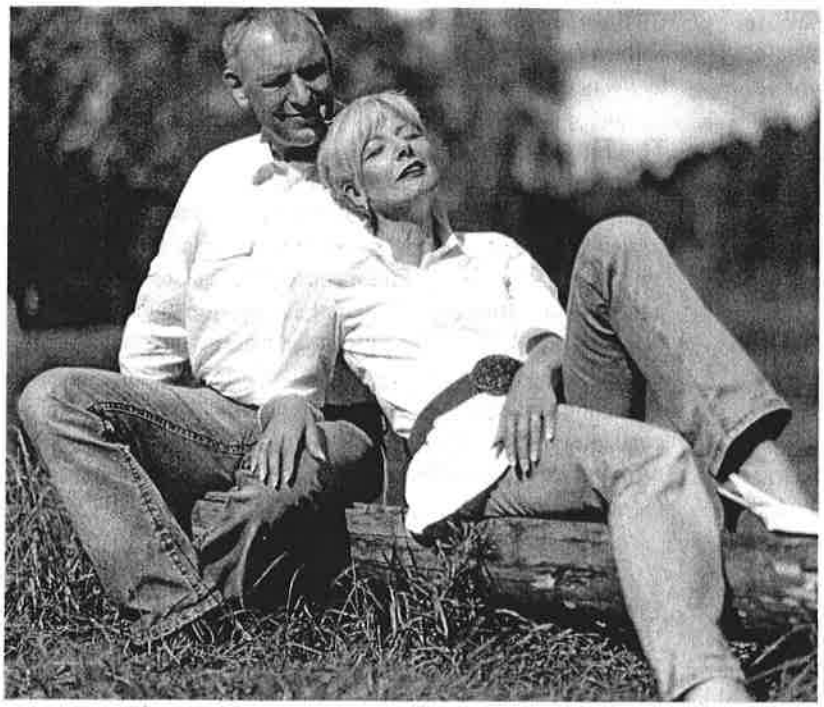

OLDER ADULT HIV RISK PREVENTION

By Karen Whiteman, MSW, PhD

By 2015, the Administration on Aging estimates that older adults will represent 50% of adults living with HIV in the United States. Among adults aged 50 and older, gay and bisexual men have the highest risk of contracting HIV/AIDS and historically have accounted for the highest incidence and prevalence of HIV/AIDS since the 1980s. Other groups disproportionally affected include blacks, Hispanics, adults with severe mental illnesses, and individuals who are homeless.

As older adults shift the profile of the U.S. HIV/AIDS epidemic, heterosexual and LGBT adults' unique age-related HIV/AIDS risk factors and barriers to prevention services must be considered.

Age-Related Risk Factors

• **Lack of knowledge:** Many older adults lack knowledge of HIV transmission and how to protect themselves because the risk factors have changed since the 1980s' outbreak. Prior to screening the national blood supply for HIV/AIDS, blood transfusion was the primary mode of transmission for this age group; however, other modes have been identified since the 1980s. Older adults need education on all possible modes of transmission and the specific ones that are high risk for their age group.

• **Biological risk factors:** Older women and men have unique age-related biological risk factors. After a woman experiences menopause, there is age-related vaginal thinning and dryness that can lead to tears in the vaginal tissues that could facilitate HIV transmission (Brooks, Buchacz, Gebo, & Mermin, 2012). Although female-to-female HIV transmission is rare, biological risk factors increase as women age. Also, men may experience erectile dysfunction, which increases the difficulty of using condoms. As a result, some men may choose to forego using them during sexual intercourse.

• **Risky sexual behavior:** Adults who lived in the 1960s during the era of the sexual revolution, the social movement that challenged traditional behaviors related to sexuality, are now aged 50 and older. They may have maintained the culture of this social movement and continue to participate in the same risky sexual behaviors that were once accepted. Many heterosexual and LGBT older adults remain sexually active into their 80s (Schick et al., 2010), and, like younger adults, many older adults also have multiple sex partners (Foster, Clark, Holstad, & Burgess, 2012).

Fifty-nine percent of LGBT older adults who have contracted HIV also are sexually active (Fredriksen-Goldsen et al., 2012). Engaging in sexual activity with a person who is HIV positive is risky, especially since many older adults do not use condoms during sexual intercourse, including older adults who are HIV infected (Onen, Shacham, Stamm, & Overton, 2010). Men who have unprotected sex with men account for 60% of all AIDS infections among older adults (Williams & Donnelly, 2002).

• **Accessibility of erectile dysfunction medications:** The highest percentage of new and refill prescriptions of sildenafil (Viagra), a medication to treat erectile dysfunction, is for older adults aged 50 to 69 (Karlovsky, Lebed, & Mydlo, 2004). The use of erectile dysfunction medications may contribute to the spread of HIV/AIDS among older adults. These prescription and nonprescription medications are easily accessible and allow men to remain sexually active at older ages, therefore increasing the likelihood of HIV transmission if safe sex precautions are not taken.

