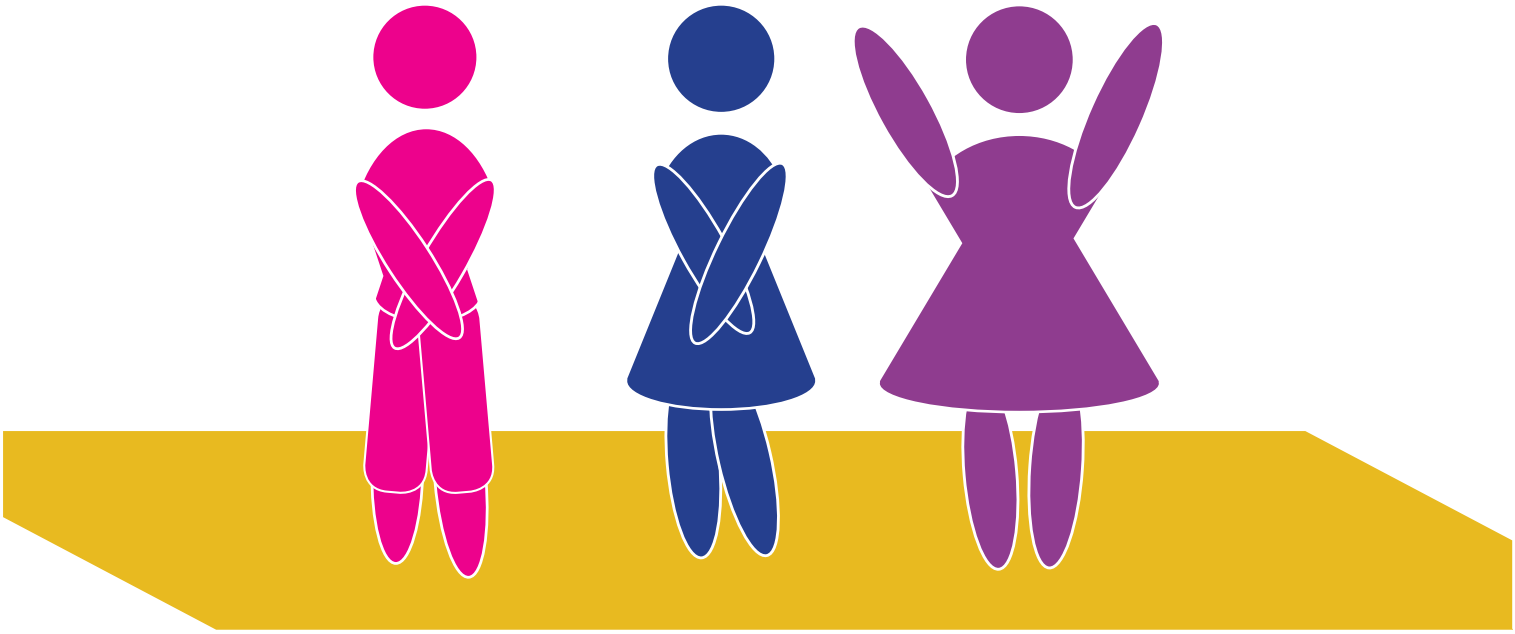
The sexual health of women aged 50 and over:

A Literature Review



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Women's Health in the South East

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Key Summary Points

- Sexual health is recognised as an area of health and wellbeing that is most influenced by social, cultural and religious factors, and moral norms and beliefs.
- Sexual activity has no age limit.
- Sexual health is not merely about reproduction or risk minimisation, but sexual wellbeing.
- Sexual satisfaction is defined in broad terms by women over fifty, not just as sexual intercourse.
- Sexual health has physiological, psychological, emotional and spiritual benefits.
- Literature and sexual health promotion disproportionately targets younger women.
- Insufficient attention is paid to this population group at a research, programs, policy and direct provider level.
- The sexual health of women over fifty is influenced by a range of complex biological, physiological, psychological factors, as well as cultural, social and religious norms and beliefs.
- Increased life expectancy for women, coupled with higher rates of separation and divorce, has resulted in many women aged fifty and over becoming single and seeking new sexual partners.
- There is a lack of information relating to the sexual health of women over fifty who identify as other than heterosexual, as well as women from Culturally and Linguistically Diverse backgrounds.
- Sexual abuse impacts sexual health.
- Women in restricted environments face unique challenges in terms of their sexual health.
- Sexual health and wellbeing plays an important role in successful ageing for women over fifty regardless of socioeconomic and cultural background and sexual orientation.
- Restrictive and confining stereotypes depicting women in this population group as physically incapable, uninterested in sex or asexual, can impact upon their sexuality and overall sexual health.
- Sexually Transmitted Infections (STIs) are increasing amongst the over fifty population in Australia.
- Women aged fifty and over are less likely to practice safe sex than younger women. This has been attributed to: self-perceived low self-risk of STIs and HIV/AIDS; the view that condoms are primarily a method of birth control; and an overall lack of knowledge and skills in negotiating safe sex practices.
- Women over fifty are vulnerable to STIs due to physiological changes.
- Compelling evidence suggests that targeted sexual health promotion is needed.

Part 1.

1. Introduction

Increased life expectancy for women, coupled with high rates of separation and divorce, has resulted in many women seeking new sexual partners in the later stages of life (Idso 2009). Research suggests that women aged fifty years and over[1] do not practice safe sex as frequently as younger women and the incidence of STIs is increasing among this population group (Bateson et al. 2011; Lusti-Narasimhan & Beard 2013; Morton, Kim & Treise 2011). In 2012, WHISE successfully obtained funding from the Ian Potter Foundation Small Grants Program to further investigate the issue of women's sexual health within the local context. Women over the age of fifty from the Southern Metropolitan Region of Melbourne were invited to participate in a focus group, individual interview or a written questionnaire. Through this process, the practices, knowledge and attitudes of women's sexual health were explored. Women from a diverse range of backgrounds participated. Service professionals also took part in the study, providing their expertise and insights into the issue.

The findings of this exploration showed that whilst women were knowledgeable about the importance of cervical and breast cancer screening and completed tests regularly, they did not understand certain aspects of their sexual health such as transmission, prevention and screening for STIs. Sexual health was understood as a narrow term, commonly referred to as heterosexual intercourse, as opposed to a broader concept relating to sexuality, sexual rights and health and wellbeing.

The service professionals who participated reported consulting with women aged over fifty on matters relating to breast and cervical cancer screening or menopausal symptoms, rather than broader discussions on sexual health issues such as sexuality and sexual function.

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[1] Peate (2004) warns that grouping the midlife population group (50-65) with adults aged sixty-five and above risks the promotion of stereotypes. Further, the term 'older women' is used consistently throughout the literature when referring to women aged over fifty (Barrett 2011; Bitzer 2011; Deacon & Minichiello 1995; Howard, O'Neill & Travers 2006; Kirkman, Kenny & Fox 2013). Notwithstanding, for the purpose of this review, women in this age group will be primarily referred to as 'women aged fifty and over'.

