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Barriers to older adults seeking sexual health advice and treatment: A scoping review

I. Ezhova[a], L. Savidge[b], C. Bonnett[b], J. Cassidy[b], A. Okwuokei[b], T. Dickinson[b,*]

[a] King's College London, James Clerk Maxwell Building, 57 Waterloo Road, London SE1 8WA, United Kingdom
[b] Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London, James Clerk Maxwell Building, 57 Waterloo Road, London SE1 8WA, United Kingdom

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ABSTRACT

Background: Sexual health is an integral part of overall health in older age. Research consistently reports that heterosexual and queer older people tend not to disclose sexual concerns and difficulties which increases the risks for sexually transmitted diseases. Older people are often absent from policies and information programmes and healthcare providers experience difficulties in initiating conversations around sexual health and history.

Objectives: To identify what are the barriers that stop older people seeking sexual health advice and treatment.

Design and method: A scoping review methodology was employed. Published and unpublished literature was scoped through development of a research question, identification of potentially relevant studies, selection of relevant studies using an iterative team approach, charting data, collating, summarising and reporting findings, and considering the implications of study findings for further research.

Data sources: Electronic databases searches were run to identify published and unpublished literature, including Medline, Embase, PsycINFO, CINAHL, ASSIA, Social Sciences, RCN and Cochrane Libraries. Additional studies were located through hand searching.

Results: Twelve studies from: the USA ($n = 6$); the UK ($n = 3$); Australia ($n = 2$); and one shared paper between New Zealand and UK met the inclusion criteria. Four barriers that stop older people seeking sexual health advice and treatment were identified, including (1) Cultural and societal views and beliefs toward sexual health; (2) Stigma, embarrassment and discrimination; (3) Lack of education and training of healthcare professionals; (4) Quality of relationship between patients and health professionals.

Conclusion: Barriers to seeking and receiving advice and treatment for sexual health in later life clearly exist and are both related to cultural and social factors. Overall, the papers reviewed in this scoping review indicate that healthcare providers are reluctant to initiate conversations around sexual health or offer appropriate advice or clinical tests, and that older people tend to be hesitant to seek medical help. Later life age groups independently from their sexual orientation represent a hidden population and are absent from sexual health campaigns and government policies. Efforts need to be made by influential institutions and healthcare providers to recognise sexuality in older age and give older people the opportunity to open up regarding their sexual health and experiences.

What is already known about the topic?

- Sexual health is an integral part of overall health in older age.
- The role of sexual health in older people's wellbeing is underestimated in clinical practice, sexual health campaigns, and government policy.
- Healthcare providers experience difficulties when talking about sexual health with older people.

* Corresponding author.
E-mail address: tommy.dickinson@kcl.ac.uk (T. Dickinson).

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What this paper adds

- There is a clear lack of interventions on sexual health prevention tailored to older people regardless of their sexual orientation internationally.
- There is a limited insight into the experiences of older people in advanced and deeper age (70+) years.
- There is a lack of recent systematic reviews on barriers that stop queer older people from seeking sexual health advice and treatment.

1. Introduction

1.1. Sexual activity in older people & risks for sexually transmitted diseases

People do not naturally become 'post-sexual' or even asexual as they reach advanced ages. However, this perception prevails across English-speaking western societies, in popular culture, and in everyday assumptions (Simpson et al., 2018; Tremayne and Norton, 2017; Taylor and Gosney, 2011; Gott and Hinchliff, 2003). Sexual health is considered an important indicator for health across the life-course (World Health Organization, 2006), yet its role in older people's wellbeing has received sparse attention at best, and resistance at worst in clinical practice, sexual health campaigns, and government policy (Family Planning Association, 2017; Garrett, 2014; Evans, 2011).

There are more older people living longer lives. From a United Kingdom perspective, increasing proportions of people are aged over 65 (18%), and even over 85 (2.4%) (Office of National Statistics, 2017). For these individuals, sexual activity can be pleasurable and fulfilling, but they face increased risks of ill health and its adverse effects on sexuality (World Health Organization, 2006). Life-course narratives have become increasingly malleable, as increased re-partnering and 'newly single' individuals, typically higher health standards, and pharmacological interventions all work to lay fertile ground for sex into later life (Age UK, 2017; Office of National Statistics, 2017).

In 2008, people aged 55 and over became the most populous age bracket for those diagnosed with HIV (Preston and Wilkinson, 2017). In 2015, one in three HIV service-users were aged 50 or over, compared to one in seven 10 years prior (Tremayne and Norton, 2017). Other sexually transmitted diseases in 50–70-year olds have risen by more than a third in the past decade (Tremayne and Norton, 2017; Davies, 2015). Rates of diagnosis fall short of their younger counterparts, at 4% of sexually transmitted infection burden in England and standing at similar proportions in other western countries (Davies, 2015). However, these figures pose increasingly urgent questions in the context of ageing populations, the advance of the 'baby-boomers' demographic into later life, and healthcare professionals' persistent lack of confidence or perceived ability to support their sexual health (World Health Organization, 2006; Davies, 2015).

1.2. Sexual health policies

The World Health Organization regards sexual health as 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 (World Health Organization, 2006). As with many other aspects of later-life care provision, current sexual health policy may not currently be equipped to meet these needs and desires.

The guidance document '*Older People in Care homes: Sex, Sexuality, and Intimate Relationships*' (Royal College of Nursing, 2018) addressed many of the themes of the World Health Organization, 2006 report. It outlined the responsibilities of care homes and care systems, underlined the lack of appropriate training available for staff, despite widespread recognition of complex issues such as consent in the context of dementia. The document noted the 'climate of discomfort', which can inhibit practitioners from easily broaching the subject of sexual health with residents, and comments on common barriers to sex-positive cultures in care-homes, including residents' lack of privacy lost to safety measures and lack of double beds. Its solutions are structural, interpersonal, and geared towards clinical practice. For example, it emphasised the importance of organisational systems, which provide opportunities to document residents' sexualities and sexual health concerns, as well as clear methods of documenting problematic sexual events as they arise. Further still, it guides nurses to 'broach the subject' through archetypal nursing skills and values, such as promoting empathy and asking open ended questions.

This Royal College of Nursing guidance examines barriers to older peoples' sexual health, experienced by residents as loss of independence, stigma, and the impact of poor health, while practitioners face embarrassment or fear of offending, inadequate training, and institutionalised care-home cultures. It summarises that nurses must strive to promote and support older adults' rights, privacy, dignity and choice and to prevent any kind of discrimination. All decisions need to depend on the individuals involved and specific circumstances. Approaches to care must be person-centred. Care should be personalised rather than based on assumptions and stereotypes.

1.3. Healthcare providers-older patients' relationship

Intrapersonal complexity only deepens the reality of the unique biological, psychological, and social challenges faced by older adults seeking advice or treatment of sexual health issues, which require correspondingly unique and appropriate responses from healthcare professionals. For example, older generations missed out on the sexual health education provided in schools as it is today. It is also often common for older people to have a more 'paternalistic' relationship with practitioners, which might mean they expect healthcare professionals to initiate discussions on sex (Williams et al., 2007; Lindau et al., 2006).

