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HIV/AIDS and Older Adults: An Overlooked Population

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Older adults were found to be at a very high risk for contracting the HIV virus, due to their lack of knowledge and understanding about the virus. Historically, prevention measures have been largely targeted towards younger adults, and the GLBT community. Older adults have been left without the crucial information that they need to know the risks of HIV, and how to practice safe sex at an older age. Prevention measures need to extend to the older population so that the spread of HIV does not continue in this population.

Walk across any university in America and more likely than not there will be colorful booths handing out free condoms with flyers about safe sex. There are information sessions in the dorms for freshman, brochures laying out in the health center, and ads in the school newspaper. All of this information is related to safe sex practices, where to get free testing for the human immunodeficiency virus (HIV), and how to make "good" choices once the weekend comes. HIV prevention has been historically targeted at certain populations, most notably younger adults, and members of the GLBT community. Although these populations have been considered at risk, there is one population that has been left out completely in recent HIV prevention measures. They are not college aged or homosexual, and they do not do intravenous drugs or live in poverty. They are older adults in America, who may not have had a sex education class in 30 to 40 years, and may not even think they are at risk for any sexually transmitted infections, let alone HIV. The last time they used a condom may have been in college to prevent against pregnancy, and now that this is not an issue, practicing safe sex may be a thought of the past.

This paper will examine the history of HIV prevention, in order to demonstrate how older adults have been excluded from prevention measures. The paper will also discuss the prevalence of HIV in older adults, and how the problem is only growing with a lack of knowledge and understanding within the demographic. The three main sources for HIV in older adults is a lack of knowledge, unwillingness to discuss sexual activity with doctors and doctors not discussing sexual activity with older adults, and medications such as Viagra, which enable older adults to have sex later in life. A case study (Unprotected sex has no age, 2009) in Brazil will be looked at to show how one country realized that they had a problem with HIV in older women, and what steps were taken to combat this. Different prevention approaches that may be successful with older adults will be reviewed, as well as possible measures to educate the older demographic about the prevalence of HIV.

History of HIV Prevention

1980's

The HIV/AIDS pandemic hit the United States in 1981, and was thought at the time to only affect homosexual men (Merson, O'Malley, Serwadda, & Apisuk, 2008). It was quickly discovered that year that the HIV virus was not only affecting homosexual men, but also IV drug users and other individuals outside of the United States. In 1985, more than 17,000 cases of AIDS were reported from 71 different countries to the World Health Organization (Merson et al., 2008). It was difficult for people in the United States, both policy makers and the public, to understand that HIV was a true risk for the overall population. It was easier to classify it as a virus that only affected marginalized populations, such as homosexual men and drug users. For this reason, the virus spread rampantly throughout the 1980's, and the U.S. continued to not engage in the tough discussions regarding sensitive social factors related to the spread of HIV (Merson et al., 2008). The 1980's in HIV prevention were more focused on attempting to change stigmas associated with the virus, and less on actual prevention measures. It was difficult for policy makers to balance how to approach prevention of the virus, and treatment measures to address the growing number of people with the virus (Merson et. al., 2008).

Soon, community groups and organizations were formed that discussed prevention. These groups had community-based prevention campaigns and care provisions, which led to awareness about prevention measures. Many safe-sex campaigns were launched, and although HIV still had a strong stigma attached to it, the messages about safe sex were being heard (Merson et al., 2008). The 1990's were a time when prevention and treatment were at the forefront of the HIV discussion, as new treatments were being discovered.

1990's

The 1990's were a very progressive time for HIV prevention and treatment, as new drugs were being developed to fight HIV, and less social stigma was being attached to the virus. It began to be accepted as a virus that could be transmitted through any sex, as opposed to only gay sex (Kelly, 1995). Prevention was aimed at young adults who were possibly engaging in sexual activity, and group interventions were started in schools and communities. These group interventions taught skills training in safe sex practices and general education about the HIV virus. Two other prevention strategies that were used in the 1990's were behavior change interventions and cognitive restructuring (Kelly, 1995). Prevention specialists realized that if they changed the cognitions in people regarding whom HIV affected, and the measures that could be taken to prevent HIV, it was possible for people to begin to understand the virus and how to protect themselves. When kids learned in school that wearing a condom was a safer way to have sex for your health, they were more likely to use a condom because they began to think of their health and different factors that could affect it, such as HIV (Kelly, 1995).