Overall women aged over fifty did not readily access information or support in regards to their sexual health. Health professionals expressed uncertainty as to whether it was their responsibility to address matters relating to sexual health, or that of individual women. Both service professionals and women recognised that the sexual practices of women over the age of fifty remains an under-discussed issue at an individual, professional and community level.

The purpose of this literature review is to further explore and unpack the complex social, cultural, biological, legal, moral and religious factors underpinning these findings. Sexual health will be analysed using the World Health Organisation's (WHO) holistic definition that identifies the physical, emotional, mental and social dimensions of sexuality and sexual relationships. The WHO's (2010) *Developing sexual health programs: a framework for action* will be used as a guide for structuring, developing and proposing potential sexual health promotion initiatives and strategies targeting women aged fifty and over.

2. Sexual health, sexuality and sexual rights: an overview

2.1 What is sexual health?

In order to set the context for women's sexual health, it is important to examine the meaning of sexual health and how it relates to, and is underpinned by, the concepts of sexuality and sexual rights. Foremost, the WHO pledges the importance of sexual health to individual health and wellbeing, and views sexual health as a human right (2006a).

The working definition of sexual health is currently defined by the WHO 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*' (WHO 2006a).

Defining sexual health in this holistic way recognises its dynamic nature (Hinchliff & Gott 2008) and acknowledges sexual health as a human right that endures throughout the lifespan. Notably, the definition delineates sexual health from reproductive health. That is, sexual health is considered a broad concept, which unlike reproductive health, is not restricted to age, fertility and reproduction, and does not exclude individuals of diverse sexualities (WHO 2010). The terms are directly and indirectly interlinked, with sexual health being recognised as a vital and necessary aspect of reproductive health (WHO 2010). As the WHO (2010, p.5) explain 'sexuality and sexual relations are central to both reproductive and sexual health'. In keeping with this broad conceptual understanding, the following points outline the key elements of sexual health when viewed holistically and positively:

- Sexual health is about well-being, not merely the absence of disease.
- Sexual health involves respect, safety and freedom from discrimination and violence.
- Sexual health depends on the fulfilment of certain human rights.
- Sexual health is relevant throughout the individual's lifespan, not only to those in the reproductive years, but also to both the young and the elderly.
- Sexual health is expressed through diverse sexualities and forms of sexual expression.
- Sexual health is critically influenced by gender norms, roles, expectations and power dynamics.
- Sexual health needs to be understood within specific social, economic and political contexts (WHO 2010, p.3).

2.2 What is sexuality?

In their publication outlining a framework for action on the development of sexual health programs, the WHO (2010 p. 4) argues that 'Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health'.

The working definition of sexuality is:

'*…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is*

experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors' (WHO 2006a cited in WHO 2010, p. 4).

2.3 What are sexual rights?

The WHO (2004) articulates the links between sexual health, sexual rights and human rights. The following working definition highlights this interface:

'The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws' (WHO 2010, p. 4).

Furthermore they state:

'The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all women's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination' (WHO 2006a cited in WHO 2010, p. 4).

Yet Lottes (2013) cautions that the meaning of sexual rights often remains unclear insofar as the terms human rights and sexual rights are often used interchangeably, without an adequate explanation. Lottes (2013) suggests that in order to facilitate effective and appropriate sexual health initiatives, professionals working in this area must first understand the meaning of human rights within this context. Human rights span multiple domains relating to equality, dignity, diversity/non-discrimination, entitlements, autonomy/self-determination/personhood, interconnectivity, nation-state responsibility and entitlements (Idso 2009). It is beyond the scope of this paper to unpack these complex meanings. Instead, the critical importance of sexual rights in the realisation of sexual health and the interplays between sexuality, sexual rights and sexual health will be the primary focus. The WHO (2010 p.4) outlines the critical sexual rights in the following points:

- The rights to life, liberty, autonomy and security of the person.
- The rights to equality and non-discrimination.

- The rights to be free from torture or to cruel, inhumane or degrading treatment or punishment.
- The rights to privacy.
- The rights to the highest attainable standard of health (including sexual health) and social security.
- The rights to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage.
- The rights to decide the number and spacing of one's children.
- The rights to information, as well as education.
- The rights to freedom of opinion and expression.
- The rights to an effective remedy for violations of fundamental rights.
- The application of existing human rights to sexuality and sexual health constitute sexual rights.

The WHO (2010, p. 4) further emphasise that 'sexual health cannot be achieved and maintained without respect for, and protection of, certain human rights' and for 'sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled'. To date, sexual rights literature has been mostly concerned with human rights violations of sexual and gender minorities, along with other marginalized populations such as sex workers, women with disabilities and women with HIV/AIDS (Lottes 2013), as opposed to the sexual rights of the general population of women over fifty.

3. Learning from the literature: the sexual health of women over fifty

3.1 Sexual health, health and wellbeing, and illness

It is widely acknowledged that populations around the world are living longer and healthier lives (Lusti-Narasimhan & Beard 2013). As such, adults are remaining sexually active for longer periods (Schick et al. 2010). Bateson et al. (2011) highlight that Australians are staying healthier for longer and hold expectations to continue sexual activity. Although it

has been suggested that the frequency of sex may decline as women age (Robinson & Molzahn 2007), and there remains a lack of consensus on what constitutes 'normal' sexual function for women over fifty (Dana R Ambler 2012; Howard, O'Neill & Travers 2006), a growing body of literature suggests that women in this age group are enjoying and engaging in sexual activities well into advanced age (Peate 2004; Robinson & Molzahn 2007; Schick et al. 2010; Syme et al. 2013). In this sense, sexual activity has no age limit and can be enjoyed well into the nineties and beyond (Comfort 1977). It is also important to acknowledge the broad terms in which women usually describe sexual satisfaction. Beyond the age of fifty, the emphasis and focus often shifts from sexual intercourse and passion (Clarke 2006) towards sexual expression, intimacy, companionship, cuddling and affection (Muliira & Muliira 2013).