Health practitioners are, therefore, to be mindful of the potential impact coiled behind the clinical encounter involving issues of sexual health. All encounters play against a background of pervasive myths, which polarise between derogatory representations such as 'mutton dressed as lamb' or 'dirty bugger' at one end, and the 'post-sexual' individual at the other (Montemurro and Siefken, 2014). In these terms, an older person who expresses sexual interest is ridiculed or perverted, and those who do not are confirmed as forever 'past it'. These biases are at odds with numerous surveys taken that attest to the sexual activity and interest maintained in the older population (Gott and Hinchliff, 2003). Such misrepresentations occlude the variety of sexual experience across older adult populations, and therefore invite healthcare professionals to overlook and neglect genuine physical or psychological threats to the sexual health of this patient group.

1.4. Queer older people

Queer older people are both notably absent in sexual health campaigns and seem to be a disadvantaged group, despite the

unique risks and adverse health outcomes they face (Tremayne and Norton, 2017; Fredriksen-Goldsen et al., 2015). The need to create informative programmes about their healthcare rights and sexual health in later life was identified, as queer adults deserve the same respect and independence from healthcare professionals as all the other patients groups and desire to maintain their dignity as they age (Hughes et al., 2011; Neville and Henrickson, 2010; Taylor, 2012). Prior research reported that many healthcare providers lack specific training to address the culturally sensitive needs of queer elders in care settings (Bell et al., 2010; Carlson and Harper, 2011).

1.5. Aims

The literature that speaks to sexuality in older adults is growing and provides a valuable resource for a scoping review to map out what is known about this topic and what further research needs to be undertaken to address sexual health and sexual health experiences in older people internationally. Therefore, the aim of this scoping review is to identify the barriers that stop heterosexual and queer older adults from seeking sexual health advice and treatment.

A scoping review was considered to be the most suitable approach to address the purpose of this work, to extract a diverse breadth of multidisciplinary evidence in a burgeoning field, identify gaps in its literature, and establish a critical starting point with a view for further, targeted research (Davis et al., 2009). To our knowledge, this is the first scoping review that conceptualises barriers for older adults, considering both heterosexual and queer older people, and health professionals' perspectives around sexual health; reviews methodological limitations, and informs recommendations for further research.

1.6. Definitions

The initialism lesbian, gay, bisexual and trans (LGBT) is not necessarily synonymous, with each term representing a different understanding of identity and desire. Therefore, we have followed the example of Dickinson (2015) and used the term 'queer' throughout this paper to reflect queer in its broadest sense – not to collapse people together but to mean those considered queer in whatever (gendered or sexualised) ways.

Different terms to describe various types of healthcare providers such as health professional, provider, doctor, healthcare practitioner, physician, doctor and nurse were also used in this paper. We did not regroup them under one term, for example 'healthcare provider' as we wanted to map and present individual healthcare professions that were included in our findings.

The acronym HIV designates human immunodeficiency virus. It infects cells of the immune system causing a progressive deterioration of the immune system, leading to immune deficiency (World Health Organization, 2017).

2. Methods

A scoping review was considered to be the most suitable approach to address the purpose of this work, to extract a diverse breadth of multidisciplinary evidence in a burgeoning field, identify gaps in its literature, and establish a critical starting point with a view for further, targeted research (Davis et al., 2009). We used the methodological framework first proposed by Arksey and O'Malley (2005) and subsequently adapted by Levac et al. (2010) and the Joanna Briggs Institute for conducting scoping studies (Peters et al., 2017). The scoping review also followed the guidelines provided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher et al., 2009). This included: development of a research question and a search strategy, identification of potentially relevant studies, selection of relevant studies using an iterative team approach, charting data and carrying out a quality appraisal, collating, summarising and reporting findings, and considering the implications of study findings for further research. An example of Prisma-ScR Checklist will be added as supplementary file.

2.1. Search strategy and data sources

In August 2018, six electronic databases were systematically searched for studies published from 2009 to 2019. A second search was run in August 2019. Databases included Medline, Embase, PsycINFO, CINAHL (Cumulative Index of Nursing and Allied Health Literature), ASSIA (Applied Social Sciences Index and Abstracts) and Social Sciences. The search strategy was developed by IE, LS and TD, then checked and validated by a librarian with expertise in Web-based information systems, systematic and scoping reviews' methodologies in the field of nursing and midwifery. A set of search terms were created with combinations of free text, medical subject headings (MeSH), truncations, and Boolean operators, as shown in Table 1. MeSH headings varied between databases, prioritising inclusivity, however, we depended on keyword searches to find specific concepts, such as treatments for sexually transmitted diseases. ASSIA and Social Sciences were searched by keywords alone.

Grey literature was also searched through RCN and Cochrane Libraries. The main objective of the grey literature search was to check what postgraduate and Ph.D.-level works have already been undertaken. Searches were conducted using a full keyword search with Booleans where possible. *Journal of Sexual Health* and *Journal of ageing Studies* were also hand-searched for additional material. Journals were chosen based on which appeared to host the most relevant papers. The reference lists of these papers were additionally hand-searched for results absent from database searches. All potentially relevant papers were abstract screened. Relevant full texts were read in full and printed off. Their reference lists were then hand searched and any potentially relevant article was title and abstract screened and full texts were read in full (we repeated the same process until we reached the 10-year limit). PubMed's suggested papers feature was also utilised for these purposes. The adapted PRISMA flow diagram (Moher et al., 2009) in Fig. 1 demonstrates the detailed search strategy and selection process of this scoping review.

2.2. Inclusion and exclusion criteria

We maintained flexible inclusion criteria based on increasing familiarity with our results (Arksey and O'Malley, 2005; Levac et al., 2010). This method was especially useful to define some complex key terms such as 'age'. Age of study participants is a clear and practical means of exclusion in the field of older adults, but there is no standard criterion (World Health Organization, 2006; Shenkin et al., 2017). We considered the ambiguous definition of 'old' when discussing means of exclusion. Furthermore, we also considered how queer older people, particularly older gay men, conceive concepts such as 'accelerated ageing' (Simpson, 2015; Schope, 2005). This means thresholds for 'old' are lowered. Given that previous studies expressed limited representation of queer populations, we left age-related exclusion for the discretion of manual review. In this way, we would not risk excluding culturally sensitive demographics through rigid search strategies or screening process. Results were further limited to English language

Table 1
Example of data search in Embase.

P	I	O
old* people*	sexual health clinic*	Improv* patient experienc*
elderly people*	MeSH sexual Health	MeSH Patient Satisfaction; Quality of
aged people*	genitourinary medicine service*	life
geriatric people*	sexually transmitted disease	emot* wellbeing*
old* patient*	treatment*	MeSH Wellbeing; Psychological
elderly patient*	sexually transmitted infection	Wellbeing
aged patient*	treatment*	improv* wellbeing
geriatric patient*	HIV* service*	physic* wellbeing
old* populat*	sexual health service*	improv* mood
elderly populat*	HIV* clinic*	MeSH Doctor Patient
aged populat*	HIV* therap*	patient* satisfac*
geriatric populat*	HIV* treatment*	stigma*
old* service user*	sexual health treatment*	MeSH Social stigma
elderly service user*	safe* sex	taboo*
old* client*	MeSH Safe sex; Sex education	embarrassment*
elderly client*	psychosexual service*	structural barrier*
aged client*	psychosexual counselling*	MeSH Healthcare access; Healthcare
geriatric client*	sexual health educat*	utilization; Attitude to health
old* adult*	sexual health advic*	communic* barrier*
old* men*	sexual health interven*	MeSH Interpersonal Communication;
old* women*	sexual health*	Nurse Patient Relationship; Health
old* male	STD* clinic*	Personnel Attitude
old* female*		financial barrier*
old* outpatient*		MeSH Healthcare cost
old* inpatient*		loneliness*
old* resident*		limit* mobil*
care home resident*		perceived need*
nursing home resident*		

Table 2
Inclusion criteria.

