

# AGEING AND SEXUAL HEALTH



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 Sexual and Reproductive Health (incl. Maternal and newborn health)  
 WHO Regional Office for Europe  
 Scherfigsvej 8  
 DK-2100 Copenhagen Ø  
 Denmark  
 Tel: (+45) 3917 17 17  
 Fax: (+45) 3917 18 18  
 www.euro.who.int/entrenous

**Chief editor**  
 Dr Gunta Lazdane

**Editor**  
 Dr Lisa Avery

**Editorial assistant**  
 Jane Persson

**Layout**  
 Kailow Creative, Denmark.  
 www.kailow.dk

**Print**  
 Kailow Graphic

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The year 2012 has been a busy year for healthy ageing, involving policy makers, stakeholder organizations and a broader public around Europe. This has been a year full of action to take stock on policies for healthy ageing and to come up with strategies for the future. Globally, 2012 marked the 10-year anniversary of the Madrid International Plan of Action on Ageing, celebrated in September at the United Nations Economic Commission for Europe Ministerial Conference on Ageing in Vienna.

The World Health Organization (WHO) celebrated World Health Day on 7 April 2012 under the theme “Ageing and health” with the slogan “Good health adds life to years.” Throughout the year, campaign activities and events have focused on how good health throughout life can help older men and women lead full and productive lives and be a resource for their partners, families and communities.

Accelerated population ageing is now observed in countries around the world. It has long been a concern in Europe, a region that has the highest median age in the world. This social transformation represents both challenges and opportunities. This was also a key message of the European Commission Year 2012 of active and healthy ageing and solidarity between generations.

While people live longer, many enjoy good health and remain active, independent and socially engaged up to their highest ages. Evidence from some countries indicates that this went hand in hand with a trend of improved quantity and quality of sexual experience for older people. Yet there are large and growing inequalities in healthy ageing: many people suffer already in their mid-life from noncommunicable diseases that may lead to multiple chronic conditions in old age. In addition, for those older people who remain sexually active, sexually transmitted infections seem to be rising.

What are the implications of these trends

for the sexual health of older people? For example, what do we know about whether “sexual active life expectancy” grows in tandem with overall life spans and what are its determinants? These questions have been subject to increasing attention and medical and social interest, slowly contributing to a changing perception of the role of sexual health for active and healthy ageing. According to the WHO sexual health is “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

Currently, our knowledge is still fragmented about how well prepared health and social care professionals and institutions are to assist older people comprehensively with their sexual health needs and rights. The articles in this edition of *Entre Nous* address a broad spectrum of aspects of ageing and sexual health, from specific medical challenges to wider social trends of changing views of society that have in many countries started to recognize that sexuality and sexual health are an intrinsic part of, if not a core indicator, for health and wellbeing in older age, for staying socially connected beyond traditional family boundaries, or even when living in residential settings. This recognition is essential to change negative stereotypes and barriers to participation that currently marginalizes older people in many instances.

For all age groups, sexual health is very personal. Older people may even have more trouble finding or asking for accurate information, requesting advice, services and protection of their sexual rights. For example, even in societies where older people might welcome

discussing their sexual health with health practitioners, these may consider that sexual health is not a legitimate topic to address. This may help explain why these issues are still not addressed openly, while services can be inadequate, fragmented and unfriendly in some countries in the European Region.

A recent edition of this journal has looked into the links between sexual (and reproductive) health and noncommunicable disease, a disease burden that is heavily concentrated on people of higher age groups. It has illustrated how both topics are linked and how sexual health and noncommunicable diseases face shared vulnerabilities and risk factors. The 2012 World Health Assembly resolution on “strengthening noncommunicable disease policies to promote active ageing” is crucial in this respect and has the potential to also contribute to further positive trends in sexual health at higher age groups.

To address sexual health needs and rights of older persons is certainly a complex task for health policy that requires intersectoral action, not least between health and social services. *Health 2020*, the new European policy supporting action across government and society for health and well-being presents a comprehensive framework for action. These principles are also at the heart of the *European strategy and action plan for healthy ageing in Europe*.

This edition of *Entre Nous* is a welcome addition to the discussions on healthy ageing. It is my hope that it will broaden our perspective on how gains in life span can be transformed into increasing health and wellbeing in older age groups, including sexual health and wellbeing that touch upon the most intimate aspects of healthy ageing.

**John Beard, MD,**  
Director, Department of Ageing and Life Course,  
WHO headquarters, Geneva

# A VISION FOR HEALTHY AGEING IN EUROPE: THE WHO STRATEGY AND ACTION PLAN

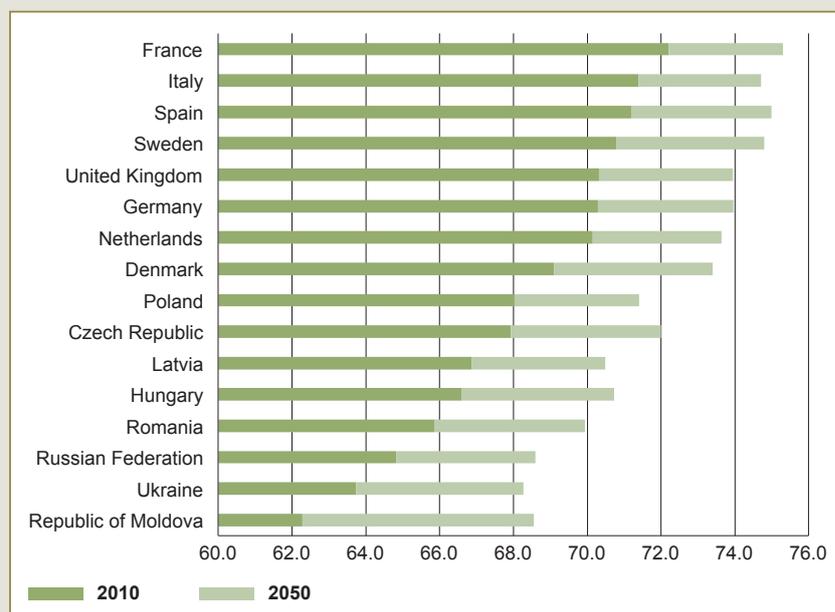
In 2012, the 53 Member States of the WHO European Region endorsed *Health 2020*, a new European policy framework supporting action across government and society for health and well-being. This framework refers to sexual health as an integral aspect of health and well-being in a life-course perspective. Improved sexual health can in fact be seen as one of the indicators for positive health trends that contributes to the overall *Health 2020* goal to “significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality” (1).

At the same time, the *Strategy and action plan for healthy ageing in Europe 2012-2020*, was adopted. Its goal is to address the specific challenges of ageing populations, to allow more people to live longer in good health and to live an active, independent and fulfilling life including at highest ages. Both the *Health 2020* policy framework and the healthy ageing strategy and action plan have been developed through a participatory process with Member States and a wide range of other stakeholders. The vision of the healthy ageing strategy and action plan is on of the building blocks for achieving the overall *Health 2020* goals (see Text Box 1).

## Text Box 1.

“The vision of this strategy and action plan is of an age-friendly WHO European Region where population ageing is seen as an opportunity rather than a burden for society. It is the vision of a European Region where older people can maintain their health and functional capacity and enjoy well-being by living with dignity, without discrimination and with adequate financial means, in environments that support them in feeling secure, being active, empowered and socially engaged, and having access to appropriate high-quality health and social services and support. An age-friendly European Region helps people to reach older age in better health and to continue leading active lives in various roles including in employment and voluntary action (2).”

Figure 1. Age at which remaining life expectancy is 15 years, 2010 and 2050 (3).



This article provides an overview on the *WHO Strategy and action plan for healthy ageing* and looks into the ways in which it can serve as a framework for addressing links between ageing and sexual health, many of which are further elaborated in several articles of this issue of *Entre Nous*.

## Trends of ageing in Europe

The median age of the population in the WHO European Region is the highest in the world and it continues to increase rapidly. Many people enjoy some of the longest life spans in the world: average life expectancy at birth for the 53 countries in the European Region is over 72 years for men and around 80 for women. Yet gaps in longevity and health experiences at higher ages continue to grow. The proportion of people aged 65 and older is forecast to almost double between 2010 and 2050 and no age group will grow faster than those aged 80 and over.

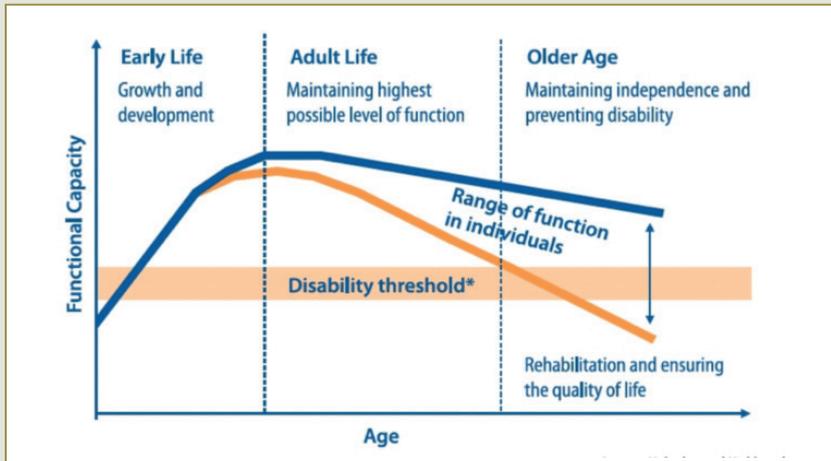
Combined with reduced fertility and population growth rates in many countries, increased average life expectancy is leading to higher old-age dependency ratios. While the average in the WHO European Region was almost 26 people aged 65 and over per 100 people

of working age in 2010, it is projected to double to around 52 by 2050. Such a static cut-off point at the age of 65 does not take into account differences in longevity across countries and increasing life expectancies, nor the growing number of people beyond this age who retain an active social life, support their families and engage in voluntary activities in their communities. More dynamic age limits and indicators for healthy and active ageing have therefore been proposed. One measure to demonstrate the large differences in longevity and population dynamics in Europe is the ratio of the number of people at or above the age at which they can expect to live another 15 years, to the number of people aged 20 and up to that age. This age limit increases over time and differs substantially between countries (Figure 1) (3). Dependency ratios grow substantially more slowly and follow different trends if the age at which people can expect to live on average another 15 years is taken as the age limit.

Enabling a greater proportion of older people to stay healthy and active has become key for the future sustainability of health and social policies in Europe. The unfavourable fiscal prospects that



Figure 2. Functional capacity over the life-course (4).



affect many countries have added to the urgency to step up implementation of policies aimed at healthy ageing.

“Healthy ageing” is a short term for the broader concept of both active and healthy ageing. Active ageing is defined by WHO as: “... the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance (4).”

Early interventions to promote an active life can reduce the proportion of older people falling below the disability threshold as illustrated in Figure 2 (4).

Allowing more people to lead active and healthy lives in their later years requires investment in a broad range of policies. The following four strategic priority areas have been singled out in the *WHO Strategy and action plan for healthy ageing in Europe*. They map how integrated health policies can respond to rapid ageing in Europe.

#### Healthy ageing over the life-course

Fighting the noncommunicable disease epidemic throughout the life-course is

broadly felt to be the key to further health gains at higher ages and for making health and social policies sustainable. Noncommunicable diseases account for the bulk of loss of healthy life years for people aged 65 and over. An individual’s health and level of activity in older age thus depend on his or her living circumstances and actions over a whole life span. However, more can be done to promote health and prevent disease, including among older populations, for whom access to prevention and rehabilitation may be impaired. A special concern is maintaining mental capacity and well-being into the highest age groups.

#### Supportive environments

A promising development is the growing network of cities and communities that cooperate amongst themselves and with the WHO to create supportive, age-friendly environments. This is also a focus of the WHO Regional Office for Europe’s contribution to the European Innovation Partnership on Active and Healthy Ageing, a commitment that has emerged from the discussions around the European Year for Active Ageing and Solidarity between Generations (5).

#### People centred health and long-term care systems fit for ageing populations

A third challenge is making health systems better fit ageing populations.

How can the different levels of health and social care be better coordinated and provide better services for people with multiple chronic conditions and with functional limitations? The degree of cost-sharing of the health bill is too high for many older people in Europe and public spending on long-term care varies enormously among countries. The evidence indicates that many people increasingly expect better access to high-quality health and social services, including public support for the informal care provided by family, friends and other volunteers.

#### Strengthening the evidence base and research

The WHO Regional Office for Europe also strives to improve the evidence for policy, to facilitate the exchange of knowledge and to fill gaps in comparable data. Knowledge exchange and transfer will continue to be key for a European Region that is rich in innovative examples of best practice for healthy ageing, including at the local level. As several authors of this issue of *Entre Nous* observe, more research is needed in particular to fill in gaps in knowledge about trends in the sexual health of older people and on how policies can better respond to their specific sexual health needs.

#### Five priority interventions

Under these four strategic areas, the WHO Regional Office for Europe proposes priority actions and supportive actions to obtain measurable results within a limited time frame. These are selected with a number of criteria in mind. They respond to questions often asked by politicians who want advice in the form of a limited number of policy recommendations, rather than comprehensive lists of actions. What interventions have a demonstrated capacity to achieve “quick wins”, if adequately implemented? Are they politically feasible? Can progress be achieved and measured within a relatively short time span of several years?