The importance of sexual health in the promotion and maintenance of health and wellbeing among adults over fifty is becoming increasingly evident (Lusti-Narasimhan & Beard 2013). Sexual health has physiological, psychological, emotional and spiritual benefits (Bach et al. 2013; Muliira & Muliira 2013), contributes to a person's 'dignity and social life' (Muliira & Muliira 2013, p. 469) and is consistently connected to increased quality of life (Hughes 2013; Robinson & Molzahn 2007; Rohde, Berg & Haugeberg 2014). Research by Diokno et al. (1990) found that men and women who were sexually active after the age of fifty reported greater life satisfaction. More specifically, sexual activity is associated with physical benefits such as cardiovascular health, increased relaxation, physical benefits of exercise, and decreased pain sensitivity (Syme et al. 2013), as well as emotional benefits such as decreased levels of depression, increased psychosocial well-being, overall quality of life, and self esteem (Syme et al. 2013). In this regard, Bitzer (2011) refers to sexual health as a 'health resource' for its ability to counteract the various physical and mental ailments older adults are often confronted with. Indeed, sexual health is consistently identified as integral to overall health and wellbeing (Howard, O'Neill & Travers 2006; Syme et al. 2013), and a vital part of healthy ageing (Hinchliff & Gott 2008; Syme et al. 2013).

Despite more adults living longer and as such engaging in sexual activity for longer, sexual activity can decline in frequency or change in type as women age (Clarke 2006; Smith 2009). The reasons for this are complex and reflect biological, psychological and social factors

(Hinchliff & Gott 2008). Menopause, for instance, is noted as a time when many women may experience a loss in sexual desire and cease sexual activity (Hinchliff & Gott 2008). A variety of factors influence sexual function for women during this transitional period including physiological and hormonal changes associated with menopause such as decreased vaginal lubrication (Muliira & Muliira 2013;Gleason-Comstock et al. 2008), as well as adverse effects of medications (Huang et al. 2009). Yet most often, this decline has been attributed to the lack of availability of a partner, due to divorce, separation or death, relationship quality or male sexual dysfunction (Schick et al. 2010). Erectile dysfunction, for instance, can impact upon sexual health and can be a source of tension for women who are in relationships (Guest & Das Gupta 2002 cited in Hinchliff & Gott 2008).

Other health conditions can impair the sexual health of women as they age including certain chronic diseases such as dementia, arthritis, multiple sclerosis, diabetes, hypothyroidism, bladder/bowel problems and renal failure (Muliira & Muliira 2013; Bach et al. 2013). These conditions lead to pain and mobility issues, which can directly affect sexual function (Muliira & Muliira 2013). In addition, the treatments for these health issues can compromise sexual health by suppressing sexual desire and sexual arousal, thereby making it difficult for women experiencing health problems to enjoy sex (DeLamater & Sill 2005). Whilst health issues and their treatments can directly affect sexual functioning in a physiological sense, they may also psychologically by undermining a person's bodily image or self esteem (Peate 2012). This in turn may exacerbate conditions such as anxiety and depression (Hinchliff & Gott 2008). Hinchliff and Gott (2008) suggest that health problems impacting upon psychological health can be problematic for sexual relationships, which in turn, further affects mental health. Lusti-Narasimhan and Beard (2013) explain that this negative cycle affects women differently across the age group, whereby the lived experiences of women in their fifties will differ to those in their seventies.

Notwithstanding the many potential factors that can impact upon sexual health, Deacon and Minichiello (1995) argue that it should not be assumed that the physical and pathological changes associated with ageing will impact upon a woman's ability to enjoy sex. Rather, emerging evidence challenges the commonly held belief that female sexual function declines with age (Deacon & Minichiello 1995; Huang et al. 2009) and suggests most women

do not lose their sexual desire as a result of ageing (Hinchliff & Gott 2008). Following their analysis of ten academic research papers, Muliira & Muliira (2013) concluded that women over fifty regularly engage in satisfying sexual activity. Moreover, Hinchliff and Gott (2008) suggest that women experience a sense of sexual freedom following menopause as they are no longer concerned with becoming pregnant. For women in their thirties and forties, tiredness and stress mainly associated with child-care and work demands impact upon their sexual health (Hinchliff & Gott 2008). On the other hand, women whose children have left home experience a new found sense of freedom, and cite a sense of liberation and an increase in sexual desire (Hinchliff & Gott 2008). This view is in direct contrast to the commonly-held belief that women become asexual as they age (Lusti-Narasimhan & Beard 2013).

3.2 The broad determinants of sexual health

Social, moral, religious and cultural beliefs and ideologies define what the acceptable and appropriate sexual behaviours are for women over fifty (Hinchliff & Gott 2008; Peate 2004; Ross, Humble & Blum 2013). For instance, whilst many women over the age of fifty experience a new found sense of freedom, many newly separated, divorced or widowed women can find this time emotionally challenging, thereby affecting their self-esteem and body image (Idso 2009). Idso (2009) notes that this time marks a general loss of identity, wherein redefining oneself and exploring new relationships can be especially challenging. Bitzer (2011) explains that women in mid to later life can experience a subjective loss of attractiveness, negative body image and loss of self-esteem, and that negative expectations and performance anxiety can act to maintain sexual problems in a self-monitoring way. Such implicitly held notions can impact upon how women over fifty may feel and view themselves. Lusti-Narasimhan & Beard (2013) suggest this internalisation could drive women to conceal their sexuality in order to fit in with social norms (Lusti-Narasimhan & Beard 2013).

Negative discourses and stereotypes can also impact upon women's psychological well-being. For example, Hinchcliff & Gott (2008) explored the discourses that women find themselves navigating from the age of fifty and over. For the most part, the discourses

were found to reinforce the idea that women lose their sexual desire post-menopause and menopause has become synonymous with ageing and loss of femininity (Hinchliff & Gott 2008). This bio-medical construction operates alongside other discourses that generally regard sex as less important in later life. Societal expectations which consider a man's sexual satisfaction as the responsibility of the woman undermine the sexuality of women over fifty, along with discourses that promote the 'sexy oldie' stereotype, which can be disempowering as it constructs sex in a strict oppositional way that limits alternative choices (Hinchliff & Gott 2008, p. 67).

Overall, discourses on sexuality for women over fifty generally regard their sexual needs, desires and interests as unimportant, and these constructs have been noted as being more influential on how a women feels and behaves than physiological factors (Hinchliff & Gott 2008). More typically, sexual health is confined to stereotypical images of young, healthy and beautiful sexually active women (Barrett 2011), whereby images and stereotypes of older women usually depict them as being physically incapable and/or uninterested in sex, or asexual (Barrett 2011). In this way, Baldissera et al. (2012) argue that women's sexuality is controlled by society. It is important to challenge these values, assumptions and ageist beliefs as these factors can influence the attitudes, values and behaviours of older women (Minichiello et al. 2012). This point will be explored in further detail in Part 2.

