felt were deterrents to proactively discussing sexual health issues. Opposite gender, older age, ethnicity (black and other minor ethnic groups), and sexuality were the core barriers identified to deter open conversations (Gott et al., 2004).

Discussing sexual health in clinic often poses a difficulty, it's not comfortable for patients or clinicians, however if clinicians do not have these conversations, then they cannot identify potentially important issues leading to their medical problems and cannot help in improving their quality of life. Anal sex is a risk factor for anal cancer, anal STIs and anorectal disorders, and if clinicians are unable to discuss it openly, then they are unable to address these risk factors. Dames and colleagues in a patient-led survey, highlight the negative impact of excluding sex and sexual function discussions perioperatively in surgical clinics (Dames et al., 2021).

Healthcare practitioners may avoid discussion of anal sex as they themselves are influenced by society's taboos. However, with the increasing trend of anal intercourse, a lack of open communication with patients exposes them to missed diagnosis, futile treatment, and lack of advice. Therefore, examining the attitudes of healthcare practitioners towards sexual history taking and determining factors that may cause a hindrance to an appropriate history could provide additional insight that would inform health policies.

Research question: What are the current attitudes and practices of healthcare practitioners towards female patients with anorectal disorders who engage in anal intercourse?

The researcher sought to answer a part of this question by conducting an online survey of general surgery healthcare practitioners within the UK.

Aims

- To identify history taking practices of clinicians who encounter female patients with anal pathology.

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- To understand potential barriers to discussing AI in clinical conditions.
- To ascertain the opinions of clinicians on the relevance of AI in the aetiology of female anal pathology, the value of commonly suggested methods of harm reduction during female AI and their opinion on current training and public health information.

5.2 Methods

5.2.1 Study design

Pilot testing of a pre-designed participant information sheet, consent, and questionnaire was initially performed by the researcher among a group of six volunteers (2 consultants, 2 resident doctors, 2 non-clinical researchers). The feedback received permitted elements of the questionnaire to be analysed and modified, in order to maximise meaningful results. The final questionnaire is provided in the appendices. The questionnaire was divided into three sections covering questions about the participant, their practice and their opinions. The final questionnaire included 16 questions, ten multiple choice questions, five matrix table questions and one question on a linear analogue scale.

All respondents were presented with the same questions. The 16 questions included in the survey were divided into the following sections:

1. demographic and diversity information
2. role and clinical practice with a screening question*
3. opinions about importance of AI in (a) patient history taking, (b) various clinical scenarios (c) clinicians ease or discomfort talking about sexual matters with patients (d) potential barriers to enquiry about AI
4. opinions on possible adverse effects of AI and possible protections against these
5. opinions on the UK prevalence of female participation in AI using a linear analogue scale.
6. training and public health information.

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*Screening question: “How often do you see patients with anal symptoms or rectal bleeding?”

5.2.2 Recruitment

The questionnaires were distributed to a non-purposive sample of healthcare practitioners who encounter individuals with anorectal disease in their clinic setting within the UK. The Association of Surgeons in Great Britain and Ireland (ASGBI) and the Association of Coloproctology of Great Britain and Ireland (ACPGBI) are associations whose members consist of advanced care or nurse practitioners, resident doctors and consultants. An application of support for this study was submitted to both organisations and after a peer-reviewed process, both organisations agreed to provide support by distributing the questionnaires via their website, social media page and mailing list. Ethical approval was sought and received from both the Faculty of Health and Medicine Research Ethics Committee (FHMREC) at Lancaster University and the NHS Research and Ethics Committee (REC). Qualtrics, a secure web application for conducting online questionnaires, was utilised to create the questionnaires. It was available online and ran for a period of 6 months between September 2023 and March 2024. Reminders were sent to potential participants over that period

5.2.3 Sample description

Healthcare practitioners include all doctors (non-consultant grade doctors grouped according to their years of training and consultants) and nurse or care practitioners who work within the department of colorectal surgery and general surgery in any hospital setting in the UK. Patients with anorectal disorders commonly present to this setting, and this group of healthcare practitioners are involved in taking a history of their symptoms and deciding on further management. Respondents who never saw patients with anal conditions or rectal bleeding were excluded by the screening question.

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Demographic data collected included gender, age group, ethnicity, sexuality, religion and grade/current position. All questionnaires were submitted anonymously, identified by study number and IP addresses were not collected. All data was securely held under password protection.

The survey was conducted, and results presented in accordance with the Consensus based Checklist for Reporting Of Survey Studies (CROSS) (Sharma et al., 2021).

5.2.4 Data analysis

Socio-demographics were summarised using descriptive statistics in Excel[®] Version 16.86. The relationship between the barriers associated with taking a sexual history against demographic characteristics of healthcare practitioners was explored using inferential statistics. The Chi-squared test of independence was applied to determine whether there was a significant relationship between demographic factors and responses in the survey data. Analysis was conducted using SPSS version 29 for MAC. The level of statistical significance was set at 0.05.

5.3 Results

Out of 438 total visits to the Qualtrics platform, 189 participants progressed to the screening stage, representing a 43% response rate. The resulting sample was predominantly male (56.1%), followed by female (43.4%) and non-binary (0.5%) respondents. Most of the participants were within the 31 – 40-year age group (38%) followed by the 41 – 50-year age group (23%). Eighty-eight percent identified as heterosexuals; sixty-four percent were Caucasians and forty-four percent identified no religious affiliation. Of the 189 participants, 49% were consultants and 48% saw at least 10 – 20 patients with anal symptoms per week. The demographic and diversity characteristics of respondents are summarized in table 4 and 5. Participants who never saw patients with anal symptoms or rectal bleeding (n=13) were excluded from further analysis.

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Data on roles, opinions and clinical practice was analysed in detail for the 173 participants who were able to proceed beyond the screening questions.

Table 4: Survey participant characteristics

		Total (N)	Male (N)	Female (N)	Non-binary
	Participants	189 (100%)	106 (56.1%)	82 (43.4%)	1 (0.5%)
Age group (in years)	21 - 30	20 (11%)	8 (8%)	11 (13%)	1 (100%)
	31 - 40	72 (38%)	38 (36%)	34 (41%)	0 (0%)
	41 - 50	44 (23%)	23 (22%)	21 (26%)	0 (0%)
	51 - 60	40 (21%)	27 (25%)	13 (16%)	0 (0%)
	60+	13 (7%)	10 (9%)	3 (4%)	0 (0%)
Ethnic group	Asian or Asian British	41 (22%)	25 (24%)	16 (20%)	0 (0%)
	Black, Black British, Caribbean or African	16 (8%)	10 (9%)	5 (6%)	1 (100%)
	White	121 (64%)	64 (60%)	57 (70%)	0 (0%)
	Mixed or Multiple ethnic background	5 (3%)	2 (2%)	3 (3%)	0 (0%)
	Any other ethnic background (please specify)	6 (3%)	5 (5%)	1 (1%)	0 (0%)
Sexuality	Heterosexual	166 (88%)	97 (91.6%)	68 (83%)	1 (100%)
	Homosexual	6 (3%)	4 (3.8%)	2 (2%)	0 (0%)
	Bisexual	10 (5%)	3 (2.8%)	7 (9%)	0 (0%)
	Other	3 (2%)	1 (0.9%)	2 (2%)	0 (0%)
	Prefer not to say	4 (2%)	1 (0.9%)	3 (4%)	0 (0%)
Religion	No religion	84 (44%)	40 (38%)	44 (54%)	0 (0%)
	Christian	60 (32%)	36 (34%)	24 (29%)	0 (0%)
	Muslim	23 (12%)	17 (16%)	6 (7.4%)	0 (0%)
	Jewish	1 (0.5%)	1 (1%)	0 (0%)	0 (0%)
	Buddhist	1 (0.5%)	0 (0%)	1 (1.2%)	0 (0%)
	Hindu	11 (6%)	9 (8%)	2 (2.4%)	0 (0%)
	Sikh	2 (1%)	0 (0%)	2 (2.4%)	0 (0%)
	I would prefer not to say	5 (3%)	2 (2%)	2 (2.4%)	1 (100%)
	Any other religion (please specify)	2 (1%)	1 (1%)	1 (1.2%)	0 (0%)
Current position/grade	Core surgical trainee/CST 1-2/ST 1-2/Trust grade year 1-2	22 (12%)	11 (10.5%)	10 (12.2%)	1 (100%)

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	Higher surgical trainee/ST3-5 /Trust grade year 3-5	27 (14%)	14 (13%)	13 (15.9%)	0 (0%)
	Higher surgical trainee/ST6-8/ Trust grade year 6-8	20 (11%)	10 (9%)	10 (12.2%)	0 (0%)
	Colorectal nurse specialist/Advanced nurse practitioner/Advanced care practitioner	16 (8%)	3 (3%)	13 (15.9%)	0 (0%)
	Staff grade surgeon/associate specialist/SAS/Trust grade over 8 years	11 (6%)	9 (8.5%)	2 (2.4%)	0 (0%)
	Consultant	93 (49%)	59 (56%)	34 (41.4%)	0 (0%)
Speciality/subspeciality (multiple selection permitted)	General surgery	103	58 (56%)	44 (43%)	1 (1%)
	Emergency general surgery	29	14 (48%)	15 (52%)	0 (0%)
	Colorectal surgery	115	63 (55%)	52 (45%)	0 (0%)
	Pelvic floor surgery	15	6 (40%)	9 (60%)	0 (0%)
	Other surgical	17	9 (53%)	8 (47%)	0 (0%)
	Non-surgical	6	5 (83%)	1 (17%)	0 (0%)
How often do you see patients with anal symptoms or rectal bleeding?	> 20 patients / week	28 (15%)	17 (16%)	11 (13%)	0 (0%)
	10-20 patients / week	45 (24%)	25 (24%)	20 (24%)	0 (0%)
	1-10 patients / week	91 (48%)	48 (45%)	43 (53%)	0 (0%)
	< 1 patient / week	12 (6%)	9 (8%)	3 (4%)	0 (0%)
	Never	13 (7%)	7 (7%)	5 (6%)	1 (100%)

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Table 5: Survey participant demographics according to current grade/position

	Surgical doctor year 1 - 2	Surgical doctor year 3 - 4	Surgical doctor year 5 - 6	Surgical doctor > 8 years	Nurse or care practitioner	Consultant
N	22	27	20	11	16	93
Gender						
Male	11	14	10	9	3	59
Female	10	13	10	2	13	34
Non-binary	1	0	0	0	0	0
Age						
21-30 years	16	4	0	0	0	0
31-40 years	6	21	17	7	7	14
41-50 years	0	1	3	2	6	32
51-60 years	0	1	0	1	2	36
>60 years	0	0	0	1	1	11
Ethnicity						
Asian or Asian British	7	7	5	5	2	15
Black, Black British, Caribbean or African	4	4	2	3	0	3
White	9	13	13	2	13	71
Mixed or multiple ethnic background	1	2	0	0	0	2
Any other ethnic background	1	1	0	1	1	2
Sexuality						
Heterosexual	16	24	18	11	13	84
Homosexual	2	2	1	0	0	1
Bisexual	3	1	0	0	3	3
Other	0	0	1	0	0	2
Prefer not to say	1	0	0	0	0	3
Religion						
No religion	12	12	10	3	7	40
Christian	4	6	3	1	7	39
Mustim	2	6	6	5	0	4
Jewish	0	0	0	0	0	1
Buddhist	1	0	0	0	0	0
Hindu	1	3	0	1	1	5
Sikh	0	0	0	0	0	2
Prefer not to say	1	0	0	1	1	2
Any other religion	1	0	1	0	0	0

5.3.1 The significance of taking a sexual history

Thirty-four percent of respondents agreed or strongly agreed that asking about anal sex was important in all women with anal symptoms, 33.5% were neutral and 19.9% disagreed or strongly disagreed, figure 9. Female clinicians (44%) were more likely to agree or strongly agree that asking about anal sex was important in all women with anal symptoms, compared to male clinicians (26%), $\chi^2(3) = 8.64$, $p = 0.05$. There were no other significant associations when age, ethnicity, sexuality, religion and grade were considered.

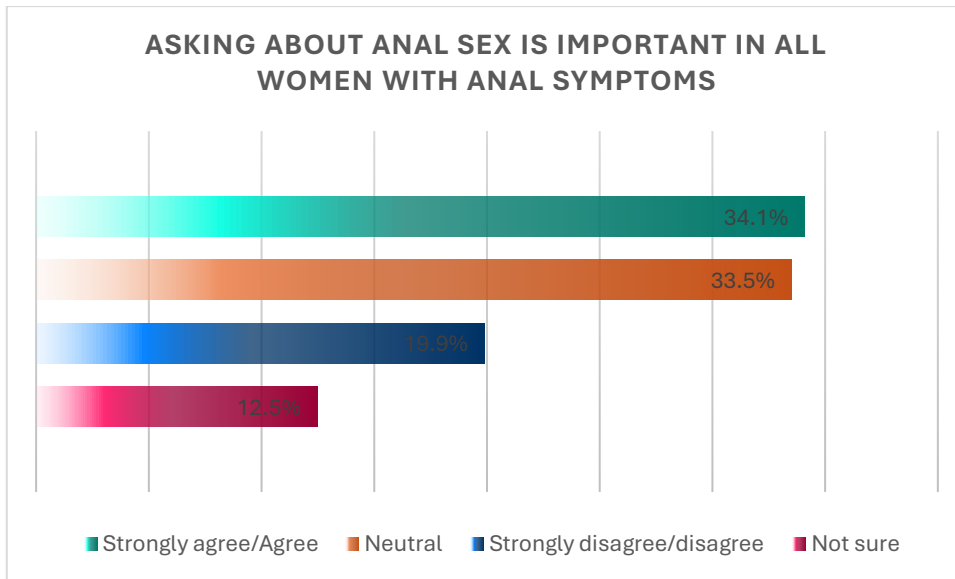


Figure 9: The significance of taking a sexual history

When given specific clinical scenarios involving women with anorectal disorders, 58% thought it was important to ask in nulliparous women with faecal incontinence, 57% thought it was important to ask in women under 40 with faecal incontinence, 43% thought it was important to ask in all women with faecal incontinence and 46% thought it was important to ask in women under 40 years with anal symptoms, figure 10. Female clinicians (68%) were more likely to agree or strongly agree that asking about anal sex was important in women under 40 years of age with anal symptoms, compared to male clinicians (48%), $\chi^2(3) = 8.15$, $p = 0.04$. There were no other significant associations when age, ethnicity, sexuality, religion and grade were considered.