- English language
- Papers published between July 2008 and July 2019
- All types of medical and non-medical settings
- Studies reporting on interactions of older adults and medical/allied-medical professionals
- Studies reporting on older adults' views and opinions regarding sexual health advice and/or treatment
- Studies reporting on risk behaviours of older adults, including safe sex, sexually transmitted infections, and HIV
- Studies reporting on interventions or theoretical models related to sexual health in older people.
- All types of sexual orientation
- Age 50+
- All study designs and methodologies
- National and international literature

only, as access to professional translation services was unavailable. For more details, please refer to Table 2: Inclusion criteria.

2.3. Data extraction

A data extraction template was created by the research team to ensure that the process of data extraction was standardised between IE, LS, CB, and TD (Arksey and O'Malley, 2005; Levac et al., 2010). For all included papers, the following information was selected:

- Author(s), year of publication, study location;
- Setting(s);
- Study population(s) characteristics (sample, age range, gender of participants, relationship status, sexual orientation, language requirements, education level, ethnicity);
- Study design & Methodology;
- Aim(s) of the study;
- Intervention type or theoretical model;
- MMAT rating & comments.

Using the agreed data extraction template, IE, LS, CB, and TD completed and crossed-checked the data extraction.

3. Findings

The literature search yielded 2806 relevant papers (see Fig. 1). Removal of duplicates, title and abstract screening left 129 for full text screening, and 117 full-text papers did not meet our eligibility criteria. Twelve studies were deemed eligible for inclusion (see Table 3), which were from USA ($n = 6$); the UK ($n = 3$); Australia ($n = 2$); and one shared paper between New Zealand and UK ($n = 1$). The majority were qualitative studies, using semi-structured individual interviews ($n = 5$) (Fileborn et al., 2017a, 2017b; Hughes and Lewinson, 2014; Politi et al., 2009; Youssef et al., 2018); quantitative studies, using survey design ($n = 1$) (Hughes et al., 2013); mixed methods approach where patient-physician communications were audio-recorded and the participants completed surveys ($n = 1$) (Ports et al., 2014); literature reviews ($n = 1$) (Hinchliff and Gott, 2011); literature review of qualitative data ($n = 1$) (Taylor and Gosney, 2011); systematic literature reviews ($n = 1$) (Nash et al., 2015); cross-sectional surveys ($n = 1$) (Adams, 2014). Chaya and Bernert (2014) did not clearly specify the type of their research paper.

3.1. Quality assessment

Quality appraisal was carried out on all 12 papers. The Mixed-Methods Appraisal Tool (MMAT) (Hong et al., 2018) was used for the qualitative, quantitative and mixed-methods studies and the JBI Critical Appraisal Checklist for Systematic Reviews and Research Syntheses (Aromataris et al., 2015) was used for the literature and systematic reviews. Each paper was independently rated by IE and TD and any disagreements were resolved through discussion. Each study received an overall rating (see Table 3).

Table 3

	Author(s), year of publication, Study location	Settings(s)	Study population(s) characteristics (sample, age range, gender of participants, relationship status, sexual orientation, language requirements, education level, ethnicity)	Study design & Methodology	Aims(s) of study	Intervention type or theoretical model	MMAT Rating & comments
1	Adams, 2014 **USA**	Participants' homes	Sample *N* = 1 474 Men *N* = not specified Women *N* = not specified Age range: 57 to 85 Relationship status: married Sexual orientation: not specified Language requirements: English & Spanish Education level: College degree (60% men; 60% women) Ethnicity: White/Non-Hispanic white (men =84%; women = 86%), Hispanic (men=6%; women = 6%), Black (men = 7%; women = 7%), Other race/ethnicity (men = 2%; women = 2%)	Cross-sectional survey Survey	To examine the relation between marital quality and comfort discussing sexual issues with a doctor in older men and women	No intervention or model described	Good Most of the participants were white and highly educated.
2	Chaya and Bernert, 2014 **USA**	Care settings (assisted living facilities, nursing homes, retirement communities)	Sexual orientation: lesbian, gay, bisexual and trans 'queer' elders	Not clearly specified	To inform sexual health promotion for queer elders	The Community Readiness Model (HIV/AIDS prevention) (Thurman et al., 2007) This model provides both qualitative and quantitative information in a user-friendly structure that guides a community through the process of understanding the importance of the measure of readiness.	Good A clear research strategy, search sources, study selection, and criteria for appraising included studies was not provided.
3	Fileborn et al., 2017a* **Australia**	Primary care	Sample *N* = 53 Men *N* = 30 (qualitative arm) Women *N* = 23 (qualitative arm) Age range: 60 – 80 Relationship status: married (men = 43%, women = 22%), in a relationship (men =23%, women =26%), single (men=17%, women=38%), in an open relationship/multiple partners (men=13%, women=9%), widowed (men=3%, women=7%). Sexual orientation: heterosexual (men = 90%, women= 87%), gay/lesbian (men= 3%, women = 4%), bisexual (men=7%, women = 9%) Language requirements: English Education level: Highly educated Ethnicity: Anglo-Saxon background	Qualitative Individual semi-structured interviews	To explore older adult's understanding of safe sex	No intervention or model described	Good Most of the participants were heterosexual, highly educated, English speaking and from Anglo-Saxon background.

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Table 3 (*Continued*).

	Author(s), year of publication, Study location	Settings(s)	Study population(s) characteristics (sample, age range, gender of participants, relationship status, sexual orientation, language requirements, education level, ethnicity)	Study design & Methodology	Aims(s) of study	Intervention type or theoretical model	MMAT Rating & comments
4	Fileborn et al., 2017b** **Australia**	Primary care	*N* = 53 Men *N* = 30 omen *N* = 23 Age range: 60 – 80 Relationship status: married (men = 43%, women = 22%), in a relationship (men =23%, women =26%), single (men=17%, women=38%), in an open relationship/multiple partners (men=13%, women=9%), widowed (men=3%, women=7%). Sexual orientation: heterosexual (men = 90%, women= 87%), gay/lesbian (men= 3%, women = 4%), bisexual (men=7%, women = 9%) Language requirements: English Education level: Highly educated Ethnicity: Anglo-Saxon background	Qualitative Individual semi-structured interviews	To examine older Australian's perspectives on how their sexual lives can be best supported and/or improved	No intervention or model described	Good Most of the participants were heterosexual, highly educated, English-speaking and from Anglo-Saxon background.
5	Hinchliff and Gott, 2011 **UK and New Zealand**	Not specified	Middle and later life age groups	Literature review	To explore patient help-seeking and physician-patient interactions regarding sexual concerns in mid-later life	No intervention or model described	Good A clear research strategy, search sources, study selection, and criteria for appraising included studies was not provided.
6	Hughes and Lewinson, 2014 **USA**	Community	Women *N* = 28 Age range: 50 - 91 Relationship status: 50% married, 28% divorced, 21% single, 4% widow. 14% of unmarried women were in a relationship at the time of interviews. Sexual orientation: not specified Language requirements: able to speak conversational English Education level: Master's degree 25%; Bachelor's degree 32%; Associate degree 11%; College degree 25%; High school degree or equivalent 7% Ethnicity: 46% White; 50% Black, and 4% Native American.	Qualitative Individual semi-structured interviews	To understand ageing women's perspectives about communicating with providers about sexual health.	Integrative model of behavioural prediction (IMBP) (Fishbein, 2009) to identify factors that predict intent and then engagement in a specific behaviour. Authors in this study used the IMBP as a theoretical framework to help understand what ageing women considered important when deciding whether to discuss sexual health with health care providers.	Good Considers the perspectives of Black participants (50%), as well as participants with various levels of education.