Under the strategy and action plan on healthy ageing, the WHO is working with countries at various levels of government

# A VISION FOR HEALTHY AGEING IN EUROPE: THE WHO STRATEGY AND ACTION PLAN<sup>1</sup> (CONTINUED)

to design and implement five priority interventions:

- prevention of falls;
- promotion of physical activity;
- influenza vaccination of older people and prevention of infectious disease in health care settings;
- public support to informal care giving with a focus on home care, including self-care; and
- geriatric and gerontological capacity building among the health and social care workforce.

These are complemented by three supporting interventions that link healthy ageing to its wider social context:

- prevention of social isolation and social exclusion;
- prevention of elder maltreatment; and
- quality of care strategies for older people, including dementia care and palliative care for long-term care patients.

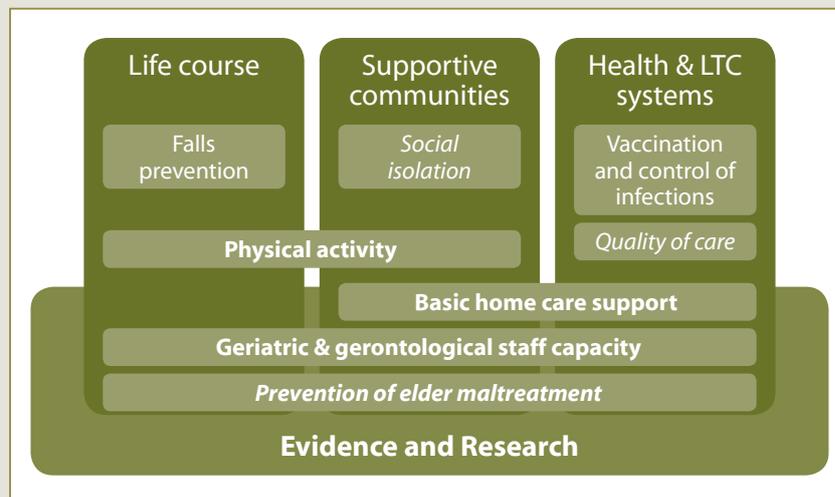
Figure 3 illustrates how priority and supportive interventions are mapped to the four strategic areas for action.

## Prevention of falls

The risk of falls increases steadily with age. About 30% of people over 65 and 50% of those over 80 fall each year. Older women are more vulnerable than older men as they tend to have less muscle strength and are more likely to have osteoporosis. Fall-related injuries in old age are more likely to be severe and, once injured, older people are more susceptible to longer-lasting ill health or hospital stays, or fatal complications. Fall-related injuries (mainly hip fractures) incur considerable costs for hospital admissions and rehabilitation interventions.

Environmental hazards account for between one quarter and one half of falls; other factors include muscle weakness, gait and balance disturbances, a previous history of falls and multiple medication. Convincing evidence reveals that most falls are preventable. Some preventive measures have been shown to be cost-

**Figure 3. Mapping actions to strategic priority areas.**



effective, or even cost-saving and there are good-practice examples of how fall prevention strategies can be successfully implemented in different settings, when supported by public policies.

## Promotion of physical activity

Physical activity is one of the strongest predictors of healthy ageing. Regular moderate physical activity promotes mental, physical and social well-being and helps to prevent illness and disability. Those who are physically fit when they enter old age tend to stay healthier for longer. For older people, physical activity is beneficial not only in preventing disease but also in lowering the risk of injuries, improving mental health and cognitive function and enhancing social involvement. The link between physical activity and better sexual health is also well documented (6).

Lack of physical activity and its consequences, such as obesity and increased risk of injuries among older persons, have become a growing public health concern. Currently a large proportion of people in the Region, over half in some countries, are physically inactive; and evidence shows that physical activity tends to decrease as people grow older.

Policy development in many countries now reflects the urgency of reversing the trend towards inactivity, including among

older people. The causes of declining physical activity among older people vary by setting, necessitating tailored responses that address gaps in public awareness, urban planning, transportation, health financing and social welfare systems, among others.

## Influenza vaccination of older people and infectious disease prevention in health care settings

Influenza is an acute viral infection of the respiratory tract that spreads easily from person to person. Influenza viruses circulate worldwide, causing annual epidemics in the WHO European Region during the winter months. Although usually a mild and self-limiting disease, older people, in particular, are vulnerable to developing severe disease, which may result in prolonged and costly rehabilitation and recovery. During seasonal influenza epidemics, people aged 65 years or older account for more than 90% of influenza-related deaths.

In 2003, the World Health Assembly recommended that influenza vaccination coverage of older people be increased to at least 75% by 2010. This recommendation was reaffirmed by a European Parliament resolution in 2005. Some countries in the WHO European Region have made considerable progress in increasing seasonal influenza vaccination coverage of

older people, but in most Member States coverage remains well below the 2010 WHO target.

In addition, influenza outbreaks associated with infected staff in health care facilities and nursing homes are well documented. It is therefore critical that personnel working in these environments are vaccinated.

### **Public support for informal care giving with a focus on home care**

As populations age in the European Region, an increasing number of older people with functional limitations need support with the activities of daily living. The growing prevalence of dementia will further increase the demand for this support. In all European countries, most care (in terms of hours) is provided informally at home (mostly by women). This is the case even in countries with well developed publicly supported elderly care sectors. Public support for informal care giving is one of the most important public policy measures for the future sustainability of health and social care in ageing populations.

This care is usually a response to multiple disorders and requires an evolving and tailored combination of acute care, rehabilitation, chronic disease management, social care, dementia care and finally palliative care. Where these services are available, however, they are often fragmented and may be prohibitively expensive.

Most people with chronic health or social care needs prefer the option of living at home and remaining independent as long as possible, over the alternative of assisted living in an institution. Access to adequate care at home can reduce the need for acute care in hospitals or other care facilities and is generally considered to be more effective and efficient in maintaining the quality of life.

Without public support, caring for a relative or friend can be associated with reduced workforce participation, a higher risk of poverty and the long-term loss of employment opportunities for the care giver. Lack of support can also

have a negative impact on the relationship between care giver and recipient and can potentially lead to mental and other health problems, the social isolation of both parties, or elder maltreatment.

### **Geriatric and gerontological capacity building among the health and social care workforce**

Over the last 20 years, substantial progress in geriatric education has been made in many countries in the WHO European Region. Geriatrics has become a recognized specialty in medical schools, in undergraduate and postgraduate teaching, and in the continuous training of health care staff at various levels. Though progress has been uneven across the Region, surveys conducted in 47 countries show that the number of established chairs for geriatrics has increased by more than 40% overall and undergraduate and postgraduate teaching activities have increased by 23% and 19%, respectively (7).

The growing number of very old people in the European Region has made it urgent to further strengthen national and subnational capacity for training in geriatrics and gerontology and to promote a stronger profile for geriatric training, including cross-specialty training. The greatest challenges are still gaps in the geriatric knowledge of general practitioners and other health care practitioners on the one hand and insufficient specialist training and a shortage of specialists in geriatrics itself on the other.

Sound evidence points to access problems and shortcomings in the quality of care as a result of these insufficiencies, including for addressing sexual health among older people. Improving the capacity of health practitioners to address sexual health among older patients would be one goal of an improved curriculum (6, 8).

**Manfred Huber,**  
Coordinator,  
Healthy Ageing, Disability and  
Long-term Care,  
WHO Regional Office for Europe,  
mhu@euro.who.int

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# TRENDS IN SEXUAL HEALTH: AN INDICATION FOR HEALTHY AGEING?

## Introduction

The sexuality of older people is an area of research that has blossomed. The complexity of the interacting factors that influence sexual functioning in older people is therefore becoming clearer. Studies in the older age group tend to be conducted in specific areas or individual countries and we have not excluded data from outside Europe when it seems applicable.

## Trends

A longitudinal study of 2 783 men over the age of 75 years residing in Perth, Australia, who provided data on their sexual activity in 2008 and 2009, reported that among men aged 75 to 79, 40% were sexually active in the previous year (1). For men aged 80 to 84, 27% were sexually active; among men aged 85 to 89, 19% were sexually active; and among men aged 90 to 95, 11% were sexually active (1).

Results from a national study in the United States (1455 men and 1550 women aged 57-85) found that sexual problems amongst the elderly were not an inevitable consequence of ageing but may be responses to the presence of stresses in multiple life domains (2). Women's sexual health was more sensitive to their physical health than for men. The mechanism linking life stress with sexual problems is likely to be poor mental health and relationship dissatisfaction. Physicians treating older adults experiencing sexual problems should take into account physical health and psychosocial health as well as their intimate relationship (2).

Of particular interest is a study spanning four decades in Gothenburg, Sweden by Beckman et al (3). This has yielded very specific data regarding sexuality in 946 seventy-year-old women and 560 seventy-year-old men and showed that the quantity and quality of sexual experiences among Swedish seventy-year-olds improved over a 30-year period. The authors' surveyed different cross-sectional samples of all the men and women aged seventy in Gothenburg, on four occasions between 1971 and 2001. They were therefore able to examine trends

in self-reported attitudes and behaviour over that period. Their data demonstrated an increase in the sexual activity of seventy year olds over the thirty years. The proportion of married men having sexual intercourse increased from 52% to 68% and for married women it increased from 38% to 56%. There were also stark increases for unmarried men from 30% to 54% and most dramatically for unmarried women from 0.8% to 12% (3). The trend also appeared to demonstrate that the sexual-lives of seventy year olds were improving as time goes on. The later birth cohort samples of both men and women reported fewer sexual dysfunctions, a more positive attitude to sexuality in later life and higher satisfaction with their own sexuality. Among those reporting intercourse, the proportion that had intercourse at least once a week roughly tripled over the 30-year period, increasing in men from 10% to 31% and in women from 9% to 26%. The authors concluded that "most elderly people consider sexual activity and associated feelings a natural part of later life. It is thus important that sexuality is taken into consideration when dealing with elderly people (3)."

Corona et al (4) used data from the European Male Ageing Study, a study that took random samples from eight European cities in eight different European countries, to examine age related changes in sexual health. A total of 3369 men aged between 40 and 70 were asked about their general health, depression and associated symptoms, prostate and urinary symptoms, as well as their sexual health. They were assessed using several commonly used questionnaires. Of this group, more than 50% reported the presence of one or more common diseases and health conditions which could negatively affect their sexual health, such as high blood pressure (29%), obesity (24%) and heart disease (16%). Thirty percent of this same diverse set of men complained of erectile dysfunction, with 70% of the older age group (70 years and above) having difficulty with erections. Yet across the group, sexual intercourse was common, with 49% having at least

one encounter per week. Whilst 75% had thought about sex, 58% had experienced petting and 28% had masturbated in the previous four weeks (4). Therefore it was evident that sexual health was important to these men and sexual activity was very common. Two further trends were identified. Firstly, the incidence of erectile dysfunction increased in proportion to age and to the number of co-morbidities. Secondly, both general and sexual health was found to be poorer in the more transitional countries with lower incomes and quality of life. This geographically diverse study, with its high numbers of participants, thus provided a useful snapshot of male European sexual health.

Whilst not relating to exclusively older age, a study by Kedde et al (5) is pertinent as it covers conditions that are more prevalent in people who are aging. In their study of 341 respondents in the Netherlands, the team explored how people with chronic disease or disability seek help with their sex lives. Of this group, 40% wanted professional help for problems in their sexual relationship or issues relating to their sexuality. Interestingly, of the group seeking help, only 35% had initiated contact with a medical professional and only a third of those actively seeking help evaluated the consultations as positive (5). Sexual dissatisfaction was the most common factor for participation in psychosexual therapy. Kedde et al found that people in their study were more likely to seek traditional sources of information, such as specialist nurses and doctors, in preference to websites and online forums. However, the biggest impediment to these people seeking this professional advice was a combination of feelings of shame and anxiety, alongside not knowing how to find a relevant medical practitioner, as well as, the perception of how they would be received. In particular, participants in the survey were concerned that medical professionals wouldn't be able to help them. Furthermore, medical professionals' own hesitancy to engage the patient in discussions about this subject was also identified as a factor that inhibited people seeking help. The authors therefore cited



**Alison Wood**



**Ross Runciman**



**Kevan R Wylie**

the importance of generating awareness of services for people with sexual health problems, as well as, teaching trainee doctors on how to approach and deal with patients' sexuality.

Hinchliff and Gott (6) specifically looked at why older people tend not to seek medical help for sexual concerns or difficulties. They undertook a comprehensive review of studies relating to people aged fifty or over, who had difficulties with their sexual functioning. Beliefs commonly elicited from qualitative studies included: sexual difficulties are a normal part of old age; sexual difficulties do not cause much distress; that sexual difficulties may not be serious; and that in time they may resolve (6). Conversely some viewed sexual difficulties at their age as irreversible. Some felt that sexual difficulties were not within the realm of medicine and were therefore not something it would occur to them to speak to a doctor about. Psychosocial barriers included shyness about talking about sex with a professional, the doctor being of the opposite sex and the doctor being younger. Some respondents in the qualitative studies feared that the doctor might be uncomfortable with the subject of sex or that a younger doctor may imply that their interest in sex, as an older person, was somehow questionable. They also examined literature relating to the attitudes of doctors, finding that doctors were more likely to broach the subject of sexual functioning with younger rather than older patients. Some studies showed that doctors lacked confidence when asked to assess and treat sexual problems in older patients, which could translate to doctors not enquiring about sexual problems in older patients or offering an inadequate response when patients do seek help. Medical training was highlighted as an area to be addressed. The authors noted "There are clear implications for sexual well-being if the doctor does not ask and the patient does not tell (6)."

