Sexual Health Care for Older LGBTQIA+ Adults | 2021

NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

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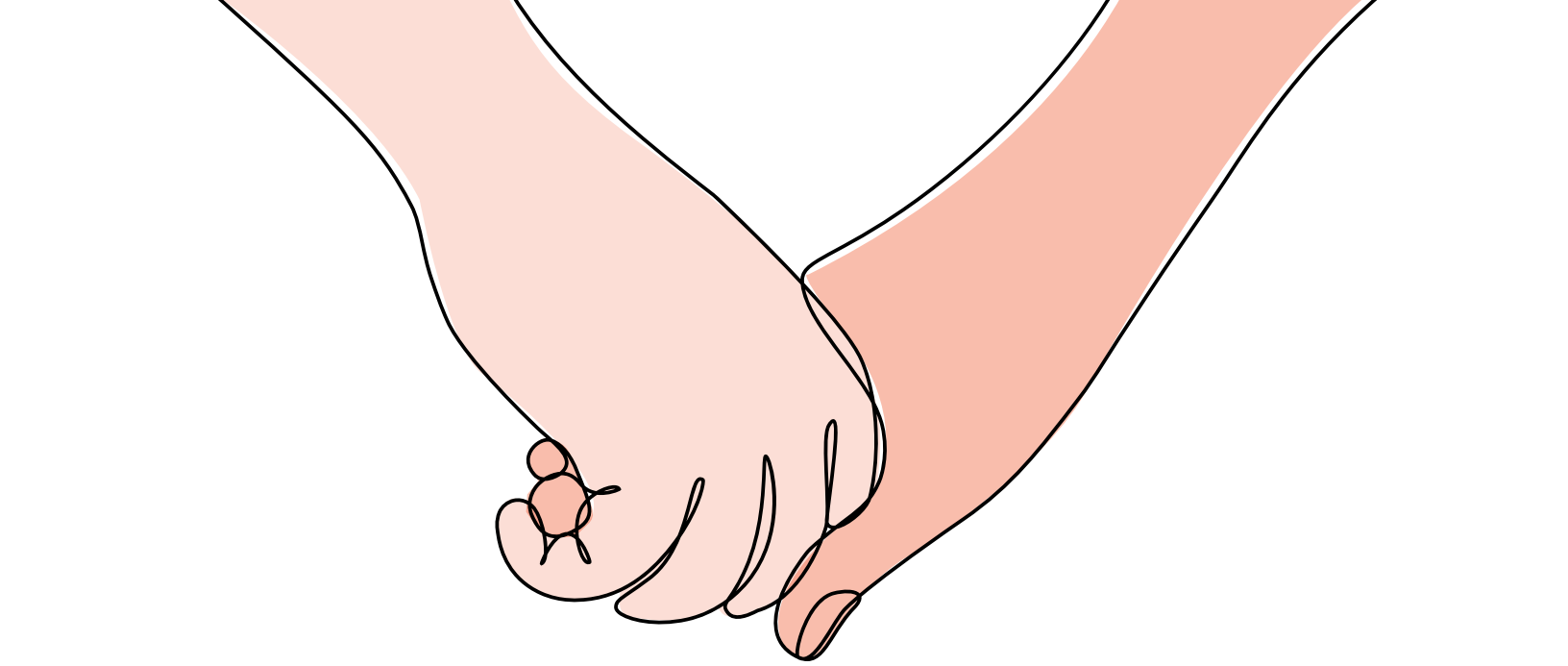

INTRODUCTION

Sexual health is an integral part of overall health, and this remains so as people age. However, clinicians often do not address older people's sexual health, because of reluctance to discuss sex or assumptions that older people are not sexually active.[1] Gaps in sexual health care may be wider for older lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) people, due to biases with regard to both age and sexual and gender minorities, general discomfort with discussions of sexuality, and lack of confidence in addressing patients' sexual concerns. Clinicians may be increasingly called upon in the coming years to address sexual health for older adults.[2] The United States' population is aging, and by 2034, people older than 65 years will outnumber the young.[3]

To help clinicians and other health service providers improve the quality of sexual health care for older LGBTQIA+ people, this publication will describe core terms and concepts for sexual orientation and gender identity, address common misconceptions about sexuality and aging, and outline special considerations for the sexual health care of older adults. The publication will also demonstrate how to elicit a sexual history that is inclusive of all sexual orientations and gender identities.