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Table 3 (*Continued*).

	Author(s), year of publication, Study location	Settings(s)	Study population(s) characteristics (sample, age range, gender of participants, relationship status, sexual orientation, language requirements, education level, ethnicity)	Study design & Methodology	Aims(s) of study	Intervention type or theoretical model	MMAT Rating & comments
7	Hughes et al., 2013 **USA**	Primary care	Women $N = 853$ Age: 60+ Relationship status = married = 48,6%, widow = 13,1%, divorced = 22,9%, separated = 2,5%, never married = 9,2%, living with a partner = 3,6% Sexual orientation = not specified Language requirements = not specified Education level = Some High school = 0,8%, High school graduate/equivalency = 8%, Some college = 23,2%, Associate's degree = 8,4%, Bachelor's degree = 26%, Master's degree = 26%, Professional degree = 3,6%, Doctorate degree = 3,9% Ethnicity = Native American = 4%, Asian = 2,7%, African American = 18,2%, White = 71%, Hawaiian or other Pacific Islander = 0,8%, Hispanic = 2,2%.	Quantitative Survey	To identify key factors that improve communication between ageing women and their primary care providers.	Integrative model of behavioural prediction (IMBP) (Fishbein, 2009) to identify factors that predict intent and then engagement in a specific behaviour. Authors in this study used the IMBP as a guide, the survey instrument captured data on attitudes, perceived norms, self-efficacy, and intent to communicate with a provider about sexual health.	Good Considers the perspectives of participants from various ethnicities and levels of education.
8	Nash et al., 2015 **UK**	Not specified	Age: 60+	Systematic literature review	To ascertain what was known about the sexual health of older adults, their safe sex behaviours, risk factors and barriers to accessing Department for Integrated Sexual Health (DISH) services	No intervention or model described	Good A clear research strategy, search sources, study selection, and criteria for appraising included studies was not provided.
9	Politi et al., 2009 **USA**	Community, primary care	Women $N = 40$ Women who partner with women (WPW) = 19 omen who partner with men (WPM) = 21 Age range = 40 - 75 Relationship status: Never married (WPW = 57,9%, WPM = 23,8%); previously married i.e. widowed, divorced, legally separated (WPW = 41,2%, WPM = 76,2%). Sexual orientation: WPW, WPM Language requirements: not specified Education level: High school, some colleague or technical training (WPW = 10,5%, WPM = 42,9%), college degree or more (WPW = 89,5%, WPM = 57,1%). Ethnicity: White, not Hispanic (WPW = 100%, WPM = 95,2%); Black, not Hispanic (WPW = 0%, WPM = 4,8%)	Qualitative Individual interviews	To describe experiences of unmarried, middle-aged and older women in communicating about sexual health and intimate relationships (SHIR) with their health-care providers.	No intervention or model described	Good Most of the participants were white and highly educated.

(*Continued on next page*)

Table 3 (*Continued*).

	Author(s), year of publication, Study location	Settings(s)	Study population(s) characteristics (sample, age range, gender of participants, relationship status, sexual orientation, language requirements, education level, ethnicity)	Study design & Methodology	Aims(s) of study	Intervention type or theoretical model	MMAT Rating & comments
10	Ports et al., 2014 **USA**	Family and general internal medicine	*N* = 483 Number of male and female participants not specified Age range: 50 – 80 Relationship status: married = 64,7% Sexual orientation: not specified Language requirements: not specified Education level: < High school diploma = 4%; High school diploma 24,3%; Some college or more 71,7%. Ethnicity: African American 27,9%; White 65,5%; Other 6,6%	Mixed method Survey recordings of patient-physician communication	To explore the content and context of physician-patient sexual health discussions during periodic health exams (PHEs)	No intervention or model described	Good Most of the participants were white, highly educated and had a health insurance.
11	Taylor and Gosney, 2011 **UK**	General medicine	Older people	Literature review of qualitative data	To present on overview of the evidence for healthcare professionals who had not previously considered the sexuality of their older patients.	No intervention or model described	Good A clear research strategy, search sources, study selection, and criteria for appraising included studies was not provided.
12	Youssef et al., 2018 **UK**	HIV clinics	*N* = 20 Men = 14 Women = 6 Age range: 52 – 80 Relationship status: not specified Sexual orientation: Heterosexual = 60%; Gay =30%; bisexual =10%. Language requirements: not specified Education level: not specified Ethnicity: White 80%; Black African/Caribbean 20% Mean time since HIV diagnosis: 17 months (range 4–31).	Qualitative Individual semi-structured interviews	To identify factors associated with testing for HIV in people aged >50 years who tested late for HIV.	No intervention or model described	Good Most of the participants were white and heterosexual.