3.4 Sexual health research

Despite the growing body of literature citing the importance of sexual health to positive ageing, and the WHO's assertion that sexual health is a human right, most cultures remain 'silent on the subject of sexuality later in life' (Muliira & Muliira 2013, p. 471). Research and literature on sexual health disproportionately targets young women (Idso 2009; Smith 2009) and this area remains comparatively under-researched despite its relevance to an ageing population. Hinchilff and Gott (2008) explain that it is common to exclude women over the ages of fifty-nine in sexual health research. Likewise, national sexual health strategies have largely overlooked adults over fifty (Bourne & Minichiello 2009), and studies relating to the epidemiology of STIs in this age group continue to receive limited attention in the literature (Bourne & Minichiello 2009). This disparity reinforces the deeply held societal assumption

that sexual activity is the domain of the young (Hinchliff & Gott 2008), and that young people are at greater risk of STIs (Bateson et al. 2011; Hinchliff & Gott 2008).

3.4.1 Sexual health research and sexual orientation

Whilst literature that document health disparities by sexual orientation are beginning to emerge, Fredricksen-Goldsen et al. (2013, p. 1802) comment that sexual health research among women who identify as other than heterosexual is 'glaringly sparse'. Although little is understood on their specific sexual health needs, women in this group were more likely to suffer from disability, poor mental health, smoking, excessive drinking and obesity. The elevated risks of disability and poor mental health have been attributed to experiences of stigmatization, discrimination and victimisation throughout the life span (Fredriksen-Goldsen et al. 2013). In light of the limited available information, sexual health research is needed if responsive and appropriate sexual health promotion programs and policies are to be developed that support and foster understanding around diversity and sexual rights.

3.4.2 Sexual health research and women from Culturally and Linguistically Diverse backgrounds

In terms of understanding the sexual health of women over fifty from Culturally and Linguistically Diverse (CALD) backgrounds, Huang et al. (2009) carried out research in the United States which showed sexual desire, satisfaction and activity varied greatly among these women according to race and ethnicity. Differences in environmental factors influencing sexual activity, as well as cultural differences in expectations about sexual activity, were recognised as possible causes to explain these differences (Huang et al. 2009). In addition, the authors acknowledged that cultural differences may influence the women's willingness to divulge their sexual health status and needs (Huang et al. 2009). Huang and et al. (2009) stipulate the need for further research to assess the cultural differences in sexuality and sexual health, which can provide evidence to develop relevant and effective sexual health promotion and policy initiatives.

3.4.3 The sexual health of women in restricted environments, and sexual abuse

For women in restricted environments, such as long-term care settings or for those women living with a caregiver, issues relating to their privacy or lack of approval from their caregivers or healthcare providers can directly impact upon their sexual health (Muliira & Muliira 2013, p. 470). According to Mulligan and Modigh (1991) biases of the caregiver are often imposed upon the resident which can lead to tensions and uncertainties. Lichtenberg and Strzepek (1990) explain that varied social, moral, cultural, educational and religious backgrounds may distort and influence their perception and attitudes towards residents' needs. Aged care facilities with religious connections have been known to actively suppress and discourage the formation of new relationships, in particular same-sex relations. In recognising sexual health as a human right, together with the findings that suggest increased sexual activity within retirement communities is associated with positive physical, social and emotional health outcomes (Bach et al. 2013), staff should be guided by their duty to provide an environment which aims to protect and fulfil the needs and desires of residents, whilst at the same time, remaining vigilant about preventing sexual abuse of vulnerable residents.

Sexual abuse, violence and experiences of separation and abandonment can also affect the sexual health of women over fifty. Bitzer (2011) states that:

'Traumatic experiences, learned misconceptions and myths about sexuality and violations of self esteem are general mechanisms that may lead to long-term damage to the personal development of one's sexual health' (Bitzer 2011, p. 683).

4. Safe sex and STIs

Increased rates of divorce and separation, or the loss of a partner due to death or serious illness requiring hospitalisation (Schick et al. 2010), has contributed to many women seeking new sexual partners later in life (Bateson et al. 2011). In line with this trend, and despite some sexual health promotion messages (Schick et al. 2010), research shows that condom use in adults over fifty remains relatively low (Bourne & Minichiello 2009; Schick et al. 2010). This trend has been attributed to the belief that younger women are at increased risk of STIs (Smith et al. 2010), that condoms are primarily a method of birth control (which

is assumed to be no longer applicable to adults over fifty) and to an overall lack of knowledge with regards to safe sex practices (Gleason-Comstock et al. 2008; Lusti-Narasimhan & Beard 2013). This lack of knowledge increases the risk of adults over fifty being exposed to STIs and HIV/AIDS, which consequently exposes others to these infections (Lusti-Narasimhan & Beard 2013). Lusti-Narasimhan and Beard (2013) suggest that women in particular are more vulnerable to STI exposure due to the physiological changes that occur during menopause in which the lining of the vagina walls starts to thin and can be more easily torn (Lusti-Narasimhan & Beard 2013). Additionally, immune function decreases across the lifespan, further increasing the risk of infection (Ongradi & Kovesdi 2010).

Ascertaining exact statistics on STI prevalence amongst the population of adults over fifty is difficult with Lusti-Narasimhan and Beard (2013) reporting that most research fails to compile statistics of STIs and HIV/AIDS among women fifty years and over. This oversight is compounded by certain factors such as an ageing population, the assumptions made by health professionals that adults over fifty are not at risk of STIs, and the tendency for healthcare providers to mistake symptoms of STIs and HIV/AIDS for other common health concerns for this age group such as Alzheimer's disease, diabetes, menopause, and prostate problems in men, or non-specific respiratory problems in women (Lieberman 2000). On top of this, research into this area can be problematic with adults over fifty displaying some reluctance to divulge details of their sex lives (Smith 2009). These confounding factors make it very difficult to ascertain reliable statistics for this age group. Nevertheless, Lusti-Narasimhan and Beard (2013) indicate that from a global perspective, it is very likely that the incidence of STIs is on the rise in this population group. In relation to local data, research by Bateson et al. (2011) suggests the prevalence of STIs is increasing among Australian women over fifty. More recently, findings by Minichiello et al. (2012) similarly indicate that STIs are increasing in the fifty and over population group.

In recognition of the increase in the number of women re-partnering later in life, the internet provides an important resource for women seeking new long-term partnerships or casual sex partners. Exploring this, Bateson et al. (2011) conducted an online survey connected to the internet dating site RSVP. Findings revealed women over fifty were

overrepresented in their sample compared to the overall RSVP membership. Respondents were mostly Australian-born, English-speaking, single and seeking a long-term partner. The most common reasons for women seeking new partnerships were due to divorce, separation and becoming widowed (Bateson et al. 2011). Findings indicated that women over fifty, who were meeting new sexual partners via this internet dating site, were at an increased risk of STI acquisition. This was because prior to meeting in person, conversing electronically enabled them to feel more comfortable and broke down personal barriers between them and their date, that would have otherwise been present without this form of courtship (Bateson et al. 2011). This made them more likely to engage in unsafe sex practice earlier on in their relationship (Bateson et al. 2011).