However, Merson et al. argues that although prevention measures were increased in the 1990's, the most dramatic gains were seen in treatment and not prevention. Huge progress was made in antiretroviral drugs, and access was increased with more affordable products (Merson et al., 2008). With more people being able to access these drugs and go through effective treatments, HIV was seen less as a death sentence in the 1990's as opposed to the 1980's. Moving into the 2000's and present day, HIV began to lose much of the stigma attached to it. The population became more educated that it was not just a disease that affected certain demographics, and instead was something that needed to be considered when engaging in sexual acts. However, many adults did not receive safe sex education in school, because they were already in their 20's or 30's, and may have only heard certain messages related to HIV. These individuals are now in their 50's or older, and are facing new risks regarding HIV.

HIV in Older Adults

Prevalence

Over a quarter of the U.S. population living with HIV is age 50 or older (Today's Research on Aging, 2009). There are many reasons why HIV has become prevalent in older adults age 50 and over in recent years. To start, there is a larger population that is aging with HIV, and with better screening more people have been diagnosed in recent years (Today's Research on Aging, 2009). According to Today's Research on Aging (2009), adults age 50 and older accounted for approximately:

- 10% of new HIV infections in the United States in 2006.
- 21% of AIDS diagnosis in 2006 and 2007.
- 28% of persons living with HIV/AIDS in 2007.
- 34% of those living with AIDS in 2007, up from 24% in 2003 (p. 1).

This data demonstrates that older adults in the U.S. have seen a steady incline in the number of people diagnosed, as well as people living with the virus. Many adults that have either been diagnosed recently or in the past have been placed on effective medications, which on average have extended their lives more than 14 years. This is in comparison to if they were not to receive any medication (Today's Research on Aging, 2009). It is also apparent that people infected with HIV are transitioning into a new population. Prior to 1990, in people age 50 and over, HIV was mostly found in cases of injection drug users, transfusions and homosexuals, whereas in 1990 and after, more than 50% of cases were through heterosexual exposure (Tabnak & Sun, 2000). These numbers clearly show that people age 50 and older are facing many risks regarding HIV because people are living longer with the disease, and more diagnosis are being made.

Sources

The rise in numbers of older adults with HIV can be attributed to any number of factors. As discussed previously, more people are being diagnosed as screening becomes easier. However, the real risk lies in older adults not being well informed on HIV prevention, and engaging in potentially risky behavior. Many adults over the age of 50 were in their 30's when the HIV pandemic hit, and therefore were not the target of prevention measures. Also, older men and women previously lived in a world where HIV was not an issue when engaging in sexual activity. McNamara (2010) states, "many older people are newly single and believe that HIV affects only younger people" (p. 33), which emphasizes the mentality of many older adults. They are no longer protecting themselves against pregnancy, and do not consider HIV to be a threat to them at their age. Also, many older people may have

difficulty associating certain symptoms with a virus like HIV, because they may attribute many symptoms to the regular aging process (Sankar, Nevedal, Neufeld, Berry & Luborsky, 2011). It makes perfect sense that this sector of the population would lack the knowledge about the virus in comparison to young adults who have received HIV prevention for most of their adult life.

Another reason for the rise of HIV among older adults is the simple fact that they may not be comfortable talking with their doctors about HIV, and their doctors may not think to bring up the issue in routine appointments. Talking about sexual activities is a delicate subject that many doctors do not discuss with older patients (McNamara, 2010). In a recent study in the New England Journal of Medicine, "73 percent of adults ages 57 to 64, 53 percent ages 65 to 74, and 26 percent ages 75 to 85 years are sexually active but a much smaller share have discussed sex with a physician since reaching age 50" (Today's Research on Aging, 2009, p. 2). This means that almost two-thirds of adults over the age of 57 are engaging in sex, however many may not be aware of safe sex practices, and as reported, are not discussing them with their doctors. Doctors may also choose to focus on primary health care issues, which they are more comfortable with, as opposed to discussing HIV (Coleman, 2003).

The third reason that HIV has risen in older adults age 50 and above is the use of erectile dysfunction drugs such as Viagra. Many older men who prior to Viagra would not be engaging in sexual activity are now able to have sex later in life. A recent study by AIDS Care, found that in the past six months, 44.8% of participants age 60-94 had used Viagra while engaging in sexual activity (Jacobs et al., 2010). This was over 10 percent higher than participants who had used alcohol two hours prior to sexual activity, which shows the prevalence of Viagra use among men. The riskiest combination is when postmenopausal women are not protecting themselves because they are not at risk of becoming pregnant, and older men are not using condoms at jeopardy of not being able to perform sexual intercourse. This is when men will take medications such as Viagra, and engage in risky behavior, which can lead to HIV (Today's Research on Aging, 2009).