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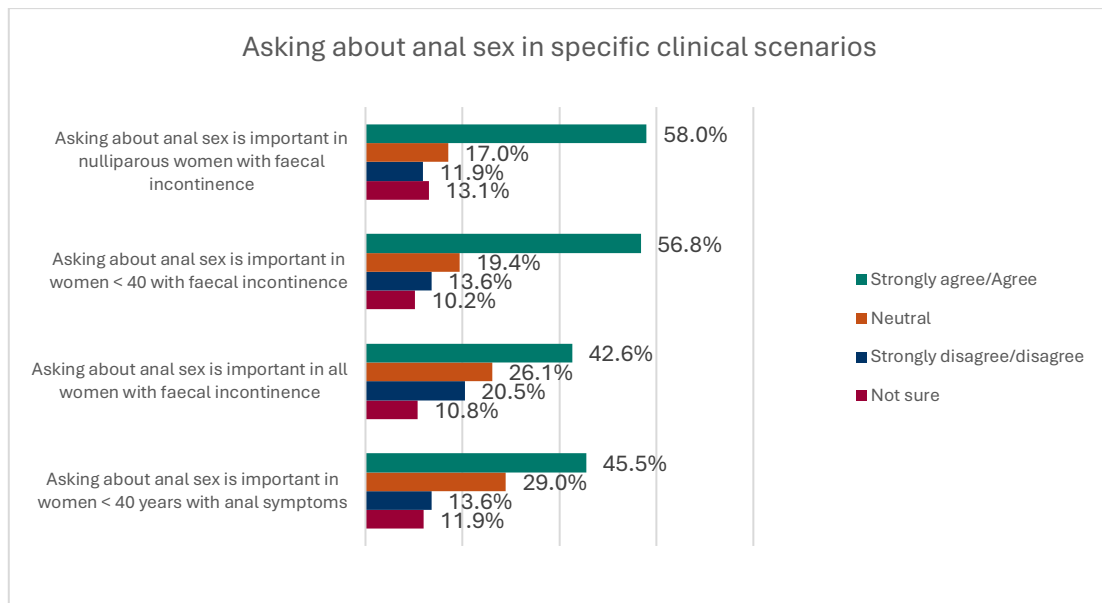


Figure 10: The significance of taking a sexual history in specific clinical scenarios

5.3.2 Frequency of taking anal sexual history

When given different clinical scenarios involving women with anorectal disorders, most participants would rarely (sometimes/less than half the time or never) take an anal sexual history from patients. The findings are summarised in figure 11.

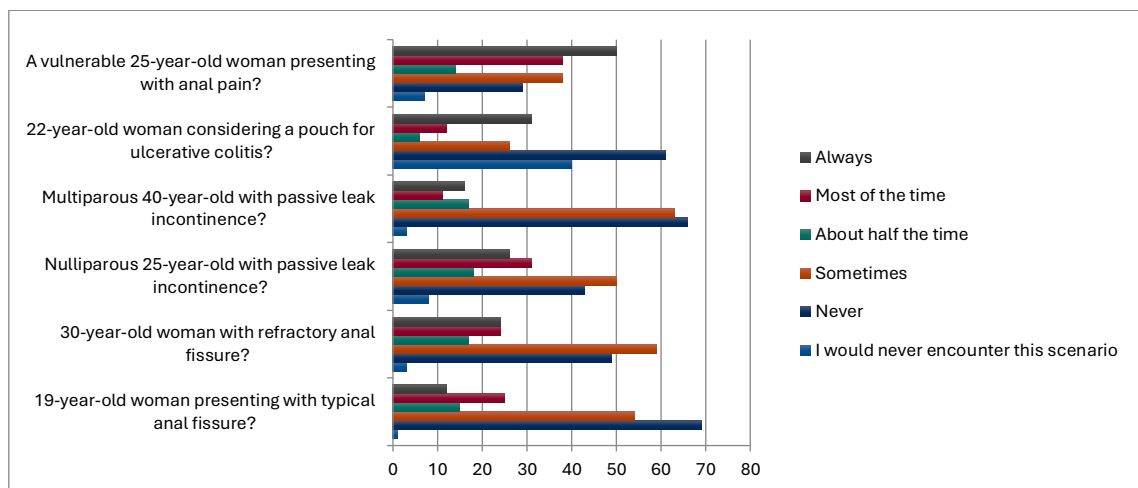


Figure 11: Frequency of taking an anal sexual history

Participants (70%) rarely asked young female patients presenting with typical anal fissures of their anal sexual history. Male clinicians (78%) were less likely to ask about anal sex (sometimes/less than half the time or never) when young women presented with an anal fissure, compared to female clinicians (58%), $\chi^2 (5) =$

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13.93, $p < 0.01$. There were no other significant associations when age, ethnicity, sexuality, religion and grade were considered.

Participants (61%) rarely asked young female patients presenting with refractory anal fissures of their anal sexual history. Surgical doctors within their first 2 years of training (CST/ST 1-2, trust grade year 1-2) were least likely to ever ask about anal sex when young women presented with an anal fissure, 57% would never ask, $\chi^2 (25) = 41.53$, $p < 0.02$. There were no other significant associations when gender, age, ethnicity, sexuality, and religion were considered.

Participants (53%) rarely asked young nulliparous patients presenting with passive leak incontinence of their anal sexual history. Male clinicians (63%) were less likely to ask about anal sex (sometimes/less than half the time or never) when young nulliparous women presented with passive leak incontinence, compared to women (43%), $\chi^2 (5) = 12.24$, $p < 0.03$. There were no other significant associations when age, ethnicity, sexuality, religion and grade were considered.

Participants (73%) rarely asked young multiparous patients presenting with passive leak incontinence of their anal sexual history. Surgical doctors within their first 4 years of training (CST 1-2, HST/ST3-5, trust grade year 1-4) were least likely to ever ask about anal sex, 57% would never ask, $\chi^2 (25) = 46.52$, $p < 0.006$. There were no other significant associations when gender, age, ethnicity, sexuality, and religion were considered.

Participants (49%) rarely discussed anal sex pre-operatively with female patients considering ileo-anal pouch procedures. Younger clinicians were least likely to discuss anal sex pre-operatively. 77% of 21-30-year-olds, 45% of 31-40-year-olds, 27% of 41-50-year-olds, 18% of 51-60-year-olds and 15% >60-year-olds would never discuss anal sex pre-operatively this subset of patients, $\chi^2 (20) = 37.82$, $p < 0.009$.

Surgical doctors within their first 2 years of training (CST 1-2, trust grade year 1-2) were least likely to discuss anal sex pre-operatively. 71% CSTs/trust grade year 1-2, 64% HST/trust grade year 3-5, 30% HST/trust grade year 6-6, 38% nurse

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practitioners, 44% SAS/staff grade/associate specialists and 21% Consultants would never discuss anal sex pre-operatively with female patients considering ileo-anal pouch procedures, $\chi^2 (25) = 52.62, p 0.001$. There were no other significant associations when gender, sexuality, and religion were considered.

Participants (58%) would ask young vulnerable female patients presenting with anal pain about anal sex half the time or more. Surgical doctors within their first 2 years of training (CST 1-2, trust grade year 1-2) were least likely to enquire about anal sex when young female patients present with anal pain, 36% would never ask, $\chi^2 (25) = 47.45, p 0.004$. There were no other significant associations when gender, age, ethnicity, sexuality, and religion were considered.

5.3.3 Taking a sexual history

More clinicians felt comfortable asking about anal sex and most aspects of a patient's sex life when indicated, than they were neutral or uncomfortable, **figure 12**.

Women were more likely to feel comfortable taking a sexual history when indicated compared to men, 65% of female clinicians agreed/completely agreed, compared to only 43% of male clinicians ($\chi^2 (2) = 12.12, p 0.002$). There were no other significant associations when age, ethnicity, sexuality, religion and grade were considered.

Clinicians who identified as heterosexual (45%) were least likely to feel comfortable asking about anal sex, compared to other sexualities (62%), $\chi^2 (8) = 18.3, p 0.01$. There were no other significant associations when gender, age, ethnicity, religion and grade were considered.

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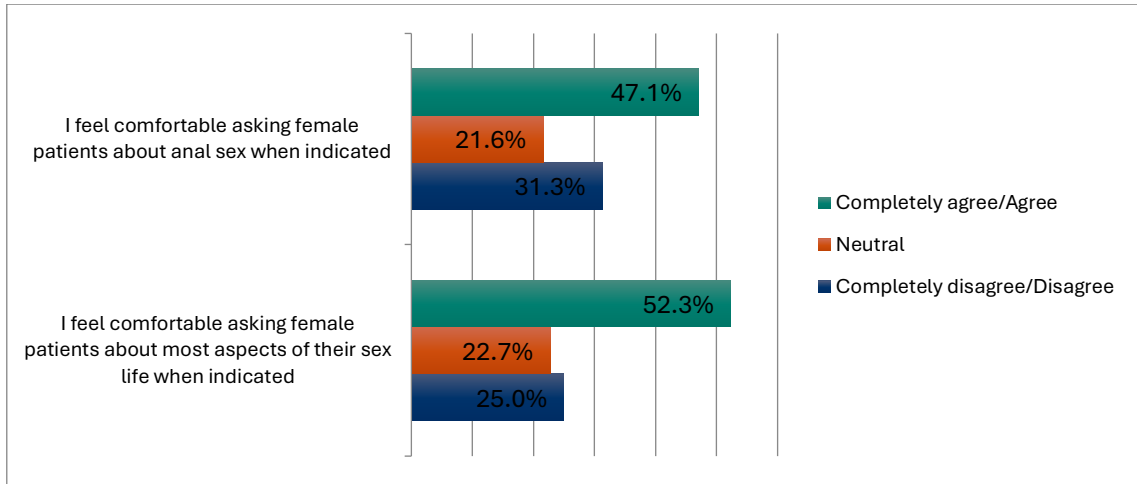


Figure 12: Taking a sexual history

5.3.4 Barriers to taking a sexual history

Concerns that clinicians would be perceived as judgemental and fear of making the patient feel uncomfortable created the most significant barrier to taking a sexual history, **figure 13**.

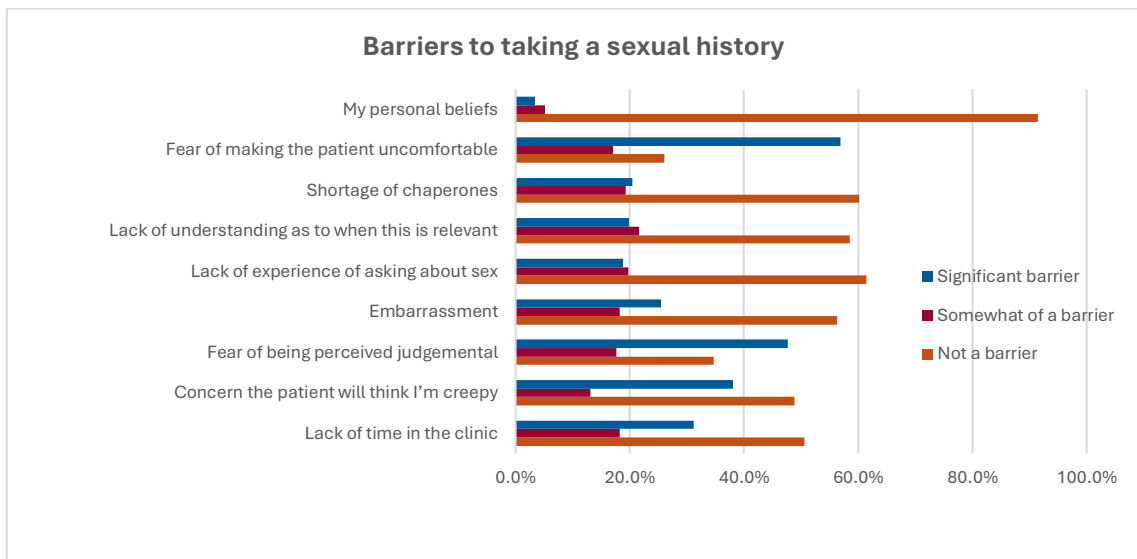


Figure 13: Barriers to taking a sexual history

Less than half the participants (49%) considered time constraints to be a barrier to sexual history taking. There were no significant associations when gender, age, ethnicity, sexuality, religion and grade were considered.

More than half the participants (51%) considered being perceived as “creepy” to be a barrier to sexual history taking. Men (52%) had more concerns female patients

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would consider them creepy for taking an anal sexual history, compared to women (21%) ($\chi^2 (2) = 20.71, p < 0.001$). Senior non-consultant clinicians (i.e. staff grade surgeon/associate specialist/SAS/Trust grade over 8 years, 67%) had greater concerns female patients would consider them creepy for taking an anal sexual history, compared to core surgical trainees (50%), higher surgical trainees year 3 to 5 (40%), higher surgical trainees year 6 to 8 (40%), advanced nurse practitioners (25%) and consultants (35%), $\chi^2 (10) = 23.5, p 0.009$. There were no other significant associations when age, ethnicity, sexuality, and religion were considered.

A significant proportion of participants (65%) considered being perceived as “judgemental” to be a barrier to sexual history taking. Men (57%) were more concerned patients would think they were being judgemental for taking an anal sexual history, compared to women (36%), $\chi^2 (2) = 9.52, p 0.009$. Clinicians who identified as heterosexual (50%) or bisexual (62%) were more likely to consider being perceived as being judgemental as a reason to avoid asking about anal intercourse, compared to clinicians who identified as homosexual (0%), ($\chi^2 (8) = 19.70, p 0.01$). There were no other significant associations.

Less than half the participants (44%) considered embarrassment to be a barrier to sexual history taking. Older clinicians (74% >50years) were less likely to consider being embarrassed as a reason to avoid asking about anal intercourse, compared to younger clinicians (31%, 21-30years), $\chi^2 (8) = 15.53, p 0.05$. Consultants (68%) and nurse practitioners (75%) were less likely to consider being embarrassed as a reason to avoid asking about anal intercourse, compared to CSTs (14%), HSTs (42%) and SAS doctors (33%), $\chi^2 (10) = 28.10, p 0.002$. There were no other significant associations when gender, ethnicity, sexuality and religion were considered.

Less than half the participants (39%) considered lack of experience to be a barrier to sexual history taking. Clinician experience of taking a sexual history increased with age, 85% of clinicians >60years did not feel they had a lack of experience of asking about anal sex, compared to 23% of 21–30-year-olds, $\chi^2 (8) = 19.98, p 0.01$. Similarly, experience of taking a sexual history increased with years of clinical

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experience, 75% of consultants did not feel they had a lack of experience of asking about anal sex, compared to 38% of CSTs, $\chi^2 (10) = 34.84$, $p < 0.001$. There were no other significant associations when gender and sexuality were considered.

Less than half the participants (42%) considered lack of understanding of relevance to be a barrier to sexual history taking. Clinician understanding of when it is relevant to take a sexual history increased with age, 80% of clinicians >60years did not feel they had a lack of understanding of when it was relevant to ask anal sex, compared to 39% of 21–30-year-olds, $\chi^2 (8) = 15.93$, $p 0.04$. Similarly, understanding of when it is relevant to take a sexual history increased with years of clinical experience, 72% of consultants did not feel they had a lack of understanding of when it was relevant to ask anal sex, compared to 43% of CSTs, $\chi^2 (10) = 43.62$, $p < 0.001$. There were no other significant associations when gender, ethnicity, sexuality and religion were considered.

Less than half the participants (40%) considered shortage of chaperones to be a barrier to sexual history taking. Male clinicians (28%) were more likely to consider the shortage of chaperones to be a barrier compared to women (10%), $\chi^2 (2) = 9.01$, $p 0.01$. There were no other significant associations when age, ethnicity, sexuality, religion and grade were considered.

A significant proportion of participants (74%) considered the fear of making patients feel uncomfortable to be a barrier to sexual history taking. Male clinicians (62%) were more likely to consider the fear of making patients feel uncomfortable to be a barrier compared to women (51%), $\chi^2 (2) = 7.72$, $p 0.02$. There were no other significant associations when age, ethnicity, sexuality, religion and grade were considered.

A significant proportion of participants (92%) did not feel personal beliefs was a barrier to sexual history taking. Female clinicians (97%) were less likely to consider their personal beliefs to be a barrier to asking about anal sex compared to male clinicians (87%), $\chi^2 (2) = 6.89$, $p 0.03$. There were no other significant associations when age, ethnicity, sexuality, religion and grade were considered.