TERMS, CONCEPTS AND DEMOGRAPHICS

Understanding terms and concepts about sexual orientation and gender identity is key to providing optimal sexual health care for older LGBTQIA+ people.

Sexual orientation refers to one's physical and romantic attraction to others. Sexual orientation may change over time, as may the terms people use to describe their sexual orientation and the extent to which they express their sexual orientation to others (i.e., their "outness"). People may label their sexual orientation with words like lesbian, gay, bisexual, and/or queer (the L, G, B, and Q in LGBTQIA+), or they may not use any label.

Sexual behavior, one dimension of sexual orientation, does not necessarily correlate with identity. For example, more than half of people who reported same-gender sexual behavior in a large, national survey identified as heterosexual, not as lesbian, gay, or bisexual.[4, 5] Because sexual behavior and identity do not always correspond, and because recommendations for some preventive care (e.g., vaccines and screening tests) are based on behavior alone, clinicians should ask patients about sexual behavior in addition to identity. The terms men who have sex with men (MSM), men who have sex with men and women (MSMW), women who have sex with women (WSW), and women who have sex with women and men (WSWM) are used in medical and public health settings to refer to sexual behavior without presuming identity, but patients are not likely to use these terms to refer to themselves.

Gender identity refers to one's inner sense of being a girl, woman, or female; a boy, man, or male; or something else. Like sexual orientation, gender identity, the terms used to describe it, and people's outness about it may change over time. All people have a gender identity. Cisgender people have a gender identity that corresponds with societal expectations based on their sex recorded at birth, and transgender people are those whose gender identities do not correspond to societal expectations based on their sex recorded at birth. Non-binary people's gender identities are neither strictly masculine nor feminine; non-binary people may or may not consider themselves transgender.[6] Gender expression refers to how a person outwardly communicates their gender through mannerisms, hairstyles, clothing, speech, and behavior.

When using terms for sexual orientations and gender identities, it is important to reflect patients' language rather than ascribe a label that a patient has not previously used. For example, the word "queer" was historically derogatory. While some sexual and gender minority people now proudly describe themselves as queer, some older LGBTQIA+ people may consider the term insulting. Clinicians should thus not describe patients as queer unless patients themselves do. If a clinician is unsure how a patient identifies their sexual orientation or gender identity, they can simply ask. For example, clinicians can say: "What is your sexual orientation?" or "How do you describe your gender identity?"

Although sexual and gender minority people have achieved broader social acceptance and several civil rights victories in recent years, older LGBTQIA+ people came of age in times of greater homophobia, biphobia and transphobia. For example, when people born in 1950 reached adulthood, homosexuality was considered a mental disorder; same-sex sexual acts were illegal in many states; gay and lesbian couples could not legally marry; and people could be fired from their jobs for being LGBTQIA+. Moreover, out LGBTQIA+ people were sometimes rejected by their families and socially ostracized or subjected to harmful "conversion therapy" aiming to change their sexual orientations and/or gender identities [7]. Past experiences of trauma and discrimination may continue to impact older LGBTQIA+ people. For example, some may be reluctant to share their sexual orientation or gender identity in clinical settings due to concerns about mistreatment. In addition, older LGBTQIA+ people who survived the harrowing early years of the AIDS epidemic prior to the advent of effective antiretroviral therapy, often witnessed partners and friends die; and may continue to experience the emotional effects of that trauma. Yet, these experiences of adversity have also fostered resilience, with the creation of strong social networks, "families of choice" for those rejected by their families of origin, and vibrant community organizations.

SEXUALITY AND AGING

In contrast to assumptions that sexual activity and interest decline with age, many older people have sex, newly initiate or re-initiate sexual activity, or explore new expressions of sexuality. In a study of more than 2,000 adults over age 65 years, approximately half of those with a partner reported sexual activity in the prior 6 months.[8] Moreover, some people first pursue same-gender sexual relationships in older age, sometimes after a long-term relationship with someone of a different gender has ended through separation, divorce, or the death of a partner.