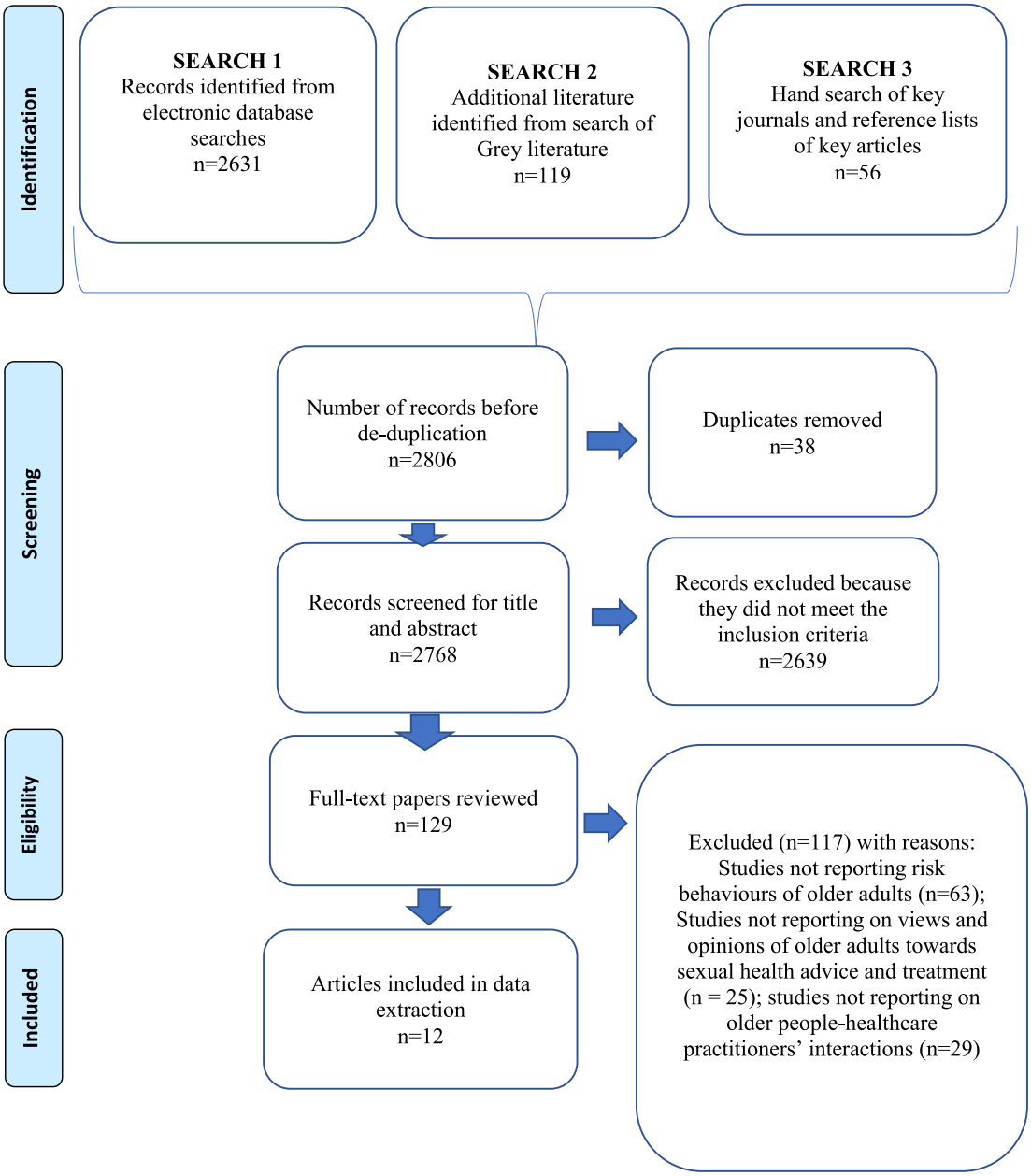

Fig. 1. Adapted PRISMA flow diagram (Moher et al., 2009).

4. Results

Narrative synthesis was used to analyse the relevant themes related to barriers that stop older adults from seeking sexual health advice and treatment. The 12 eligible studies were compared and synthesised to form emergent and final themes. Four overarching barriers were identified that stop older people seeking sexual health advice and treatment. These are:

(1) Cultural and societal views and beliefs toward sexual health;
(2) Stigma, embarrassment and discrimination;
  (a) Stigma and stereotypes,
  (b) Embarrassment and fear,
  (c) Discrimination.
(3) Lack of education and training of healthcare professionals;
(4) Quality of relationship between patients and health professionals;
  a) Quality of older people-healthcare providers relationship,
  b) Lack of information.

Table 4 presents a summary of the identified barriers to sexual health advice and treatment.

4.1. Cultural and societal views and beliefs toward sexual health

4.1.1. Sex in older age seen as unnatural by older people

Negative cultural views that frame sex as unnatural in old age appeared to be a barrier for married older women when engaging in conversations around sexual health with a doctor. Compared to women, findings from the same study suggest that a positive relationship with one's spouse may be a protective factor against feelings of discomfort concerning such discussions among older men

Table 4
Barriers to sexual health advice and treatment.

N	Barrier	Details	Author(s), year
1	Cultural views and beliefs toward sexual health	• Negative cultural views of female patients toward engaging in conversation around sexual health	Adams, 2014
		• Negative cultural views of healthcare professionals (e.g. physicians, nurses) & reluctance to initiate conversations around morally controversial issues	Politi et al., 2009
		• Lack of perceived need to talk about sex (in long-term monogamous relationship)	Hinchliff and Gott, 2011
		• Gender differences between men and women toward seeking medical help in general	Hinchliff and Gott, 2011; Fileborn et al., 2017a
		• Gender discordance between doctors and patients	Fileborn et al., 2017a
		• Race discordance between health professionals and patients	Ports et al., 2014; Politi et al., 2009; Taylor and Gosney, 2011
		• Age gap between doctors and patients	Ports et al., 2014
		• Anticipated perceived embarrassment, assumptions and preconceptions of older people related to interactions with health professionals.	Fileborn et al., 2017a; Hinchliff and Gott, 2011; Piliti et al., 2009; Hughes et al., 2013
		• Perceived heavy workload faced by GPs in the UK from the perspective of older people	Hinchliff and Gott, 2011
		• Lack of perception of problem by older people	Hughes and Lewinson, 2014
		• Belief that older people are not a priority group from the perspective of the National Health Service (NHS) and local Department for Integrated Sexual Health (DISH) services (in the United Kingdom).	Nash et al., 2015
		• Hidden diagnosis of STIs and confusion with other symptomatology of infection in women by both health professionals and patients	Nash et al., 2015
2	Stigma, embarrassment and discrimination	*a Stigma and stereotypes*	Chaya and Bernert, 2014
		• Society's stigma toward sexuality of lesbian, bisexual, gay (LGB) elderly	
		• Stigma related to utilising dedicated sexual health services	Youssef et al., 2018
		• Stigma related to being diagnosed with HIV in older age	Youssef et al., 2018
		• Stigma related to sexual orientation or asexuality in older age	Youssef et al., 2018; Nash et al., 2015
		• Stigma around being sexually active in older age	Fileborn et al., 2017b
		• Stereotyping and lack of perceived risk of HIV and STIs in ageing population by both older adults and health professionals	Youssef et al., 2018
		b Embarrassment and fear	
		• Embarrassment and fear of lesbian, bisexual, gay (LBG) elderly toward their sexuality	Chaya and Bernert, 2014;
		• Embarrassment in heterosexual women to talk about sex in older age	Fileborn et al., 2017a;
		• Embarrassment and social discomfort in medical professionals to initiate discussions about sexual health with older patients.	Hughes and Lewinson, 2014; Nash et al., 2015
			Nash et al., 2015
		c Discrimination	
		• Discrimination related to sexual identity in care homes in the USA	Chaya and Bernert, 2014
		• Discrimination of lesbian, gay, bisexual (LGB) elderly by healthcare providers	Chaya and Bernert, 2014
		• Denial of civil and human rights of lesbian, gay, bisexual (LGB) elderly by the U.S. government and influential institutions	Chaya and Bernert, 2014
		• Both heterosexual and lesbian, gay, bisexual (LGB) elderly are a hidden population	Nash et al., 2015
		• Heterosexist attitudes of healthcare professionals towards lesbian, gay, bisexual (LBG) elderly	Nash et al., 2015
		• Considering older people as asexual regardless of their sexual orientation	Fileborn et al., 2017b
		• Absence of older adults from the majority of policies on sex and sexual health	Fileborn et al., 2017b
		• Aged care facilities not adapted to older residents' sexual needs and sexual expression	Fileborn et al., 2017b
3	Lack of education and training of healthcare professionals	• Lack of educational resources, knowledge and research on sexuality specific to lesbian, gay, bisexual (LGB) elderly and to older people in general	Chaya and Bernert, 2014; Politi et al., 2009; Ports et al., 2014.
		• Lack of understanding of elderly lesbian, gay, bisexual (LGB) specific needs	Chaya and Bernert, 2014
		• Non-adapted approach of health professionals to discuss sexual health	Politi et al., 2009
4	Quality of relationship between patients and health professionals	*a Quality of older person-healthcare provider relationship*	Fileborn et al., 2017a
		• Negative, dismissive or stigmatising responses from health professionals	
		• Dismissing and discouraging attitude when older adults request STI tests	Fileborn et al., 2017a
		• Speciality of healthcare provider	Youssef et al., 2018
		• Reluctance to talk about sexual health due to previous negative experiences with healthcare providers	Nash et al., 2015
		• Lack of time to talk about sexual health during medical consultations	Politi et al., 2009
		b Lack of information	
		• Lack of information regarding where to seek HIV/STI test	Youssef et al., 2018
		• Lack of information related to sexual health in older people in general	Nash et al., 2015

(Adams, 2014). Sexual health might also be seen by older people as an unimportant aspect in their lives, as Hinchliff and Gott (2011) found that where older participants engaged in long-term monogamous relationships, they reported that they felt they did not need to talk about sexual health.