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5.3.5 Clinical manifestations of anal sex

Most clinicians completely agreed or agreed that anal sex could lead to mucosal tears/fissures (83%), anal pain (84%), anal bleeding (85%), incontinence (66%) and damage of the internal anal sphincter in women (72%), figure 14.

Thirty-eight percent of clinicians agreed or completely agreed that women who engaged in anal intercourse carried a greater risk of faecal incontinence than men, 33% did not know and 29% disagreed or completely disagreed. Female clinicians (71%) were more likely to agree or completely agree that women who engaged in anal intercourse carried a greater risk of faecal incontinence than men, compared to male clinicians (61%), $\chi^2(5) = 11.08, p 0.05$.

Most clinicians were uncertain that the anal sphincters can be protected by using lubrication or relaxation techniques during anal sex.

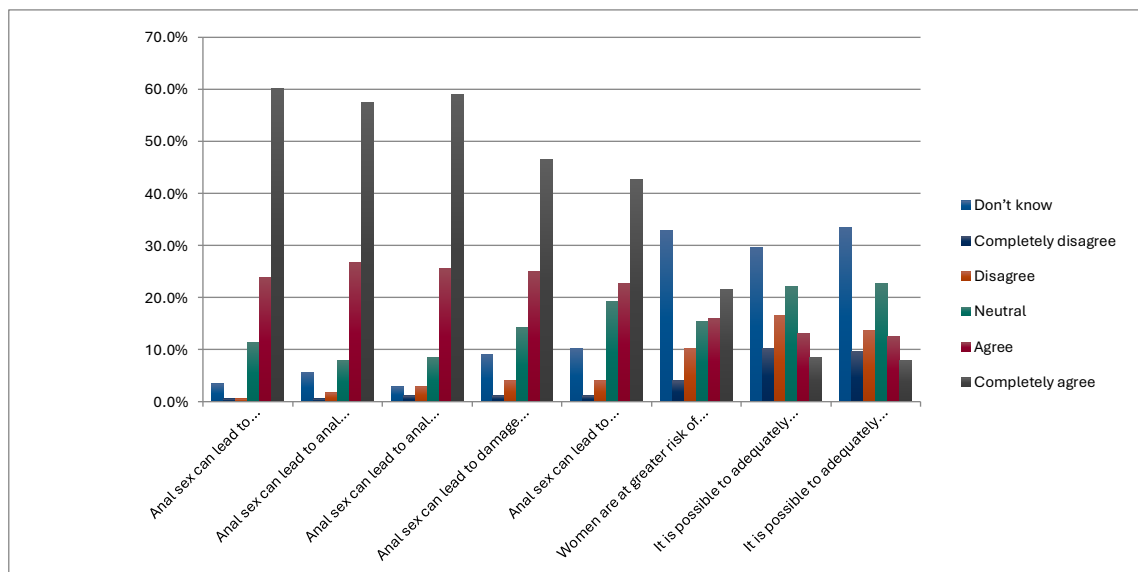


Figure 14: : Clinical manifestations of anal sex

5.3.6 Prevalence of anal sex among females in the UK

When asked to estimate the prevalence of anal sex among women in the UK, clinicians believed that 39% (95% CI = 36%, 41%) of young women in the UK have had anal sex, **figure 15**.

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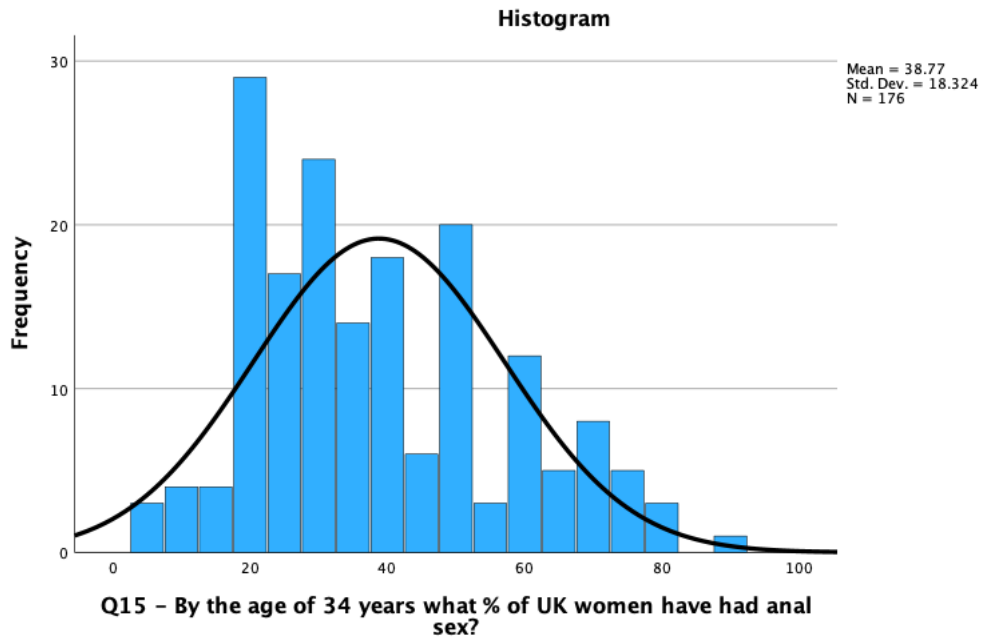


Figure 15: Prevalence of anal sex among females in the UK

5.3.7 Training and awareness

More than 95% of participants believe that more training is required on anal sex and sexual history taking among healthcare practitioners and believe that more public health awareness is required, **figure 16 and 17**.

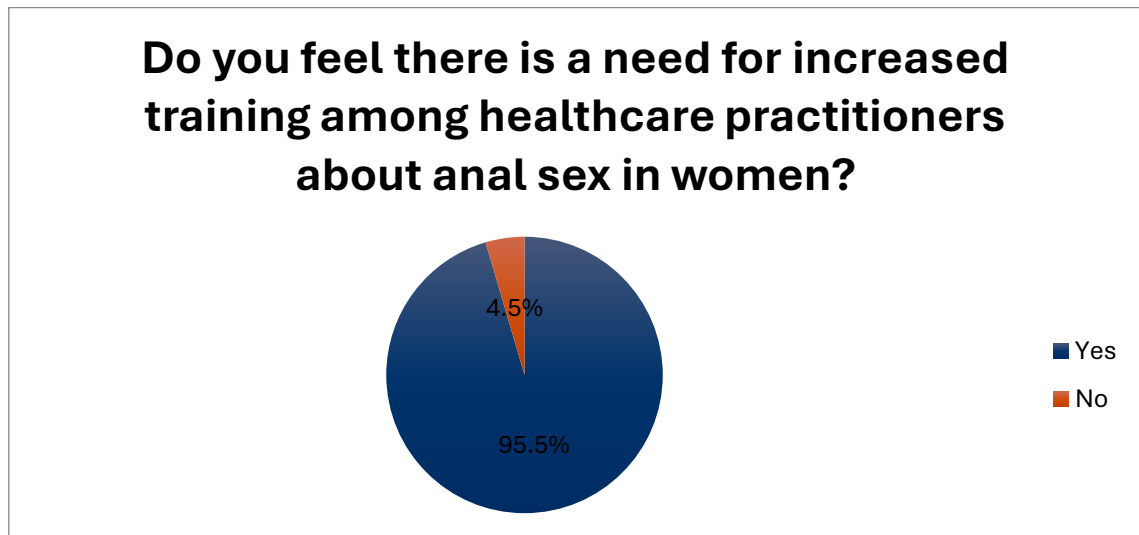


Figure 16: Training among Clinicians

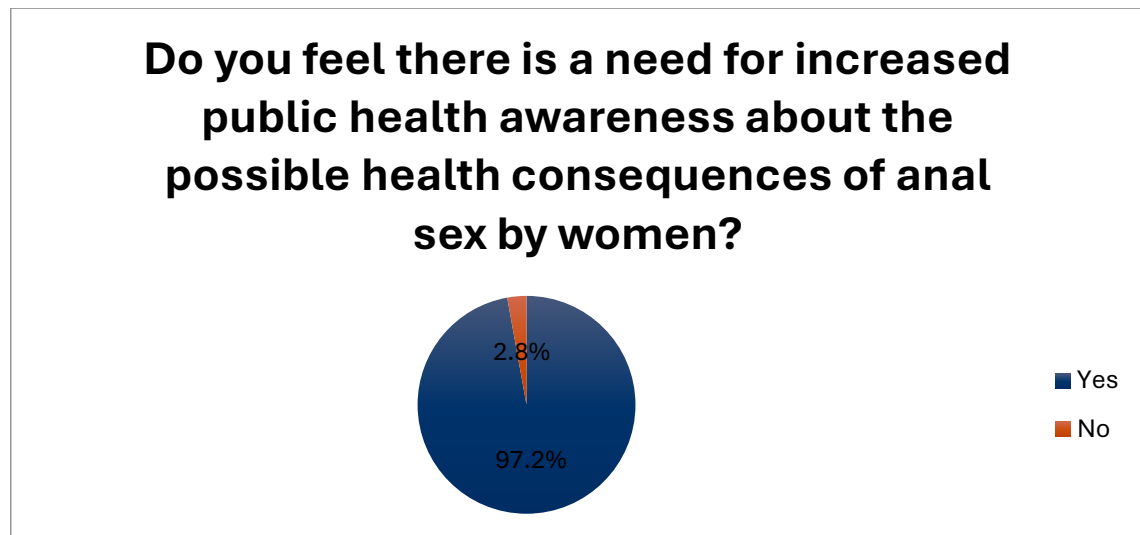


Figure 17: : Public health awareness

5.3.8 Summary of the key findings

1. Most clinicians agreed that anal sex could lead to anal tears (83%), anal pain (84%), anal bleeding (85%), incontinence (66%) and damage of the internal anal sphincter in women (72%).
2. Most clinicians were uncertain that the anal sphincters could adequately be protected by using lubrication or relaxation techniques during anal sex.
3. Clinicians feel comfortable enough asking about anal sex (47%) and most aspects of a patient's sex life (52%) when indicated. Female clinicians and clinicians who identified as homosexual felt more comfortable.
4. Despite this, only 34% agreed or strongly agreed that asking about anal sex was important in all women with anal symptoms. Female clinicians (44%) were more likely to agree or strongly.

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5. And only over 40% agreed or strongly agreed that asking about anal sex was important in specific clinical scenarios
 - a. Asking about anal sex in nulliparous women with faecal incontinence was considered important by 58% of clinicians.
 - b. Enquiring about anal sex in women under 40 years presenting with faecal incontinence was considered important by 57% of clinicians.
 - c. Asking about anal sex in all women with faecal incontinence was considered important by 43% of clinicians.
 - d. Enquiring about anal sex in women under 40 years presenting with anal symptoms was considered important by 46% of clinicians, with female clinicians (68%) being more likely to agree or strongly agree with this view.

6. Therefore, clinicians seldom asked patients about their anal sexual history
 - a. Young female patients presenting with atypical anal fissures were rarely asked about anal sex by 70% of clinicians. Male clinicians (78%) were less likely to enquire.
 - b. Young female patients presenting with refractory anal fissures were rarely asked about anal sex by 61% of clinicians. Surgical doctors within their first 2 years of training were least likely to enquire.
 - c. Young nulliparous patients presenting with passive leak incontinence were rarely asked about anal sex by 53% of clinicians. Male clinicians (63%) were less likely to enquire.
 - d. Young multiparous patients presenting with passive leak incontinence were rarely asked about anal sex by 73% of

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- clinicians. Surgical doctors within their first 4 years of were least likely to enquire.
- e. Anal intercourse was rarely discussed pre-operatively with female patients considering ileo-anal pouch procedures by 49% of clinicians. Younger clinicians and surgical doctors within their first 2 years of training were least likely to discuss anal sex pre-operatively.
 - f. Enquiry about anal sex among young vulnerable female patients presenting with anal pain was undertaken half the time or more by 58% of clinicians. Surgical doctors within their first 2 years of training were least likely to enquire.
7. Several barriers were identified as serving as deterrents to this pertinent aspect of aspect of a clinic consultation. Causing discomfort to patients and being perceived as creepy or judgemental were the most commonly cited barriers to asking about anal sex. Male clinicians were more likely to cite these as barriers. Personal belief was the least common
- a. Making patients feel uncomfortable was reported as a concern by 74% of participants.
 - b. Concerns about being perceived as “judgemental” were identified by 65% of participants.
 - c. Fear of being perceived as “creepy” was reported by 51% of participants.
 - d. Time constraints were considered a barrier by 49% of participants.
 - e. Embarrassment was identified as a barrier by 44% of participants.
 - f. A lack of understanding of relevance was reported as a barrier by 42% of participants.
 - g. A shortage of chaperones was considered a barrier by 40% of participants.

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- h. A lack of experience was identified as a barrier by 39% of participants.
 - i. Personal beliefs were considered a barrier by 8% of participants.
- 8. Clinicians believed that 39% (95% CI = 36%, 41%) of young women in the UK have had anal sex.
- 9. More than 95% of participants believe that more training is required on anal sex and sexual history taking among healthcare practitioners and believe that more public health awareness is required

5.4 Discussion

This national survey of hospital-based general and colorectal surgery clinicians found that while they recognized the importance of taking a sexual history or inquiring about anal intercourse when women presented with anorectal disorders, they often avoided incorporating it into routine practice. Clinicians occasionally inquired about anal sex but typically reserved such questions for specific clinical scenarios, rather than applying them broadly to all anorectal disorders.

A 2023 census of general surgery consultants in England and Wales found that only 15% of consultant colorectal surgeons were female, with 85% being male (Dosis et al., 2024). In contrast, this study saw a higher proportion of female respondents, with 37% being women and 63% men. This discrepancy may reflect a greater interest among female clinicians in the study's subject matter. Given the rising prevalence of anal intercourse (AI) among women, female clinicians may feel a stronger connection to the affected population and, therefore, may be more inclined to participate in research on the topic. Additionally, studies have shown that women are generally more likely than men to respond to surveys (Becker & Glauser, 2018; Porter & Whitcomb, 2005; Wu et al., 2022), which could further explain the gender distribution in the respondent pool.

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A moderate proportion of clinicians reported feeling comfortable discussing AI and sexual history when clinically relevant, yet notable gender differences emerged. Female clinicians were significantly more at ease with such discussions—65% reported feeling comfortable asking about AI, compared to only 43% of male clinicians. This gender divide may also explain why male clinicians were less inclined to participate in this survey. Similarly, clinicians who identified as homosexual were more comfortable discussing AI in clinical consultations, underscoring the value of diversity within the healthcare workforce. The NHS has long championed diversity as a means of improving equitable access to care, fostering trust, and enhancing patient outcomes (Khuntia et al., 2022; NHEngland, 2023b).

Despite clinicians acknowledging the health risks associated with receptive AI, there was a clear disconnect between their awareness and their routine clinical practice. A significant majority agreed that AI could cause anal tears (83%), anal pain (84%), anal bleeding (85%), internal anal sphincter injury (72%), and faecal incontinence (66%). These findings indicate substantial concern regarding the potential long-term consequences of AI, such as faecal incontinence. Nevertheless, only 34% of respondents agreed that routinely asking about AI was important for all women presenting with anal symptoms. This suggests that while clinicians recognize the potential harm, they do not consistently integrate AI-related inquiries into their practice.