While prescription drug use and medical co-morbidities, such as vascular disease and osteoarthritis, tend to accumulate with age and may impact sexual function and interest, these impacts may be temporary or can often be mitigated or modified, allowing older people to continue to enjoy sexual expression. For example, hip replacement may improve sexual quality of life among older people.[9]

Beyond changes in health, older people may face other challenges to their sexual expression. Social isolation and/or the death of a partner or spouse may limit opportunities for sex. In addition, communal living settings, such as skilled nursing facilities, may not provide sufficient privacy for residents to engage in sexual activity. These concerns may be particularly prominent for older LGBTQIA+ people, who may also face or be concerned about staff members' biases about their sexual behavior. Similarly, older LGBTQIA+ couples who require home-based care may hide the nature of their relationships from visiting nurses or health aids to avoid discrimination. Those who initiate or resume sexual activity in older age may also not be aware of messaging around risks and prevention of STIs that is typically focused on younger generations.

Clinicians' assumptions about sexual activity, regarding both heterosexuality and age, also pose challenges to older adults' sexual health. Clinicians may assume that patients are not sexually active or are heterosexual and/or cisgender, eroding LGBTQIA+ patients' trust and missing opportunities to provide care recommended for LGBTQIA+ people.

IMPROVING SEXUAL HEALTH CARE FOR OLDER LGBTQIA+ PEOPLE

The most important step clinicians can take to foster sexual wellness for older LGBTQIA+ people is to discuss sexual health in a non-judgmental and affirming manner. Discussing sexual health in this way requires asking about anatomy, partners, and sexual behavior without assumptions about sexual orientation or gender identity.

Conveying a welcoming message and tone to LGBTQIA+ people begins before they enter the examination room. Routinely asking all patients about sexual orientation and gender identity, such as at patient registration, informs patients that the health care organization is committed to serving LGBTQIA+ people and that knowing someone's sexual orientation and gender identity is important for their care. LGBTQIA+-friendly images, such as posters or brochures featuring transgender and gender diverse people or same-gender couples, also serve to convey a welcoming atmosphere. All staff should be trained in core LGBTQIA+ concepts and terms. Patients should be asked which names and pronouns staff should use; this information should then be shared with members of the care team and integrated into electronic health records, patient portals, and clinical decision support systems.[10,11] The built environment is also crucial; ensuring access to an all-gender and/or single-stall restroom or posting a policy that people may use whichever restroom aligns with their gender identity, improves the experiences of transgender and gender diverse people.

During the clinical encounter, clinicians can discuss sexual behavior in an open, affirming, and sex-positive way, focusing on the older person's concerns and/or goals. Sex positivity refers to the idea that sexuality is a healthy part of human life and that all types of sexual activity between consenting adults are normal. When eliciting a sexual history, clinicians may first wish to explain why it is important for health care. This may be particularly important for older people, who may have never been asked about sexual behavior in a medical setting, or who may be concerned about how the information will be used. Clinicians can then ask about sexual activity in a way that does not convey assumptions. (See the table below for examples of statements and questions in a comprehensive sexual history)

According to the Centers for Disease Control and Prevention (CDC), a comprehensive sexual history includes information about[12]:

1. Partners: Number, gender, and any known sexually transmitted infection (STI) or HIV risks among one's partners (e.g., HIV infection, injection drug use)

2. Practices: Use of alcohol and/or drugs in conjunction with sex, and the types of sex one has

3. Past history of STIs: A recent history of some STIs, such as gonorrhea, confers an indication for HIV pre-exposure prophylaxis (PrEP). In addition, some STIs, such as syphilis, require longer-term follow up.

4. Protection from STIs: This includes condoms, as well as other preventive strategies, such as PrEP.

5. Pregnancy plans: Some older people do not face the possibility of pregnancy because of menopause or hysterectomy, but those whose bodies produce sperm could impregnate others, and pregnancy intentions should be discussed in these cases.

Some experts add additional Ps for "pleasure" and "parts". Asking about sexual satisfaction not only provides patients the opportunity to discuss concerns they may have but may not mention unless a clinician does so first, but also underlines that sex is not only, or even primarily, about risks, but rather pleasure and health as well.

Parts refers to an anatomical inventory of organs that are present, such as vagina, penis, and testes. Understanding what anatomy is present is important for guiding screening and counseling about sexually transmitted infections. The anatomical inventory can be performed by the clinician during a clinical encounter, or it may be part of a pre-visit survey.