4.1.2. Sex in old age seen as immoral and controversial by healthcare providers and physicians

Cultural views toward sex as an immoral and controversial issue were reported by Politi et al. (2009) where healthcare providers such as physicians and nurses were reluctant to initiate conversations about sexual health and intimate relationships with unmarried middle-aged and older women. In addition, if physicians do not think that it is right for older people to be sexually active, then issues may not be discussed at all (Politi et al., 2009).

4.1.3. Specific gender and race differences between older men and women

Gender and race differences were also found to be among the main barriers that stop older adults seeking sexual health advice and treatment. Mixed results and differences between countries were identified. Fileborn et al. (2017a) showed gender differences between older men and women toward seeking medical help in general where women were more likely to seek help than men. The literature review by Hinchliff and Gott (2011) found that male participants in the U.S. arm of the Global Study for Sexual Attitudes and Behaviours (GSSAB) talked to a doctor more often than female participants, but overall the proportion of men and women who reported not seeking help was very similar. In Brazil, twice as many women than men reported talking to a medical doctor about sexual problems. In the European arm of the GSSAB, British men were more likely to talk to a medical doctor, yet women were more likely to do so when they lived in other parts of Europe. The GSSAB study also highlighted some cultural and social differences between countries that influenced the likelihood of seeking medical support for sexual help. For instance, specific sexual difficulties, primarily sexual difficulties and lubrication problems in women were not associated with help-seeking in Korea. In Brazil, erection difficulties were not associated with help-seeking, yet lubrication difficulties for women were. Ports et al. (2014) paper based on audio-recordings of patient-physician communications, revealed that sexual health discussions occurred more often with female patients. Most sexual conversations with women occurred around cervical screening, whereas men's conversations focused on sexual performance, most commonly erectile dysfunction. Sexual performance conversations with female patients tended to be initiated by the patient, while physicians often initiated these with male patients. This may partly explain the low frequency of sexual performance discussions among older women, as patients are more likely to discuss sexual health when the conversation is prompted by the doctor. Thus, sexual performance concerns among older adult female patients may be more likely to remain undetected and, subsequently underrepresented.

4.1.4. Age and perceived experience of the doctor

Age and perceived experience of the doctor may affect women's willingness to discuss sex with their primary care physician, along with preferences for a same-sex physician (Ports et al., 2014). Taylor and Gosney (2011) suggest that General Practitioners (GPs) may recognise that many older people would prefer discussing sexual issues with a doctor of the same gender and as close as their age range as possible. Appointments with colleagues should be offered as appropriate. Hinchliff and Gott (2011) reported a connection between age and reduced likelihood of having contact with a doctor and increasing age plus cohabitation with a partner were found to be related to a decreased desire to discuss sexual matters as well.

4.2. Stigma, embarrassment and discrimination

4.2.1. Stigma and stereotypes

Stigma and stereotypes toward sexuality in older age was one of the largest categories of barriers related to sexual health and treatment, particularly stigma related to sexual orientation or asexuality in older age (Chaya and Bernert, 2014; Nash et al., 2015). Nash et al. (2015) hypothesised that this can be related to the criminalisation of homosexuality in the UK prior to legal reform in 1967. Although, the sexual lives of homosexual men are no longer considered as criminal offence, the shadow of criminalisation may continue to stop older queer adults from discussing their sexual lives with healthcare professionals (Dickinson, 2015). The same author highlighted that there has been sustained campaigning and awareness-rising with queer communities about the transmission of Sexually Transmitted Infections and notably of human immunodeficiency virus (HIV), but more engagement is clearly needed.

Heterosexual older adults also appeared to be stigmatised when utilising dedicated sexual health services or being diagnosed with HIV in older age (Youssef et al., 2018). Stereotyping and a lack of perceived risk of HIV and in ageing populations by both older adults and health professionals was also described in the latter study. Patients formed stereotypes of at-risk individuals (which affected their own perception of risk), but also, they felt that clinicians stereotyped them to be low risk because of their age. In addition, participants acknowledged a lack of understanding about HIV and often held on to outdated views formed as a result of early health promotion campaigns (Youssef et al., 2018). A qualitative Australian study examining older Australians' knowledge and practices related to sex and sexual health highlighted that being sexually active in older age can also be stigmatising and viewed as unnatural (Fileborn et al., 2017b).

Stigma and stereotyping appeared to be related to feelings of embarrassment and fear in both queer and heterosexual participants. Chaya and Bernert (2014) found feelings of fear and embarrassment among queer older people toward their sexuality. Heterosexual women were also embarrassed to talk about sex in older age. They were concerned that physicians would think less of them if they expose their sexual lives (Fileborn et al., 2017a; Hughes and Lewinson, 2014; Nash et al., 2015). Older people were not the only ones who were concerned by such feelings. Nash et al. (2015) reported embarrassment and social discomfort shared by medical professionals who may be reluctant to initiate discussions about sexual history with older people in fear of causing personal offence, evoking responses of embarrassment, or because of negative feelings of disgust, associated with dominant discourses of ageing and sex.

4.2.2. Embarrassment and fear

A range of authors reported anticipated perceived embarrassment, assumptions and preconceptions of older people related to interactions with health professionals (Fileborn et al., 2017a; Hinchliff and Gott, 2011; Piliti et al., 2009; Hughes et al., 2013). Hinchliff and Gott (2011) highlighted that further research is needed to identify whether these beliefs are related to participants' preconceptions or real interactions with their doctors.

Some older people believed that sexual problems are not health problems. Thus, they did not view sexual problems to fall within the remit of medicine. In addition, the willingness of participants to discuss sex with their primary care physician was closely tied to their interpretations of specialist versus generalist domains of health care, with primary care physicians falling into the latter (Hinchliff and Gott, 2011).

Another interesting finding by Hughes et al. (2013) is that when considering taking steps to talk to providers, some women privileged the physical than the emotional component of health. This gives insight into their views of what healthcare providers can provide for them. A focus only on the physical could greatly limit their use of providers as resources. If providers are considered as separated from the emotional and relational aspects of health, women may miss opportunities to manage their health on multiple levels.

The belief that older people are not a priority group from the perspective of the National Health Service (NHS) and local Department for Integrated Sexual Health (DISH) services in the United Kingdom was reported by Nash et al. (2015). The latter authors also highlighted that diagnosis of sexually transmitted infections in older people can be hidden due to confusion with other symptomatology of infection in women by both healthcare professionals and patients. The perception that HIV is a young person's disease, that older people are asexual, or that they find sexual health to be a private topic may also be a barrier (Youssef et al., 2018). Hughes et al. (2013) found that women in their study were sensitive to the opinions and actions of significant others in their lives, and this influenced their intent to engage in communication about their sexual health. Authors concluded that providers can be powerful models of communication behaviour, and through normative pressure increase the likelihood that their clients will follow suit. Women who see this will understand that their provider endorses communication and engages in the behaviour themselves. Beliefs which relate to sex in later life can work in two ways: they can prevent people from seeking help or they can prevent doctors from raising the topic (Hughes and Lewinson, 2014).

4.2.3. Discrimination

Chaya and Bernert (2014) identified societal stigma related to the sexuality of queer older people accompanied with discrimination by healthcare providers and denial of civil and human rights of queer elders by the USA Government and influential institutions. Queer older people were also discriminated by care homes in the USA where their applications of residence in a retirement community were declined. The prevailing assumption that all older people live heterosexual lives may blinker health and social care providers from appropriately responding to queer-identifying older adults or recognising adults in same sex relationships (Nash et al., 2015).