### Conclusions

Sexual activity as we age is slowly becoming less of a taboo subject amongst individuals, health professionals, researchers and within the media. Research appears to demonstrate that sexual health and activity is increasing. There is likely to be variation within the cultural and religious traditions throughout Europe. Challenges remain. There is work to be done to encourage awareness within our older population of available help with sexual difficulties. Health professionals need sufficient training to allow them to be receptive rather than daunted, when older people present with sexual difficulties, which frequently arise within a relatively complex picture of chronic physical illness and poly-pharmacy. The active benefit to older people's health from ongoing sexual activity is an area of research which may encourage future resourcing of services, as sexuality becomes increasingly viewed as an integral ingredient of healthy ageing.

**Alison Wood, BSc (Hons), MBChB, MRCPsych,**  
ST5 Trainee in Old Age Psychiatry,  
Sheffield Health and Social Care Trust,  
Sheffield, the United Kingdom,  
alison.wood@shsc.nhs.uk

**Ross Runciman, BA (Hons), MBChB,**  
Foundation Year 1 Doctor,  
Rotherham Hospital,  
Rotherham, the United Kingdom,  
ross.runciman@live.co.uk

**Kevan R Wylie, MD, FRCP, FRCPsych, FRCOG,**  
Consultant in Sexual Medicine,  
Porterbrook Clinic,  
Urology, Royal Hallamshire Hospital,  
Sheffield, the United Kingdom,  
k.r.wylie@sheffield.ac.uk

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# AGEING IN THE CONTEXT OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Globally, in both developed and developing countries, the population is rapidly ageing, which will impact considerably upon the field of sexual and reproductive health (SRH) and rights. At present the global population numbers 7 billion people, out of which 900 million people are over 60 years old. It is estimated that by 2050 this number will reach 2.5 billion.

In the field of SRH ageing has not been an issue of priority. This is because ageing is often thought of as a process that relates more to problems, deficits, taboos and less to pleasure, change and diversity; a separate life stage and not a process throughout the lifecycle. Thus, the focus on ageing has trended towards medicine and therapy rather than empowerment.

From the beginning NGOs in the field of SRH, such as Pro Familia, the German affiliate of the International Planned Parenthood Federation (IPPF), have reacted to deficits in sex education in the family and schools and therefore, concentrated on younger age groups, especially children and adolescents. Yet, family planning and sexual counselling organizations cannot escape the demographic changes taking place in society. People seeking information and advice come to these organizations and expect a range of services that are tailored to their particular circumstances.

During the 70's and 80's, developing services to adequately meet the needs of ageing individuals was predominantly trial and error. Menopause formed a key aspect of the sexual counselling services and focused on ageing and female sexuality at a very specific stage of ageing. Menopause was considered to be the entry point to getting old. Often, as was the case of Pro Familia, there were also attempts to build up services on sexuality in the second half of life, with the objective of breaking the taboo of sexuality at older ages and thus supporting older women (and men) to be able to lead a fulfilled sexual life. However, the lack of strategic planning meant that singular counselling centres with high expertise on

sexuality and ageing developed instead of broad and regular services on sexuality for women and men at 50 years of age and older.

Without doubt, the Programme of Action approved at the 1994 UN Conference for Population and Development in Cairo carried significant impact for family planning organizations in the area of ageing and SRH. Subsequent to Cairo IPPF developed the *IPPF Charter on Sexual and Reproductive Rights*, which was adopted by its member associations. Section 3.3.2 of the Charter reads: *“All persons have the right to equal access to education and information to ensure their health and well-being, including access to information, advice and services relating to their sexual and reproductive health and rights, irrespective of race, colour, poverty, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status (1).”*

The paradigm change of Cairo with its human rights perspective led Pro Familia to develop a new six-year programme in which the focus on ageing and sexuality was a prominent feature. In fact, Pro Familia added a 6th strategic priority to IPPF's existing five: ageing. Moreover *“Sexual Rights: An IPPF Declaration”* pinpointed and profiled the institutional commitment to the right of sexual health and sexual well being of older people. As part of the programme a new three-stage training course on *“Age and Sexuality”* was introduced.

Parallel to this development, the Pro Familia range of services for older people diversified and now includes: sexual counselling; counselling for couples; menopause groups; issue-based discussion groups: events linked to wishes and needs of older people; as well as gymnastics groups. Demand is particularly high for telephone counselling on love, sexuality and relationships issues. Family members and health professionals also use this service. Additionally, for many years Pro Familia has been involved in training health care providers on sexuality

and ageing in conjunction with nursing and geriatric homes and universities for applied sciences.

## Longtime commitment and insights gained

Given Pro Familia's experience with sexuality and ageing, what have been the effects of such a longtime commitment and what insights have been gained?

- ▶ First, institutional commitment is a must. Institutional commitment, laid down in resolutions, strategic plans and concrete programmes, obliges organizations to implement and to take responsibility. It provides legitimacy for the organization internally, as well as, externally.
- ▶ Second, the right to sexual health and well being for older people is indispensable, yet adequate provision of these services will prove challenging as the numbers of ageing people continue to increase. In the case of financial constraints with regard to new services, alternatives have to be found. The focus on training of providers is an effective strategy to cope with the problem of service provision but it does not substitute services.
- ▶ Third, if nation-wide service provision can only be achieved slowly, do not hinder singular initiatives. These initiatives can transform into future centres of competence on sexuality and ageing. They can share their knowledge and experience with those facilities that may want to go into the field at a later stage.
- ▶ Fourth, do not forget gender and age. As Robert Bolz, former counsellor of Pro Familia Munich states: *“My assumption – which would certainly be upheld by analysis – is that counsellors should not be too young if they are to work effectively with older people. After all, who wants to discuss their relationships and sexual problems with someone the same age as their own children - or even their own grandchildren? Therefore, I believe it is essential that older colleagues should also be*



*included in expert teams, and both male and female of course.”*

- ▶ Fifth, patronizing stereotypes, taboos, discrimination and health inequities with regard to older people will continue to exist. However, if you dogmatize the taboo and deficit approach you will never be able to see the potential, diversities and changing realities of older people.

### Looking forward

As we move forward with the field of ageing and SRH and rights, it is important that we recognize change and the important role that the ageing population plays in it. The 50+ generation of today is different, for example:

- Part of their background are the new social movements, the sexual revolution, the introduction of the contraceptive pill and the liberalization of the abortion law. Alexandre Kaleche, the international expert on ageing, is convinced that this new cohort of people carries significant potential for change: *“The baby boomers have transformed every stage of life they have experienced and retirement is proving no different. This cohort is healthier and better educated. The boomers have more access to information and are more activists.”*
- The “European Patient of the Future” study confirmed that patients increasingly want to have better and more reliable information, free choice of health care and more participation with regard to medical intervention and therapy (2).
- The “50+ Study. How the Young Old Revolutionize Society,” found that

the life phase we used to describe as not old is continuously extending and that the visible differences of age roles are permanently levelling. The research results also question the prevailing idea of the taboo of sexuality at a later age. *“Sex plays an astonishingly important varied role in the life of people over 50: over 80% of men and 60% of women have sexual intercourse (3).”*

The changes illustrated above are important indicators for significant improvements in the development of an ageing population. Keywords are self-determination, independence and participation. Are the SRH NGOs prepared to meet such needs of older persons? Can they adapt their systems to these needs? In order to do so a stronger emphasis must be placed on empowerment and potentials. We need to be more innovative. The Internet holds great opportunity for new ways of communication, consultation and information, which may lead to more independence, and self-management of older persons. It also improves access for those with difficult access to public transport.

An additional priority for meeting the needs of ageing populations is that of maintaining independence while at the same time preventing disability. SRH NGOs should therefore intensify activities in this direction and envisage new alliances with doctors, nutritionists and other needed specialists. Independent quality information about SRH and rights is needed as well. So far, information services about health and sexuality for older people tend to be too product and medicine driven. Independent information about sexual health and ageing could

be provided as an online service by NGOs focussed on SRH and rights.

For the ‘new old’ participation is as important as for any other age group. Yet, there is a difference. The ‘new old’ are better educated, more experimental and more open to controversial issues such as sexuality, different sexual life styles and abortion than their predecessors. It is these competencies, experiences and broader minds that SRH NGOs need to successfully fight for when it comes to sexual and reproductive rights. The ‘new old’ could be bridge builders not only between generations but also between SRH and rights opponents in the political sphere and the SRH NGO’s.

Finally, we should unlock ageing and free it from being a determined life phase. Ageing concerns all age groups. Ageing is a process with different meanings in different life phases. Ultimately if we begin to see ageing as a process, it will loose its dramatic image and allow appropriate policies and programmes to be developed.

**Elke Thoss,**  
Sociologist, SRHR Consultant,  
Former Executive Director of the  
German Affiliate of IPPF, Pro Familia,  
[e.thoss@pratho-health.eu](mailto:e.thoss@pratho-health.eu)

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# TOO OLD FOR LOVE?

## INTERVIEW WITH TWO AUTHORS OF BOOKS ON THE TOPIC OF AGEING AND SEXUALITY

*This autumn in Denmark there has been a virtual boom in articles and publications covering the topic of ageing and sexuality. This article is based on interviews with two authors of books with different approaches to the issue. Ditte Trolle has written the book “Sex efter 50” (Sex after 50) which focuses on love, body and culture beyond the age of 50. The book builds on facts from research and the author’s experience as a gynaecologist illustrated with interviews of men and women over 50.*

*The photographer, Maria Fonfara has put together a photo book “Elsk hele livet” (Love for life) with 24 inspiring accounts of how sexuality can be an important part of life even after the age of 70. The book gives a rare insight into the intimate lives of the older generation and breaks down the taboos associated with older people and sex. “It is time we refreshed our perception of what it means to get older. We need to understand that sexuality is not owned by the young”, says Gunta Lazdane, Sexual and reproductive health programme manager of the WHO Regional Office for Europe.*

**Ditte Trolle author of “Sex efter 50” MD, Senior consultant at Benign Gynecology Clinic, Department of Obstetrics and Gynaecology, Aarhus University Hospital, Skejby**

### **Why this topic?**

Through her work in obstetrics and gynaecology, the author has held many lectures and seminars to general practitioners on the subject of ageing and sexuality and collected a lot of material. Participants encouraged her to write a book on this subject. Furthermore, at age 62 Ditte Trolle is in the target group herself and felt the topic was relevant to her own life.

The aim of the book was to describe what happens to our sexuality when we age. This is a discussion that is not often public, as sex has more or less been “patented” by younger age groups. It was also her ambition to describe the life of older people and how sex and sexuality still play an important part in their lives. The book is not intended as a monograph about older people’s sexuality, but gives a description of how sexuality is perceived by older people and what role it plays in their lives.

### **What kind of feedback did you receive after publishing your book?**

There was a big difference in the feedback from young and older people. In general younger people did not really feel the need for this topic – in particular they were not interested in hearing about the challenges and health related difficulties that naturally come with age. However, the older readers expressed appreciation that the book openly addresses some of the issues many are dealing with, showing that they are not alone with their difficulties. It is the author’s hope that the openness will help de-stigmatize some of these issues.

It was also important that the book was scientifically supported and does not build on myths and media hype – for example, media has long sold the message

that sex is healthy and an active sex life is a prerequisite to be healthy. This is a claim that has never been scientifically proven but is commonly believed. It is important to know for those who do not have a partner and for those contented with a relationship without sex – they should not feel that they are living an “un-healthy” life-style.

### **What happens when society ignores the sexuality of older people?**

As many older people are reserved and private about this subject, it is important that the social and health care system takes the issue seriously and opens the opportunity for a dialogue – the older person can then decide if this is relevant to them or not.

### **More time for sex?**

In conducting the interviews, it was a surprise to Ditte Trolle how varied sex life is among older people – and how creative older people can be in expressing their sexuality in case they have age-related physical limitations.

The frequency of sex was also a surprise, ranging from frequent sexual intercourse several times a week to none at all. An important factor for staying sexually active was the fact that older people often have more time and less stress in their lives than younger people with small children, careers and stressed lives and can give more priority to their sex lives. In general, feedback from the interviewees was that the spontaneous lust/libido had in general decreased with age but once active the sexual satisfaction was as good as or even better than at a younger age.

The book also covers cultural differences and reveals that in some cultures sex is still strongly associated to reproduction. In some countries women stop being sexually active at the age of 40, while in others sexual activity is considered an important element throughout life.



Tina  
Kiær



Jane  
Persson

**Maria Fonfara, Photographer  
and author of "Elsk hele livet"  
(Love for life)**

**Why this topic?**

I was amazed that in many surveys, statistics regarding sexuality seemed to stop at age 70 - people over 70 did not figure at all in the surveys that I checked. I then started looking for photos of older people and found that there were hardly any dignified pictures of older people in intimate situations. The only photos that I was able to find were of depressing scenarios in connection with health care and old people's homes.

**How did you find your models?**

I wanted my models to represent ordinary older people and not the extremes, so I found my models mainly through the Internet. Some were found through dating sites, some through my personal network.

Those who declined to participate replied that it was great that I was taking



# TOO OLD FOR LOVE?

## INTERVIEW WITH TWO AUTHORS OF BOOKS ON THE TOPIC OF AGEING AND SEXUALITY (CONTINUED)

up this issue, but they did not have the personal courage to go public.

### **How did you encourage so much openness among your models?**

At the end, I felt very privileged that 24 couples and singles opened their homes and shared their most intimate part of their life to me.

Among those models whom I found via dating sites on the Internet, in general, the women were more open and it surprised me that many single women sought younger men and not vice versa. Also, several women were not looking for a steady relationship, but had several lovers. They explained this as a result of having spent 40+ years of their life looking after children and being in a monogamous relationship, they had found a freer expression of their sexuality late in life and could now be more explicit about their needs. It was also amazing to meet couples that had spent a long life together talking so freely and openly about ageing together and accepting the changes they had gone through. For example, Esther and Alfred aged 87 and 91, who met when they were 17 and 21 and who had led a wonderful life together.