Three main sources of HIV contraction in older adults are lack of knowledge of HIV and safe sex practices, not being comfortable discussing sex with a physician, and medications such as Viagra, which enable older men to engage in risky sexual behavior. With all of these risk factors, as well as the data, which indicates a rise in older adults being diagnosed with HIV, it is discouraging that policy makers and organizations have not taken notice and began HIV prevention measures aimed towards older adults. As discussed previously, most HIV prevention is taught to young adults, or specific to certain populations, such as homosexual males. However, in Brazil, the country has a new campaign that is trying to including older adults in the HIV discussion.

Case Study: Brazil—"Unprotected Sex Has No Age"

One woman in Brazil is on a mission to change thoughts relating to HIV in older adults. Beatriz Pacheco was diagnosed with HIV in 1997, when she was married and working as a lawyer. Her doctor tested her for HIV after she had been sick for over a year, but she did not think that it was a virus that could affect her. After learning that she was HIV positive, she decided to work with the Brazilian government to attempt and change notions relating to HIV and the older population. She found that many elderly women were HIV positive, and yet the government campaigns and official statistics had never mentioned this portion of the population. She explained this may be attributed to the fact that in Brazil there is prejudice related to sexuality and age, where many people do not think that the elderly are sexually active (Jurberg, 2009). Likewise as in the United States, older adults in Brazil also feel that HIV is a disease of young people, and therefore they are not knowledgeable about the true risks and nature of HIV.

After many efforts by Beatriz Pacheco, in 2008, the Brazilian government launched a new campaign on World AIDS Day, under the slogan: "Sex has no age. Nor has protection" (Jurberg, 2009). This campaign was revolutionary in extending the HIV and safe sex discussion to an older population, and not just targeted groups such as young adults or homosexual males. Brazil is attempting to do what other countries, including the United States has not, which is extend HIV prevention to older adults, and through large-scale prevention campaigns. The United States cannot sit back and ignore the fact that HIV is reaching an older population, and lawmakers and doctors alike have not addressed the issue on any type of level. By not educating and talking with older adults about the risks of HIV, it is only doing them more of a disservice because they are many decades behind in safe sex practices. As Beatriz Pacheco did in Brazil, something needs to be done here in the United States to help put the words "elderly" and "HIV" together, in order to reduce the spread of HIV.

Prevention Strategies

General

There are many common factors to an effective HIV prevention program, however a program aimed towards older adults has not been developed in the

United States. The programs that have been successful are evidence-based interventions (EBI) for HIV prevention, which promote behavioral change (Rotheram-Borus et al., 2009). Rotheram-Borus et al. (2009) suggest five key points that every prevention program should entail:

> *(1) establish a framework to understand behavior change; (2) convey issue-specific and population-specific information necessary for healthy actions; (3) build cognitive, affective, and behavioral self-management skills; (4) address environmental barriers to implementing health behaviors; and (5) provide tools to develop ongoing social and community support for healthy actions p. 399).*

These programs have been successful in the past because they have addressed specific behaviors of individuals, and have targeted individual populations. The number of evidence-based HIV prevention programs targeting at-risk or HIV-infected populations have risen rapidly since the 1990's, and at least 144 interventions qualify as evidence-based interventions (Rotherman-Borus et al., 2009). It is especially important to promote evidence-based interventions and behavioral change models when dealing with HIV, because there is no cure, and protection is entirely in the hands of the individual. Historically, community organizations have not used evidence-based interventions, however with the evolving dynamics of HIV, it is necessary to begin to implement more evidence-based interventions in order to change cognitions and behaviors related to HIV.

Establish a Framework to Understand Behavior Change

It is simply not enough for a successful intervention program to only address behavioral change. It also needs to address objectives for participants so that they can meet certain life goals, and thoroughly understand why they are changing certain behaviors (Rotheram-Borus et al., 2009). When participants in the prevention program are able to take the steps towards initiating life goals, and learning the ways to make these goals a reality, they are personalizing their prevention and taking on a new identity and social role. In order to understand this new social role, many prevention programs may have participants engage in role-playing or share stories, so they can understand how the role would look like in real life (Rotheram-Borus et al., 2009). Once this new role is understood and accepted, it is possible for the intervention to encourage positive behaviors that support the new role.