Table. Example statements and questions in a comprehensive sexual history	
Topic	**Example statement or question**
Beginning the sexual history	"I would now like to ask you about sexual behavior. This information will allow us to determine the care that will best meet your needs."
Determining if the patient is sexually active	"Have you had sex in the past year?" "How have you been sexually active in the past year?" *It may be helpful to specify what is meant by sex, since some patients may not consider certain practices (e.g., oral sex) to be sex.*
Establishing the patient's number of sexual partners	"How many people have you had sex with in the past year?"
Asking about the genders of a patient's sexual contacts	"What are the genders of the people you have had sex with in the past year?"
Identifying which types of sex the patient has	"What types of sex do you have?" "Have you put your penis in anyone's anus?" (or another similarly specific question, if medically warranted)
Assessing a history of STIs	"Have you ever had an infection spread by sex?" *It may be helpful to provide examples, such as herpes, chlamydia, gonorrhea, and/or syphilis.*
Asking about condom use	"How often, if at all, do you use condoms for sex?"
Evaluating sexual function and pleasure	"Do you have any concerns about sexual function or satisfaction?"

SCREENING AND PREVENTION OF STIs

Because no guidelines specifically address STI screening, prevention, or treatment for older LGBTQIA+ people, clinicians should apply guidelines for the general population, adapting these as needed to account for medical co-morbidities and/or drug interactions[13].

Clinical practice guidelines for STI screening are based on behavior, not identity, highlighting the importance of a comprehensive sexual history for all patients. For MSM/MSMW, the CDC recommends screening for HIV, syphilis, gonorrhea, and chlamydia at least annually, and more often in those at higher risk.[14] Testing for gonorrhea and chlamydia should be performed at all sites that may have been exposed, regardless of condom use. MSM/MSMW who have engaged in oral and receptive anal sex should thus be screened for gonorrhea and chlamydia in the throat and rectum, in addition to the urine.

CDC's Advisory Committee on Immunization Practices recommends hepatitis A and hepatitis B vaccination for all MSM.[15] Hepatitis B vaccination became routine for infants in 1991, so older MSM may not have previously received this vaccination unless it was administered for travel or another indication. The human papillomavirus vaccine is recommended for people up to age 26 years; for those ages 27 through 45 years, "shared clinical decision-making" is recommended.[16] There is currently no recommendation for immunization against human papillomavirus in adults older than 45 years; nevertheless, clinicians may consider it on an individual basis, especially for people who are first initiating sexual activity in older age, after counseling patients about the unproven benefit in this context.

PRE- AND POST-EXPOSURE PROPHYLAXIS (PREP AND NPEP) FOR HIV

Pre-exposure prophylaxis (PrEP) refers to the daily use of antiretroviral medication to prevent HIV in those with a high, ongoing risk for infection. Non-occupational post-exposure prophylaxis (nPEP) refers to the use of antiretroviral medication for 28 days following a discrete exposure to HIV. Both strategies are recommended by the CDC and may benefit older LGBTQIA+ patients at increased risk for HIV, though special considerations apply to the use of these interventions for older people.

Two medications are U.S. Food and Drug Administration approved for PrEP; both are combination tablets of emtricitabine and tenofovir: emtricitabine/tenofovir disoproxil fumarate (TDF/FTC, Truvada) and emtricitabine/tenofovir alafenamide (TAF/FTC, Descovy). Both prevent HIV when taken as prescribed and are well-tolerated in the young participants included in clinical trials,[17-19] but their side effect profiles differ. TDF/FTC can cause renal toxicity and decrease bone mineral density. These side effects may be of particular concern in older adults, who may have age-related declines in renal filtration and/or other medical conditions that affect the kidneys and/or bones. TDF/FTC should be avoided when the estimated creatinine clearance is less than 60 mL/minute or when osteoporosis is present; clinicians may also avoid this drug when risk factors for these conditions are present. TAF/FTC has less renal and bone toxicity, but it is associated with weight gain and unfavorable effects on blood lipid profiles.[19]

Recommended first-line regimens for nPEP feature three antiretrovirals: TDF/FTC with dolutegravir, or TDF/FTC with raltegravir.[20] Longer term toxicities are less of a concern with nPEP than with PrEP, since nPEP is prescribed for 28 days only, though TDF/FTC should still be avoided if the estimated creatinine clearance is less than 60 mL/minute. Importantly for older people who may take multiple other medications, these agents have few drug-drug interactions, aside from an interaction between dolutegravir and metformin, a drug widely prescribed for diabetes mellitus.