### **Did the models have any concerns about participating?**

If the participants were worried about reactions, it was the reactions of their own children and grandchildren they worried about. Luckily, all reported to have received positive feedback from their families after the book had been published.

### **How has the reaction been in the public?**

In the discussions that were sparked by the book, there has been an acknowledgment that many people maintain a need for closeness and intimacy at an older age and that sex can be an important part of that. Interestingly enough, negative reactions have come mainly from other older people and not from the younger generation. I teach at a folk high school (school



for adults focussing on mind-broadening education) and reactions from younger people are by far positive, saying, “I hope I am like that when I am old...”

The few older people that have reacted more negatively have expressed that these are private stories that should have not been disclosed.

### **What has been your personal experience from producing this book?**

It has really been a life-affirming experience to learn about love and intimacy from the strong and self-asserted people that volunteered as models of the book. The book has truly given me a better insight into and understanding of what it means to grow older.

The book is first and foremost about love between people, about dealing with the process of getting older and accepting a body that is under change. It is

also about allowing space for each other, staying together for many, many years and finally about finding new partners after losing your loved-one. The book has taught me that even after the loss of your great love in life some older people find a new loved one.

It is my hope that the book will eliminate some of the taboos connected with ageing and sexuality.

**Tina Kiær,**  
Communications Officer,  
Noncommunicable Diseases and  
Health Promotion,  
WHO Regional Office for Europe,  
tki@euro.who.int

**Jane Persson,**  
Editorial Assistant, *Entre Nous*,  
WHO Regional Office for Europe,  
jpe@euro.who.int



# THE IMPACT OF PRESCRIBED MEDICATIONS ON THE SEXUAL HEALTH OF OLDER PEOPLE

## Introduction

There is increasing evidence that older people engage in and enjoy sex and report that it is an important contribution to their well being. There has been a growth in research into what affects the sexual activities of older people. As the amount of research increases on the subject of older people having and indeed enjoying sex, so does the concern and enquiry into what affects sexual activity. One such area of interest is the impact of prescription medications on the sexual function of older people.

Unfortunately sexual dysfunction is a common side effect of many prescription medications (1). Furthermore, older people are more likely to be taking long-term prescription medications and to have multiple prescriptions (polypharmacy) due to chronic disease states. The breadth of medications that can negatively affect sexual health is wide and includes anti-hypertensive medications, psychotropic medications, as well as some anti-epileptic agents. In addition some medications can cause hypersexuality, such as a number of anti-parkinsonian drugs.

In this article, we will focus on three prescription medications used by many millions of older people worldwide: antidepressants, PDE5 inhibitors (such as sildenafil (Viagra)) and hormone replacement therapy used to ameliorate side effects of menopause.

## Antidepressants

A study by Jespersen found that common types of antidepressants can affect sexual functioning (2). The importance of distinguishing sexual dysfunction as a consequence of the depression from that as a result of the treatment of the disease is important to identify, but not always easy to do. Selective serotonin reuptake inhibitors (SSRI's) are the most common class of antidepressant and can cause sexual difficulties (predominantly decreased libido and delayed orgasm) in 58% to 73% of patients who use them (2). Among this drug class, citalopram and paroxetine have a particularly high incidence of sexual dysfunction, whilst

fluoxetine has the lowest. However, the overall incidence of sexual dysfunction is so high with SSRI use that differentiation between them is of limited clinical value. Also, different SSRIs have different sexual side effects.

An older class of antidepressant, often used as second line to SSRI's, called tricyclics, have a lower incidence of sexual dysfunction of 30%, but decreased libido, erectile dysfunction, delayed orgasm and impaired ejaculation are still common sexual side effects (2). However, one tricyclic antidepressant, clomipramine, also used for obsessive compulsive disorder, had 95% of patients reporting sexual side effects – fortunately this medication is used relatively uncommonly, especially in older people.

Another type of antidepressant, monoamine oxidase inhibitors, used as second line antidepressants if SSRIs are not tolerated, caused sexual problems in 40% of patients taking them (2). When caring for people with depression it is critical to realize the impact this may have – those with depression already have their relationships under strain and sexual dysfunction from antidepressants can heighten this strain, as well as impact on the patient's compliance with such treatment for a typically long-term disease.

A review article on the impact of antidepressants on sexual function by Clayton and Montejo came to similar conclusions (3). In fact, the authors felt that the amount of sexual dysfunction due to antidepressant use was actually underestimated. Yet their data collated from multiple studies highlights a much lower incidence of sexual dysfunction in comparison to Jespersen, with 24% of patients experiencing problems, again more commonly in those taking SSRIs compared with older classes of antidepressants (3). They identified one particular medication, bupropion sustained release, which has a different mechanism of action to SSRIs (and is also used as a stop-smoking aid), as having the least sexual effects – as few as 7% of patients experienced problems. Clayton and Montejo caution against drug holidays as it can undermine

the therapeutic benefit of the medications as well as long term compliance and instead suggest adjustments to the dose or switching to antidepressants with fewer side effects. The authors also advocate non-pharmacological treatments such as psychosexual therapy and exploring problems more generally. The importance of taking a sexual history before and during antidepressant therapy, as well as, initiating discussion about sex rather than waiting for patients to do so is also critical.

## PDE5 inhibitors - Viagra

In their multicentre study of 180 heterosexual men with erectile dysfunction who were in stable (6 months plus) relationships in outpatient clinics, Heiman et al examined how sildenafil (Viagra) impacted the sexual lives of the patient and their partners (4). They undertook a double blind trial in which neither doctor nor patient knew whether they had the drug or a placebo. Interestingly, the majority of the partners were post-menopausal. Those men who received sildenafil, compared with placebo, had improved erectile function, increased frequency of successful and satisfactory intercourse, as well as, better well being as measured by standard sexual function tools. Their partners, however, showed a more complex pattern of responses dependant on their own sexual problems, including how they viewed their relationship. Therefore, women who viewed their relationship as generally happy were more likely to report increased sexual satisfaction if their partner with erectile dysfunction was treated with Viagra rather than placebo (4). This implies a limitation of sildenafil – creating the erection is not in itself enough for a mutually satisfactory sexual experience.

Fujisawa et al attempted to assess the impact of the use of sildenafil on the quality of life of 40 men with erectile dysfunction (5). Unfortunately this study did not ask the same of women. They did identify how erectile dysfunction caused depressive symptoms, such as low self-esteem and psychological distress. Furthermore their work showed that this



**Ross Runciman**



**Kevan R Wylie**



**Alison Wood**

distress increases proportionality to the amount of time the patient had been living with erectile dysfunction before seeking help. They used standardized tools to assess quality of life, including bodily pain, general health, mental health and the quality of their relationships. They found that men taking sildenafil below the age of 50 showed improvement in all of these measures, whereas men over 50 showed improvements in almost all of these measures except for bodily pain. This small study concluded that sildenafil improves erectile function and also the male patient's quality of life, including his satisfaction with relationships (5).

### **Hormone Replacement Therapy (HRT)**

A randomized, double blind study of 502 women from the United Kingdom, Australia and New Zealand looked at how HRT affects the quality of life of the patients taking it (6). After a year of taking HRT or placebo, the women were asked about their experiences. Those who actually took HRT, reported less sexual dysfunction, less insomnia, fewer hot flushes, as well as decreased vaginal dryness from those taking placebo (6). However these improvements in sexual function, whilst statistically significant, were small. However they reported more breast tenderness and vaginal discharge; these were the most common reasons for women stopping the use of HRT. They found no difference between those taking HRT and placebo for other menopausal symptoms, incidence of depression and overall quality of life after 12 months (6).

A study by Cumming et al exploring women's attitudes to HRT (n=3000) found that 95% of women wanted to try alternative therapies before trying HRT and 73% felt they didn't know enough to make an informed decision (7). The study also found that 53% of women reported experiencing dyspareunia - painful sexual intercourse - with more than half of this subset of women hiding their symptoms. In addition 31% of women made excuses to avoid sex as a consequence of this dyspareunia and 54%

felt their confidence had been affected as a result of this. Finally, only 20% had sought help with their symptoms and 12% had been prescribed treatment for their problems (7).

It is important to recognize sexuality in post-menopausal women is much more complex than proven benefits associated with HRT. How couples view ageing is crucial to their sexual health, as well as the complex, interaction between themselves and their partner's problems. For example, older bodies take longer to adapt and vaginas atrophy and narrow with age. This means that often the impact on post-menopausal women of men who are suddenly able to get erections, through use of Viagra, can be that of secondary sexual dysfunction, including dyspareunia or vaginismus (8). Pills that increase libido, decrease vaginal dryness or enable erections do nothing to address the more intricate and delicate issues of relationships, such as how happy the couple is, sexual repertoire and education.

### **Conclusions**

Many prescribed drugs affect sexual function both in terms of direct side effects, such as delayed ejaculation and erectile dysfunction and quality of life. These drugs are more commonly prescribed in the older population, who have a greater disease burden and are more likely to experience side effects. In addition treatments used to treat sexual dysfunction in the elderly have mixed results. For example, Viagra may improve erections, but sex is an inherently cooperative enterprise for which an erection is only one component of a caring happy relationship. As medical professionals, while it is tempting to reach for the prescription pad to prescribe medications, we have a duty to initiate and lead discussions with people that explore the many complex issues involved in sexual relationships.

**Ross Runciman, BA (Hons), MBChB,**  
Foundation Year 1 Doctor,  
Rotherham Hospital,  
Rotherham, the United Kingdom,  
ross.runciman@live.co.uk

**Kevan R Wylie, MD, FRCP, FRCPsych, FRCOG,**  
Consultant in Sexual Medicine,  
Porterbrook Clinic & Urology,  
Royal Hallamshire Hospital,  
Sheffield, the United Kingdom,  
k.r.wylie@sheffield.ac.uk

**Alison Wood, BSc (Hons), MBChB, MRCPsych,**  
ST5 Trainee in Old Age Psychiatry,  
Sheffield Health and Social Care  
Trust,  
Sheffield, the United Kingdom,  
alison.wood@shsc.nhs.uk

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# INTIMACY AND THE HUMAN RIGHTS OF OLDER PEOPLE IN CARE

## Introduction

Human rights do not decrease with age or dependency; neither does the need for intimacy. In reality, however, as individuals grow older their rights are more likely to be ignored or even consciously violated. Intimacy in advanced age is not only about expressing one's sexuality, although this aspect of a senior's life - and its impact on health and wellbeing - is often disregarded if societies share the distorted view that the 'inevitable destiny of old age' is to become senile and inactive in all spheres of life. Intimacy is also about respecting preferences and feelings of modesty when carrying out intimate tasks, such as undressing, bathing, or helping to use the toilets; involving the partner in decisions that affect the life of the couple, like moving into a care home or needing hospitalization; allocating time and space to meet in private; offering an environment and quality of care that empowers people to develop or maintain relations; preventing and tackling sexual abuse; and accommodating the needs of Lesbian Gay Bisexual Transgender and Intersex (LGBTI) people.

## The challenge of intimacy

Across Europe cases of people in care settings being forced to stay in bed for long periods of time, not being allowed to make private calls or to maintain relationships and having no control of the visits they receive, are commonly reported as a lack of respect for intimacy. Such cases are often exacerbated due to austerity and limited resources, as excessive caseloads, lack of time or staff organization and poor working conditions may deter care providers from catering for all individual needs. Lack of respect for intimacy is not typical to institutional care alone. Care at home, when it lacks an appropriate assessment of needs entails equal risks for privacy and intimacy. For example, an inquiry by the Equality and Human Rights Commission has uncovered a number of insensitive treatments in home care that stem from a poor care path and the disregard of the dignity of the older person (1).

Moreover, people with dementia experience changes in cognition and judgement and the expression of their sexuality may result in behaviors that are challenging to manage in a communal environment (2). Adapted spaces and staff trained to the challenges of residents with dementia are thus essential. Likewise, when environments do not enable seniors to live independently, autonomy is limited in an insidious way and can have a profound effect on their personal relations, health and wellbeing (3). In the case of older LGBTI, enjoying their human rights and having access to appropriate care is often impossible due to multiple forms of discrimination, even in countries where same-sex couples are recognized. This is particularly important as LGBTI may have specific health and support needs and often end up in residential care, as they cannot rely on the same family support as others when they become frail (4).

## Intimacy through a human rights lens

Intimacy as such does not constitute a human right, but it is closely related to a number of rights, in particular:

- respect for dignity and integrity;
- respect for private life;
- protection of autonomy and promotion of independent living;
- right to the highest attainable standard of health;
- protection from inhuman and degrading treatment;
- right to receive relevant and adequate information and education;
- freedom of choice; and
- non-discrimination.

These rights are enshrined in various human rights instruments but their realization is not age-neutral.

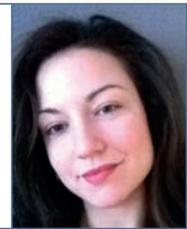
At the European Union (EU) level the Charter of Fundamental Rights declares that human dignity is to be protected (Article 1); inhuman or degrading treatment or punishment is to be prohibited (Article 4); private and family life has to be respected (Article 7); the rights of older people to lead a life of dignity and

independence and to participate in social and cultural life should be protected (Article 25) while the Union shall aim at a high level of health protection (Article 35). These rights however apply only to the EU legal order and although positive action is needed to promote and fulfill these rights, no new competences are conferred to the EU to adopt policy and legislation on these matters.