In older adults, it is possible to use this measure in a variety of ways. It is necessary for the public as well as doctors to encourage older adults to take on a new role as sexually active members of the community, who can practice the same safe sex measures as younger adults. The stigmas attached to older adults that were discussed above, such as the stigma that older adults do not have sex, or that HIV is a disease of youth; need to be shed in order to embrace a new social role. Doctors and patients alike need to become comfortable with the fact that sex occurs at any age, and so does HIV. Once doctors and older adults accept that their role in society is the same sexually as any other member, discussions can begin about behavior choices and changes, which in turn can lead to older adults taking responsibility for their sexual health and hopefully prevent the spread of HIV.

Convey Issue-specific and Population-Specific Information

Rotheram-Borus et al. (2009) argue that in order for interventions to be successful, they must be tailored to particular populations, but also address specific issues that may be a part of the participant's life. The specific issues are HIV-related issues that the particular population faces, and a successful intervention needs to understand these issues and the best way to incorporate them into the intervention. For example, an HIV prevention program that targets HIV-positive mothers or pregnant women, not only needs to focus on this population, but also have information regarding parenting strategies (Rotheram-Borus et al., 2009). Also, programs targeted at youth populations need to stay committed to dealing with youth, and may also incorporate pregnancy and STI prevention, as well as overall sexuality facts. The main goal is to identify a specific population, and determine the issues that this population faces. When this is achieved, the prevention will be more successful because it is unique to that population and will discuss the needs that they may face.

Since there are limited programs for older adults and HIV prevention, this population needs to be addressed and the issues that they face need to be dealt with and understood. There are many population specific issues that older adults face, such as postmenopausal women who do not need to use a condom for pregnancy prevention, and therefore they do not take steps to protect themselves. There is also a lack of knowledge of general sexual health issues that have arisen in present day, including HIV information. Older adults also need specific information on how to discuss their sexual health with their doctors, and what questions they should be asking regarding safe-sex practices and the best ways to protect themselves. It is apparent from the data that this population needs information, and that they have many issues that can be discussed through proper information in a prevention program.

Build Cognitive, Affective, and Behavioral Self-Management Skills

As explained in the first section, changing behavior cannot start until changes in cognition have occurred. A successful prevention program needs to teach participants to think differently, and how to become aware of their emotions, thoughts and actions (Rotheram-Borus et al., 2009). These include general problem solving skills, goal setting, and planning. Participants need to understand their goals, know how to implement a plan, and solve a problem if it arises, because these are the issues that they will face when engaging in sexual behavior and risking the contraction of HIV because they did not use safe sex practices. If a prevention program can teach people these skills, when faced with difficult situations they will be able to understand their emotions in the situation and how best to deal with them (Rotheram-Borus et al., 2009).

It is difficult to implement this part of prevention with older adults, because many have already settled into a "style of life" and may not prescribe to the more cognitive aspect of prevention. It may be easier for them to change behaviors once they are given the information regarding HIV, however working on understanding their emotions and actions may be complicated later in life. It is important that the prevention program stresses that older adults need to understand their actions, and that engaging in sexual activity means that they are at risk for contracting HIV.

Address Environmental Barriers to Implementing Health Behaviors

The beginning part of a successful prevention program examines population and issue-specific information, and how to best target certain populations. This section of prevention goes one step further within the targeted population, and attempts to identify and address environmental barriers that the population may face in regard to health concerns (Rotheram-Borus et al., 2009). These populations may not be able to access certain information, or may have issues that they need help overcoming in order to participate in prevention and making behavioral changes in their health. For example, youth who are homeless or have run away cannot engage in a prevention program until they have shelter and access to health care. If these environmental barriers are not addressed, they will not be able to participate in a population and issue-specific prevention plan.

There are different ways in which these environmental barriers are addressed. At a minimum, all evidence-based interventions need to "indirectly target environmental barriers by helping participants identify, anticipate and problem solve barriers to the new behaviors, as well as meeting the instrumental needs that drive vulnerability to HIV, AIDS, and other negative outcomes" (Rotheram-Borus et al., 2009, p. 404). By understanding their behaviors and specific barriers, participants will hopefully be able to make positive choices. The second intervention that can be used to target environmental barriers are direct interventions at the community-level. These interventions are structural interventions which aim to change community norms or policies, and can be as simple as ensuring access to condoms and healthcare for participants (Rotheram-Borus et al., 2009). This is less of a cognitive based approach, and ensures that environmental barriers are removed in the community through action-based measures.