UNDETECTABLE = UNTRANSMITTABLE AND OLDER LGBTQIA+ PEOPLE

Multiple studies have shown that people with HIV who have suppressed HIV viral loads on antiretroviral therapy cannot transmit the infection through sex; in other words, undetectable = untransmittable (U=U).[21,22] The public health impact of this observation is immense, but so is the personal impact; educating patients about U=U reduces stigma. The effect may be especially important for older people living with HIV, who may have longstanding anxiety or shame around sex due to concerns – now disproven – that they are contagious even if their viral loads are suppressed. Clinicians should share the message of U=U with all patients living with HIV.

SUMMARY/CONCLUSION

- Culturally affirming sexual health care for older LGBTQIA+ people is an important aspect of fostering their overall health.
- Changes in sexual function or desire may occur as people age, but these changes can be temporary or modifiable. Many older people continue to engage in sexual activity as they age.
- Challenges to optimal sexual health in older LGBTQIA+ people include caretakers' biases, lack of privacy due to communal living arrangements, and missed opportunities to discuss sexual health with clinicians.
- Clinicians should ask older patients about sexual behavior in a manner that does not convey assumptions of heterosexuality or gender conformity.
- A comprehensive sexual history includes information about partners, practices, past history of STIs, protection from STIs, pregnancy, and pleasure.
- Interventions to prevent or treat STIs and HIV, such as PrEP, nPEP, and vaccines, should be based on sexual behavior, not on age. Modifications in recommended sexual health care are not required because of age alone.

RESOURCES

Documents and guides:

- Issue Brief: LGBT and Dementia (2018, SAGE & Alzheimer's Association) https://www.sageusa.org/resource-posts/issues-brief-lgbt-and-dementia/
- Older Adults and Sexual Health: A Guide for Aging Services Providers (Updated 2020, New York State Dept. Of Health) https://www.health.ny.gov/diseases/aids/general/publications/docs/sexual_health_older_adults.pdf
- Understanding Issues Facing LGBT Older Adults (2017, MAP & SAGE) https://www.lgbtmap.org/file/understanding-issues-facing-lgbt-older-adults.pdf
- Safe Sex for Older Adults (2019, Patient resource, Health in Aging Foundation https://www.healthinaging.org/sites/default/files/media/pdf/HIA-TipSheet%20Safe-SexAug19.pdf
- Sexual Health: Tips for Taking a Geriatric Sexual History (2019, The University of Arizona Center on Aging) https://www.uofazcenteronaging.com/sites/default/files/sexual_health_tips_for_taking_a_geriatric_sexual_history-_2019.pdf *(If clicking this link doesn't work, please copy and paste into browser.)*
- COVID-19 and Your Sexual Health (2020, National LGBTQIA+ Health Education Center) https://www.lgbtqiahealtheducation.org/publication/covid-19-and-your-sexual-health/

Organizations:

- National Coalition on Mental Health and Aging: Education, resources, state and local coalitions http://www.ncmha.org/
- LGBT Aging Project: Cultural competency training, community engagement, resources for LGBTQIA+ older adults, and a Senior Speakers Bureau https://fenwayhealth.org/the-fenway-institute/lgbt-aging-project/
- National Resource Center on LGBT Aging: Training and publications, fact sheets, guides, and assistance on topics relevant to LGBT aging, as well as links to Sage Advocacy and Services for LGBT Elders. www.lgbtagingcenter.org
- Transgender Aging Network: Training, technical assistance, and projects focused on improving the lives of transgender older people and their social support networks. https://forge-forward.org/aging/
- Nurses' Health Education about LGBTQ Elders (HEALE) Cultural Competency Curriculum: Continuing education training for nurses and health care professionals who serve older LGBTQ adults. www.nursesheale.org
- Aging with Pride: National longitudinal study of LGBT adults aged 50 and older funded by the United States National Institutes of Health and the National Institute on Aging with over 50 publications. www.age-pride.org
- American Academy of HIV Medicine: Provider resources. Advocacy, HIV focused credentialing https://aahivm-education.org/hiv-age
- National Resource Center on HIV & Aging: https://aginghiv.org/

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ACKNOWLEDGEMENTS

This publication was written by Kevin L. Ard, Arielle Mather, and Christine A. Riedy.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of awards as follows: U30CS22742 totaling $700,000 with 0 percent financed with non-governmental sources,and U30CS30788 totaling $1,723,158 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.