In addition to these heterosexist attitudes, the practice of care workers providing support to older people in residential and nursing settings may be confounded by assumptions of asexuality. This can prevent staff from discussing sexual histories with residents, resulting in this information being absent from residents' care plans (Nash et al., 2015). Both heterosexual and queer elderly seem to be a hidden population, absent from most of the policy on sex and sexual health (Fileborn et al., 2017b). The latter study reported that aged care facilities and other supported living environments are not accommodating of residents' sexual needs and expression. There is a lack of a 'sex-positive' culture that is supportive of residents' sexual needs.

4.3. Lack of education and training of healthcare professionals

Despite a few education resources that address sexual health specific to older persons, such as '*Older, Wiser, Sexually Smarter: 30 Sex Ed Lessons for Adults Only*' by Brick et al. (2009) and '*Naked at Our Age: Talking Out Loud About Senior Sex*' by Price (2011) a perceived lack of educational resources, knowledge and research on sexuality of older people in general was expressed by health professionals in numerous studies (Chaya and Bernert, 2014; Politi et al., 2009; Ports et al., 2014). Although the authors provide a wealth of information and guidance, the above books are not queer focused and lack theoretical underpinnings. Therefore, the Community Readiness Model (CRM) is suggested as a theory-based framework that can help sexuality educators prepare care facilities for planning and implementing sexual health promotion, education, and services for queer elders (Chaya and Bernert, 2014).

Approaches to opening communication about sexual health used by doctors, such as medical intake forms were negatively received by women regardless of partner gender. The authors of this study commented that clinicians use these forms to gather background information rather than as a substitute for communication about relevant topics (Politi et al., 2009).

4.4. Quality of relationship between patients and health professionals

4.4.1. Quality of older person-healthcare provider relationship

Mixed results were found regarding the quality of the relationship between the healthcare professionals and the patients. When perceiving and/or experiencing negative, dismissive or stigmatising attitudes and responses from health providers, older people are less likely to request a sexually transmitted infection test or other information about sex (Fileborn et al., 2017a). However, there is evidence to support claims that clinicians are less comfortable offering HIV and sexually transmitted infection tests to older people (Youssef et al., 2018). Hughes et al. (2013) found that participants in their study were happy to discuss sexual health with their healthcare providers and would generally be happy to accept the offer of an HIV test, even if they did not perceive themselves to be at risk. Most women in Ports et al. (2014) study felt that having the physician initiate the discussion about sexual health when relevant would make the conversations easier for them. In addition, some women believed that providers should ask about sexual history only if they are experiencing an associated health problem.

4.4.2. Speciality of healthcare practitioner

The speciality of the healthcare practitioner was also found to be an important factor. Never married women who partner with women and previously married women reported feeling more comfortable discussing sexual health with a gynaecologist than with a primary care provider (Politi et al., 2009). According to these authors, this hesitancy is consistent with the variability in women's comfort with topics that they consider personal. Women in this study also reported being more likely to disclose information about sexual health if providers did not make assumptions and appeared non-judgmental. Queer women were more hesitant to share information about sexual health because of prior negative experiences disclosing such information to providers (Politi et al., 2009). Healthcare professionals need to create protected time and space for sexual discussion to happen. For instance, many older people attend medical appointments with their adult children and might not feel comfortable discussing sexual issues in front of them (Nash et al., 2015).

4.4.3. Gender discordance between doctors and patients

Gender discordance between doctors and patients was reported by several authors. Consulting a doctor who shares similar demographics to themselves may decrease feelings of embarrassment and help discussions (Fileborn et al., 2017a; Ports et al., 2014; Politi et al., 2009; Taylor and Gosney, 2011). For instance, women reported feeling more comfortable discussing sexual health and intimate relationships with female providers than with male providers (Politi et al., 2009). In addition, Ports et al. (2014) highlighted race discordance as a barrier between patients and health professionals. Being white and female were also associated with engaging in sexual health discussions more often. Given that physician-patient gender and race concordance/discordance predicted sexual health

discussion, extra attention should be paid to training medical students to be comfortable in gender discordant and race concordant patient interactions

4.4.4. Lack of information

Youssef et al. (2018) reported a lack of information regarding where to seek a HIV/ test. In addition, there is a lack of sexual health information targeted toward and provided for the older adult population in general (Nash et al., 2015). Furthermore, a lack of knowledge about what symptoms may be associated with HIV meant participants often attributed symptoms either to ageing or to a condition of which they already had experience (Youssef et al., 2018). The lack of information about sexual health and where to seek sexual health advice and treatment resonates with the lack of educational resources for both older people and healthcare providers internationally.

5. Discussion

Barriers to seeking and receiving advice and treatment for sexual health in later life clearly exist and are both related to cultural and social factors. Overall, the papers reviewed in this scoping study indicate that healthcare providers are reluctant to initiate conversations around sexual health or offer appropriate advice or clinical tests, and that older people tend to be reluctant to seek medical help.

5.1. Normalising sex in later life

Further efforts are needed to normalise sex in later life. This will require changes in social and cultural norms, particularly those defining older people as asexual, and sex in older age as unnatural. Efforts should be made to challenge stigma that surrounds sexuality in older age independently from sexual orientation. Participants in Fileborn et al.'s (2017b) study highlighted that in addition to normalising sex, there is a need to normalise the diversity of sexual expression and desire in later life, rather than only promoting the 'sexy' older person. Some initiatives have already been launched such as the books authored by Joan Price (Davis, 2012). Given that many older people believed they would receive a negative or dismissive response if they attempted to talk to healthcare professionals about sex, there is a need to normalise conversations about sex within healthcare settings by incorporating a discussion on sexual history into more general healthcare discussions. This may happen through the creation of template and example questions with a clear framework for initiating but also responding to discussions around sexual health (Fileborn et al., 2017a). Healthcare professionals need to learn how to proactively raise the topic of sex and sexual health with older people. Previous research showed that a proactive style adopted by the physician can be beneficial to some patients because it establishes that their doctor is open to being asked questions around sexual matters (Laumann et al., 2009; Lindau et al., 2006; King et al., 2007; Moreira et al., 2008; Warner et al., 2008). This could be achieved by ensuring that sexual health across the lifespan is included in both university education and ongoing professional development opportunities and can be effective when the centrality of sexual health to overall wellbeing is recognised rather than viewed as an optional extra (Fileborn et al., 2017a).

5.2. Policy changes

Permanent policy changes for queer older people in long-term care organisations must also be made. For instance, declining an older person's application of residence in a retirement residence based on their sexual or gender identity should no longer be an issue (Chaya and Bernert, 2014). Long-term facilities should also make efforts to include queer older people in their community events, social occasions, advertising, and informational literature. Queer older people and their partners should feel welcomed and could have private time or share rooms with each other (Simpson et al., 2018). Healthcare professionals should broaden the literature with meaningful research that can inform policies and practices to expand the inclusion of queer older people in care communities. As an advancement, major provisions of the Patient Protection and Affordable Care Act were implemented. The policies of this reform are expected to make important changes to the structure of health insurance that as a result may create affordable health insurance options available to individuals who identify as queer and their family members (National Gay and Lesbian Task Force, 2013).