Although in the Convention for the Protection of Human Rights and Fundamental Freedoms older person's rights remain intangible, the Court's jurisprudence on articles 3 (prohibition of inhuman and degrading treatment) and 8 (private and family life) can set states' obligations to address breaches of intimacy. Nevertheless, national standards may be inconsistent or entail protection gaps, covering only institutional settings or care provided and/or funded by the public sector (5).

With the ratification of the Convention on the rights of persons with disabilities (CRPD), the EU and States party to the treaty, have to take measures to protect the private life (articles 22 and 23), independent living (article 19), health (article 25) and integrity (article 17) of people with disabilities. Yet, clarity on whether older people with functional limitations or high support needs meet the definition of disability is lacking. There is also an implementation gap as the intersection of age and disability is rarely taken into account by decision-makers in the application of the CRPD.

Human rights instruments do not only aim to offer remedy but also to promote and efficiently protect rights. This implies that human rights treaties should have a preventive and awareness-raising effect. In the case of human rights of older persons however, lack of clarity, specificity and implementation guidance has led to insufficient safeguards. This is why the Council of Europe decided to draft a Recommendation to address older people's challenges from a human rights perspective (6), while a consortium of stakeholders from 10 EU countries drafted the European Charter of Rights



and Responsibilities of Older People in Need of Long-term Care and Assistance (7). This document, which is based on existing national initiatives, includes a provision on private life and encompasses the right to develop and maintain intimate relations. The European Charter has become an EU-level reference document and its accompanying guide (8) has given specificity to the content of this right by declaring that *'Decisions about the personal and sexual relationships belong to individuals. Caregivers should treat residents with sensitivity and understanding and must not place restrictions on their ability to have intimate physical relationships. Service providers should guarantee that facilities, such as a private room, are provided to enable residents - regardless of age or infirmity - to continue to have intimate relationships when they choose. Information about the scope of facilities that allow intimate relations must be made available before a contract for residence is concluded'*.

Such voluntary approaches can enhance understanding of the reality of older age, which is an essential step to the realization of rights. They also put human rights obligations in context and help raise awareness that shortcomings are associated with how society treats older people: like non-productive human beings who don't deserve choice and respect of their dignity. Lacking legal enforcement and monitoring mechanisms, however, they cannot efficiently tackle protection gaps and fragmented policies to improve the existing discrepancy across Europe.

## Conclusions

According to a recent Eurobarometer survey, advanced age is the most commonly experienced ground of discrimination in the EU (9). This finding verifies that as long as prejudices around ageing persist, seniors' human rights will continue to be undermined. On the one hand we need comprehensive human rights frameworks that can have a strong preventive effect and address inequalities. In this regard the work of the Open Ended

Working Group on Ageing is crucial, not only to evaluate the adequacy of existing instruments, but also to consider future steps. For some UN Member States and NGOs, a human rights treaty dedicated to older persons is gaining ground as the preferred option to efficiently address the challenges of older people. On the other hand, building on the concepts of active ageing and age-friendly environments, we need to create spaces that enable seniors to live autonomously for as long as possible, empower them to define how their needs and expectations can be met and support care givers in their tasks. Ultimately, raising awareness of older people's rights across sectors of society would help tackle stereotypes and create age-appropriate services; improve education and information of professionals and individuals; encourage the collection of data and the development of evidence-based policies; and establish procedures through which older people are able to claim and enjoy their rights regardless of their age, sex, ability or disability, sexual orientation, religion or ethnic origin.

**Nena Georgantzi,**  
Legal & Research Officer,  
AGE Platform Europe,  
[Nena.georgantzi@age-platform.eu](mailto:Nena.georgantzi@age-platform.eu)

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5. See for example: *YL v Birmingham City Council and Other [2007] UKHL 27*
6. [http://www.coe.int/t/dghl/standard-setting/hrpolicy/other\\_committees/cddh-age/default\\_EN.asp](http://www.coe.int/t/dghl/standard-setting/hrpolicy/other_committees/cddh-age/default_EN.asp)
7. The EUSTaCEA project funded by the DAPHNE programme: <http://www.age-platform.eu/en/daphne>
8. [http://www.age-platform.eu/images/stories/22495\\_EN\\_06.pdf](http://www.age-platform.eu/images/stories/22495_EN_06.pdf)
9. [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_393\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_393_en.pdf)

# ELDER MALTREATMENT PREVENTION IN THE WHO EUROPEAN REGION

## Population at risk

Life expectancy is increasing in most countries in the WHO European Region and the populations are therefore ageing rapidly. In 2050, one third of the population will be older than 60 years. This ageing population will place more older people at risk of maltreatment. Whereas much of old age is a healthy period, there may be ill health, which leads to disability and dependence, especially in late old age. This may increase the demands on family caregivers and the need for a trained health and social care workforce. This is particularly the case in supporting people with dementia and multiple problems. Many older people have reduced incomes, which increases their dependence on family and societal support. Older women have a much higher risk of poverty than older men. The current economic downturn has put more strain on these support structures in Europe and older people living in deprived neighbourhoods are likely to be more at risk.

## Why is preventing elder maltreatment a priority in the WHO European Region?

Older people are at risk from interpersonal violence and 8500 people older than 60 years die from homicide annually in the Region. Interpersonal violence is an important cause of great inequality in health and 9 of 10 homicide deaths among older people are in low- and middle-income countries. Assaults affecting older people are more common in sections of society that are more socioeconomically deprived. Elder maltreatment leads to an estimated 3200 (30%) annual homicides among older people; these are committed by family members. Information on fatal and nonfatal cases is grossly incomplete from routine databases in the Region, whether these are from the health, justice or social care sectors. The scale of the problem has only come to light by using population surveys in the community in the last few decades. Surveillance using routine information sources needs to be improved using standardized practices and definitions across all sectors and all countries.

The prevalence of elder maltreatment in the previous year in the community and other settings is high in the Region. Surveys of older people living in the community suggest that, in the previous year, 2.7% of older people have experienced maltreatment in the form of physical abuse – equivalent to 4 million people older than 60 years in the Region (1). For sexual abuse, the proportion is lower at 0.7%, equivalent to 1 million older people; for mental abuse, this is far higher at 19.4%, equivalent to 29 million older people; and 3.8% have been subjected to financial abuse, equivalent to 6 million older people (1). It is therefore important to define the type of maltreatment being measured.

The prevalence of elder maltreatment increases among people with disability, cognitive impairment and dependence and reports suggest that this may be much higher among older disabled people with high support needs. The prevalence of elder maltreatment varies according to culture and country and using more standardized definitions, instruments and methods would make European surveys more comparable (2). Surveys of family caregivers and professional caregivers show that large proportions report having maltreated older people in their care. These approaches could be better exploited to understand the scale of the problem of elder maltreatment. Elder maltreatment may lead to lasting harmful physical and mental effects among older people. The societal costs of elder maltreatment are thought to be high, but need to be better studied in the Region.

## What are the risk and protective factors for elder maltreatment?

Numerous biological, social, cultural, economic and environmental factors interact to influence the risk of being a victim or perpetrator of elder maltreatment (2, 3). Studies show that older people with dementia and with a disability that results in increased dependence on caregivers increases the risk of elder maltreatment. Similarly, living in the same household

as the perpetrator also increases the risk. Perpetration is most often carried out by caregivers who are partners, offspring or other relatives, although professional health and care workers and visitors can also be perpetrators in institutions or at home. Perpetrators are more likely to have mental health problems, especially depression or a history of violence and may suffer from substance misuse, especially alcohol abuse. The latter may increase the perpetrator's financial dependence on older people. Increased dependence of the perpetrator on the victim, either financially or emotionally, increases the risk. One of the factors that appear to be important is the past quality of the relationship between the perpetrator and victim before the onset of maltreatment. Furthermore, social isolation and not being part of social networks will also put older people at greater risk. Income and social inequality are risk factors for violence, and some evidence indicates that this is also the case for elder maltreatment. Social and cultural norms such as ageism, tolerance of violence and gender inequality may reinforce maltreatment in society and need to be better studied. The characteristics of institutions in which elder maltreatment has occurred have been described and include poor training and support of staff, tolerance of violence in the institution, inadequate support for activities of daily living and a lack of respect for and lack of autonomy among residents (1-3).

Protective factors such as positive life experiences and community connectedness seem to prevent and mitigate the effects of maltreatment and should be promoted. Having visitors and relatives visiting residents appears to protect older people in care homes from maltreatment.

Additionally, the role of perpetrators' previous exposure to violence in perpetuating the cycles of violence needs to be better understood and the intergenerational effect of earlier exposure to interpersonal violence on perpetration needs to be examined. High-quality research studies of risk and protective factors pertaining to elder maltreatment



**Francesco Mitis**



**Dinesh Sethi**

are lacking, both within the European Region and elsewhere. These would assist in developing and targeting strategies to prevent and intervene in situations of elder maltreatment.

### **What can be done to prevent elder maltreatment?**

Numerous interventions have been implemented across Europe and globally to prevent and protect older people and to improve risk factors related to elder maltreatment (2, 3). Although the evidence on which they are based is very often lacking, they nevertheless indicate that governments and nongovernmental organizations are giving this health and social problem greater priority and are beginning to address it. The lack of high-quality evaluation studies of interventions specifically designed to reduce or prevent elder maltreatment substantially limits conclusions about which interventions may be most effective.

The review of the evidence shows mixed findings for the effectiveness in reducing elder maltreatment of: professional awareness and education courses; legal, psychological and educational support programmes; and restraint reduction programmes. More research is needed to clarify the positive effects of these interventions. Evidence is emerging of effectiveness for psychological programmes for perpetrators, which have been associated with a reduction in self-reported abusive behaviour. However, further high-quality evaluations of these programmes are needed to provide a better understanding of potential effects. While promising evidence supports the use of programmes designed to change attitudes towards older people or improve caregiver mental health, the effects on reduced elder maltreatment as an outcome have not yet been measured. Some interventions have been studied to show that they are associated with an apparent increase in reported maltreatment and whether this results from better reporting or possibly even worse outcomes needs to be further clarified. The weak evidence base of what works needs to be improved.

Further research is also needed on the costs associated with implementing elder maltreatment interventions. Policy-makers and practitioners should ensure that whenever possible, programmes should be implemented using an evaluative framework that includes elder maltreatment outcomes, longer-term follow-up and measures of cost-effectiveness. More general strategies for preventing violence, such as those designed to create safe, nurturing parent-child relationships and equipping children and young people with the social skills necessary to successfully navigate through life, are also likely to be important in preventing elder maltreatment and long-term studies are needed to delineate whether this is the case.

### **The way forward in the WHO European Region**

Until recently, the policy response for elder maltreatment prevention has been weak and too few countries have devoted adequate resources to this growing public health priority. A resolution of the WHO Regional Committee for Europe emphasized a public health approach to preventing violence and injuries and protecting vulnerable groups (4.) In response to the rising concern about elder maltreatment, an *Action plan for healthy ageing in Europe, 2012-2020*, (5) emphasizes it as a strategic priority area. A set of actions is proposed for Member States and other stakeholders. These aim to reduce the burden of elder maltreatment as well as decrease inequalities across countries in accordance with the new European health policy, *Health 2020* (6). These actions are:

1. *Develop and implement national policies and plans for preventing elder maltreatment;*
2. *Take action to improve data on and surveillance of elder maltreatment;*
3. *Evaluative research needs to be undertaken as a priority;*
4. *Responses for victims need to be strengthened;*
5. *Build capacity and exchange good practices across the sectors;*

6. *Address inequity in the maltreatment of older people;*
7. *Raise awareness and target investment for preventing elder maltreatment;*
8. *Protective factors, a life-course approach and intergenerational cohesion; and*
9. *Ethics and the quality of services in the community and in institutions.*

**Francesco Mitis**,  
Technical Officer,  
Violence and Injury Prevention,  
WHO Regional Office for Europe,  
mit@euro.who.int

**Dinesh Sethi, MSc, MD, FFPH**,  
Programme Manager,  
Violence and Injury Prevention,  
WHO Regional Office for Europe,  
din@euro.who.int

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# ONGOING ISSUES RELATED TO SEXUALLY TRANSMITTED INFECTIONS (STIs) INCLUDING HIV/AIDS IN THE POPULATION OVER THE AGE OF 50 IN THE WHO EUROPEAN REGION

Limited data exist in the WHO European Region about sexual health (SH) and adverse SH outcomes in older people, who, for the purpose of this article, have been defined as being older than 50 years. Globally, older people are a population largely ignored in HIV and STI prevention, care and treatment programmes, possibly due to a common perception of sexual inactivity in older age (1). This is in spite of growing evidence of increases in STIs and HIV in the UK, North America, Australia and China (2). Several factors have been identified as contributing to higher rates of STIs and HIV in older age groups such as increased longevity and well-being, higher rates of divorce, partner change and less safe sexual practices (3). Other factors include limited SH services for older people, who are rarely a target population for safer sex promotion campaigns, inadequate awareness of risks of STIs and insufficient

patient-provider communication (4). In addition, several biological factors have been suggested as associated with a higher risk of HIV acquisition in older age such as thymic involution and corresponding low 'T cell reserve', increased expression of key T cell chemokine co-receptors which may facilitate viral entry into immune cells and reduced capacity to produce interleukin-2 (5, 6).

According to recent data 5674 new cases of HIV in people older than 50 years were reported in 2010 in the WHO European Region and of these the majority (73.4%) were men (Table 1) (7). In the countries of the west, men and women older than 50 years of age contributed to 13.1% (n=2200) and 7.9% (n=738) in the total number of newly reported cases in 2004, respectively, increasing to 15.3% (n=3038) and 12.5% (n=893), respectively in 2010 (7).