Barriers to Prevention

• **Aging stereotypes:** Many people believe that older adults are not having sexual intercourse because they no longer have a libido. Many health care providers also may believe in this stereotype. Due to their own discomfort, health care providers are less likely to talk to their older patients about their sexual activity and ask questions such as "Are you sexually active?" "Do you know how to use a condom? or "Are you heterosexual, gay, lesbian, bisexual, or transgender?"

• **Low HIV testing rates:** HIV testing and linkage to medical care are essential to the National HIV/AIDS Strategy to identify

all adults with HIV infections and begin timely treatment. However, for heterosexual and LGBT older adults, HIV screening is dangerously low. Low HIV testing rates among older adults may be attributed to poor awareness of their risk of contracting HIV and health care providers' failure to recommend HIV testing to older adults.

- **Underdiagnosis of HIV/AIDS:** Providers may underdiagnose HIV/AIDS and/or not offer HIV testing because HIV/AIDS symptoms can mimic the normal aging process, such as lack of energy, weight loss, and short-term memory loss. Most older adults learn of their HIV diagnosis while being hospitalized for other medical issues (Kohli, Klein, Schoenbaum, Anastos, Minkoff, & Sacks, 2006), not from their physician.
- **Late diagnosis of HIV infection:** HIV infection is diagnosed at a later stage in older adults than in younger adults. A late diagnosis of HIV infection implies that antiretroviral treatments start late in the disease's progression, possibly compromising their efficacy. As a result, older adults are diagnosed with a more advanced version of HIV or AIDS than younger adults (Centers for Disease Control and Prevention, 2013) and are more likely to progress to AIDS at a faster rate since treatment is delayed (Kirk & Goetz, 2009).
- **Discrimination:** Many LGBT older adults postpone treatment because they fear discrimination. In addition to AIDS-phobia, homophobia and ageism create personal barriers that may prevent people from accessing the services they need. The culmination of a lifetime of discrimination toward LGBT older adults can affect their health behaviors and result in decreased access and engagement in services. However, when HIV-positive patients do seek out services, they are more likely to be refused care or be provided inadequate treatment compared with HIV-negative patients (Fredriksen-Goldsen et al.), thus further substantiating the fear of discrimination.
- **Internalized stigma:** Individuals from historically disadvantaged groups can internalize larger societal values, beliefs, and negative attitudes toward LGBT people, and then, in turn, feel that way toward themselves. Many LGBT older adults have experienced a lifetime of hearing negative views about their identity. These constant negative messages about themselves can become internalized and tremendously affect an individual's identity. People aged 80 and older report the highest rates of internalized stigma compared with other age groups (Fredriksen-Goldsen et al.).

Research suggests that internalized stigma can complicate HIV/AIDS treatment. Internalized stigma in HIV-positive older adults is related to depression and worsening HIV-related symptoms (Emlet, 2006).

Implications for Social Work Practice and Policy

The NASW policy statement on HIV/AIDS states that efforts must be taken to educate vulnerable populations. As the number of HIV-positive heterosexual and LGBT adults living in the United States aged 50 and older increases, it is critical to take steps to prevent the spread of the disease by addressing health care providers' age- and LGBT-related stereotypes and increasing age- and LGBT-appropriate HIV prevention services.

To create a wide-scale systems change, providers, including physicians, nurses, and social workers, need personal awareness of age- and LGBT-related stereotypes they may have toward older adults that may affect their care. It is necessary to incorporate joint staff training on heterosexual and LGBT older adults' sexuality and older adults' risk of HIV into ongoing professional development with health care agencies and staff. Accredited educational curricula for health care professionals should require courses and continuing education units on geriatrics and discuss aging stereotypes, the normal aging process, and unique risk factors for infectious disease for both heterosexual and LGBT older adults.

The needs of LGBT older adults with HIV/AIDS are not adequately addressed in practice, policies, or research. Specifically for LGBT older adults, age- and LGBT-appropriate prevention services that take into account the effects of lifelong discrimination and internalized stigma are necessary. HIV prevention in the form of risk screening, risk assessment, risk reduction counseling, and HIV testing should be incorporated into health facilities as part of routine care. All clinical staff within these health facilities should be trained in HIV prevention for older adults and the barriers to prevention services for LGBT older adults.

HIV prevention services (e.g., testing or educational workshops) should not be confined to health care facilities; rather, these services should be provided at easily accessible locations where both heterosexual and LGBT older adults participate in activities or reside, such as older adult centers, retirement communities, nursing homes, health fairs, or LGBT health services agencies.

Examining heterosexual and LGBT older adults' unique age-related HIV/AIDS risk factors and barriers to prevention services has provided direction for communities, health care professionals, researchers, policymakers, and other stakeholders to develop prevention measures for this population. Challenging the barriers to prevention and developing age- and LGBT-appropriate prevention services that address the unique needs of older adults will offer this group the services necessary to protect themselves from HIV/AIDS.

— Karen Whiteman, MSW, PhD, is a research gerontologist at the Robert Stempel College of Public Health and Social Work who specializes in management and organizational issues in behavioral health care systems.