5.3. Education and training of healthcare providers

It is pertinent for sexual health professionals to expand upon their research and knowledge of queer health needs and focus on policies and programming that will prepare geriatric professionals to address the older queer cohort (Chaya and Bernert, 2014). Older adults in general are absent from most of the policy on sex and sexual health (Kirkman et al., 2013; The Kirby Institute, 2018; Poynten et al., 2013). Likewise, education and training for healthcare providers on how to discuss sexual health with older patients may be positive in ensuring that older adults' sexual healthcare needs are met, and in beginning to normalise such discussions within healthcare environments. As reported by Fileborn et al. (2017b), some educative initiatives have been implemented within the Australian context (The OPAL Institute, 2019). However, it is too early to determine their impact.

Clinical interventions should also be developed and should focus on creating services which are flexible enough to meet the different needs of unique demographic groups, including knowledge about older people's specific sexual needs, addressing stigma, assessing different testing methods and how these are initiated, and adapting sexual healthcare delivery to better meet the needs of older people (Youssef et al., 2018). Training in this area may significantly improve these outcomes. The lack of training had largely been identified in previous research where healthcare providers reported barriers to taking a comprehensive sexual history, including inadequate training, insufficient knowledge of sexual health, time constraints, lack of privacy, and personal factors such as age and gender (Loeb et al., 2011; Maes and Louis, 2011). The inclusion of interactive workshops that deliver sexual history and HIV counselling curriculum to medical and nursing students was recommended. Interactive workshops were associated with students asking more thorough sexual histories and providing HIV counselling (Haist et al., 2004). Early HIV/AIDS campaigns were found to promote fear and stigma, and as a result messages should be revisited and made accessible to the older population. National HIV testing week in the UK is successful at promoting HIV testing. However, it is focused on younger populations and men who have sex with men, consequently old people felt it was not adapted and relevant to them (Bath et al., 2016; Youssef et al., 2018).

5.4. Sexual activity in older people & risks for sexually transmitted diseases

More research is also needed to understand general views about acceptability of routine opt-out testing. Routine offers of HIV testing, independently from potential perceived risk, could encourage testing in older people who might not feel comfortable asking for the test or disclosing sexual risk behaviours or their sexual orientation (Alencar and Ciosak, 2016; Nóbrega et al., 2017; Youssef et al., 2018). Another suggestion to encourage testing is to utilise HIV

self-sampling. Even if participants in Youssef et al. (2018) study did not consider this acceptable, previous research has demonstrated that this method was acceptable to people who do not want to use sexual health services or have never been tested for HIV (Brady et al., 2014; Brady et al., 2016). Current UK guidelines recommend that HIV testing should be offered to anyone having a blood test for any reason in an area of high HIV prevalence. Research is needed to better understand whether integrating routine opt-out testing would encourage healthcare professionals to perform HIV testing (Youssef et al., 2018).

5.5. Queer older people

Queer older people seem to be a particularly disadvantaged group (Chaya and Bernert, 2014). Previous research supports this finding and highlights the need to create support groups and informative programmes about their healthcare rights and sexual health in later life, as queer adults deserve the same respect and independence from healthcare professionals as everyone else and desire to maintain their dignity and integrity as they age (Hughes et al., 2011; Neville and Henrickson, 2010).

By designing and implementing queer adults specific support groups, healthcare providers could allow participants to share their feelings, discuss any potential issues when they meet, and talk to other older adults who have the same sexual and/or gender identity as they do. Healthcare providers could also benefit from these support groups as they can have the opportunity to better identify queer individuals' specific needs, provide them education and resources to maintain a higher and healthier quality of life experiences, and evaluate the success of sexual health programmes. Prior research reported that many healthcare providers are not properly trained or culturally sensitive to the needs of queer older people in care settings (Simpson et al., 2018). Therefore, training programmes should address the misconceptions among their healthcare staff regarding sexuality and promote the use of non-bias and open language that will transition queer older people into more comfortable environments (Bell et al., 2010; Carlson and Harper, 2011; Hughes et al., 2011; Neville and Henrickson, 2010).

5.5.1. Recommendations and limitations

There was a lack of consistency across the studies in terms of the questions utilised to gather information around sexual health. Some studies also used convenience samples. This means that participants who were very uncomfortable discussing sexual health might not have volunteered to participate in these types of studies. One of the studies surveyed a SurveyMonkey audience. This sample was self-selected and may reflect the participation by people who have a particular interest in the topic, and thus possible selection bias. All the studies were conducted in developed countries. All review papers included in this scoping review did not provided a clear research strategy, search sources, study selection, and criteria for appraising included studies.

More research is needed to examine in detail the ways to build efficacious therapeutic relationships between healthcare providers and patients when discussing matters relating to sexual health, including specific language healthcare professionals should use to effectively initiate dialogue around this topic; techniques to open discussions around sexual health and sexual history; ways to create a non-judgmental approach; and systems to create protected time and space where conversations around sexual health can be officially implemented.

There is a need to further explore healthcare professionals' experiences and perceptions of their own practices when discussing sexual health with older people. Most of the studies in this scoping review focused on interactions between older patients and physicians (e.g. general practitioners, gynaecologists). Interactions with other healthcare providers should also be studied. Most of the participants of the studies in this scoping review were typically well-educated, English-speaking, with a health insurance (in the USA studies) and comfortable discussing sexual health. Further research should explore populations that did not have access to higher education and who are not English-speaking. In addition, most of the participants were white, which means that Black, Asian and Minority Ethnic people were underrepresented. This raises the question of culture and cultural beliefs as a barrier to seek sexual health advice and treatment. More research on patients' race and ethnicity and how this might impact the therapeutic relationship with providers should be undertaken.

Our findings reported only two interventions related to informing sexual health promotion. These are: The Community Readiness Model (Colorado University. Tri-ethnic Center for Prevention Research, 2014) and the Integrative Model of Behavioural Prediction (IMBP) (Fishbein, 2009). However, these interventions were used as theoretical frameworks to inform discussion and recommendations. There is a need to design, implement and assess effectiveness of interventions that help older adults seeking sexual health advice and treatment. There is a clear lack of interventions on sexual health prevention tailored to older people in the international literature as well. We found no Randomised Controlled Trials. The quantitative studies that we included used surveys and were descriptive in nature.

There is also a limited insight into the experiences of those in deeper age. Most samples from the selected papers for data extraction in this scoping review used large age ranges. However, most of the participants were in their late 50 s and 60 s. Further research needs to include participants aged 70+. Findings also showed that most of the participants in the samples were heterosexual and the queer older people were underrepresented. There is also a lack of systematic and literature reviews, especially on barriers that stop queer older people from seeking sexual health advice and treatment and stigma related to sexual orientation and asexuality.

The search strategy of this scoping review was limited to papers published in English language due to lack of resources for translation. This means that important international literature reflecting the situation where English is not the primary language has not been included.

6. Conclusion

Barriers to seeking and receiving advice and treatment for sexual health in later life clearly exist and are both related to cultural and social factors. The papers reviewed in this scoping review indicate that healthcare providers are reluctant to initiate conversations around sexual health or offer appropriate advice or clinical tests, and that older people tend to be reluctant to seek medical help on sexual matters. Later life age groups, independent from their sexual orientation, represent a hidden population and are absent from sexual health campaigns and government policies. Sexual experiences and sexual desire in older people are often stigmatised and healthcare professionals feel unskilled, undertrained and unprepared to initiate discussions around sexual health in older age. Efforts need to be made by influential institutions and healthcare providers to recognise sexuality in older age and give older people the opportunity to open up regarding their sexual health and experiences.

Declaration of Competing Interest

No conflict of interest has been declared by the authors.

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Supplementary materials

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