In the centre, the number of newly

reported HIV cases who were older than 50 almost doubled when the year 2010 is compared to 2004 – from 105 cases in men in 2004 to 203 cases in 2010, and in women from 27 cases in 2004 to 50 in 2010. Proportionally, the increase was more prominent in women in this period (from 5.4% in the total number of HIV cases reported in 2004 to 11.0% in 2010) compared to men (from 9.3% to 10.8%, respectively) (7).

In the east, people older than 50 accounted for 2.9% (n=301) of reported HIV cases in men and 2.1% (n=121) in women in 2004, increasing to 4.9% (n=784) and 4.1% (n=458) in 2009, respectively (7). With data from the Russian Federation in 2010, the east region reported 926 HIV cases in men and 564 in women who were older than 50 years (however, for 36 177 cases in men and 26,410 cases in women data on age were missing) (7).

**Table 1. Number of newly reported HIV cases in the WHO European Region by age groups, 2004-2010 (7).**

		2004		2005		2006		2007		2008		2009		2010	
		Men	Women	Men	Women	Men	Women								
<b>West</b>	<49	14439	8537	14801	8238	14177	7339	15183	7106	15644	6973	16039	6600	16570	6163
	>50	2200	738	2435	793	2339	791	2655	745	2797	879	2906	921	3038	893
	Unknown	68	41	57	27	1246	441	1297	488	1425	478	1802	577	231	63
	<b>Total</b>	<b>16707</b>	<b>9316</b>	<b>17293</b>	<b>9058</b>	<b>17762</b>	<b>8571</b>	<b>19135</b>	<b>8339</b>	<b>19866</b>	<b>8330</b>	<b>20747</b>	<b>8098</b>	<b>19839</b>	<b>7119</b>
<b>Centre</b>	<49	977	443	1091	462	1190	446	1261	417	1459	434	1644	440	1660	400
	>50	105	27	139	36	110	32	162	41	172	48	202	50	203	50
	Unknown	50	28	37	17	38	6	47	13	31	4	32	3	22	4
	<b>Total</b>	<b>1132</b>	<b>498</b>	<b>1267</b>	<b>515</b>	<b>1338</b>	<b>484</b>	<b>1470</b>	<b>471</b>	<b>1662</b>	<b>486</b>	<b>1878</b>	<b>493</b>	<b>1885</b>	<b>454</b>
<b>East</b>	<49	6146	2729	7525	3372	8817	4117	10648	5670	14167	9866	15104	10755	15325	10593
	>50	301	121	302	136	444	176	572	267	655	345	784	458	926	564
	Unknown	3808	2868	3426	2836	3841	3255	3319	2316	7	14	19	3	36177	26410
	<b>Total</b>	<b>10255</b>	<b>5718</b>	<b>11253</b>	<b>6344</b>	<b>13102</b>	<b>7548</b>	<b>14539</b>	<b>8253</b>	<b>14829</b>	<b>10225</b>	<b>15907</b>	<b>11216</b>	<b>52428</b>	<b>37567</b>

**West** includes the following countries: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland and the United Kingdom. **Centre** includes: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, the former Yugoslav Republic of Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia and Turkey. **East** includes: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, the Republic of Moldova, Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.



**Ivana  
Bozicevic**



**Martin  
Christopher  
Donoghoe**

The increase in the number of people older than 50 years living with HIV in Europe can reflect an ageing cohort of persons living with HIV who are successfully treated with antiretrovirals (ARVs) as well as increases in newly acquired infections among older adults.

Health professionals are often reluctant to address SH issues in their older patients, which may lead to misdiagnosis of HIV symptoms or late HIV diagnosis. A study that included 8255 HIV positive adults older than 15 years that accessed HIV care in England, Wales and Northern Ireland in 2007 found that, when compared with younger adults at diagnosis, older adults were significantly more likely to be men and infected through sex between men (8). Almost half (48%) of older adults were late presenters compared to 33% of younger adults. Importantly, older late presenters were 14 times more likely to die within a year of diagnosis compared with older adults who were not diagnosed late and had 2.4 times higher risk of dying than younger late presenters (8). Older adults tend to be diagnosed at a more advanced stage of HIV infection at diagnosis than younger people, and have a higher HIV morbidity and mortality and a faster disease progression (9).

Age-related co-morbidities occur earlier in HIV-infected patients than in those without HIV infection mainly due to chronic inflammation and chronic immune activation (10). Side effects of ARVs may occur more frequently in older patients due to other co-morbidities, altered drug metabolism and a higher risk of pharmacological interactions with other medications.

Data on sexual behaviours in mature and older individuals in Europe are largely lacking. A survey conducted on a national-level representative sample in the United States in 2006 in 57 to 85 years old individuals found that the prevalence of sexual activity declined with age (73% among respondents who were 57 to 64 years of age, 53% among respondents who were 65 to 74 years of age, and 26% among those who were 75 to 85 years

of age) (11). Women in all age groups surveyed were significantly less likely than men to be sexually active. Among respondents who were sexually active, about half of men and women reported at least one bothersome sexual problem and women were found less likely than men to have discussed these with a physician.

Concern has traditionally focused on STI and HIV prevention and treatment in the younger age groups who are often considered an especially vulnerable population. UNAIDS only considers new infections in the 15-49 year age range in its measurement of progress towards “zero new infections”. Given the growing numbers of newly reported HIV infections in people older than 50 years across the Region, efforts should be made in the countries to describe epidemiological trends in HIV and STIs in this age group, explore factors associated with HIV transmission and assess more extensively the effectiveness of prevention and treatment programmes. There is also a need to better understand how to make prevention and treatment responses better tailored to the SH needs of older people and more accessible. With increasing access to antiretroviral therapy (ART) and better management of treatment, people with HIV can now expect to live longer. With an aging population of persons living with HIV, noncommunicable and chronic disease programmes will need to adapt to address prevention and treatment of conditions associated with both long term use of ART and ageing.

**Ivana Bozicevic,**  
WHO Collaborating Centre for  
HIV Surveillance,  
University of Zagreb School of  
Medicine, Zagreb, Croatia,  
[Ivana.Bozicevic@ishtm.ac.uk](mailto:Ivana.Bozicevic@ishtm.ac.uk)

**Martin Christopher Donoghoe,**  
BA, MPH,  
Programme Manager, HIV/AIDS,  
STIs and Viral Hepatitis,  
WHO Regional Office for Europe,  
[mndo@euro.who.int](mailto:mndo@euro.who.int)

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# UNSAFE SEX AT 50 +

## Introduction

Globally, an estimated 498 million new cases of syphilis, gonorrhoea, chlamydial infection and trichomoniasis occurred in adults between 15-49 years in 2008 (1). However, the real figures are likely to be higher as asymptomatic cases are not reported, and there is a lack of reliable surveillance and reporting mechanisms in many settings. For populations over the age of 50, no reliable data for these and other curable sexually transmitted infections (STIs) is available because assessments of incidence and the prevalence of risky sex focuses essentially on populations of reproductive age. The little data that is available indicates that the incidence of STIs is on the rise among older populations. In the United Kingdom for instance, although the 15 to 24 year old group is the group most affected by STIs, 32% of all new syphilis and 11% of all new herpes diagnoses were in individuals over the age of 45 (2).

More data is available on HIV, although here again, the focus of surveillance, treatment and care is primarily in populations of reproductive age. UNAIDS estimates that 2.8 million people aged 50 and over were living with HIV in 2006 and the prevalence of HIV in South Africa among people age 50-54 was 10.8%, 4.5% among those aged 55-59, and 3.9% among those aged 60 and over (3). The increasing availability and coverage of antiretroviral therapy implies that the burden of HIV is shifting to older age groups. However, little is known about the unique considerations required to adequately treat and retain older populations (4). In addition, older people already suffering from one chronic or infectious disease are especially vulnerable to additional infectious diseases (5). Unsafe sex can result in STIs, including HIV, at any age.

## Implications

What this data indicates is that despite cultural perceptions of a lack of sexuality in older people and significant lack of research in this area, people over 50 years of age, irrespective of their serostatus, engage in sex and will face exposure to

STIs, including HIV, in a potential sexual partner (6). The European Male Ageing Study (EMAS), for example, noted that almost half of men aged over 70 years reported having sexual intercourse at least once a week (7). The attitudes by health care workers and policy makers towards sex and ageing have yet to adapt to this reality and although noncommunicable disease is the dominant cause of morbidity and mortality among older populations, communicable diseases as a result of unsafe sex is becoming an important source of concern (8).

In almost every country, the proportion of people aged over 60 years is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates. This can be seen as a success story for public health policies and for socioeconomic development, but for many resource-constrained settings, it also challenges communities to adapt and provide them with adequate health care. By 2050, 80% of older people will live in what are now low or middle-income countries (9). Many of these countries lack the adequate infrastructure and health care to deal with sexual and reproductive health issues for all age groups and there is a general exclusion of people over 50 from many health care programmes, including HIV screening programmes, or advice on safe sex practices (10). Added to this, the lack of training in providing sexuality education to the elderly and the perceived lack of need of STI care and management for this populations may be increasing the magnitude of mortality and morbidity in the older populations.

An integrated continuum of long-term care can support older people to age in place and provide institutional care for those with severe limitation. Although several developed countries have established such systems, a major challenge will be to maintain these sustainably and also to develop integrated long-term care in resource poor settings (11).

## Recommendations

In order for health care services ad-

ressing STI and HIV prevention and treatment to maximize their impact in the future and adapt to the world's changing demography, the following recommendations have been highlighted by WHO for HIV/AIDS and can also apply to other STIs (12):

- provide concrete support to older people (for example social pensions);
- train HIV/AIDS service and health providers on gerontological issues;
- provide psychological and medical support for older people living with ill family members; and
- include older people in sexuality counselling and HIV/AIDS education/training programmes.

Studies indicate that older people can retain their health and if they live in an environment that allows them to remain active participants in society, this is desirable for the welfare of the whole community. It also implies that prevention messages with regards to safer sex need to target the older populations, as maintaining better health implies retaining sexual health as well.

**Manjula Lusti-Narasimhan, MD,**  
Dept. of Reproductive Health  
and Research,  
WHO headquarters,  
lustinarasimhanm@who.int

**John Beard, MD,**  
Director, Dept. of Ageing and  
Life Course,  
WHO headquarters,  
beardj@who.int

**Marleen Temmerman, MD, PhD,**  
Director, Dept. of Reproductive  
Health and Research,  
WHO headquarters,  
temmermanm@who.int



**Manjula  
Lusti-  
Narasimhan**



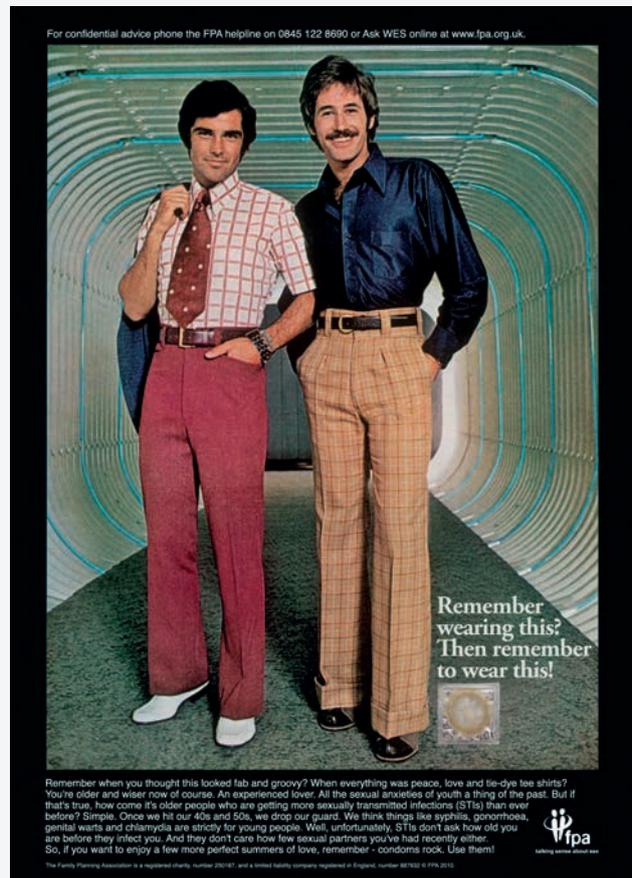
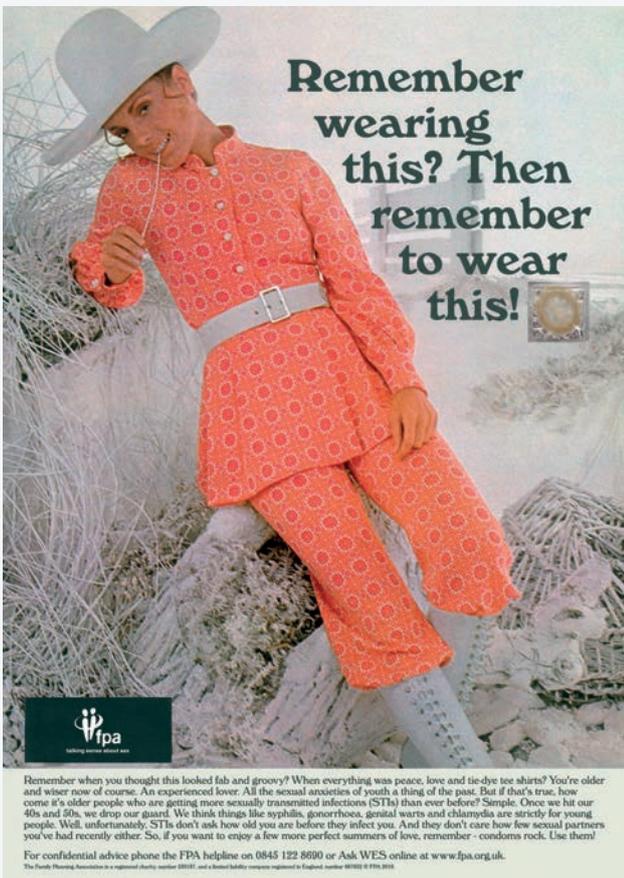
**John  
Beard**



**Marleen  
Temmerman**

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Images from the first ever national health campaign in the United Kingdom, held in 2010, for people over 50 – “The Middle Aged Spread” during sexual health week by the sexual health charity FPA. For more info please visit: <http://www.fpa.org.uk/campaignsandadvocacy/sexualhealthweek/stisandsafersexover50>

# FOR MATURE AUDIENCES ONLY - UNDERSTANDING SEXUALITY AND INTIMACY OF PEOPLE OVER 55

## Background

Following the trend of much of the western world, the Portuguese population has aged considerably in recent decades. In the last few years, raising HIV infection rates among people over 55 has proven that as people get older they can and often will stay sexually active (1). It has also demonstrated that many times they will not protect themselves against sexually transmitted infections (STIs). This realization contributed to the development of a research and intervention project, called “For mature audiences only,” aimed at increasing our knowledge about the sexual behaviours and HIV knowledge and information of this population. The research part of the project was designed as a cross-sectional and descriptive study using a behavioural questionnaire based on previously designed and tested questionnaires. In addition, we also used the Sexual Attitudes Scale (SAS) which had previously been adapted and tested for the Portuguese population (2, 3).