In addition, Bateson et al. (2011) noted other factors which placed women using internet dating sites at increased risk of STIs including reduced vigilance regarding the use of condoms, difficulties in negotiating the use of condoms, concerns about genital irritation from condoms, as well as perceived low risk of infection (Bateson et al. 2011). Bateson et al. (2011) attributed the lack of knowledge and skills in negotiating safe sex practices to the absence of safe sex campaigns, which to date, have predominately targeted a younger audience.

4.1 Sexual health and the healthcare system

Whilst healthcare providers have a unique opportunity to educate women over fifty about the importance of safe sex, STI transmission, and negotiation and communication skills with new partners (Idso 2009), in practice, very few women over fifty discuss their sexual problems or concerns with their healthcare providers (Idso 2009) when compared to younger women (Nusbaum, Singh & Pyles 2004). Various factors have been found that might inhibit open discussions between female patients and healthcare providers. Many women over fifty, as well as health professionals, were brought up in a conservative environment where open communication about sexual health was not discussed. These implicit cultural and social understandings influence knowledge levels, behaviours and attitudes, which in turn, can impact upon the level of comfort and willingness in raising sexual health concerns, and therefore stifle positive exchanges (Ross, Humble & Blum 2013).

More specifically, from the perspective of many women over fifty, issues such as the age and gender of the healthcare provider (Nusbaum, Singh & Pyles 2004), feelings of shame, embarrassment, fear of possible negative judgement, as well as a lack of knowledge concerning sexual health-related services all act as barriers (Muliira & Muliira 2013; Adams 2014; Bitzer 2011; Lindau et al. 2007). In contrast, the healthcare providers own attitudes towards later-life sexuality, the attribution of sexual problems to the normal ageing process, the perception of women's sexual problems as 'not serious' or low risk, embarrassment, and ageist perspectives and attitudes can also act as a barrier to addressing women's sexual health concerns (Gleason-Comstock et al. 2008; Lindau et al. 2007; Tomlinson 1998).
The implications for this lack of communication are broad:

- It reduces the likelihood that women over fifty are being screened for STIs (Lindau et al. 2006).
- Primary care physicians may mistakenly conclude that sexual issues are 'unimportant to divorced or widowed mature women' (Grant & Ragsdale 2008, p. 495).
- Lack of 'acknowledgement of older women's sexuality impacts at a service delivery level and reduces the likelihood of health professionals completing sexual histories or suggesting any type of sexual testing' (Kirkman, Kenny & Fox 2013, p. 135).
- It reinforces ageist values and beliefs based on age and gender biases that women over fifty are asexual (Grant & Ragsdale 2008) and that younger women are more sexually active and thereby at greater risk of STIs (Grant & Ragsdale 2008).
- Ignoring sexual concerns can be to the detriment of the creation of intimate relationships, which in turn, can impact negatively upon mental health and wellbeing (WHO, 2010).
- Healthcare professionals may overlook the important role sexual affection and intimacy plays in the establishment and maintenance of healthy relationships and overall individual well-being (Muliira & Muliira 2013, p.469).
- It is important that sexual dysfunction in women over fifty, which includes women from CALD backgrounds and those with diverse sexual orientations, be considered by healthcare providers as it is commonly associated with depression and low quality-of-life scores (WHO 2010).

Given that sexual health has been linked to overall positive health and wellbeing (Muliira & Muliira 2013), it is essential that healthcare providers adequately facilitate discussions relating to sexual health and do not impose barriers that devalue their sexual health needs. Thus, it is not enough to be ideally placed: healthcare providers need to also demonstrate empathy and understanding towards the patient in order to encourage disclosure of intimate feelings concerning sexual health (Peate 2004, p. 188). Trust, non-judgemental attitudes, and recognising the turbulent time of women over fifty redefining themselves are considered important factors that encourage open communication (Idso 2009).

Part 2.

5. Sexual health promotion

Compelling evidence suggests that targeted sexual health promotion initiatives are needed for women over fifty (Idso 2009; Lieberman 2000). At present, insufficient attention is paid to this population group in terms of sexual health at a research, policy and direct provider level. In a similar way, Barrett (2011) attributes the paucity of targeted sexual health promotion initiatives across the spectrum of healthcare agencies, human service organisations, and aged care facilities and governments, to sexual ageism.

When discussing the integral components of sexual health promotion, the WHO (2010) recognises that the potential for men and women to achieve sexual health and wellbeing depends upon a range of factors including access to comprehensive information about sexuality, knowledge about risks and vulnerability to the adverse consequence of sexual activity, access to good-quality sexual healthcare, and an environment that affirms and promotes sexual health.

The WHO (2010) offers a rights-based approach to sexual health promotion and recommends a multi-sectoral approach that crosses five key domains, these being:

- Laws, policies and human rights
- Education

- Society and culture
- Economics
- Health systems

5.1 Laws, policies and human rights

In essence, the role of policy relating to sexuality is to reinforce legislation and to support a range of health promotion measures (Kirkman, Kenny & Fox 2013, p. 145). In their developing sexual health programs framework document, the WHO (2010, p. iv) emphasises the 'need for governments to promote healthy sexuality throughout the individual's lifespan'. However, as stated previously, in Australia and other countries, policy and resources are often directed toward young women, particularly towards STI and teen pregnancy (Smith 2009). Policies also concentrate on reproduction, which is not always applicable to women in same-sex relationships and post menopausal women (Kirkman, Kenny & Fox 2013).

In their review of Australian federal, state and territory government health policy documents, Kirkman et al. (2013 p. 135) found that the 'sexual health of midlife and older adults was not specifically referred to in most documents'. Moreover, they did not find any policy specific to midlife and older adult sexuality and sexual health (Kirkman, Kenny & Fox 2013, p. 135). They argue that until a national sexual health policy is developed that supports and promotes positive sexual health, health promotion and STI testing strategies will continue to overlook the sexual health needs of adults over fifty. Lack of sexual health policies that support and promote sexual health among adults over fifty is also evident in international literature (Kirkman, Kenny & Fox 2013).

The clear absence of policy relating to the promotion of sexual health amongst the over fifty population directly reflects the overall paucity of research and health promotion initiatives. It also testifies to the narrow terms in which sexual health continues to be viewed across governmental spheres, healthcare systems and the broader population (Kirkman, Kenny & Fox 2013). Several authors argue the importance of recognising the sexual health and wellbeing of adults over fifty at a policy level, and the equal importance of employing and

supporting the WHO's holistic definition (Hinchliff & Gott 2008; Kirkman, Kenny & Fox 2013; Peate 2004). Peate (2004 p. 190) posits that for sexual health policies to be underpinned by the broader meaning of sexual health, political discussions 'must be deliberated in a more open and transparent manner'. Indeed, sexual health issues are relevant to women's continued health and wellbeing (Grant & Ragsdale 2008) and as such, resources and efforts need to be allocated to devising policies that support this.

