REPRODUCTIVE HEALTH matters

EDITORIAL

Sexuality and older people: a neglected issue

Shirin Heidari

Director and Editor, Reproductive Health Matters, London, UK / Geneva, Switzerland.
Correspondence: SHeidari@rhmjournal.org.uk

Is 70 the new 60, or maybe the new 50?

Globally, life expectancy has been rising rapidly over the course of the last century, thanks to technological advances in medicine, rises in public health expenditure, overall socioeconomic development, and increased respect for women's autonomy in preventing undesired pregnancies. We are living longer and healthier lives and will continue to do so. It is estimated that the number of people over the age of 60 will double by 2050, translating into longer productive – albeit not necessarily reproductive – lives during which we are able to seek sexual intimacy and enjoy sexual activity as we age.[1]

This contrasts with the stereotyped views of aging and social prejudices that consider older adults asexual or disinterested in sex. Growing evidence confirms that sexual desires persist into old age, with older men and women having sex in their 80s and beyond, and enjoying it more than ever.[2,3] A longitudinal US study shows that nearly three quarters of participants aged 57–64 were sexually active, and while the proportion declined by age, nearly a quarter of those aged 75–85 reported being sexually active.[2]

Emerging evidence is predominantly from high-income settings, though we have every reason and some evidence to believe that the same pattern applies in low- and middle-income countries. A global study looking at sexual attitudes and behaviours of older adults, aged 40–80, from 29 different countries confirms that "sexual desire and activity are widespread among middle-aged and elderly men and women worldwide and persist into old age".[4] Sexual activity in older age, as defined much more broadly than coital activity, is strongly correlated with improved mental and overall wellbeing. Thus, sexuality remains an important and enduring component of life.[5]

However, while as early as in 1994 the Programme of Action recognised that "older women and men have distinct reproductive and sexual health issues which are often inadequately addressed", research, policy and programmes have consistently failed to adequately attend to their needs.[6] Even data collected through Demographic and Health Surveys and health indicators focus primarily on adults of reproductive age 15–49 years. Sexuality in later life has received growing attention in the past decade, though it has mainly centred around medical aspects of sexual functioning, with a prime focus on addressing erectile dysfunction in heterosexual men. This is likely an outcome of the successful marketing of sildenafil (Viagra) and other sexual performance enhancers. However, except for this myopic focus on clinical/pathological aspects of sexuality, there has been a dearth of literature on sexuality, sexual and (post-) reproductive health and rights of people in later life.

Women beyond their childbearing potentials (or reproductive desires), in particular, are invisible in the health research agenda. Some frame this as "double jeopardy", where the intersection of ageism with sexism renders older women more vulnerable and neglected.[7] Crockett and Cooper in their commentary in this issue eloquently remind us how older women specifically are conspicuous by their absence from the global development and health agenda.

Research on the sexuality of older gay, lesbian, bisexual, transgender and intersex (LGBTI) individuals is similarly scant, silencing the diverse and distinct SRHR needs of this group, and mirroring the continuous hetero-normative and heterosexist biases in societies.[8]

Policy and programmes equally neglect the sexual and reproductive health needs of older adults, including those of LGBTI persons, with healthcare providers often uninformed and poorly trained about the relevant issues, and thus uncomfortable discussing sex and sexuality with their elderly clients. Sexual and reproductive health and rights in older adults seems to remain a " 'blind spot' in the policy architecture", excluded from the development agenda and absent from investment frameworks, which are often directed at younger

adults of reproductive age and primarily through the lens of maternal health.[9]

Recent data on the rise of HIV transmission in older adults have generated some awareness of the SRHR needs in this population. Nearly 120,000 people above the age of 50 are infected with HIV every year in low- and middle-income countries.[10] While biological factors play an important role in the susceptibility to infection in this age group, particularly in women, a number of other socio-economic factors result in the underestimated risk of transmission of HIV and sexually transmitted infections (STIs), and late HIV diagnosis. Gender-based violence remains an unknown risk factor for older women, with sparse data on the extent and experience of violence in this group and its significance for their sexual and reproductive health.[11] Other factors include low perception of risk, unsafe sexual practices, and limited knowledge about sexuality, sexual health and STIs. A paper in this issue by Dalrymple and co-authors presents data on the limited knowledge about HIV and other STIs among heterosexual middle-aged adults in Scotland, examining how socio-cultural factors influence the process of knowledge acquisition on STIs throughout the life course. Sexuality education and HIV information are almost exclusively targeting younger people, and HIV testing and counselling programmes often deny or discourage older adults from HIV testing as a result of misconception about their risk.

While we need to rethink and reshape HIV prevention information and programmes to reach older adults, HIV treatment programmes must also integrate SRHR services for the aging population of people living with HIV. Thanks to successful antiretroviral treatment, life expectancy of HIV positive persons is approaching that of the general population, resulting in a shift in demographics, with a greater share of HIV amongst older adults. According to UNAIDS 2015 data, out of 36.7 million people living with HIV worldwide, 5.8 million are aged 50 and older, with more than 2.7 million in Sub-Saharan Africa. These numbers are projected to triple in the coming years.[10]

Despite these demographic trends, the literature on the SRHR needs of people above 50 living with HIV is scant. A systematic review by Narasimhan et al in this issue, on ageing and healthy sexuality among women living with HIV, highlights only four studies on this topic. The only study from a low-income setting (Uganda) reports a notable gender gap, while confirming that adults remain sexually active beyond the age of 50. A markedly smaller proportion of women living with HIV (14%) reported being sexual active, than the corresponding male group (49%), and with only a fraction of older women (5%) considering sex as an important aspect compared to men of the same age (41%).

Similar gender gaps have been reported elsewhere,[4,12] including by Chirinda and Zungu in this issue who estimate sexually active life expectancy in a cohort of older men and women in South Africa. In this study, women reported a markedly shorter sexually active life expectancy than men at the age of 50, with HIV having a negative impact on sexual activity only among women. These statistics prompt us to consider the impact of HIV on the sexual health and sexuality of older women, men and transgender persons living with HIV. More importantly, it is surprising that the underlying reasons for this gender disparity remain unexplored. While limited data have reported biological factors contributing to diminishing sexual appetite in aging post-menopausal women, undoubtedly patriarchal cultural norms and social biases could result in women repressing their sexual drive or shying away from expressing their sexual desire. Or these biases could simply cause under-reporting in research settings of frequency of sexual activity or number of sexual partners. Many social determinants such as stigma (including HIV-related) and taboos concerning sex and sexuality, body image, self-esteem, marital status and other psychosocial as well as biological factors (including the presence of chronic or mental ill-health) influence sexuality. With increased life expectancy, women can live 30 to 40 years post-menopause, thus it is essential to understand how to promote healthy sexuality in this stage of life.

This is particularly important in the context of loss of one's life companion and sexual partner. While studies have been dedicated to comprehending the process of grief, no attention has been paid to sexual bereavement, as highlighted by Radosh and Simkin in this issue. The authors shed light on this forgotten domain in an exploratory study in the US, sharing women's perspectives and anticipation of sexual grief were they to lose their sexual partners. The findings add to the body of evidence that sex is an important element of healthy ageing and reiterate the importance of health care providers' awareness of the sexual health needs of the elderly.

The limited attention to the sexual and reproductive health needs and rights of older adults was clearly reflected in the volume and spectrum of the