In collaboration with Senior Academies in the larger Lisbon metropolitan area we organized several free information sessions about relationships, sexuality and ageing with groups of people over 55 years of age. In total 17 sessions were conducted, with some cases followed by focus groups to collect more in depth information about the topics of interest with a smaller group of participants. The questionnaires were self-administered at the beginning of the information sessions and also collected at day care centres and other organizations that cater to the elderly. At the centres and institutions a trained outreach worker filled out the questionnaires during one-on-one interviews. The SAS was only used in the context of the latter for practical reasons.

## Results

In total, 316 questionnaires were completed: 251 (79.4%) from the information sessions and 65 (20.6%) from centres and institutions. The average age of participants was 67.9 years (55-64: 40.2%; 65-74: 39.6%; >75: 20.3%) and 73% of sample members were females. Around

half of the participants were married (50.3%), 26.3% were widowers, 14.2% were divorced, 7.3% were single and 1.9% were in domestic partnerships. In accordance with life expectancy patterns – women living longer than men – more of the men (78.8%) were married when compared with the women (39.8%) and there were more women widowers (31.6%) than men (11.8%).

Regarding their sexual orientation, 96% of men and 98% of women identified as heterosexual. However, 91% in general said they had an exclusive opposite-sex attraction on an adapted five point Kinsey scale. The discrepancy between self-identification and measure of attraction is noteworthy and should be subject to further research. However, we believe it may be attributed to cohort effects.

One of the myths concerning the sexuality of older people is that as they grow older people will stop having sex, be it for lack of interest or due to physical incapacity. In our study the data revealed that half of the participants (47%) were sexually active; more men were sexually active (70.2%) than women (38.2%).

Of the sexually active (n=145), we were interested in learning what activities were maintained from a repertoire of different possible sexual and intimate acts. The results show us that the majority maintained some type of intimate act with their partners on a daily or an almost daily basis (Figure 1), such as holding hands, hugging or kissing. Less than a third had vaginal intercourse and only a minority engaged in other forms of sexual intimacy, such as mutual masturbation and oral or anal sex, with the same frequency. These numbers indicate that in our sample many sustained active and diverse sex lives, breaking away from the stereotype of the asexual existence often associated with older age. In fact, intimacy, desire and pleasure are universal experiences that are not bound by age barriers. These results make that reality ever more clear.

However, we also found indicators that the asexual myth may play a part in some

older people’s lives. We found that as age increases, the likelihood that people will be sexually active diminishes; while 62.7% of 55-64 year olds were sexually active, only 43.8 % of 65-74 year olds and 21% of those over 75 were. When we asked about the reasons for not having sex among the non sexually active men reasons given were: due to sickness (28%); due to lack of interest (24%); and due to lack of a partner (24%). Of the non-sexually active women, just under half said that it was due to lack of partner (45.3%) and 40.3% said it was due to lack of interest. It would be worthwhile to further investigate to what extent some of these results are products of effective problems that impede sexual activity, or if they could be the consequence of the internalization of the same myths that desexualise the elderly.

Shedding some light onto these questions, when we specifically focused our questions on the five years previous to the study, 40.8% of all sample members said they could not identify any changes in their sexuality. Of those who did identify such changes, 49.7% considered them to be due to ageing. Many considered these changes to have either a neutral (47.1%) or a negative (39.2%) impact upon them. A third would like to see their sexual issues resolved (29.9%). Therefore, we registered mixed reactions to sexual difficulties, from the plain conformism to a problem-centred approach with willingness, even if not necessarily with a plan, to do something about it.

Looking at the results from the SAS questionnaire (n=65), the overall picture is of a conservative outlook towards sexuality, with sex being valued mostly within steady relationships. However, men tended to have a more instrumental attitude towards sexuality when compared with women, in accordance with previous research and with traditional gender norms (3).

Finally, of particular interest to our study were the results about knowledge and attitudes regarding HIV. 37.8% of participants thought their level of HIV knowledge was good, while 33.3% rated



**Nuno Nodin**



**Nuno Margalha**

their knowledge as average. The main sources of information were the media (69.9%); publicity (41.5%); and health organizations (30.1%). Two thirds (66.4%) said they had not changed their behaviours since first hearing about HIV and AIDS and indeed a large majority (73%) indicated not using condoms during sex. These results, although not totally surprising considering the high rates of HIV infection in this age group in Portugal, are of concern as they reveal a pattern of low to average perceived HIV knowledge and high-risk sexual behaviours.

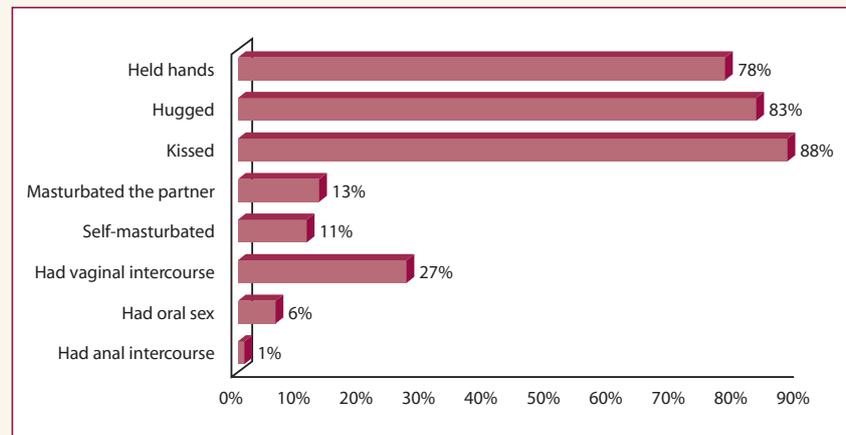
### Interventions

Based on what we learned from all our results and with the active collaboration of focus-group participants, we developed a range of informational resources targeted at people over 55. These materials covered a broad range of topics including: STIs, condom usage, sexual difficulties, lifestyle issues and positive aspects of sexuality. For example, in addressing the lack of sexual activity within long term relationships we developed the leaflet “Keeping the passion alive,” with tips about communication and easy ways to reignite sexual activity, as well as another one about “Sensuous massage for the elder”. For single older people seeking sexual partners we created a leaflet about “Meeting people online,” with suggestions about how to make the most of using the Internet to meet others in a safe way. Using recommendations offered by volunteers during some of the focus groups and working in direct collaboration with them, we developed leaflets about “Looking after yourself,” and “The couple after retirement”. These are just a few of the 15 leaflets that were developed in the context of the “For mature audiences only” project.

### Conclusions

Important lessons were learnt from this project. One of them was that older people are not asexual beings, even when they are not sexually active, as shown by

**Figure 1: Sexual activities performed daily or several times a week (n=145)**



the comments about masturbation that came up in some of the activities we conducted. Also relevant was the enthusiasm with which the people we worked with welcomed the project and the materials we developed, which means that they are open and have an interest in leaning more about and in improving their sexual health. We believe these are all relevant elements to be considered in future programmes and interventions targeting mature audiences.

**Nuno Nodin, M.Sc,**  
Health Psychology,  
nunonodin@gmail.com

**Nuno Margalha, M.Sc,**  
Clinical Psychology,  
nunomargalha@gmail.com

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# SEXUAL FUNCTION IN THE AGEING FEMALE

## Introduction

Sexual health is an important part of human reproductive existence as it not only carries out the essential function of reproduction, but also has a significant impact on quality of human life, psychological well-being and physical health, as well as, social and family life.

A woman's life span consists of several subsequent physiological stages. One of the crucial changes is a transition from reproductive to non-reproductive – or growing older – phase. At the beginning of the 20th century, the average life expectancy for women was 47 years, whereas, nowadays it has reached 76 years (1). With the increase in life expectancy, the period after menopause represents a significant part of a woman's life which she has every right to enjoy. According to prior research data, as many as 68% of women aged 39–50 years acknowledge sexual desire at least once per week as compared to 65% of women aged 51–64 years (2). Sexual function is a consequence of different changes in the human mind, physical health and the relationship with the partner. Problems with sexual function during menopause are associated with personal distress, weakening ego, lower self-esteem and self-respect, as well as, lower quality of life and relationship with the partner (3). Changes in the hormone concentration, as well as, social and emotional conditions that accompany the very process of growing older, are among the factors having influence on female sexuality that are being studied today (4). However, what constitutes normal female sexual behaviour, including the multiple factors that affect it, has not been well described (5). Several biological, psychological and social relational factors are associated with a women's sexual health; thus, they may negatively affect the entire sexual response cycle, inducing clear changes in desire, arousal, orgasm and satisfaction (6). The objective of our study was to assess sexual function in a clinical sample of Lithuanian postmenopausal women and identify the most important determinants of sexual function,

including social factors and menopausal symptoms.

## Methods, participants and tools

The target population was postmenopausal females attending the outpatient clinic of the Department of Obstetrics and Gynaecology at the Hospital of the Lithuanian University of Health Sciences, during a 1-year period. The study enrolled 246 postmenopausal women who had been referred to a gynaecologist for their routine yearly check-up. Inclusion criteria for the research were: age from 45–65 years, more than 12 months of amenorrhea and being sexual active during the period of the previous 4 weeks.

Several study tools were used. A specific diagnostic instrument - the Female Sexual Function Index (FSFI) - was used to evaluate the sexual function of study participants. The full-scale range is 2.0 - 36.0 and the optimal cut-off score of 26.55 differentiates women with and without sexual dysfunction (SD). Higher scores indicate better sexual function. The Dyadic Adjustment Scale (DAS) was used for self-reported measures of relationship quality and function. A person can obtain a score from 0 to 151 – the higher the score, the better the dyadic adjustment. For the evaluation of menopausal symptoms, the Greene Climacteric Scale (GCS) was used. It is a questionnaire designed to provide a brief but comprehensive measure of climacteric symptoms. The sociodemographic questionnaire was used to evaluate reproduction history, education and social status, biological and partner-related factors.

## Results

The mean age of the 246 study participants was 55.5 years (range 45–65). The study participants were divided into groups according to age. Significant differences in sexual function in all domains among participants in all age groups were detected; sexual function was better among younger women (45–50 years of age) compared to older women (age groups 51–60 and 61–65).

In order to explore factors that may be related to better or worse sexual functioning the following variables were also assessed: education, financial status, employment, reproductive history, somatic health, Body Mass Index (BMI) and menopausal symptoms.

## Education, financial status and employment

Of the respondents, 17.9% (n=44) had lower than high school education, 28.0% (n=69) had high school education, 25.6% (n=63) had college education and 28.5% (n=70) had a university degree or more than one university degree. The respondents with the university and college degrees reported better sexual function.

Financial status was estimated according to the women's monthly income (after excluding the amount deducted for taxes). Of the women, 5.7% (n=14) had a low income ( $\leq$ 1000 Lt), 41.5% (n=102) had a medium income (1000–2000 Lt), 48.0% had a sufficient income (2000–3000 Lt) while 4.9% (n=12) had more than a sufficient income ( $\geq$ 3000 Lt). Sexual function was also found to be better in women with higher income in comparison with lower ones.

More than half of participants in our study were still working and their sexual function was better as compared to the retired women. Moreover, more than half of the respondents lived in towns and their sexual function was also reported as better.

## Reproductive history, somatic health and menopause

Sexual function improved in women with a shorter period of amenorrhea and also among those with fewer children. Of the children still sharing a residence with their parents, 5.7% (n=14) of the children were younger than 18 years, 17.9% (n=44) were 19–25 years old and 17.1% (n=42) were older than 25 years of age. Scores for sexual desire, arousal, orgasm and total scores were consistently better in women with children younger than 18 years of age.