When presented with specific clinical scenarios, clinicians were more likely to consider taking an anal sexual history relevant. For instance, 58% agreed it was important to ask nulliparous women with faecal incontinence about AI, while 57% considered it important for women under 40 with faecal incontinence. However, only 43% felt it was necessary to inquire about AI in all women with faecal incontinence, and 46% deemed it important for women under 40 presenting with anal symptoms. These findings suggest that although clinicians acknowledge the importance of sexual history-taking, they tend to restrict AI-related inquiries to select clinical situations rather than applying them universally.

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Gender differences were also evident in assigning importance to AI history-taking. Female clinicians were more likely than their male counterparts to deem it relevant in all cases, particularly for women under 40 with anal symptoms. Research has shown that female clinicians often adopt a more patient-centred and holistic approach, building stronger rapport with patients and addressing personal issues more comprehensively than male clinicians (Jefferson et al., 2013; Roter et al., 2002). This tendency may explain why female clinicians placed greater emphasis on obtaining a detailed sexual history.

Interestingly, although clinicians expressed comfort in taking a sexual history and recognized the importance of AI-related inquiries in specific cases, they rarely asked about AI in several scenarios. For example, while 83% agreed that AI can cause anal fissures, only 7% would always ask a 19-year-old presenting with an anal fissure about AI, with an additional 14% indicating they would inquire most of the time. Slightly higher rates were observed in cases of refractory fissures (14% always, 14% most of the time). The likelihood of inquiry increased in cases of vulnerable young women experiencing anal pain, where 58% of clinicians reported they would ask about AI at least half the time. The recent ACPGBI guidelines emphasize the necessity of obtaining a sexual history when assessing anal fissures (Cross et al., 2023). Failure to do so may lead to ineffective treatment and prevent clinicians from addressing a key underlying risk factor.

Motivations for engaging in AI do not always reflect personal agency. Studies suggest that women often participate in AI due to partner pressure, relationship maintenance, or societal norms (Fahs & Gonzalez, 2014; Marston & Lewis, 2014; McBride, 2019; Reynolds et al., 2015) and coercion is also prevalent (Faustino, 2020; Roye et al., 2013). Clinicians' reluctance to routinely ask about AI not only risks leading to ineffective treatments but also represents missed opportunities to support vulnerable young women and teenage girls who may be engaging in AI against their own interests.

Resident surgical doctors (within their first 2 years of training) were the least likely to inquire about AI in young women presenting with refractory anal fissures ($\chi^2(25) = 41.53, p = 0.02$) or anal pain ($\chi^2(25) = 47.45, p = 0.004$). Given the rigorous

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training required to become a consultant colorectal surgeon, early-career doctors may lack the experience and understanding necessary to appreciate the importance of AI-related history-taking. Proctology is a specialized field, and its nuances may not be well covered in early medical training, leaving junior resident doctors less confident in assessing anorectal disorders.

As with anal fissure a similar pattern was seen in the assessment of women presenting with faecal incontinence. Although 72% agree it can cause injury to the internal anal sphincter and 66% agree it can cause faecal incontinence, only 58% of clinicians felt it was important to ask nulliparous women with FI about AI and only 33% said they would actually ask nulliparous women about AI most of the time or always. Male clinicians were less likely to ask about anal sex compared to women (39%), $\chi^2 (5) = 12.24$, $p 0.03$, perhaps this is not surprising, as male clinicians feel less comfortable asking women about anal sex, compared to female clinicians, ($\chi^2 (2) = 12.12$, $p 0.002$). Discomfort has previously been cited by male clinicians as a reason to avoid discussing patient's personal issues (Jefferson et al., 2015). Despite the significance to healthcare, many may consider sexual practices a "personal issue" and seek to avoid such conversations.

It was interesting to find that although clinicians felt comfortable taking a sexual history and thought it was important to ask about anal sex in scenarios they believed were clinically indicated, they would rarely ask about anal sex in several scenarios. So, what were the barriers to taking a sexual history for these clinicians?

Barriers to discussing AI with patients included concerns about causing patient discomfort, being perceived as inappropriate, and lacking chaperone availability. Over 50% of clinicians cited these as reasons for avoiding AI-related discussions, with male clinicians more likely than female clinicians to report these concerns. Studies have highlighted the benefits of gender-concordant care, particularly between female clinicians and female patients (Bertakis & Azari, 2012; Roter et al., 2002; Sandhu et al., 2009). Male clinicians may feel unwelcome discussing sexual health with female patients, especially given that instances of sexual misconduct in healthcare overwhelmingly involve male clinicians (Begeny et al., 2023; Lancet, 2018). It is a clinician's responsibility to be aware of how their behaviour may

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influence patients (GMC, 2024a). This awareness may also lead to an increased sensitivity and concerns when male clinicians are faced with female patients. Perhaps the presence of a chaperon would alleviate the concerns male clinicians have. Their absence was cited as a barrier by 40% of clinicians, and men were more likely to consider it as a barrier than women.

Communication styles have been found to differ between male and female clinicians. Women in healthcare are thought to spend more time with patients, build a rapport and address personal issues (Roter et al., 2002). Building a rapport is particularly important in helping create an environment which would foster comfort for both clinicians and patients.

Time constraints were another significant barrier, cited by 49% of clinicians. There is increasing pressure on the national health service (NHS), a recent report on doctors' workplace experiences from the general medical council (GMC) found that over a third of doctors are struggling with their workload (GMC, 2024b). In an effort to decrease patient waiting times several targets have been set on NHS Trusts by governing bodies, e.g., number of patients expected to be seen per clinic session (NHSEngland, 2023a). Clinicians are expected to take a history, examine a patient, recommend a management or diagnostic plan and document their findings within the allocated time slot for the consultation, which is sometimes as little as 10 minutes. In the presence of increased workload pressures and limited consultation times, some clinicians may avoid raising topics like AI due to fears of "opening a can of worms" that could extend the consultation beyond its allotted time.

Lack of experience and lack of understanding of relevance were less commonly selected barriers, 39% and 42% cited this respectively. Younger clinicians (21-30 years) and clinicians in their earlier years of training or specialisation were more likely to consider these factors as a barrier. Detailed history taking is a skill that is developed during the course of training; therefore, it is not unsurprising, that clinicians in their earlier years consider these factors to be a barrier. Medical education often does not emphasize pelvic floor anatomy and anorectal pathology

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until higher surgical training, leaving junior resident doctors less equipped to recognize the relevance of AI in clinical assessments.

Personal belief was the least common barrier to these conversations. Socio-demographic characteristics of the respondents played no role in assigning significance to personal beliefs. The clinicians appear to be able to separate their personal characteristics from the professional work.

When asked to estimate women's experience of AI by the age of 34 on a linear analogue scale from 1-100%, mean estimated rate was 39% (95% CI = 36%, 41%). This closely approximates to the latest published 2012 data from Natsal and reflects clinician awareness of prevalence. Women have less robust anal sphincters compared to men, with a shorter anal canal and lower sphincter pressures as measured by manometry (Reginelli et al., 2012b). Consequently, it is reasonable to hypothesize that AI may pose a greater risk to female continence. In this study, 38% of respondents agreed or strongly agreed with this assertion. However, this question elicited more uncertainty than others in the section, with 15% expressing uncertainty, 14% disagreeing, and 33% indicating they did not know. This uncertainty may stem from a broader lack of research on the impact of receptive anal intercourse across all genders.

Respondents were generally sceptical about the effectiveness of relaxation techniques and lubrication in preventing anorectal disorders associated with AI. Considering existing knowledge on the impact of anal stretching and the use of lubricated circular staplers (Nelson, 2010), it is somewhat unexpected that more clinicians did not explicitly refute the notion that these methods provide complete sphincter protection. This scepticism highlights the need for more contemporary research in this area. Comprehensive studies are essential to ensure that public health campaigns advocated by clinicians gain widespread support and avoid criticism.

Ultimately, the findings highlight a critical gap in medical education and public health awareness regarding the consequences of AI. More than 95% of clinicians expressed the need for better training on AI-related health risks and greater public

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health outreach. In the absence of clear, evidence-based guidance, non-medical sources have filled the information void, often offering misleading or incomplete advice. Future research should focus on evaluating the long-term effects of AI, improving clinician training, and developing public health initiatives that provide young women with the knowledge necessary to make informed decisions about their sexual health.

5.4.1 Strengths and Limitations

This study had its limitations. As with most surveys, responses are self-reported, therefore clinicians may have over or under-estimated their history taking practices. The number of participants selecting neutral answers in this study were limited, which suggests selected responses are likely to have been thought-through and intentional. Individuals who chose to participate in this survey may have an interest in the subject matter and not necessarily represent the larger population of surgical clinicians. This selection bias as well as the low response rates lessens its generalisability.

On the other hand, this is a novel study, being the first of its kind to collect data on the opinions and practices of surgical clinicians across the UK. It identifies an important gap in assessing anorectal conditions among female patients. Clinicians believe AI poses risks to the anus and agree that in several clinical conditions, a detailed sexual history including that of anal sex should be taken, however, they do not put this into practice due to several barriers.

5.4.2 Conclusion

Although clinicians generally agree on the association between anorectal disorders and anal intercourse, there are still significant barriers to addressing topics like anal sex and other aspects of sexual health. Expert opinions suggest that anal intercourse is a risk factor for anorectal disorders, even with the use of lubrication and relaxation techniques, though further research is needed to

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explore this more thoroughly. Additionally, there is a lack of significant quantitative studies assessing the impact of anal intercourse on the anal sphincters, and further research in this area would be valuable in assisting clinicians with their patient discussions.

Chapter 6: Barriers and Facilitators in Discussing Sensitive Topics in Healthcare

This chapter presents the qualitative component of the mixed methods study, detailing its design, data collection, analysis, and results. It concludes with a discussion of key findings and their relevance to the research question.

6.1 Introduction

The ability of healthcare practitioners to discuss sensitive topics like anal sex is crucial for identifying risk factors, providing appropriate care, and promoting patient well-being. Despite its importance, conversations on such topics are often avoided, leading to gaps in care.

Despite the importance of sexual health, data suggests that sexual health is seldom addressed within healthcare settings. Consistent with this study's quantitative findings, research in other non-surgical specialties also highlights a disconnect between recognizing the importance of sexual history taking and its practice. Lincoln and Haboubi in a survey of over 800 participants, identified that although 90% healthcare professionals recognised the need for addressing sexual issues as part of holistic patient care, 94% were still unlikely to raise sexual issues with their patients (Haboubi & Lincoln, 2003). Several personal and systemic barriers have been identified as barriers to these conversations, including inadequate training, time constraints, fears of "opening a can of worms", assumptions, and cultural and religious beliefs (Abbott & Howarth, 2007; Gott et al., 2004; Hinchliff et al., 2004; Hinchliff et al., 2005). This study identifies similar challenges, particularly inadequate training and concerns about wrongful assumptions. While personal beliefs were the least influential factor, they still affected 8% of clinicians.

Beyond traditional sexual health topics, anal intercourse is fast emerging as a sexual norm (Faustino, 2020). The medical profession has lagged behind societal changes, creating challenges for clinicians in managing women with anal

conditions. While the quantitative aspect of this study provides a valuable foundation for understanding why discussing sexual health is often avoided in healthcare, more in-depth exploration of these barriers is essential to uncover how these barriers function in practice and how they may be addressed. This overall findings of both aspect of this mixed methods study aims to help policymakers and healthcare providers enhance how sexual issues are addressed in healthcare.

Aims and objectives

This study seeks to synthesize findings from qualitative interviews to gain a deeper understanding of clinicians' subjective experiences when discussing anal sex with patients, focusing on identifying the factors that hinder and support these conversations in clinical practice.

6.2 Methods

6.2.1 Study design

A qualitative study design was chosen to allow for an in-depth understanding of participants' experiences and attitudes. Semi-structured interviews were selected for their ability to provide both structure and flexibility. The use of an interview guide ensured a focused exploration of key topics while allowing participants to respond in depth and steer the discussion in relevant directions. This approach facilitated a balance between maintaining consistency and capturing participants' perspectives on the subject matter.

The interview questions were developed based on the study's objectives and a review of relevant literature on barriers to discussing sensitive topics, such as sexual health, in clinical settings. As the interview process progressed, the questions were refined through iterative review, incorporating insights gained from previous interviews. Additionally, a reflection diary was maintained at the outset of the interview process, which contributed to the continuous improvement of interview techniques.

Ethical approval was sought and received from both the Faculty of Health and Medicine Research Ethics Committee (FHMREC) at Lancaster University and the NHS Research and Ethics Committee (REC).

6.2.2 Recruitment

A purposive sampling approach was employed to recruit a minimum of eight participants, ensuring representation across different specialist tiers, including advanced nursing or care practitioners, resident doctors, staff grade surgeons and consultants, as well as a balance of genders. All participants were required to be active healthcare practitioners who saw at least one female patient in the clinical setting with anorectal disorders. The maximum sample size was set at 30, as it was anticipated that thematic sufficiency would be reached within this range, and managing a larger dataset could pose practical challenges.

Information on the semi-structured interviews was embedded at the end of the survey questionnaire. Participants were invited to click on a link which redirected them to a different webpage containing further details on the semi-structured interviews. Interested participants (n=42) shared their contact details. All volunteers were contacted via email on 2 separate occasions. The emails contained an information leaflet on the study and a consent (appendix) Therefore, this study aimed to establish an evidence base for best practices for sexual history taking in clinical settings, specifically concerning anorectal disorders in females. Participants were not required to complete a written consent. Volunteers were invited to schedule an interview with the researcher. Interested participants contacted the researcher and a meeting was arranged on Microsoft Teams.

Each interview began with a briefing, reiterating the purpose of the study. Verbal consent was then obtained by reading aloud the consent form to participants and offering opportunities to ask questions before the interview began.

6.2.3 Data Analysis

Interviews were conducted via Microsoft Teams, recorded, and transcribed automatically. Each interview transcript was reviewed, anonymised, and any obvious inaccuracies and time stamps were deleted. Data collection stopped when no new important themes emerged, presuming sufficient thematic coverage had been achieved.

To ensure accuracy, the researcher reviewed both the interview recordings and corresponding transcripts, this was also an important step in further data familiarisation. This process led to a development of the researcher's first impressions, which were noted. Thematic analysis was used to identify key themes from the interviews, following Braun and Clarke's approach (Clarke & Braun, 2017). The anonymised transcripts were uploaded to the NVIVO software, where each transcript was read line-by-line and codes were developed. All codes were reviewed and condensed or renamed where appropriate. Codes with similarities were grouped together and their highlighted participant quotes reviewed to develop descriptive themes. The emerging themes were categorized and condensed to provide a richer understanding of healthcare professionals' perspectives.

The results are presented narratively with anonymous quotations.

6.3 Results

Nineteen interviews occurred between 19 November 2023 and 17 May 2024. Participants were aged 32–66 years (median 46 years) and included 9 female and 10 male clinicians. Interviews lasted 19–58 min. Twenty-three additional people showed interest in the study but did not respond to invitations to participate. A summary of participants is given in Table 6. Analysis identified five overlapping and interconnected analytical themes.