Table 1: Laws, Policies and Human Rights Action Plan:

Health Promotion Action	Strategies	Population Target Groups	Settings For Action
Policy and legislative reform	Influence and inform government planning Education and workforce development for private medical providers STI and HIV/AIDS prevention strategies	Government policy makers Healthcare Providers	Local Government Medical Services

5.2 Education

The role of education in the promotion of sexual health for women over fifty will be discussed in relation to promoting sexuality and avoiding risk, E-health promotion, and the use of traditional educational options such as brochures and pamphlets.

5.2.1 Exploring the evidence-base

Lusti-Narasimhan and Beard (2013) directly link the lack of available education and information to poor safe sex practices. And according to Ross et al. (2013) this failure to educate further contributes to societal notions that STIs are not a threat to the over fifty population. Not only is sexual health promotion urgently needed to minimise risk, but having good knowledge levels about sexual health may contribute to healthy relationships in women over fifty (Ross, Humble & Blum 2013) and the promotion of sexual health in women over fifty has been linked to improved emotional wellbeing (Barrett 2011). Given the multiple potential benefits, Barrett (2011) urges practitioners working with adults over fifty across the spectrum to embrace sexual health promotion.

In 2012, Family Planning NSW (2012-2013, p. 12) launched an educational campaign targeting women forty years and over entitled *Little Black Dress,* citing the mantra 'safe sex is an easier conversation to have with your clothes on'. The campaign aimed to reduce the risk of STI contraction through education and raising awareness on the importance of wearing condoms in new relationships. Family Planning NSW identified this campaign as an Australian first, and as a result, the campaign made international headlines. Strategies employed included a YouTube clip, media exposure, online information articles uploaded to the RSVP *Over 50 and Fabulous* website, along with the dissemination of safe sex packs comprising of a condom and lubricant.

This campaign focused upon risk prevention, as opposed to the promotion of positive approaches to sexual health and wellbeing. Avoiding negative outcomes is typically adopted by policy, researchers and health promotion practitioners (Kirkman, Kenny & Fox 2013). However, a limitation of the risk prevention focus is that it excludes a practical education component where women learn the skills required to negotiate the use of condoms. Bateson et al. (2011) suggest that women over fifty would benefit from such skills-based education because the internalization of sexist and ageist attitudes, as well as discrimination based upon their age and gender, can impact upon a woman's willingness to discuss condom use openly with a new sexual partner.

A second limitation is that this campaign did not challenge ageist and sexist constructs. Whilst tackling such overarching constructs is difficult (WHO 2010), they should be considered when developing sexual health promotion initiatives as negative societal notions can inhibit and undermine a women's capacity to negotiate condom use. More generally, negative constructs can also hinder a women's ability to increase knowledge regarding sexual health (Ross, Humble & Blum 2013, p. 167). Overall, sexual health promotion that works positively within social, cultural and religious norms has the potential to debunk assumptions and positively influence societal and individual attitudes, beliefs and behaviours (WHO 2010).

An example of a sexual health promotion initiative that moved beyond the focus of risk prevention was undertaken in the United Kingdom (Smith et al. 2010). An ageing

population, rising rates of STIs amongst the over fifty population, coupled with increasing divorce rates and apparent low awareness of safe sex practices, prompted the service professionals to devise a comprehensive program that aimed to improve the quality of life of adults over fifty based upon the WHO's holistic understanding (Smith et al. 2010). The program worked at both a strategic and operational level and strategies included the development of a paper resource filled with a series of health messages and positive images of adults over fifty which aimed to normalise sexual needs, desires and activities. This approach generated a lot of media interest. As part of their comprehensive approach, the author implemented other strategies, which included:

- Training of healthcare providers on matters relating to sexual health of adults over fifty.
- Adults over fifty were the primary focus of sexual health week.
- Creating a citywide HIV prevention program for adults over fifty (Smith et al. 2010).

5.2.2 Promoting sexuality

Educational initiatives should also focus upon sexuality. Muliira and Muliira (2013, p. 472) state that 'knowledge about sexuality in later life is associated with a more positive attitude towards sexuality of older women'. Meanwhile, Lusti-Narasimhan and Beard (2013, p708) highlight that women would benefit from accessing health education where they can 'learn how to find ways to express their sexuality'.

A program undertaken by Baldissera, Bueno and Hoga (2012) involving the education of twenty women aged sixty in a rural area in Brazil tackled the broader issues of sexuality and societal stereotypes. The authors aimed to provide opportunities for these women to discuss and build a new configuration of sexuality (Baldissera, Bueno & Hoga 2012). The women participated in a series of group health sessions that enabled them to discuss issues and concerns relating to sexuality, as well as engage in relevant educational activities. Discussions and activities covered topics such as:

- Challenging the adoption of expected societal behaviours regarding ageing.
- Social images of young women as being associated with sex and beauty.

- Social imagery shaping women's sexuality.
- Lack of a partner as the major obstacle confronted by women in their expression of sexuality.
- Critical discussions on gender relations.
- Reshaping perceptions on sexuality based on cultural beliefs and values.

The authors' noted that 'passive attitudes of the participants were replaced by active attitudes, and the shame in discussing some themes, such as gender relations, sexuality, family, and social roles, was overcome and then freely approached' (Baldissera, Bueno & Hoga 2012, p. 961). It was concluded that the promotion of women's sexuality, which had never been done before in this context, had far reaching benefits, and 'the capacity to experience sexuality, in multiple possibilities, should be encouraged within sexual health promotion activities' (Baldissera, Bueno & Hoga 2012, p. 961).

Baldissera et al. (2012) also recognised difficulties in transmitting the messages. All women have their own internalised view or 'sexual script' (Bitzer 2011) and as such, attention needs to be paid to verbal and nonverbal communication strategies, as well as delineating the different meanings of terms and messages, and how they are received and transmitted (Baldissera, Bueno & Hoga 2012). They emphasised the importance of reshaping the paradigm of women's sexuality across the generations so that younger populations accept and recognise women's experiences, which will subsequently enable women over fifty to live more freely in regards to their sexuality. Interrupting the cycle that confines sexuality to youth is integral to allowing a new paradigm that promotes a constructive, positive and unprejudiced view with regards to women over fifty (Baldissera, Bueno & Hoga 2012; Howard, O'Neill & Travers 2006).

Featuring a component aimed at increasing knowledge and understanding on the normative physiological changes associated with menopause and ageing is also considered integral to modifying attitudes towards women's sexual health. For example, Lusti-Narasimhan & Beard (2013) emphasise the importance of educating women on how to adjust to bodily changes across the lifespan. Ross, Humble and Blum(2013) expand on this point, arguing that increased knowledge on sexual development across the latter stage of the lifespan may

encourage women over fifty to seek further knowledge about HIV/AIDS or other STIs (Ross, Humble & Blum 2013, p. 176).

