FACT SHEET

RURAL CENTER for AIDS/STD PREVENTION

A Joint Project of

INDIANA UNIVERSITY, UNIVERSITY OF COLORADO, AND UNIVERSITY OF KENTUCKY

Older Adults and HIV/AIDS

Approximately 1 in 6 people living with AIDS is age 50 or older (Mack & Ory, 2003). In 2004, nearly 6,000 individuals age 50 and older, hereafter referred to as older adults, were diagnosed with HIV/AIDS (CDC, 2005). Since the beginning of the HIV epidemic, older adults have accounted for 10-11% of the cumulative number of AIDS cases in the US (Stall & Catania, 1994). The number of AIDS cases and HIV infections among older adults continues to increase as people of all ages survive longer due to advanced drug therapies (Fox-Searman, 2005) and as older adults continue to engage in HIV-risk behaviors. It is important to note that despite our current estimates of HIV infection rates among older adults, it is difficult to determine actual rates of HIV infection among this population because older adults are not routinely tested for HIV (Stall & Catania, 1994).

Disparities

Just as in younger populations, health disparities related to HIV/AIDS exist among older adults, especially among minorities. For example, of all older adult AIDS cases in the United States, more than half (55%) are among African Americans and Hispanics. Among older men diagnosed with AIDS, 51% are African American and Hispanic. Among older women diagnosed with AIDS, 73% are African American and Hispanic (CDC, 2001). Nationally, African American women account for approximately 11% of the total female population age 50 and older (USCB, 2001), yet account for more than 50% of AIDS cases and more than 65% of HIV infections among women in the same age group (CDC, 2001).

Sexual Risk

Contrary to the prevailing stereotype, older adults want to, and are able to, have an active, satisfying sex life (National Institutes of Health, 1981; Reinisch & Beasley, 1990; Wooten-Bielski, 1999). Sexual contact is the most reported transmission route of HIV among older adults (Chiao, Ries, & Sande, 1999) indicating both sexual activity and sexual risk behaviors among this population. Indeed in a study among older, African American women living in the rural south, 60% reported at least one HIV risk behavior (Winningham, Corwin, et al., 2004). In a national study of older women between 40 and 75, 13% reported that they did not know if their primary sex partner engaged in any HIV-risk behaviors. Additionally, most of these women reported they did not know if their primary partner was having sex with additional partners (Binson, Pollack, & Catania, 1997). Furthermore, a study among older, rural African American women found that sexual partners influenced HIV risk perceptions (Winningham, Richter et al., 2004).

Despite remaining sexually active, older adults are one-sixth as likely to use condoms during sex compared to younger adults (Stall & Catania, 1994). This may be because they do not feel susceptible to pregnancy or sexually transmitted diseases. For example, research conducted with older women indicated that despite reporting HIV risk behaviors, women reported low perceived susceptibility to HIV (Winningham, Corwin et al., 2004). Moreover, among older men who have sex with men (MSM), denial has been identified as a contributing factor to HIV risk (Grossman, 1995).

The risk of HIV transmission among older women and MSM is exacerbated during intercourse due to normal aging changes (Moore & Amburgey, 2000). For women, these changes include decreased vaginal lubrication and estrogen deficiencies which cause thinning of the vaginal walls. For older MSM and women, thinning of the epithelial structure of the anal area also occurs naturally with age. These physiological changes allow for more microscopic tearing during sexual penetration and therefore, provide a direct route for HIV transmission.

Injection Drug Use

The second most reported route of HIV transmission among older adults is injection drug use (IDU). Between 1991 and 1996, 19% of older adults diagnosed with AIDS attributed their HIV infection to IDU (Chiao, Ries, & Sande, 1999). Individuals may become infected with HIV through sharing needles with HIV-infected IDUs or through sexual contact with HIV-infected IDUs. In a study comparing older and younger IDUs, older IDUs reported participating in less risky injection practices than their younger counterparts. However, in terms of risky sexual behavior, older IDUs reported engaging in correspondingly high rates as the younger cohort (Kwiatkowski & Booth, 2003).

Implications for Prevention

As with any population, HIV prevention efforts for older adults must be designed to address their specific needs. To

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determine those specific needs in relation to their psychosocial context, additional research must be conducted. For example, the content of educational materials for older adults should be designed with the adult learner in mind. Adult learners, particularly older adults, are unique learners such that they tend to be independent and self-directed as well as prefer a problem-centered curriculum with skills that can be applied immediately (Stroot et al., 1998). Also, educational materials may need to be tailored for those individuals who have experienced physical decline. For instance, materials may need to be designed with certain colors, font sizes, or formats to be more easily viewed by those experiencing vision problems.

In addition to attending to physical differences, educational materials, messages and settings should consider generational and cultural factors specific to older adults. For example, many older adults, born prior to the sexual revolution, may not feel comfortable sharing details of their sexual behaviors in group settings and, therefore, may prefer one-on-one educational sessions. HIV prevention materials may be particularly effective if they include images of older adults. Moreover, HIV prevention efforts need to consider language, lifestyle, and the social context in which older adults engage in risk behavior. For example, HIV testing and counseling may be more acceptable if it is incorporated into routine medical treatment visits and discussed within the context of other health-related messages that specifically target older adults. It is also essential to consider the behaviors of sexual partners.

In rural communities, where issues of confidentiality, social isolation and stigmatization may be of great concern, special considerations must be made when developing prevention programs. For example, in order to reach high-risk populations in rural areas, public health officials have utilized community outreach workers to provide direct contact and individual or group discussions (Whyte & Carr, 1992). Moreover, public health officials may need to find creative ways to improve access to care, as well as, take extra measures to ensure confidentiality among those in rural areas (Thomas et al, 1996).

The ongoing challenge for prevention is to deliver prevention messages that are age-appropriate, clear and effective—especially when the messages have to reach populations that do not perceive themselves to be at risk for HIV and therefore, do not attend to the prevention messages or seek prevention services. Successful HIV prevention efforts focused on reducing HIV risk behaviors and increasing HIV testing among older adults will require collaborative efforts among health providers, health educators, researchers and public health officials.

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