Chapter 6: Barriers and Facilitators in Discussing Sensitive Topics in Healthcare

Table 6: Interview participant characteristics

		Total	Male	Female
	Participants	19	10	9
Age group (in years)	31 - 40	5	1	4
	41 - 50	7	3	4
	51 - 60	5	4	1
	60+	1	1	-
Ethnic group	White British or Irish	13	7	6
	Black, Black British, Caribbean or African	3	1	2
	Mediterranean	2	1	1
	Asian or Asian British	1	-	1
Sexuality	Heterosexual	15	8	7
	Homosexual	3	2	1
	Bisexual	1	-	1
Religion	No religion	12	7	5
	Christian	4	2	2
	Muslim	3	1	2
Current position/grade	Consultant surgeon	11	7	4
	Staff grade surgeon or surgical trainee	6	1	6
	Advanced care practitioner	1	1	-

6.3.1 Theme 1: Patient Selection: When do clinicians feel it is appropriate to ask about anal sex?

Clinicians expressed varied perspectives on the appropriateness of discussing anal sex during consultations, often influenced by patient demographics such as

age, presenting symptoms, and social context. Several participants highlighted the increased openness among younger patients regarding anal sex. A 46-year-old female clinician observed that

“younger women are actually quite open about it,” noting that they discuss the topic candidly, whereas “older women... get defensive”

or may only allude to such experiences later in the consultation. Similarly, a 32-year-old female clinician remarked that anal sex *“seems more accepted and discussed among younger populations... regardless of sexual orientation,”* while older patients often find it a taboo subject. Age-based biases in practice were common. Some clinicians expressed personal biases or discomfort when faced with different patient age-groups. A 46-year-old male acknowledged,

“I think I would be more inclined to do that in young women, and I don’t know whether that’s correct or not... it’s probably just my own kind of personal bias.”

This aligns with the perspectives of other clinicians, who have reported a greater level of comfort when discussing anal sex with younger generations of women. A 44-year-old male clinician admitted,

“I probably haven’t asked older women about anal sex if there’s rectal bleeding or faecal incontinence.”

Likewise, a 45-year-old female noted that while she was taught to inquire about anal intercourse in cases of incontinence, it remains *“quite an awkward question to ask of a sort of 75-year-old woman.”* For a 55-year-old male clinician, the perceived relevance of anal sex as a contributing factor to symptoms also influenced his decision to ask, explaining,

“When I’m seeing a 70-year-old lady, it’s probably not as relevant from a percentage perspective, than somebody who might be 25.”

Considering older women to be more likely to have been exposed to other significant risk factors for anorectal symptoms in their lifetime, e.g., childbirth and aging related weakness of the pelvic floor, and therefore suggesting inquiring about anal sex was less relevant. Some clinicians even regarded age as a determining

factor in disregarding concerns related to anorectal risk factors. A 42-year-old consultant remarked:

“when you're in your 70s and 80s, I actually don't think what you put up your bum is relevant at that point, because there's so many other factors that are going to make the difference. And I just think, well, if you're gonna enjoy anal intercourse when you're 80, then please go do it, just please go out and do it, whatever pleasure you can get at that point, please do it.”

Practical considerations, such as time constraints, also shaped clinicians' approaches. A 60-year-old male noted that asking all patients with anal or anorectal symptoms about anal sex would be impractical, stating,

“You're not always going to meet the world's best patient at talking about it... It's going to be that added bit of sensitivity and time that is going to slow you down.”

Instead, clinicians tended to be selective, prioritizing cases where anal sex was perceived to be more relevant to the presenting complaint. For instance, a 34-year-old female clinician admitted, *“In many situations, I've probably not even thought about the link with anal sex,”* particularly when other plausible explanations, such as their obstetric history, were apparent.

In contrast, other clinicians emphasized the importance of addressing the topic consistently albeit selectively to certain clinical conditions. Faecal incontinence and atypical or recurrent anal fissures were considered the most relevant clinical conditions. A 56-year-old male clinician explained that he would ask about anal intercourse in cases of faecal incontinence or when common causes of symptoms had been excluded, noting,

“If they were referred for faecal incontinence, I would ask about ano-receptive intercourse at their first visit.”

A 54-year-old female surgeon also noted,

“I tailor the phrasing to the patient, but I always ask patients with anal fissures about [anal intercourse] as it influences the management plan.”

Overall, clinicians' willingness to discuss anal sex was shaped by their interpretation of the relevance to the clinical presentation, patient characteristics, and their own biases or comfort levels. While many acknowledged the growing openness of younger generations and societal shifts toward greater acceptance of discussing sexual practices, some expressed unease, particularly when addressing older patients or when constrained by time and societal expectations.

6.3.2 Theme 2: Sexual History Taking: Why clinicians don't ask about anal sex.

Clinicians' practices in sexual history taking, particularly regarding anal intercourse, were influenced by a variety of factors, including personal comfort, demographic factors, cultural sensitivities, and knowledge. Despite the clinical importance of this discussion, the topic remains challenging to broach due to its sensitive and often stigmatized nature.

Personal Comfort and Bias

Several clinicians acknowledged their own discomfort as a barrier to asking about anal sex. A 46-year-old male clinician reflected on his challenges, noting that *"as a male surgeon... it's not something that comes easily and comfortably to me."*

Similarly, a 32-year-old female clinician admitted,

"I haven't found a way to ask without it being uncomfortable for either myself or the patient."

For some, overcoming this discomfort required conscious effort and experience, with one clinician stating, *"As I've become more conscious of this issue, I've tried hard to... get over my own embarrassment."* Discomfort was more evident among male clinicians. Phrases like *"dirty old man"*, and *"what kind of pervert is he?"* were used to express their concerns about how they might be perceived when asking female patients about anal sex.

Biases also shaped clinicians' likelihood of initiating these discussions. A 34-year-old female clinician admitted to asking men more frequently than women about anal intercourse, a tendency she attributed to assumptions:

"I've probably not even thought about the link [in women]... especially if there's a more likely explanation for the condition."

The assumption that the anal intercourse was only practiced in the homosexual population, was highlighted as another factor that deters a detailed sexual history taking.

Socioeconomic and Cultural Considerations

Cultural and religious considerations played a role in clinicians' willingness to broach the subject. For some clinicians, their own cultural backgrounds shaped their discomfort in addressing the topic. A 34-year-old Muslim female of African descent reflected,

"In my culture, it is taboo... it's not really discussed, and so maybe that plays a role in how I approach these patients."

Similarly, a 49-year-old male surgeon of African descent described how his cultural upbringing made discussing sexual practices challenging, though his medical training and years of experience helped overcome this barrier. These personal influences highlight the deep impact of cultural and societal norms on clinical practice.

Religious factors also shaped patient interactions. For instance, a 66-year-old male clinician working in a conservative area noted,

"Lots of my female patients are Muslim... coming out with a straight question to a young female Muslim is not going to go very far."

This clinician adapted his approach by framing questions more generally about trauma or injury, allowing patients to disclose relevant information at their comfort level. This strategy underscores the need for culturally sensitive communication techniques in clinical settings.

Patients' preferences for clinicians of a specific gender were also linked to cultural and religious considerations. A 46-year-old male clinician observed,

“women from certain religions or cultures tend to ask to see a female surgeon.”

While accommodating these preferences is important, it raises questions about whether such dynamics limit the availability of comprehensive care, particularly in settings with fewer female clinicians.

Societal norms and taboos further complicate the conversation. A 66-year-old clinician explained that addressing anal intercourse often provoked *“blank expressions”* from patients, reflecting its status as a *“big taboo issue.”* However, younger generations' increasing openness to discussing sexual practices offers hope for change. A 60-year-old clinician noted that *“taboo subjects are becoming more openly discussed in society,”* suggesting that generational shifts could gradually ease these conversations in clinical practice.

Perceived circumstances also played a role, suggesting clinicians sometimes made assumptions about patients. A 49-year-old male clinician suggested that in trauma or socially complex cases, he was more likely to ask about sexual history, whereas in *“a normal decent-looking person,”* such questions were often omitted. Another clinician noted: *“As a visibly Muslim person, Muslim patients might feel judged...”*, making an assumption about a patient's willingness to discuss their sexual practices and how these taboos could influence both the patient's and clinician's comfort.

Patient discomfort

Patient discomfort also contributed to the difficulty of these conversations. The stigma surrounding sexual health, particularly anal sex, made some patients reluctant to engage, and clinicians noted that even discussing vaginal sex could be challenging. A 38-year-old female remarked,

“I think it's difficult sometimes for patients sometimes to talk about having vaginal sex and you know symptoms like dyspareunia. So then when you're getting into

something that's more taboo, then they're just feeling a bit more reluctant. Maybe a bit embarrassed as well."

Some clinicians also discussed situations where patients sometimes became defensive when asked, either because they felt judged or because they were uncomfortable admitting their experiences. This defensiveness made the conversation harder to manage, even for clinicians who were otherwise comfortable with the topic. A 32-year-old female clinician remarked,

"I wouldn't hesitate, but it's a sensitive topic. Even with men, I've seen patients feel judged or defensive, which can make the interaction tricky. Personally, I'm fine asking, but managing the patient's defensiveness can be challenging."

Gender and Sexuality

A major concern was the fear of causing offense, with some worried that questions on anal sex could be perceived as inappropriate or even lead to accusations of harassment. A 33-year-old male clinician explained,

"you might end up being in quite a difficult situation yourself like accused of harassment or whatever".

Gender played a role in these perceptions, as female clinicians felt they might navigate these discussions more easily, whereas male clinicians feared their questions could be misinterpreted. A 32-year-old female clinician suggested,

"Being a woman helps, I think if a male doctor were to ask those questions, there could be different connotations, which would make it harder."

Another female clinician had similar views, *"Male surgeons struggle with these topics due to fears of inappropriate conduct."* Clinician sexuality also influenced these discussions. Those who identified as LGBTQ+ felt more at ease due to their personal experiences and familiarity with open conversations about sexual health. In contrast, those without such exposure found it more difficult to normalize these discussions. A clinician explained,

“Being part of the gay community and having open discussions about these topics in my personal life also makes it less taboo for me”

Clinician experience

Beyond these interpersonal challenges, a lack of knowledge and training further contributed to clinicians' hesitation. Some admitted they had not considered the importance of taking a detailed sexual history, especially regarding anal sex, because it was not emphasized in medical training or clinical practice. A clinician remarked, *“I haven’t fully appreciated the importance of these questions”*. Others lacked experience in seeing these discussions modelled by senior colleagues, which made them unsure about how to approach them in a sensitive yet effective way. A 32-year-old clinician remarked, *“I haven’t seen anyone do it, I’d need to think of a way that wouldn’t offend them”*

Building Trust and Reducing Stigma

Clinicians emphasized the need to build rapport and create a judgment-free environment to facilitate open discussions. A 38-year-old female clinician explained,

“It’s about making it clear that it’s a judgment-free zone... and trying to make it clear that it’s not a judgment on them.”

Being nonjudgmental and direct was seen as key to putting patients at ease. For instance, one clinician stated, *“I ask in a way that’s straightforward but also approachable.”*

The stigma surrounding anal sex was acknowledged as a significant barrier for both patients and clinicians. A 48-year-old female clinician highlighted the need to address societal biases: *“Social media posts mocking patients... only perpetuate embarrassment and delay care.”* Another clinician emphasized the importance of addressing root causes: *“If you’re not tackling the causes of the problem, you can’t expect to see good results.”*

Overall, these barriers highlight a mix of personal, professional, and structural challenges that prevent clinicians from confidently taking a sexual history.

Addressing these issues through improved education, open discussion, and clear guidance on navigating sensitive topics could help normalize these conversations and reduce clinician hesitation.

6.3.3 Theme 3: Is Our Healthcare System Appropriately Set Up to Explore Sexual History?

Clinicians described significant challenges in addressing sexual history within the current healthcare setup, citing issues related to privacy, time constraints, and the need for standardized tools and training. While some recognized the importance of discussing sexual history, systemic barriers often hindered these conversations.

Privacy and Environment

A recurring concern was the lack of privacy in both ward and outpatient settings. Many clinicians noted that shared spaces, such as wards with thin curtains or communal bays, deterred open discussions. A 38-year-old female clinician explained,

“Those curtains are not soundproof... patients are always a bit nervous and reluctant about talking about intimate things.”

Similarly, a 34-year-old clinician pointed out,

“In ward settings, there’s no privacy whatsoever... even routine questions about bowel habits can feel intrusive.”

Outpatient clinics were viewed as slightly more conducive to sensitive discussions, but privacy concerns persisted, particularly when patients were accompanied by family members or partners. A 48-year-old female clinician observed,

“Patients are more open when I’m alone with them. Having another person in the room can make it more challenging for them to share.”

Time Constraints

Time limitations were another critical barrier. Many clinicians felt unable to thoroughly address sexual history within the constraints of a busy clinic. A 60-year-old male surgeon remarked,

“If you ask everybody who came with some kind of anal or anorectal symptoms, I think you’d really struggle to complete your clinic.”

The limited time available during consultations was identified as a significant barrier to initiating discussions about anal sex. Clinicians reported that the constrained duration of appointments hindered their ability to establish the necessary rapport with patients—an essential prerequisite for addressing sensitive topics such as anal sexual practices. A 32-year-old clinician commented:

“You need time to build rapport and ensure patients feel comfortable.”

Additionally, restricted consultation times were perceived as a major limitation, reducing opportunities for clinicians to explore concerns beyond the patient’s immediate presenting issue. There was particular concern that introducing sensitive subjects could lead to prolonged discussions, especially if patients disclosed traumatic experiences. As one 60-year-old clinician reflected:

“I’ve had people break down in tears... and if that’s your first patient of the day in a clinic with 25 patients, it’s a practical disaster.”

Role of Chaperones

The availability and role of chaperones emerged as a complex issue. While chaperones were often used to ensure medicolegal safety, some clinicians believed their presence could hinder open communication. A 48-year-old female surgeon shared,

“If a nurse or healthcare assistant is present, it can create an awkward atmosphere... make things a little bit uncomfortable.... it affects the patient’s willingness to open up.”

On the other hand, clinicians emphasized the necessity of chaperones in certain cases, particularly for medicolegal protection when discussing sensitive topics

with young women. A 56-year-old surgeon commented, *“there’s nearly always been a female nurse or healthcare worker”* otherwise, he would *“feel uncomfortable about asking the history”*. Another 33-year-old male clinician stated, *“I always bring a chaperone with me in these practices because it can get quite sensitive”*.

Standardized Tools

Clinicians expressed a need for standardized tools, such as proformas or pre-consultation questionnaires, to facilitate discussions about sexual history. These tools were seen as beneficial for normalizing the topic and reducing discomfort for both clinicians and patients. A 33-year-old clinician described the value of checklists:

“Having a checklist prompts you to ask the question... it just takes all that haziness of a difficult conversation out of it.”

Similarly, a 60-year-old male clinician suggested,

“Questionnaires might allow people to tick a box... which could flag an area they might want to talk about, rather than facing a direct question.”

Digital solutions, such as apps or online forms, were also proposed. A 49-year-old male clinician suggested,

“Patients should have access to a link... to answer questions in their comfort zone before coming in. That would make it easier for both patients and clinicians.”

Clinicians acknowledged that systemic changes were necessary to create an environment more conducive to discussing sexual history. Enhanced privacy, longer consultation times, and greater integration of psychosexual services were identified as key areas for improvement. As a 46-year-old female clinician summarized,

“It’s a sensitive topic, and we need clear pathways for referrals, but funding for psychosexual services is lacking.”

Several clinicians highlighted the importance of training to normalize such discussions. A 54-year-old female surgeon noted, *“The more you ask, the better you get at it,”* advocating for robust education to equip clinicians with the skills and confidence to navigate these conversations. However, a 45-year-old male surgeon acknowledged the lasting influence of historical practices: *“Convention is quite a powerful thing to overcome.”*

6.3.4 Theme 4: Expert opinion: is anal sex a risk factor for anal symptoms in women?

Clinicians offered a range of insights into the relationship between anal sex and anal symptoms in women, discussing anatomical, psychological, and social factors. While some acknowledged an increasing prevalence of anal intercourse and related symptoms, others highlighted gaps in research and education that complicate understanding and management. Although this was not specifically sought as part of the research question, it emerged as clinicians discussed their knowledge and experiences when seeing female patients with anorectal disorders. Given the dearth of published research in this area, it was important to include this theme.