5.2.3 E-health

The internet is recognised as an important medium for education based sexual health promotion. E-health services are defined by Minichiello et al. (2013) as 'internet-based healthcare delivery characterised by the movement away from tele-medicine and tele-health' which can be used within the health sector for clinical, educational, preventative, research and administrative purposes (Minichiello et al. 2013, p. 790). The authors highlight that E-health services need to comprise of information that is current, clinically valid and effective, and should include preventative approaches for various client groups with diverse needs.

The internet is the preferred source for many consumers to learn about sexual health as it provides the opportunity to avoid potentially awkward discussions with healthcare providers as well as family and friends. In this regard, the internet offers anonymity, is non-discriminate and convenient, maintains privacy and confidentiality, as well as providing interactive information and solving mobility issues (Minichiello et al. 2013). Yet there are factors which affect the efficacy of E-health resources. These include: community inequalities, upholding quality of information, difficulty in targeting specific group, education levels, cultural and language differences, access to technology, user-friendliness, accuracy and reliability of information, avoiding too much information, and disorganisation and search difficulties (Minichiello et al. 2013).

Although the topic of sexual health is one of the most commonly explored on the internet for adults over fifty (Minichiello et al. 2013), most studies have looked at how young women engage with these outlets (Minichiello et al. 2013). As a result, the majority of websites focus on STI prevention and avoidance of unwanted pregnancies. Upon reflection of these shortcomings, Minichiello et al. (2013) recognise the potential to include a broad range of topics for the over fifty population group.

5.2.4 Information and resources

In addition to skill development initiatives and information sharing using platforms such as websites, providing brochures is regarded as a key element to increasing sexual health knowledge and awareness (Idso 2009). The brochures need to be informative and non-judgemental, whilst remaining mindful of culture, language and health literacy levels. Topics could address normative physiological changes associated with ageing and their effects on sexual health, and issues regarding sexuality and communication skills when discussing condom use with a new partner (Hinchliff & Gott 2008). The brochure could be distributed through healthcare agencies, community groups such as divorce support groups and widow care groups, to name a few (Peate 2004).

Table 2: Education Action Plan:

Health Promotion Action	Strategies	Population Target Groups	Settings For Action
Communication and social marketing Community education and capacity building Sector and workforce development Research, monitoring and evaluation	Local media exposure Online information articles Infographics YouTube clip(s) Paper resources: brochures, pamphlets etc Community wide campaigns Embedding messages online Feature articles for organisational/business newsletters WHISE's social media channels: Facebook and Twitter Community sexual health education sessions Training and workforce developed for healthcare providers	Primary target group: All women[2] living in metropolitan, rural and semi rural areas Secondary target groups: Women with a disability Widowed, divorced and separated women Women from migrant and refugee backgrounds Women from CALD backgrounds Lesbian, bisexual, transgender and intersex people Aboriginal and Torres Strait Islander women	Online Medical providers Local and Melbourne-wide newspapers Age and gender specific blogs SMR local government areas Community centres Women's sports clubs Workplaces Volunteer organisations

[2] All references to women refer to the fifty and over population group.

5.3 Society and culture

Sexual health promotion should attempt to deconstruct stigmatized societal views and provide a more holistic and legitimized view of women's sexuality (Baldissera, Bueno & Hoga 2012). Focus should be directed towards the dehumanising barriers that impinge upon the sexual identity of women over fifty and the difficulties they experience in expressing themselves. Initiatives should challenge the current limited definitions of sexual health as being about young women and disease prevention (Barrett 2011, p. 31), and should address the determinants as well as the consequences. The WHO (2010) urges program developers to consider the wider contexts as they are more likely to have positive long-term impacts (WHO 2010). That is, in order to generate positive outcomes and impacts relating to sexual health, working within the social, cultural, religious norms is considered essential (WHO 2010). Careful consideration must be paid to these broader constructs as the resulting attitudes and behaviours may inhibit efforts at the policy, community and individual level. This means that in order to respond to the needs and experiences of women over fifty, sexual health promotion initiatives should recognise that women experience sexuality in different ways throughout the various stages of life (WHO 2010).

Table 3: Society and Culture Action Plan:

Health Promotion Action	Strategies	Population Target Groups	Settings For Action
Communication and social marketing Community education and capacity building Policy and legislative reform Research, monitoring and evaluation	Local media exposure Online information articles Infographics YouTube clip(s) Paper resources: brochures, pamphlets etc Community wide campaigns Embedding messages online Feature articles for organisational/business newsletters WHISE's social media channels: Facebook and Twitter Community sexual health education sessions Training and workforce developed	Primary target group: All women[3] living in metropolitan, rural and semi rural areas Secondary target groups: Women with a disability Widowed, divorced and separated women Women from migrant and refugee backgrounds Women from CALD backgrounds Lesbian, bisexual, transgender and intersex people Aboriginal and Torres Strait	Online Medical providers Local and Melbourne-wide newspapers Age and gender specific blogs SMR local government areas Community centres Women's sports clubs Workplaces Volunteer organisations

[3] All references to women refer to the fifty and over population group.

	for healthcare providers Advocate for policy recognition Develop partnerships with academic institutions Continuous monitoring and evaluation of all WHISE initiatives Publication of project/research outcomes	Islander women	

5.4 Economics

Due to the interrelationship between poverty, commercial sex work and poor sexual health, the WHO (2010) cite economics as a critical factor in promoting sexual health. However, given that this project will not be targeting these complex issues, an analysis on the sexual health, economics and women aged fifty and over will not be undertaken.

5.5 Healthcare

The role of healthcare providers will be discussed in relation to sexual histories, overcoming barriers, and training and resources, followed by a discussion on broader organisational policies and approaches in the promotion of sexual health for women over fifty.

5.5.1 Taking sexual histories

Following a comprehensive review of the literature on sexual rights, and given the widespread uncertainty of the meaning of basic human rights across the United States, Lottes (2013) urged professionals to tie sexual rights discourse to human rights. This, she argues, will help to avoid the empty rhetoric evidenced in the inconsistent human rights discourse. Moreover, she urges all professionals working in the area of sexual health to 'integrate sexual rights principles into their work' (Lottes 2013, p. 382). In practice this translates to healthcare workers examining clients' sexual health histories, problems and concerns. Bitzer (2011) offers a three-part framework for healthcare providers to approach and facilitate sexual health histories. He highlights that one of the most effective ways of improving the sexual health of patients is through exploring factors affecting sexual health

during health assessments and his framework identifies what topics a sexual history should include, therapeutic processes and interventions, and overcoming barriers (Bitzer 2011).