The participants' somatic health



**Giedre  
Jonusiene**



**Virginija  
Adomai-  
tienes**



**Rosita  
Aniuoliene**



**Ruta  
Jolanta  
Nadisauskiene**



**Birute  
Zilaitiene**

and its possible correspondence with sexual function after menopause was also explored. 76.8% of the participants (n=189) suffered from any somatic disease. The sexual function of the respondents reporting no somatic disorder was better than that of those reporting at least one somatic disorder. This finding was consistent and significant across all realms of sexual function (desire, arousal, lubrication, orgasm, satisfaction and pain), including total sexual function. Partners' somatic health and respondents' sexual function were also examined. 61.4% (n=151) of the respondents' partners reported to have at least one of the following disorders: diabetes mellitus, arterial hypertension, chronic respiratory distress, chronic thyroid disorder and/or vertebral disorder. Women whose partners did not report somatic disorders demonstrated a higher sexual function.

All participants had partners. 76.4% of them (n=188) were married. No relation between relationship status and sexual function was established. However, better sexual function was observed in those with partners with university education. 30.9% (n=76) of partners did have low sexual desire. The women whose partners suffered from low sexual desire had worse sexual function after menopause. 18.7% (n=46) of partners reported that they had erectile dysfunction, which had a negative influence on female arousal, orgasm, and total sexual function.

BMI was measured and its correlation with the sexual function was also evaluated. 9.8% (n=24) had a low BMI (<18.5), 53.3% (n=131) had a normal BMI (18.5–24.9), 34.1% had a higher than medium BMI (25–29.9), while 2.8% (n=7) had an overweight BMI (BMI ≥ 30). Significant differences in desire, arousal, orgasm and total sexual function were observed between respondents across the BMI categories; the women with higher BMI demonstrated the lowest scores in desire, arousal, lubrication, orgasm, satisfaction and total sexual function.

A relationship between sexual function and menopausal symptoms was also found. In women with psychological and

somatic symptoms of menopause, desire, arousal, lubrication, orgasm and satisfaction were lower, whereas pain was higher.

Of the total participants, 67.9% (n=167) had a total FSFI score at the level of risk for sexual dysfunction ( $\leq 26.55$ ). The mean age of these women was 57. In order to assess the risk factors for development of sexual dysfunction according to the optimal cut-off score of 26.55, a multivariate logistic regression was performed. Odds ratio for sexual dysfunction was higher in older women (1.16, 95% CI [1.1–1.23]); in women with expressed menopause symptoms (1.04, 95% CI [1.0–1.08]); and among women whose partners' had somatic health problems (2.13, 95% CI [1.07–4.24]). Better dyad adjustment (0.97, 95% CI [0.96–0.99]) and better desire before menopause (0.5, 95% CI [0.37–0.68]) act as protective factors against sexual dysfunction.

### Conclusion

In conclusion, sexual function was significantly lower among women of older age who were retired, of lower education, lower income, rural residents, with more and older children, reporting somatic diseases and with higher BMI. The better sexual function was found in women with partners of university education, no reported somatic diseases or sexual function disorders, as well as with a better dyad adjustment. More than half of the respondents were found to have sexual dysfunction or the risk of its development. Better dyad adjustment and positive attitudes towards sexuality act as protective factors for sexual function.

**Giedre Jonusiene**,  
Department of Psychiatry,  
Lithuanian University of  
Health Sciences,  
Kaunas, Lithuania

**Virginija Adomaitiene**,  
Department of Psychiatry,  
Lithuanian University of  
Health Sciences,  
Kaunas, Lithuania

**Rosita Aniuoliene**,  
Dept. of Obstetrics and  
Gynaecology, Lithuanian University  
of Health Sciences,  
Kaunas, Lithuania

**Ruta Jolanta Nadisauskiene**,  
Dept. of Obstetrics and  
Gynaecology, Lithuanian University  
of Health Sciences,  
Kaunas, Lithuania

**Birute Zilaitiene**,  
Institute of Endocrinology,  
Lithuanian University of  
Health Sciences,  
Kaunas, Lithuania

**Correspondence to:**  
[jonusiene@lytinesveikata.lt](mailto:jonusiene@lytinesveikata.lt)

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This document focuses on priority action areas and interventions that correspond to the four priority areas of Health 2020, the new European policy framework for health and well-being, in addressing the public health priority of healthy ageing. Available in English, German, French and Russian at:

<http://www.euro.who.int/en/what-we-do/health-topics/Life-stages/healthy-ageing/publications/2012/eurrc6210-rev.1-strategy-and-action-plan-for-healthy-ageing-in-europe,-20122020>



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This document focuses on key strategies and priority interventions to show how integrated health policies can respond to rapid ageing in Europe. Available in English, German, French and Russian at:

<http://www.euro.who.int/en/what-we-do/health-topics/Life-stages/healthy-ageing/publications/2012/policies-and-priority-interventions-for-healthy-ageing>



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Focusing attention on the public health issue of elder maltreatment throughout the European Region, this report highlights the biological, social, cultural, economic and environmental factors that influence the risk of being a victim or perpetrator of elder maltreatment, as well as the protective factors that can help prevent it. Available in English at:

<http://www.euro.who.int/en/what-we-do/health-topics/Life-stages/healthy-ageing/publications/2011/european-report-on-preventing-elder-maltreatment>



## **Knowledge Translation on Ageing and Health: A Framework for Policy Development 2012, WHO, 2012.**

Designed to assist policy- and decision -makers in integrating evidence-based approaches to ageing in national health policy development processes, policies and/or programmes, this document addresses older population needs concerned with such issues as HIV, reproductive health and chronic diseases. Available in English at:

[http://www.who.int/ageing/publications/knowledge\\_translation/en/index.html](http://www.who.int/ageing/publications/knowledge_translation/en/index.html)



## **Good health adds life to years - Global brief for World Health Day 2012, WHO, 2012.**

This publication, released on World Health Day 2012, looks at existing health data and draws on exciting new work to help better understand the needs of older people and identify actions we can all take to help older people live healthier, longer lives. Available in English at:

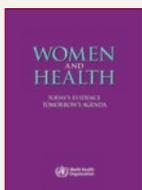
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Recognizing the ongoing demographic change that is occurring as more people age, this report raises awareness about the critical link between global health and aging, as well as, the importance of rigorous and coordinated research to close gaps in knowledge and the need for action based on evidence-based policies. Available in English at:

[http://www.who.int/ageing/publications/global\\_health/en/index.html](http://www.who.int/ageing/publications/global_health/en/index.html)



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Using current data, this report takes stock of what is known about the health of women throughout their lives and across the different regions of the world. Available in English at:

<http://www.who.int/gender/documents/9789241563857/en/index.html>



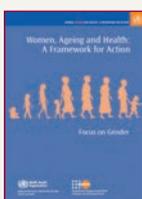
**Women, Ageing and Health, Achieving Health Across the Life Span, WHO, 2008.**

This report proposes a framework for action on health for ageing women within the Health for All context. In recognition of the diversity of older women and their health, the framework aims to set directions and give some examples of actions that can be taken. Available in English at:  
<http://www.who.int/ageing/publications/women/en/index.html>



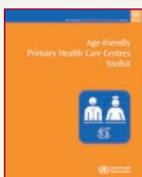
**Men, Ageing and Health, Achieving Health Across the Life Span, WHO, 2008.**

The document summarizes the knowledge gained in recent years about the health of male individuals as they age, identifies knowledge gaps requiring research efforts and recommends specific actions that need to be taken to improve the health of ageing males. Available in English at:  
<http://www.who.int/ageing/publications/men/en/index.html>



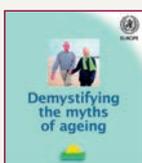
**Women, Ageing and Health: A framework for Action. Focus on Gender, WHO, UNFPA, 2007.**

This Framework for Action addresses the health status and factors that influence women’s health at midlife and older ages with a focus on gender. It provides guidance on how policy-makers, practitioners, nongovernmental organizations and civil society can improve the health and well-being of ageing women by simultaneously applying both a gender and an ageing lens in their policies, programmes and practices, as well as in research. Available in English at:  
[http://www.unfpa.org/upload/lib\\_pub\\_file/684\\_filename\\_ageing.pdf](http://www.unfpa.org/upload/lib_pub_file/684_filename_ageing.pdf)



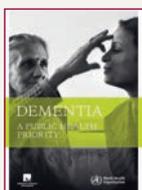
**Age-friendly Primary Health Care Centres Toolkit, WHO, 2008.**

Designed to improve the health care response to older people, the toolkit comprises a number of instruments that can be used by primary health care workers to assess and address older persons’ health. Available in English at:  
[http://www.who.int/ageing/publications/upcoming\\_publications/en/index.html](http://www.who.int/ageing/publications/upcoming_publications/en/index.html)



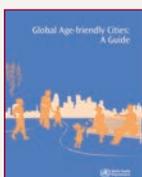
**Demystifying the Myths of Ageing, WHO, 2008.**

This pamphlet indicates how certain problems associated with old age can be largely attributed to myths surrounding the ageing process. It aims to broaden the debate on the changes necessary to ensure that people of all ages take advantage of a longer and healthier life. Available online only in English at:  
<http://www.euro.who.int/en/what-we-do/health-topics/Life-stages/healthy-ageing/publications/pre-2009/demystifying-the-myths-of-ageing>



**Dementia: a public health priority, WHO, Alzheimer’s Disease International, 2012.**

The comprehensive report raises awareness of dementia as a public health priority, articulates a public health approach and advocates for action at international and national levels. Available in English at:  
[http://www.who.int/mental\\_health/publications/dementia\\_report\\_2012/en/index.html](http://www.who.int/mental_health/publications/dementia_report_2012/en/index.html)



**Global Age-Friendly Cities: A Guide, WHO, 2007.**

Informed by WHO’s approach to active ageing, the purpose of this guide is to engage cities to become more age-friendly so as to tap the potential that older people represent for humanity. Available in English at:  
<http://www.who.int/topics/ageing/en/>

**Useful websites**

**Age Platform Europe:** <http://www.age-platform.eu/en>

**WHO Ageing and Life Course:** <http://www.who.int/ageing/en/>

**Healthy Ageing, WHO Regional Office for Europe:** <http://www.euro.who.int/ageing>

## *Entre Nous*

*The European Magazine  
for Sexual and Reproductive Health*

WHO Regional Office for Europe  
Division of Noncommunicable Diseases  
and Health Promotion  
Sexual and Reproductive Health  
(incl. Maternal and newborn health)

Scherfigsvej 8

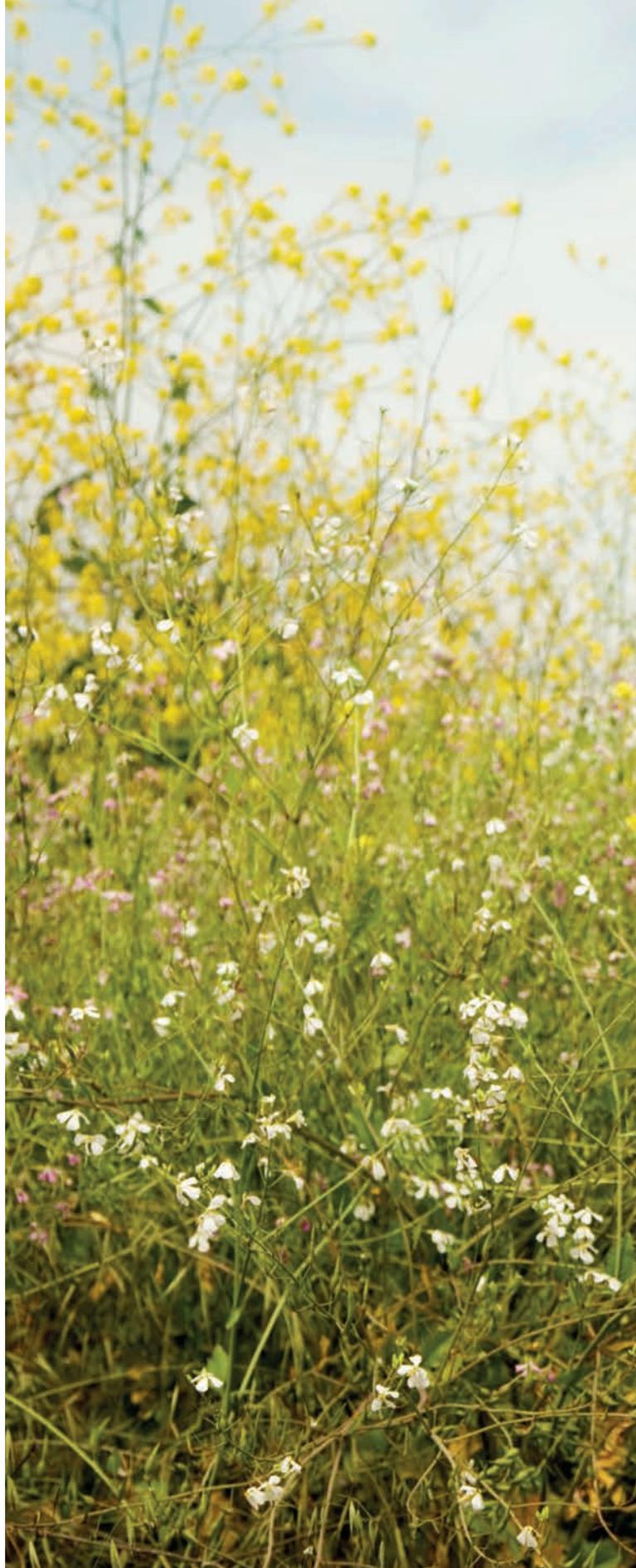
DK-2100 Copenhagen Ø

Denmark

Tel: (+45) 3917 17 17

Fax: (+45) 3917 1818

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