Anatomical Vulnerability

Several clinicians underscored the anatomical differences between men and women that contribute to women's increased susceptibility to anorectal trauma. Women possess congenitally shorter and structurally less robust anal sphincters compared to men (Reginelli et al., 2012a; Williams et al., 2001) and are at heightened risk of faecal incontinence (FI) due to pregnancy and childbirth (Frudinger et al., 1999). A 34-year-old female clinician emphasized this point, stating:

“Women have a shorter sphincter complex and therefore are at a higher risk of things like incontinence, especially if they’ve got an obstetric history.”

Similarly, a 45-year-old female surgeon highlighted the structural limitations of the female sphincter, noting:

“the female sphincter isn’t really designed for anal intercourse; it’s much shorter and not as resilient.”

In addition to congenital differences, postpartum and menopausal changes were identified as exacerbating factors. A 55-year-old male clinician explained:

“pregnancy and childbirth cause some degree of damage to the sphincter, and as you age, sphincter function deteriorates,”

which may increase the risk of incontinence, particularly when additional stressors, such as anal intercourse, are introduced. A 48-year-old female surgeon voiced concerns about the future of the current generation of women who engage in anal sex,

“I’m increasingly anxious about the growing number of women we’ll see with incontinence due to anatomical differences, postpartum changes, and menopause.”

Impact on Symptoms and Quality of Life

Consistent with findings in the published literature (Gaither et al., 2024; Hemaly & Mousa, 2020; D. Herbenick et al., 2015; Nzimbala et al., 2009), many clinicians reported observing in their practice that anal intercourse may contribute to a spectrum of anorectal symptoms, including fissures, bleeding, and sphincter injuries. A 56-year-old male surgeon noted, *“I’ve seen women who’ve tried anal intercourse and experienced pain or fissures,”* while another emphasized the potential for chronic issues:

“Repeated trauma, which again interestingly nobody ever talks about, repeated friction and trauma increases the bulk of the haemorrhoids.”

Beyond physical symptoms, some clinicians highlighted the psychological impact. A 32-year-old female clinician explained,

“Symptoms like pain or bleeding might not just cause physical problems but also affect a patient’s ability to have intercourse in their usual way... something we might not consider enough in medicine.”

Sexual abuse and Psychological Dimensions

Sexual abuse emerged as a significant, albeit under-discussed, factor contributing to anal symptoms among women. Many clinicians reported encountering cases where anal symptoms were linked to a history of sexual abuse, resonating with some of the findings of the systematic review. A 45-year-old female clinician recounted her experience at a pelvic floor tertiary referral centre, noting the alarming frequency of women presenting with incontinence due to forced or coerced anal intercourse. She emphasized,

“It was frightening... the number of women who hadn’t talked about it until we asked the question.”, “About 10-15% of our pelvic floor patients report some kind of physical or emotional abuse.”

These examples further underscore the importance of discussing anal sex in relevant clinical encounters. Similarly, a 56-year-old male clinician observed that patients with chronic constipation or anorectal dysfunction often revealed histories of childhood sexual abuse during consultations. These cases highlight the long-term physical and psychological consequences of abuse, even in the absence of identifiable structural abnormalities.

Several clinicians noted the overlap between anal symptoms and domestic violence. A 34-year-old female clinician emphasized the role of healthcare professionals in addressing potential domestic abuse:

“If we’re concerned that anyone is at risk of domestic abuse or sexual abuse, we should be able to direct them to the right help.”

Despite the importance of addressing sexual abuse, clinicians identified significant barriers to its identification and management. Many patients are hesitant to disclose abuse, either due to shame, fear, or the perceived stigma associated with such discussions.

6.3.5 Theme 5: Public Health and Training: What Do Clinicians Know About Anal Sex?

Clinicians consistently identified a gap in education and public health resources related to anal sex, particularly regarding its role in anorectal symptoms and its potential risks. They highlighted a lack of standardized training, limited public health initiatives, and personal uncertainty about how best to address this sensitive topic.

Deficient Formal Training and Knowledge

Most clinicians reported that training on anal sex was either absent or insufficient throughout their education. A 32-year-old female clinician reflected, “*Medical schools don’t cover faecal incontinence, let alone anal intercourse,*” while another stated, “*We learn about trauma as a differential, but we aren’t taught how to ask about sexual history.*” Similarly, a 45-year-old surgeon noted that when anal intercourse was mentioned during training, it was predominantly in the context of STIs among men who have sex with men, neglecting the experiences of women.

For many, knowledge about the relationship between anal intercourse and anorectal conditions developed later in their careers, often through self-directed learning. A 33-year-old male surgeon described how his awareness grew only after working in colorectal surgery:

“I didn’t pick it up in medical school. It came later... through asking colleagues, reading, and realizing its importance during clinical practice.”

This reliance on informal learning may lead to inconsistent practices across the profession.

Challenges in Practice

Clinicians frequently expressed uncertainty about how to discuss anal intercourse with patients coupled with limited research data available to support discussions. The lack of robust research on the long-term effects of anal intercourse hampered

these conversations. A 54-year-old female surgeon cited anecdotal data suggesting “a 70% occult sphincter injury rate associated with anal intercourse” but emphasized the need for more studies to clarify the risks. A 66-year-old male surgeon echoed this sentiment, stating,

“There’s a dearth of data out there... it must have the potential for leading to a variety of issues over time.”

The difficulty of linking anal symptoms solely to anal intercourse was highlighted as a challenge. They overlap with anal sex and other risk factors which many women may be exposed to, presented as a challenge for some clinicians in deciding whether or not to broach an already sensitive topic. A 46-year-old male clinician explained,

“So, sphincter injury, for example, particularly women that have given birth, it’s very difficult, almost impossible, I would say to be sure about that....there’s lots of other, potential causes completely unrelated to anal intercourse.”

The role of clinicians in mitigating risk factors and offering advice was also considered. A 46-year-old male surgeon highlighted the difficulty of balancing patient autonomy with clinical advice, stating,

“I don’t want to overcompensate and make women unduly fearful... it’s hard to offer advice without robust data.”

A 38-year-old female clinician noted that clinicians often hesitate to ask sensitive questions due to concerns about offending patients or the stigma surrounding anal sex.

Many felt unequipped to provide detailed advice beyond addressing immediate clinical issues. A 56-year-old surgeon explained,

“I advise abstinence [to anal sex] for three months after a fissure... but beyond that, I lack the knowledge to guide patients comprehensively.”

The Need for Public Health Resources

A recurring theme was the absence of reliable public health materials for both patients and clinicians. A 48-year-old female surgeon noted,

“I haven’t come across any public health materials on this topic. Most resources focus on STIs, but there’s little about sphincter damage or incontinence.”

Others called for accessible, evidence-based information to counteract the influence of dubious online sources. A 46-year-old male surgeon stressed,

“There’s a lot of dubious information online... We need something reputable, like from the ACP or NHS, that we can confidently share with patients.”

Public health initiatives were also seen as critical for normalizing discussions around anal sex. A 49-year-old male clinician suggested that awareness campaigns could mirror successful programs like bowel cancer screening, providing both educational resources and destigmatization. Similarly, a 45-year-old surgeon emphasized the importance of addressing societal influences, noting that young people often learn about sex from pornography, which may promote unsafe practices.

Proposals for Training Improvements

Clinicians strongly advocated for integrating anal sex history taking into medical curricula. A 38-year-old surgeon emphasized,

“It needs to start in medical school and continue through postgraduate surgical training. Topics like anal intercourse need to be normalized and included in teaching.”

Others recommended immersive, hands-on workshops to help clinicians develop practical communication skills. A 60-year-old surgeon recounted the value of role-playing sessions during a communication course, stating,

“It was intense but incredibly useful... It helped me understand how patients feel and how to navigate difficult conversations.”

Training should also address the stigma surrounding anal sex to foster a more open, judgment-free dialogue. A 48-year-old clinician noted that mocking

behaviours, such as sharing X-rays of foreign bodies on social media, only perpetuate patient embarrassment and delay care. Clinicians stressed that normalizing these discussions would not only improve patient outcomes but also reduce clinician discomfort.

The Role of Public Education

Beyond medical training, clinicians called for broader public education efforts. Many believed that educating adolescents about anal intercourse in schools could help counter harmful stereotypes and promote safer practices. A 46-year-old surgeon advocated for incorporating these topics into social education, stating, *“I’m all in favour of teaching this to older school children. It’s vital for informed decision-making.”* Public health resources, such as NHS-provided leaflets or websites, were also seen as crucial for disseminating accurate information.

Ultimately, clinicians recognized the importance of addressing this educational gap to ensure comprehensive patient care. A 66-year-old male surgeon emphasized that doctors must separate personal values from clinical practice, stating, *“Our role is not to impose moral positions but to provide evidence-based advice and minimize harm.”* Many called for collaboration between healthcare providers, public health agencies, and educators to create a cohesive framework for discussing anal sex, ensuring that patients receive consistent, nonjudgmental, and accurate information.

6.4 Discussion

This thematic analysis synthesizes insights from 19 interviews with general surgery clinicians to explore attitudes, practices, and gaps in knowledge regarding sexual history-taking and anal sex. The findings build on the quantitative aspect of this study. It highlights the complexities surrounding sexual history taking, particularly around receptive anal intercourse. The relationship between sexual practices and anorectal conditions is an underexplored yet critical area in clinical practice.

Women presenting with symptoms such as anal fissures, incontinence, and rectal

bleeding often require sensitive, nuanced discussions about sexual history to ensure accurate diagnosis and effective management. Despite this, many clinicians face challenges in addressing topics related to anal intercourse due to cultural taboos, limited training, and systemic barriers.

Participants identified similar barriers to discussing anal sex as the questionnaire including discomfort, time constraints and lack of adequate training. The process of sexual history taking was shaped by a combination of personal comfort, patient dynamics, and systemic constraints. Several clinicians highlighted their own discomfort with discussing anal sex, particularly with female patients. Phrases like "...a dirty old man" and "...what kind of pervert is he?" describe some of the ways some male clinicians feel they are perceived by women if they attempt to take a sexual history.

Concerns regarding male clinicians treating female patients have been documented, often tied to medicolegal challenges (Clemens et al., 2021). Cases where male doctors have faced accusations of sexual misconduct with female patients have contributed to these concerns, heightening caution (DuBois et al., 2019). Interestingly, female clinicians have also reported challenges when dealing with male patients, indicating that these issues are not one-sided (Guardian, 2023). The preference of many female patients to be seen only by female clinicians, while understandable and important to accommodate, may inadvertently create additional barriers in care delivery, as it limits opportunities for open dialogue with male clinicians. Chaperones, although controversial, may provide a significant role in this area, for both male and female clinicians.

Cultural and religious factors further complicate this dynamic. Unconscious biases often lead to assumptions about patients' behaviours based on their appearance or religious identity (Dyer & das Nair, 2013). For example, assuming a female patient does not engage in anal intercourse solely because of her perceived religious beliefs is an inappropriate approach. Such assumptions risk overlooking relevant risk factors, which could lead to mismanagement of the patient's condition.

The findings also suggest that many clinicians who are willing to take a sexual history are often selective about who they would ask, basing decisions on clinical presentation, clinical setting and age group. These issues raise fundamental questions about how sexual history taking is approached. Should discussions about anal intercourse be restricted to specific conditions, such as anal fissures, while being overlooked in cases of incontinence? Are these questions only relevant in outpatient settings, or should they be incorporated more broadly? Limiting these discussions to specific circumstances risks missing valuable opportunities to identify contributing factors to anorectal symptoms.

To address these challenges, sexual history taking must become a standardized component of clinical practice. Without such consistency, we risk failing to identify a critical risk factor for anorectal symptoms. Furthermore, incorporating these discussions into routine practice would normalize the topic and reduce stigma. Regular, open conversations about anal intercourse not only improve clinical practice but also build clinician confidence through experience, ensuring better patient outcomes.

Gaps in clinician education, systemic support, and public health initiatives are also highlighted. These deficiencies may significantly impact patient outcomes, as clinicians may miss relevant aspects of the patient's history that are important in aiding diagnosis and effective treatment. Unresolved symptoms could persist if clinicians feel hesitant or unprepared to address sensitive topics like anal sex. Absence of appropriate clinical education erode clinician confidence, as many report feeling inadequately trained or supported when navigating these complex conversations. This underscores the importance of equipping healthcare professionals with both the knowledge and tools to approach these discussions confidently and competently. While societal attitudes toward sexual practices are evolving, such as increased openness about sexual health and normalization of discussions around sexual diversity, these changes are not reflected in medical training or practice (Prize et al., 2023b). Younger generations are highlighted as more likely to discuss sexual preferences more openly, influenced by greater representation in media and culture. However, clinicians report that medical

education remains focused on traditional sexual health topics, often neglecting the implications of anal intercourse for women. This disconnect highlights the need for medical curricula to advance alongside societal progress to ensure that clinicians are prepared to address diverse patient needs. Many clinicians expressed discomfort or uncertainty when discussing anal sex, emphasizing the need for training to equip healthcare professionals with the skills and confidence to navigate these conversations. With adequate training and experience, this process is likely to become less challenging for clinicians, destigmatizing anal sex, and ultimately normalizing it as a routine part of history taking.

The lack of reliable public health materials on anal intercourse—beyond its association with STIs—is a significant barrier to both patient and clinician education (NHS, 2022). Developing evidence-based resources could help normalize discussions, reduce stigma, and empower patients to make informed decisions about their health. These resources should be tailored to address both the clinical and psychological aspects of anal intercourse, providing clear, actionable advice for patients and clinicians alike. Sexual health education in schools was also raised by some participants. Addressing anal sex and the potential consequences, including STIs and anal symptoms, earlier in life will also help destigmatisation and improve openness on this topic. One must however consider the implications and acceptability from parents and guardians (Brooks, 2022). It is clear from studies even within the UK that 16- & 17-year-old are more aware of sexual options beyond ones considered as traditional and engage in anal intercourse (Lewis et al., 2017).

Furthermore, systemic changes, such as improving privacy in clinical settings and addressing time constraints, are essential for fostering open, judgment-free dialogues. Practical solutions could include redesigning clinic workflows to allocate dedicated more time for sensitive discussions, creating more private consultation spaces, and integrating pre-consultation questionnaires to help clinicians identify relevant topics beforehand. These measures would enhance the clinical environment, making it more conducive to discussing sensitive issues like anal sex without compromising patient or clinician comfort.

6.4.1 Limitations

Certain limitations of the study must be acknowledged. First, the data is based on interviews with 19 clinicians, which may not fully capture the diversity of perspectives across different specialties, regions, or cultural contexts. The small sample size therefore limits the generalizability of findings to broader clinical practice. Nonetheless, the researcher felt it appropriate to end recruitment as very similar themes had emerged from the interviews based on initial reviews and no new insights were being generated. Furthermore, additional data would have proved difficult to manage for the researcher. The self-reported nature of the data also introduces potential biases, such as recall bias or social desirability bias, which may have influenced clinicians' responses.

The researcher's profession as a consultant surgeon and contents of the questionnaire may have influenced those who volunteered to participate. Participants may be clinicians who are more likely to inquire about anal sex and sexual health in their clinic setting, sharing similar viewpoints to the researcher. Although all effort was made to create a "judgement free zone" during interviews, being a clinical topic between clinicians (i.e. researcher and participants who are both clinicians), participants may have felt that it was an interview that would test their knowledge, and as result research their responses prior to the interviews.