Yet as discussed previously, whilst healthcare providers are consistently cited as suitably placed to impart important sexual health messages to the target group (Field et al. 2013; Hughes 2013; Peate 2004), very few physicians provide routine sexual health checks and discuss sexual histories, and those undertaken are often incomplete (Gleason-Comstock et al. 2008). When the topic is addressed, communication is usually poor, although little is known about how women communicate the issue(s) and what dialogue actually takes place within a clinical setting (Lindau et al. 2007). When sexual health concerns have been discussed within the healthcare setting, the majority of women find these discussions helpful (Muliira & Muliira 2013). A study by Lindau et al. (2006) found that the majority of women in their sample (55 community residing women aged 58-93) who engaged in potentially risky sexual behaviour 'believed that physicians should ask patients about their sex life and address issues of sexuality' (Lindau et al. 2006, p. 762). This viewpoint is shared by Smith (2009) who argues that clinicians should address sexual health issues with older patients, whilst Huang et al. (2009, p. 1366) argue that healthcare providers should consider 'women's sexual functioning in the context of their overall physical and mental functioning'.

Given that the discomfort between doctor and patient permeates between embarrassment, ambivalence, shame and humiliation, challenging these beliefs will need to be a core focus of any training program (Tomlinson 1998). Encouraging communication will help to 'improve detection and treatment of sexual problems' (Hughes 2013, p. 256) and will help to address core values and beliefs relating to sexual health (Barrett 2011). Skill development training among healthcare providers would therefore need to focus on the physiological aspects[4] of sexual health and therapeutic processes and interventions, as well as the individual and societal values that hinder open and non-discriminate dialogue. More specifically, training will need to focus upon dispelling destructive myths about sexuality

[4] Associations between certain health conditions, such as diabetes, hypertension, cardiovascular disease, and sexual inactivity, will help alert healthcare providers to identify and potentially treat sexual health problems (Bach et al. 2013). Similarly, knowledge of pharmacological and psychotherapeutic therapies, and how they can either inhibit or help sexual health and dysfunction, would need to be included as part of the training (Muliira & Muliira 2013).

(Bitzer 2011). Further, healthcare providers need to be educated on the similarities and differences between male and female sexuality, and how to acknowledge and talk about the similarities and differences between genders. Healthcare providers can also play an important role in enabling patients to express their feelings and discuss their needs with family and/or friends (Peate 2004).

5.5.2 Organisational reform

The sexual health of adults over fifty is continuously overlooked by mainstream services (Barrett 2011). In order to effectively undertake sexual histories, impart information and encourage open discussions with female patients, it is important that services embrace and acknowledge the links between sexual satisfaction and quality of life (Baldissera, Bueno & Hoga 2012) and the overall importance of sexual health for women over fifty as part of their operational processors and procedures.

To aid a reform in mainstream organisational operations, responses and attitudes, Barrett (2011) formulated an organisational auditing tool aimed at promoting the sexual health of adults over fifty. The audit tool, which comprises of seventeen questions, is based upon the WHO's principles for successful sexual health promotion that is underpinned by the view that sexual health is a right for women regardless of age, sex, ethnicity, lifestyle, income, sexual orientation or gender expression and marital status (WHO 2010, p.vii). It is intended to educate not only healthcare practitioners and relevant organisations, but to also educate adults over the age of fifty that they have the right to pursue sexually healthy lives in which desires, needs and respectful relations are met that are free from coercion, discrimination and violence.

Table 3: Healthcare Action Plan:

Health Promotion Action	Strategies	Population Target Groups	Settings For Action
Service and program delivery and coordination Community education and capacity building	Training and workforce development for healthcare providers Implement Barrett's (2011) organisation audit tool Formulate a working group involving relevant agencies/service providers Develop informational resources: brochures, pamphlets etc Develop sexual history check-list for healthcare providers	Healthcare providers in private and mainstream services	Medical providers SMR local government areas Community centres

6. Sexual Health Promotion Action Plan

The following table identifies the broad factors which influence sexual health and provides a conceptual framework to guide sexual health promotion for women over fifty across the Southern Metropolitan Region.

6.1 Southern Metropolitan Sexual Health Promotion Framework

Social Determinants of Sexual Health of Women Aged Fifty and Over							
Gender and socio-cultural norms	Discrimination and violence	Situational, biological and physiological determinants	Access to comprehensive information about sexuality	Knowledge about risks and vulnerability to the adverse consequences of sexual activity	Public policy	Policies, attitudes and values within restrictive care settings	Access to good-quality sexual healthcare
Behavioural Determinants							
Sexual expression	Sexual practices	Religious beliefs and practices	Sexual health literacy	Drugs and alcohol use	Biological and physiological determinants	Early sexual experiences	Medications and treatments
Population Target Groups							
Women[1] living in metropolitan, rural and semi rural areas	Women with a disability	Widowed, divorced and separated women	Women from migrant and refugee backgrounds	Women from CALD backgrounds	Lesbian, bisexual, transgender and intersex people	Aboriginal and Torres Strait Islander women	
Health Promotion Action							
Advocacy	Policy and legislative reform	Sector and workforce development	Community education and capacity building	Service and program delivery and coordination	Research, monitoring and evaluation	Communication and social marketing	
Settings for Action							
Health Service Providers	Community and women's groups	Community health services	Media, social media, arts and popular culture	State and local government			

(Citation: Adapted from Women's Health West's Sexual and Reproductive Health Promotion Framework 2011)

[1] All references to women refer to the fifty and over population group.

7. Conclusion

Sexual health is an integral part of general health and healthy ageing. Australians are living longer and healthier lives and are thus remaining sexually active well into advanced age. The low-use of condoms amongst adults over fifty is well documented and efforts to respond to the growing incidence of STIs are scarce both in Australia and internationally. Insufficient attention is paid to the sexual health of adults over fifty at a program, policy and direct provider level, with even less attention attributed towards women over fifty. Sexual health is influenced by a complex interaction between biological, psychological, physiological and socio-cultural forces.

Multiple factors are shaping the current situation. Foremost, women primarily view condoms as a method of birth control, perceive themselves as low risk, experience embarrassment procuring condoms and discomfort when seeking sexual health advice from healthcare providers, and lack the necessary skills and knowledge to negotiate safe sex with a new partner. Other confounding issues also need to be considered: the desexualisation of older age in Western societies, sexual ageism and stereotypes, the interplay between physiological and psychological factors and sexual health, and the social construction of sexual identities for women over fifty.

The internet provides a safe platform by which adults over fifty can safely access information, enhance their sexual health knowledge and avoid the stigmas associated with diversities in sexualities and experiences. Other evidence-based health promotion initiatives include brochures, social media, community education sessions, further research and advocating for responsive policies. Sexual health promotion initiatives must not solely focus on risk and vulnerability, but look to the broader situation and tackle the assumptions, beliefs and values that influence behaviours. Indeed, developing appropriate sexual health promotion initiatives that are responsive to the wider context are more likely to be effective.

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