There are many ways that both indirect and direct interventions can occur in HIV prevention for older adults. To start, indirect measures can help older adults identify HIV as something that can affect them, and know the behaviors that can be taken to protect them against it. There is an apparent environmental barrier of knowledge and information distribution in older adults. Direct measures at the community level can be something like the Center for Disease Control creating a pamphlet for older adults and their risk of HIV. This pamphlet can be placed in doctor's offices, and when discussing general health, older adults can read information pertaining to them and HIV. It is also necessary for community organizations in local cities to incorporate HIV prevention measures for older adults, and for them to realize that the largest environmental barrier that older adults face is their limited access to information.

Provide Tools to Develop Ongoing Social and Community Support

In order for behavioral change to continue in the long-term, ongoing social support is vital (Rotheram-Borus et al., 2009). This support can be in the form of groups, counseling, and self-help networks that have a common goal of the participant taking control of their prevention and developing support for themselves. Behavioral and cognitive change occur over time, and therefore programs such as support groups are vital after the prevention program has been completed, in order to maintain change. After the successful prevention program has ended, it is important that participants feel that there is still a core element of the program in the support (Rotheram-Borus et al., 2009).

This aspect of prevention may also be difficult to tailor to older adults, because they may not be engaging in formal prevention programs. They are not in school to sit through a month long information session on HIV prevention, and they are not in a mandated program for IV drug users. The prevention for older adults should be targeted in simple and effective ways, such as doctor's visits and general education in the community. Therefore, having formal support groups may be

difficult to implement, however there are ways that it can be incorporated. For example, if a nursing home or daycare facility implements a prevention program for older adults, which details general information on safe sex and HIV, it is possible to have support groups after the program in order to discuss other issues. Since there is a social stigma attached to older adults and having sex, it may be beneficial for them to have support groups to understand this stigma is not true, and other older adults are in the same situation as they are.

Summary of Prevention Program

The five step, evidence based intervention program was chosen for older adults, because it was population and issue specific, and was aimed at changing cognitions as well as behaviors. It is very comprehensive, and is detailed enough to tackle the tough challenge of discussing sexual issues with a population that has not had formal sex education in 30 years, if at all in their life. As a group with a social stigma attached, it is important for the prevention program to be aimed at changing these cognitions, and allowing older adults to take control of their sexual activity. In turn, they will hopefully change sexual behaviors, and stop the increase in HIV in older adults.

Conclusion

In conclusion, this paper addressed the lack of HIV prevention measures in the older adult population, and how historically prevention measures have been aimed at populations such as homosexual men and IV drug users. HIV prevention has changed dramatically since the 1980's, when the pandemic was discovered, however older adults have continued to be left out of the discussion. As diagnosis and treatment have progressed, the older adult population has seen dramatic increases in numbers of adults with HIV. More than a quarter of all people living with HIV are now over the age of 50, and these numbers may only continue to rise without proper prevention measures. HIV is prevalent among older adults age 50 and over for three main reasons. One, older adults lack the vital information regarding the risks of HIV and the necessity for safe sex. They may have never received this information, and may think that HIV is simply a disease that affects young people, or other groups. Second, doctors are not discussing safe sex and HIV with older adults, because they may either not feel comfortable about it, or may not think of HIV as an issue. Older adults are also not comfortable discussing their sexual activity, even though over 70% of people over the age of 57 are engaging in sexual activity. Third, medications such as Viagra have made it possible for older adults to engage is sexual activity later in life, and therefore increase their risk of HIV. This in combination with postmenopausal women not using condoms for pregnancy prevention means that older adults are having sex later in life, without protection.

All of this data shows the obvious need for HIV prevention measures tailored to older adults. However, in the United States, our prevention programs have been aimed at other demographics. The case study of Brazil was examined to show how one country realized they had an issue with HIV among older women, and started a national campaign. This campaign addressed the social stigma of older adults not having sex, by saying that unprotected sex has no age. A measure like this in the United States would be very beneficial to start the conversation about older adults having sex, and the prevalence of HIV.

It was determined that the best prevention program for HIV prevention among older adults would be an evidence based intervention, because it is comprehensive, is directed at specific populations and issues, and attempts to change cognitions as well as behaviors. This five-step process would engage older adults and enable them to become aware and educated on HIV prevention, as well as have access to information in the community.

It is vital that HIV prevention does not stop only at the groups that are typically associated with the disease. This will only fuel the inaccurate social stigmas that exist today, and that people worked so hard to change in the 1980's. Society needs to start the discussion that HIV can and will affect everyone if proper prevention and protection measures are not taken. Simple and effective steps can be taken to ensure that our older population is taken care of and protected, because it is true that "sex has no age".

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