Lastly, this analysis focuses primarily on clinicians' perspectives and does not include patient viewpoints. Understanding the patient experience is essential for a comprehensive approach to improving sexual history-taking and addressing sensitive topics like anal intercourse. Although some insights have been gained from the systematic review, future research should aim to incorporate patient perspectives to provide a more holistic understanding of these issues.

6.4.2 Conclusion

This analysis underscores the need for systemic and educational reforms to address gaps in clinicians' knowledge and practices related to anal sex and sexual history taking. Training programs should include comprehensive guidance on discussing sensitive topics, with an emphasis on practical communication

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strategies and risk assessment. Specific elements such as role-playing scenarios can provide clinicians with hands-on experience in navigating complex conversations. Incorporating feedback from patients can further refine these skills, helping clinicians build confidence when addressing sensitive issues. Public health initiatives must also prioritize the development of accessible, evidence-based resources to inform both clinicians and patients. By addressing these challenges, the healthcare system can better support women presenting with anorectal symptoms, ensuring holistic and compassionate care.

Chapter 7: Conclusion

7.1 Linking the two studies

This thesis aimed to examine healthcare practitioners' (HCPs) attitudes toward sexual history-taking in female patients presenting with anorectal disorders. By doing so, it sought to provide evidence-based recommendations for sexual history-taking in both general and colorectal surgical practice.

Anal intercourse has become increasingly normalized within the heterosexual population. In the UK, up to 28.5% of women report engaging in anal intercourse (Lewis et al., 2017), with similar prevalence rates of 22–40% documented in the USA (Chandra et al., 2011; Gorbach et al., 2009; Habel et al., 2018; Reynolds et al., 2010; Joy D. Scheidell et al., 2020). Although research on this topic remains limited, several studies have identified associations between anal sex and anorectal disorders, including faecal incontinence, in women (Gaither et al., 2024; Geynisman-Tan et al., 2018; Goddard et al., 2021; Debby Herbenick et al., 2015; Markland et al., 2016; Nzimbala et al., 2009). Women are at an increased risk of developing anorectal conditions due to their less robust anal sphincter muscles, as well as the impact of aging, hormonal changes, pregnancy, and childbirth on the pelvic floor muscles supporting the anal canal (Williams et al., 2001).

Effective clinical management of anorectal disorders requires a comprehensive understanding of contributing risk factors, with thorough sexual history-taking serving as a critical diagnostic tool. In its absence, patients may experience recurrent symptoms without appropriate intervention. Consequently, one would expect healthcare practitioners to recognize anal intercourse as a relevant risk factor for anorectal disorders and to routinely incorporate sexual history-taking into their clinical practice to facilitate early identification and mitigation of these risks.

Chapter 7: Conclusion

The findings of this study indicate that sexual history-taking in female patients presenting with anorectal disorders is not universally practiced in the UK among healthcare practitioners in general and colorectal surgery. Only 34% of clinicians agreed or strongly agreed that asking about anal sex was important in all women with anal symptoms. Female clinicians were more likely to conduct sexual history assessments, which may reflect their greater awareness of the challenges women face when this aspect of care is overlooked, or their generally more comprehensive approach to clinical practice. Research has shown that female clinicians tend to communicate more effectively with patients than their male counterparts, adopting a more patient-centred approach and spending additional time with patients (Jefferson et al., 2013; Roter et al., 2002).

Clinicians also demonstrated selectivity in deciding which patients to question about sexual history. They were more likely to inquire about sexual practices in younger female patients, particularly in the presence of specific clinical conditions and when other potential causes had been excluded. Some clinicians perceived discussing sexual history with older women as either "awkward" or "irrelevant" and there was a common assumption that younger women are generally more "open" about their sexual practices, with anal intercourse being more "accepted" in this demographic. However, there is no empirical evidence to suggest that anal sex is exclusive to younger women. On the contrary, previous research has highlighted that the sexual health of older individuals is often overlooked due to the assumption that they are not sexually active (Hinchliff, 2016).

Selective history-taking based on a patient's age and clinical condition presents several concerns. Firstly, it implies that clinicians may be making assumptions about patients' sexual behaviours, which may not always be accurate. Secondly, it risks overlooking certain groups of women who could benefit from appropriate healthcare interventions should these assumptions prove incorrect. Lastly, it undermines the advantages of a standardized approach to sexual history-taking, such as ensuring consistency, improving clinical practice through experience, and fostering comprehensive patient care (Nichol JR, 2024; Peart, 2022). Such

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assumptions and biases can contribute to discriminatory practices and adversely affect patient care (Sabin Janice, 2022).

Clinician experience was another influential factor. Less experienced clinicians, particularly those early in their careers, were less likely to conduct sexual history assessments when female patients presented with certain anorectal disorders. This finding underscores a gap in knowledge and formal training at the early stages of medical education. Interviews revealed that some clinicians only developed this skill informally over time. A 33-year-old male surgeon reflected on how his awareness of the importance of sexual history-taking emerged later in his career:

“I didn’t pick it up in medical school. It came later... through asking colleagues, reading, and realizing its importance during clinical practice.”

Only 47% of clinicians surveyed reported feeling comfortable asking patients about anal sex. Comfort levels were influenced by both gender and sexual orientation. Female clinicians were significantly more comfortable discussing this topic, with 65% reporting ease compared to only 43% of male clinicians ($\chi^2(2) = 12.12, p = 0.002$). Male clinicians, in particular, expressed apprehension about raising the topic due to concerns about being perceived as inappropriate or facing accusations of sexual misconduct. A 60-year-old male consultant surgeon articulated this concern:

“It’s easier for me to say, bring up the topic and all of a sudden, a patient will write in or phone PALS and say I’ve just been seeing this bloke about my constipation and all the sudden we’re talking about anal sex and what kind of pervert is he. Whilst I think I need to be a professional and do my job properly, at the same time it’s definitely a human trait to be hesitant.”

This hesitancy is situated within the broader context of increasing awareness and reporting of sexual misconduct in healthcare. A joint investigation by The BMJ and The Guardian found that between 2017 and 2022, NHS trusts documented over 35,000 cases of rape, sexual assault, harassment, stalking, and abusive remarks (Torjesen & Waters, 2023). As a result, clinicians may adopt a more cautious approach in patient interactions, prioritizing professional boundaries and clear

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communication. Consequently, discussing a sensitive topic such as anal sex may be particularly challenging within the male clinician–female patient dynamic.

Sexual orientation also influenced clinicians' comfort levels in discussing anal sex. Heterosexual clinicians were the least likely to feel comfortable (45%), whereas those identifying with other sexual orientations reported significantly higher comfort levels (62%) ($\chi^2(8) = 18.3, p = 0.01$). Insights from the qualitative interviews suggest that clinicians who identified as LGBTQ+ felt more at ease discussing anal sex due to personal experiences and familiarity with open conversations about sexual health. One clinician explained:

“Being part of the gay community and having open discussions about these topics in my personal life also makes it less taboo for me”

Clinician sexuality may shape their approach to sexual history-taking, as those with lived experiences in LGBTQ+ communities may demonstrate greater ease in discussing practices often stereotypically associated with non-heterosexual individuals (Ho et al., 2023). However, clinicians must remain mindful of their own biases regarding what constitutes “normal” sexual behaviour and gender expression, as these biases can compromise the quality and inclusivity of patient care (Saenz, 2020).

Systemic factors also posed significant barriers to discussing sexual health. A lack of chaperones was identified as a challenge by 40% of respondents. While some clinicians suggested that the presence of a chaperone could create an “awkward atmosphere”, there was also broad recognition of their essential medicolegal role. A 55-year-old male consultant surgeon highlighted this dual function:

“clearly the question of a chaperone is safety for the patient, but safety for the medical professional as well”.

Chaperones serve as a safeguard for both patients and clinicians, helping to prevent potential allegations of misconduct. The Ayling Report (2004) underscored the importance of chaperones following multiple cases of indecent assault on

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female patients (Richardson, 2005). However, as this study highlights, chaperones are not always readily available in many NHS Trusts, further complicating these discussions.

Patient discomfort was another significant barrier, with 74% of clinician respondents expressing concerns about making patients uncomfortable. While clinicians worry about causing distress, patients, in turn, often perceive that clinicians themselves are uncomfortable and therefore avoid these conversations. In an interview study of 29 heterosexual women, participants reported that they felt clinicians were neither interested in nor at ease discussing sexual matters (Hebert et al., 2017). A systematic review further found that older patients frequently feared that their sexual health concerns would be dismissed by healthcare professionals, leading them to refrain from raising such issues altogether (Stowell et al., 2023).

Concerns about being perceived as judgmental also contributed to hesitancy among clinicians, with 65% of respondents expressing apprehension in this regard. This highlights the persistent stigma associated with anal intercourse. The preceding systematic review findings indicate that women often worry about societal disapproval of anal sex, which extends into healthcare settings. If clinicians fear appearing judgmental and female patients fear being judged, a communication impasse is created. However, as healthcare providers, clinicians have a primary responsibility to their patients and must work to overcome these apprehensions to ensure comprehensive care.

Time constraints within NHS consultations further exacerbate these challenges. The average consultation length is approximately 10 minutes (Oxtoby, 2010), a timeframe that must accommodate history-taking, physical examination, clinical recommendations, and documentation. Unsurprisingly, 49% of survey participants considered this insufficient for exploring complex topics such as sexual history. While a simple yes-or-no inquiry about sexual practices may take only seconds, addressing potential concerns—such as safe anal sex practices or disclosures of domestic abuse—requires more time and sensitivity. Some interview participants reported that they addressed such topics only in specialized pelvic floor clinics,

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where longer appointment slots were available. Others highlighted the contrast between NHS and private healthcare settings. A 55-year-old male consultant shared his perspective:

“I definitely enjoy my outpatient experience as a professional more in that environment than in the bog-standard NHS environment. Because it puts me at ease, and I think if I'm at ease then hopefully my patients will be at ease and then it's possibly easier to have some of those difficult discussions.”

Given the discomfort surrounding these discussions, adequate time to build rapport and foster a comfortable environment is often necessary for effective communication and patient-centred care.

Another potential approach explored was the use of questionnaires administered either before or during consultations. While some clinicians expressed concerns about the potential “disconnect” this method could create in patient interactions, many acknowledged its structured format as a valuable tool. Questionnaires were seen as a means to save time, standardize history-taking, and ensure that discussions about anal sex were not overlooked by prompting clinicians to inquire. A Cochrane review found that the use of such tools provided advantages in patient-clinician communication and improvements in patients' quality of life (Gibbons et al., 2021).

Public health resources on anal sex are limited, with mainstream media serving as the primary source of information. For every TV show, movie, or social media portrayal that glamorizes anal sex, there is likely at least one woman who feels pressured, curious, or compelled to engage in it. More than 95% of clinicians from the survey highlight the need for more public health awareness. This is further emphasized by interview participants, calling for evidence-based resources, which would ultimately empower patients to make informed decisions about their health. The NHS information website on sexual activities and risks addresses anal sex only in relation to STIs, without mentioning other potential risks such as anal pain, bleeding, tears (fissures), or incontinence due to sphincter injury (NHS, 2022).

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While this thesis highlights the need for further research on the causal link between anal intercourse and anorectal disorders, existing evidence already establishes a strong connection. Therefore, public health platforms like the NHS should consider incorporating information on these additional risks to provide more comprehensive guidance on anal sex.

Sexual health education is also an essential platform for effectively sharing accurate information. Introducing discussions about anal intercourse in school curricula can help dispel harmful stereotypes and encourage safer practices. Regardless of whether it is openly acknowledged, anal sex remains a present and significant aspect of sexual behaviour. If adolescents turn to pornography and unreliable online sources for guidance on their sexual experiences, they may receive misleading or incomplete information about the risks involved.

Healthcare practitioners avoid discussion of anal sex as they themselves are influenced by society's taboos. However, with the emergence of anal intercourse as a sexual norm, a lack of open communication with patients exposes them to missed diagnosis, futile treatment, and lack of advice. There is clearly a stigma associated with discussing anal intercourse, for patients, healthcare staff and society. Individual values and preconceptions affect the ability of clinicians to have these conversations openly.

To facilitate more open discussions between clinicians and patients, several barriers must be addressed. Clinicians need more training on anorectal disorders, female anatomy, and their links to anal intercourse. Many clinicians receive little to no formal training in discussing sexual health. More than 95% of participants believe that more training is required on anal sex. While sexual history taking is covered in medical education, it is not typically integrated into the training for anorectal conditions. Consequently, as clinicians specialize in fields such as general surgery, they may cease practicing sexual history assessments. This lack

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of both training and awareness of its importance creates a significant barrier to effective patient communication.

Healthcare professionals participate in regular training programs; however, these programs primarily focus on disease-specific topics rather than sexual health (Prize et al., 2023a). It is strongly recommended that sexual health education and counselling skills be incorporated into professional training curricula.

Respondents in this study identified workshops as a particularly valuable method of education, especially for clinicians who are already specialized. Incorporating interactive learning methods, such as role-playing with sexual health specialists, could serve as a valuable training approach. Role-playing exercises can help clinicians navigate patient inquiries and develop nonjudgmental responses, ultimately improving patient care.

In summary, several policy changes and initiatives are recommended to improve patient care, education, and research on anorectal disorders associated with anal intercourse (AI).

Guidance on Sexual History Taking in General Surgery Clinics

- Implement standardized protocols for sexual history taking, ensuring a chaperone is always available for sensitive discussions.
- Utilize structured questionnaires or proformas to streamline history taking and improve consistency.
- Allocate additional time in specialists' clinics to address concerns related to AI and its potential health implications.
- Provide training for healthcare professionals on managing cases involving AI, including safeguarding measures when intercourse is unwanted and promoting safe practices.

Enhancing Public Health Information

- Ensure the NHS website includes comprehensive information on anorectal disorders, particularly those associated with AI, to improve public awareness and patient self-management.

Sex Education and Policy Development

- Investigate ways to incorporate discussions on AI and its potential health risks into sex education curricula.
- Develop targeted health policies aimed at reducing unsafe AI practices and mitigating associated health risks from an early age.

Further Research on AI and Anorectal Disorders

- Conduct robust, up-to-date studies to establish a clearer causal relationship between AI and anorectal disorders.
- Support research that informs clinical guidelines and public health campaigns, ensuring that interventions are evidence-based and widely accepted.

Addressing the potential health risks associated with AI requires a multi-faceted approach, including improved clinical guidance, enhanced public education, policy interventions, and further research.

This study highlights the prevailing attitudes and practices of healthcare practitioners in managing female patients with anorectal disorders. It also presents a set of recommendations that, if implemented, can help healthcare providers better support patients, mitigate risks, and ensure that public health initiatives are well-informed and effective.

7.2 Contributions to Health Economics and Policy

This thesis makes a distinctive and timely contribution to the fields of health economics and health policy by illuminating how the omission of sexual history-taking in female patients with anorectal disorders may lead to inefficiencies in clinical practice, disparities in care, and missed opportunities for preventive health intervention. The findings suggest that when clinicians neglect to inquire about anal intercourse—a risk factor for certain anorectal conditions—patients may receive suboptimal or misdirected care. This not only has implications for patient outcomes but also introduces inefficiencies into the healthcare system through unnecessary repeat consultations, diagnostic delays, and ineffective treatments. As such, this research underscores the potential for more economically efficient care delivery if sexual history-taking is standardized and embedded within routine clinical assessment.

The study also highlights the critical role of clinician education and training in ensuring consistent, equitable care. A significant proportion of clinicians, particularly those early in their careers, reported discomfort and uncertainty in discussing anal sex with patients. These gaps reflect a broader systemic issue wherein sexual health is insufficiently covered in postgraduate and specialist medical education. From a health policy perspective, the integration of targeted sexual health training into surgical and general medical curricula represents a valuable investment in workforce development. Enhancing clinician competency and confidence in this area may reduce medico-legal risks, support clinician well-being, and improve the overall quality of care.

Furthermore, this research reveals patterns of implicit bias that affect clinical decision-making. Selective sexual history-taking—based on assumptions about a patient's age, openness, or perceived relevance of their sexual behaviour—creates inequities in access to appropriate assessment and care. In highlighting how older women, in particular, are often excluded from such discussions, the thesis adds to the body of evidence advocating for policy interventions aimed at promoting health equity. Ensuring that all patients receive comprehensive, non-discriminatory

sexual health assessments is vital to achieving fair and inclusive healthcare delivery.

Finally, the study identifies a significant shortfall in public health resources addressing the risks associated with anal sex. The absence of clear, evidence-based information in public-facing platforms such as the NHS website limits patients' ability to make informed decisions. As current NHS guidance focuses almost exclusively on the risk of sexually transmitted infections, it overlooks other important clinical consequences such as sphincter injury or faecal incontinence. In calling for broader public health education and improved sexual health curricula, this research supports the development of cost-effective, population-level interventions that empower patients while reducing the burden on secondary care services.

7.3 Future research directions in Health Economics

The findings of this thesis point to several promising avenues for future research in health economics, particularly with respect to evaluating the efficiency and equity of sexual health practices within clinical settings. One important direction would be to undertake a formal cost–benefit analysis of implementing routine sexual history-taking in the assessment of female patients with anorectal symptoms. Such research could quantify the potential savings from reduced misdiagnosis, fewer repeat consultations, and more targeted treatment interventions, thereby providing a robust economic argument for changes in clinical guidelines and service delivery models.

In addition, future studies could examine the cost-effectiveness of enhanced training programs in sexual health communication for clinicians working in general and colorectal surgery. While the findings of this thesis suggest a clear need for such training, empirical economic evaluations—comparing outcomes in institutions that do and do not incorporate sexual health into continuing professional development—would help determine the value of these interventions. Role-play exercises with sexual health specialists, offers a

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particularly rich area for evaluation given its reported acceptability and potential to reduce clinician discomfort.

Finally, there is scope to explore how targeted interventions affect health equity. Longitudinal or cross-sectional studies that measure healthcare utilization, diagnostic outcomes, or patient satisfaction across different demographic groups—before and after the introduction of standardized sexual history-taking—could reveal whether these interventions reduce disparities in care. A health economics perspective would further allow for the identification of high-risk or underserved groups, enabling more strategic allocation of resources.

Appendices

Appendix 1. Systematic Review Search Strategy

PubMed		
Search terms	Limits	Type
<p>perspective OR views OR perception OR experience OR feelings</p> <p>AND</p> <p>female* OR "Women"[Mesh]</p> <p>AND</p> <p>anal OR "anal sex" OR "anoreceptive intercourse" OR "anal intercourse" OR "Coitus"[Mesh]</p>	<p>-Searched in all fields</p> <p>-Full text</p> <p>-From 2010 to 2023</p> <p>-English</p>	Advanced
EMBASE		
<p>perspective OR views OR perception OR experience OR feelings</p> <p>AND</p> <p>female* OR woman OR women OR girl*</p> <p>AND</p> <p>anal OR "anal sex" OR "anoreceptive intercourse" OR "anal intercourse" OR Coitus</p>	<p>-Searched in all fields</p> <p>-Full text</p> <p>-From 2010 to 2023</p> <p>-English</p> <p>-Remove Medline records</p>	Multi-field search
PsycINFO		
<p>perspective OR views OR perception OR experience OR feelings</p> <p>AND</p>	<p>-Find all my search terms in TX All text</p> <p>-Full text</p> <p>- From 01/01/2010 to 31/12/2023</p> <p>-Peer reviewed</p> <p>-English</p>	Advanced

References

<p>female* OR woman OR women OR girl*</p> <p>AND</p> <p>anal OR “anal sex” OR “anoreceptive intercourse” OR “anal intercourse”</p>		
<p>CINAHL</p>		
<p>perspective OR views OR perception OR experience OR feelings</p> <p>AND</p> <p>female* OR woman OR women OR girl*</p> <p>AND</p> <p>anal OR “anal sex” OR “anoreceptive intercourse” OR “anal intercourse”</p>	<p>-Find all my search terms in TX All text</p> <p>-From 01/01/2010 to 31/12/2023</p> <p>-Peer reviewed</p> <p>-English</p> <p>-Exclude MEDLINE records</p>	<p>Advanced</p>

Appendix 2. Survey questionnaire: Anal sex & anorectal disorders, let's talk about it!

Survey Flow

Block: Questions about you (9 Questions)

Standard: Questions about your practice (2 Questions)

Standard: Questions about your opinions (6 Questions)

Page Break

Start of Block: Questions about you

Q1 Thank you for taking the time to complete this survey.

This survey explores the attitudes of healthcare practitioners towards sexual history taking, particularly in the context of anorectal disorders. Anorectal disorders are defined as anal pain, anal fissures or tears, bleeding from the anus or rectum, anal sphincter injury and faecal incontinence.

Completion is anonymous and entirely voluntary. You can decide to stop and withdraw your participation at any time.

We promise, your data is safe! The data collected for this study will be stored securely and only the researchers conducting this study will have access to it.

If you have any questions about the study, please contact the researchers:

Tabitha Gana, t.gana@lancaster.ac.uk

Lesley Hunt, lesley.hunt3@nhs.net

This will take approximately 5 minutes...

References

Q2 Which of the following best describes you?

- Male (1)
- Female (2)
- Non-binary (3)
- Prefer not to say (4)

Q3 What age group do you belong to (in years)?

- 21 - 30 (1)
- 31 - 40 (2)
- 41 - 50 (3)
- 51 - 60 (4)
- 60+ (5)

Q4 What is your ethnic group? (Choose one option that best describes your ethnic group or background)

- Asian or Asian British (2)
- Black, Black British, Caribbean or African (3)
- White (4)
- Mixed or Multiple ethnic background (5)

References

- Any other ethnic background (please specify) (6)
-

Q5 Which of the following best describes how you think of yourself?

- Heterosexual (1)
- Homosexual (2)
- Bisexual (3)
- Other (4)
- Prefer not to say (5)

Q6 What is your religion? Are you...

- No religion (1)
- Christian (2)
- Muslim (3)
- Jewish (4)
- Buddhist (5)
- Hindu (6)
- Sikh (7)
- I would prefer not to say (8)

References

- Any other religion (please specify) (9)
-

Q7 What is your current position?

- Core surgical trainee/CST 1-2/ST 1-2/Trust grade year 1-2 (1)
- Higher surgical trainee/ST3-5 /Trust grade year 3-5 (2)
- Higher surgical trainee/ST6-8/ Trust grade year 6-8 (3)
- Colorectal nurse specialist/Advanced nurse practitioner (4)
- Staff grade surgeon/associate specialist/SAS/Trust grade over 8 years (5)
- Consultant (6)

Q8 What is your specialty +/- subspecialty? (You can select multiple)

- General surgery (1)
- Emergency general surgery (2)
- Colorectal surgery (3)
- Pelvic floor surgery (4)
- Other surgical (5)
- Non-surgical (6)

References

Q9 How often do you see patients with anal symptoms or rectal bleeding?

- > 20 patients / week (1)
- 10-20 patients / week (2)
- 1-10 patients / week (3)
- < 1 patient / week (4)
- Never (5)

Skip To: End of Survey If Q9 = 5

End of Block: Questions about you

Start of Block: Questions about your practice

Q10 To what degree do you agree with the following statements

	1- Strongly disagree (1)	2 (2)	3 (3)	4 (4)	5- Strongly agree (5)	Not sure (6)
Asking about anal sex is important in all women with anal symptoms (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

References

Asking about anal sex is important in women < 40 years with anal symptoms (2)

Asking about anal sex is important in all women with faecal incontinence (3)

Asking about anal sex is important in women < 40 with faecal incontinence (4)

Asking about anal sex is important in nulliparous women with faecal incontinence (5)

References

Page Break

Q11 How often would you enquire about anal sex in the following scenarios?

	Never (1)	Sometimes (2)	About half the time (3)	Most of the time (4)	Always (5)	I would never encounter this scenario (6)
19-year-old woman presenting with typical anal fissure? (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30-year-old woman with refractory anal fissure? (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nulliparous 25-year-old with passive leak incontinence? (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

References

Multiparous
40-year-old
with passive
leak
incontinence?
(4)

22-year-old
woman
considering a
pouch for
ulcerative
colitis? (5)

A vulnerable
25-year-old
woman
presenting
with anal
pain? (6)

End of Block: Questions about your practice

Start of Block: Questions about your opinions

Q12 To what degree do you agree with the following statements

	1-	2 (2)	3 (3)	4 (4)	5-
	Completely disagree (1)				Completely agree (5)
I feel comfortable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

References

asking
female
patients
about most
aspects of
their sex life
when
indicated (1)

I feel
comfortable



asking
female
patients
about anal
sex when
indicated (2)

Page Break

References

Q13 To what degree do any of the following act as a barrier to taking a history of anal sex from female patients?

Please select the box which most accords to your view

	1- Not a barrier (1)	2 (2)	3 (3)	4 (4)	5- Significant barrier (5)
Lack of time in the clinic (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concern the patient will think I'm creepy (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fear of being perceived judgmental (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Embarrassment (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of experience of asking about sex (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of understanding as to when this is relevant (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

References

Shortage of
chaperones (7)

Fear of making
the patient
uncomfortable
(8)

My personal
beliefs (9)

Page Break

References

Q14 To what degree do you agree with the following statements

	1- Completely disagree (1)	2 (2)	3 (3)	4 (4)	5- Completely agree (5)	Don't know (6)
Anal sex can lead to mucosal tears/fissures in women (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal sex can lead to anal pain in women (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal sex can lead to anal bleeding in women (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal sex can lead to damage of the internal anal sphincter in women (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal sex can lead to incontinence in women (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

References

Women are at greater risk of incontinence after having anal sex compared to men (6)

It is possible to adequately protect the anal sphincter by using lubrication during anal sex (7)

It is possible to adequately protect the anal sphincter by relaxation techniques during anal sex (8)

Page Break

Q15 By the age of 34 years what % of UK women have had anal sex?

References

0%

50%

100%

0 10 20 30 40 50 60 70 80 90 100

Use the linear scale to give your best estimate in % ()



Q16 Do you feel there is a need for increased training among healthcare practitioners about anal sex in women?

Yes (1)

No (2)

Q17 Do you feel there is a need for increased public health awareness about the possible health consequences of anal sex by women?

Yes (1)

No (2)

Page Break

End of Block: Questions about your opinions

Appendix 3. Participant consent form for semi-structured interviews

IRAS Project ID: 323585

Consent form for interviews

Project Title: Anal intercourse among females in the UK

Name of Researchers: Tabitha Gana

Email: t.gana@lancaster.ac.uk

We are asking if you would like to take part in a research project exploring the attitudes of healthcare practitioners towards sexual history taking in the context of anorectal disorders.

Before you consent to participating in the study, we ask that you read the participant information sheet. If you have any questions or queries please speak to the principal investigator, Tabitha Gana. A verbal consent will be taken on the day of the interview.

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	
2. I understand that my interview will be audio recorded and then made into an anonymised written transcript.	
3. I understand that audio recordings will be kept until the research project has been examined.	
4. I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study and within one month after I took part in the study, without giving any reason. If I withdraw within one month of taking part in the study, my data will be removed.	
5. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.	

References

6. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published; all reasonable steps will be taken to protect the anonymity of the participants involved in this project.	
7. I consent to information and quotations from my interview being used in reports, conferences, and training events.	
8. I understand that the researcher will discuss data with their supervisor as needed.	
9. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisor.	
10. I consent to Lancaster University keeping written anonymised transcriptions of the interview for 10 years after the study has finished.	
11. I consent to take part in the above study.	

By proceeding with this interview, you confirm that:

- You have read the participant information sheet and understand what is expected of you within this study
- You understand that any responses/information you give will remain anonymous
- Your participation is voluntary
- You consent for the information you provide to be discussed with my supervisor at Lancaster University
- You consent that the data will be pooled and published and that if quotes are provided, they could be published
- You consent to Lancaster University keeping the anonymised data for a period of 10 years after the study has finished.

Appendix 4. Participant information leaflet for semi-structured interviews

IRAS Project ID: 323585

Sponsor: Bradford Teaching Hospitals NHS Foundation Trust

Title of study: Anal intercourse among females in the UK

Participant Information sheet for interviews

Anal sex & anorectal disorders; let's talk about it!

My name is Tabitha Gana, and I am conducting research on anal intercourse among females in the United Kingdom (UK). I am a student in the PhD programme of Health Economics and Policy at Lancaster University, UK. I am also an employee of Bradford Teaching Hospitals NHS Foundation Trust (BTHFT).

What is the study about?

The purpose of the study is to explore the attitudes of healthcare practitioners towards sexual history taking, particularly in the context of anorectal disorders. Anorectal disorders are defined as anal pain, anal fissures or tears, bleeding from the anus or rectum, anal sphincter injury and faecal incontinence.

Why have I been approached?

You have been approached because the study requires information from healthcare practitioners who work within the field of general and colorectal surgery. We want to know more about your practice and your views of anal intercourse, its impact on sexual health and gastrointestinal health.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. Taking part is entirely voluntary and if you decide to, we thank you for taking the time.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked questions in a semi-structured interview in a virtual setting. Interviews take about 30 - 60 minutes. We thank you in advance for your time and participation.

Will my data be Identifiable?

We will need to use information from you for this research project.

References

This information will include your initials, gender, and occupation. People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure. The data collected for this study will be stored securely and only the researchers conducting this study will have access to this:

- Audio recordings will be destroyed and/or deleted once the project has been submitted for publication.
- Electronic transcriptions will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected. These documents will be stored for a maximum of 10 years
- Electronic transcriptions of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

References

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

What will happen to the results?

The results will be summarised and reported in a dissertation/thesis and may be submitted for presentation at conferences and publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

You can find out more about how we use your information

on our leaflet available to read from Bradford Teaching Hospitals NHS Foundation Trust Privacy Notice <https://www.bradfordhospitals.nhs.uk/privacy-statement/>

by asking one of the research team

by sending an email to Tabitha Gana, t.gana@lancaster.ac.uk, or

by ringing us on 01274542200

Complaints

References

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Bruce Hollingsworth

Director of Studies, Health Economics and Policy

Health Research Division

Tel: 0152465201

Email: b.hollingsworth@lancaster.ac.uk

Lancaster University

Lancaster

LA1 4YW

If you wish to speak to someone outside of the Division of Health Economics and Policy Programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973

Chair of FHM REC Email: l.machin@lancaster.ac.uk

Faculty of Health and Medicine

(Lancaster Medical School)

Lancaster University

Lancaster

LA1 4YG

Thank you for taking the time to read this information sheet.

References

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance:

<https://www.supportline.org.uk/problems/rape-and-sexual-assault/>

<https://sexualabusesupport.campaign.gov.uk>

<https://www.sarsas.org.uk>

<https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/sexual-violence-services/>

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