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Safer sex in later life: Qualitative interviews with older Australians on their understandings and practices of safer sex

Abstract

Rates of sexually transmitted infections (STIs) are increasing in older cohorts in Western countries such as Australia, the U.K. and the U.S., suggesting a need to examine the safer sex knowledge and practices of older people. This article presents findings from 53 qualitative interviews from the study "Sex, Age & Me: a National Study of Sex and Relationships Among Australians aged 60+." Participants were recruited through an online national survey. We consider how participants understood "safer sex," the importance of safer sex to them, the safer sex practices they used (and the contexts in which they used them), and the barriers to using safer sex. Older adults had diverse understandings, knowledge, and use of safer sex practices, although participants tended to focus most strongly on condom use. Having safer sex was strongly mediated by relationship context, trust, perceived risk of contracting an STI, concern for personal health, and stigma. Common barriers to safer sex included erectile difficulties, embarrassment, stigma, reduced pleasure, and the lack of a safer sex culture among older people. The data presented has important implications for sexual health policy, practice, and education and health promotion campaigns aimed at improving the sexual health and wellbeing of older cohorts.

Introduction

A raft of recent research illustrates that many people continue to have sex well into and throughout later life (Bergstrom-Walan & Nielsen, 1990; Bourne & Minichiello, 2009; Field et al., 2013; Lindau et al., 2007; Mercer et al., 2013; Schick et al., 2010). Indeed, Swedish research by Beckman, Waern, Ostling, Sundh and Skoog (2014) illustrated that levels of sexual activity may be on the rise amongst older cohorts, suggesting it is increasingly important that we pay attention to the sexual health and well-being of older people. For many, sexual expression, pleasure and identity remains important as they age, although research also indicates there is diversity amongst older adults in this regard (Field et al., 2013; Fileborn et al., 2015a; Fileborn, Thorpe, Hawkes, Minichiello, & Pitts, 2015b; Gott & Hinchliff, 2003; Gott, Hinchliff & Galena, 2004; Lindau, Leitsch, Lundberg, & Jerome, 2006; Minichiello, Plummer & Loxton, 2004). Changes in social norms in the English-speaking West regarding the acceptability of divorce and re-partnering after divorce or the death of a partner also mean that there are greater opportunities for initiating new sexual and romantic relationships in older age (Bateson, Weisberg, McCaffery, & Luscombe, 2012; DeLamater, 2012; DeLamater & Koepsel, 2015; Idso, 2009; Nash, Willis, Tales, & Cryer, 2015). Accompanying advances in technology and the development of online dating have facilitated the process of finding sexual and romantic partners in middle and later life (Bateson et al., 2012; Malta, 2007; Malta & Farquharson, 2014).

This continuation of sexual activity and shifts in sexual partnerships in later life have, however, been accompanied by increases in the rates of sexually transmitted infections (STIs). While older cohorts still make up a minority of STI diagnoses overall, rates in these groups have steadily increased in many countries across the Anglophone- West. For example, in Australia, rates of chlamydia diagnoses rose from 16.4 per 100,000 in 2010 to 26.6 per 100,000 in 2014 in the 55-64 age group (The Kirby Institute, 2015). Rates of gonorrhoea and

syphilis in this age group also rose during this timeframe. This mirrors international trends across countries such as the U.S. and U.K. (Centers for Disease Control and Prevention, 2014; Minichiello, Rahman, Hawkes, & Pitts, 2012; Poynten, Grulich & Templeton, 2013; Public Health England, 2016).

Despite rising STI rates in older populations, we know surprisingly little about their safer sex practices and knowledge of STIs. The limited research undertaken to date suggests that older people do not consistently practice safer sex (Altschuler & Rhee, 2015; Bourne & Minichiello, 2009; Dalrymple, Booth, Flowers, & Lorimer, 2016; de Visser et al., 2014; Foster, Clark, McDonnell Holstad, & Burgess, 2012; Grant & Ragsdale, 2008; Lindau et al., 2006; Reece et al., 2010; Schick et al., 2010), may lack effective condom use skills (Foster et al., 2012), and report low rates of testing for HIV and STIs (Bourne & Minichiello, 2009; Dalrymple et al., 2016; Grulich et al., 2014; Schick et al., 2010; Slinkard & Kazer, 2011). Several authors have noted that older heterosexual women may face a higher susceptibility to HIV and STI transmission on account of the physiological and hormonal changes that typically accompany ageing, such as decreased estrogen production leading to thinning of the vaginal wall and subsequent greater susceptibility to tears and cuts (Altschuler & Rhee, 2015; Brooks, Buchacz, Gebo, & Mermin, 2012; Idso, 2009; Johnson, 2013), and the low rates of condom use of post-menopausal women who no longer fear unintended pregnancy (Altschuler & Rhee, 2015; Bateson et al., 2012; Idso, 2009; Johnson, 2013; Lindau et al., 2006). Older men can be reluctant or unable to use condoms as a result of erectile difficulties (Idso, 2009; Johnson, 2013), and older men who take erection-enhancing medications can face a higher likelihood of contracting an STI (Smith & Christakis, 2009). However, we know comparatively little about how older adults understand and define “safer sex,” nor the contextual factors that shape and inform their use of safer sex practices and the importance of safer sex to them.

Older people grew up in a time when discussions of sex and sexual health were largely taboo, comprehensive sexuality education was generally not available (Cook, 2012; May, 2006; Pilcher, 2005), and STIs were highly stigmatised (though this is arguably still the case in many respects) (Altschuler & Rhee, 2015; Bourne & Minichiello, 2009; Grant & Ragsdale, 2008; Idso, 2009; Nash et al., 2015; Slinkard & Kazer, 2011). Additionally, the dominant sexual and gendered sexual scripts that older people grew up with may restrain their ability to openly negotiate condom use or other safer sex practices in new sexual relationships (Altschuler & Rhee, 2015; Bateson et al., 2012; Nash et al., 2015; Zablotsky & Kennedy, 2003). Further, safer-sex campaigns and policy are typically targeted towards younger people (Bateson et al., 2012; Bourne & Minichiello, 2009; European Expert Group on Sexuality Education, 2016; Gedin & Resnick, 2014; Kirkman, Kenny & Fox, 2013; Nash et al., 2015). Health care professionals are often reticent to discuss sex per se with older patients (Gott et al., 2004; Grant & Ragsdale, 2008; Nash et al., 2015; Nusbaum, Singh, & Pyles, 2004) and older people often wait for their health care provider to initiate discussions on sex (Lindau et al., 2006; Nash et al., 2015; Nusbaum et al., 2004; Slinkard & Kazer, 2011). These contextual factors may shape and limit the safer sex knowledge and practices of older people; however, further qualitative research is required to examine and confirm the extent to which this may occur (Bateson et al., 2012).

There is currently a lack of research, particularly qualitative, on older people's knowledge of safer sex and the safer sexual practices they engage in (Bateson et al., 2012). Qualitative research is needed to provide a detailed understanding of the perspectives and decision making processes that older people engage in when having sex in circumstances that present a higher likelihood of STI transmission (Dalrymple et al., 2016). In particular, knowledge is currently lacking about the ways in which older people understand and define "safer sex," the importance they attach to safer sex in particular relationship contexts, the

types of safer sex they use, and the potential barriers to using different types of safer sex. Our study, "Sex, Age and Me: a National Study of Sex and Relationships Among Australians Aged 60+" was established, in part, to examine these issues. Key aims of this exploratory project were to explore older adults' knowledge of, and use of STI prevention and safer sex. The first Australian study of its kind, Sex, Age and Me collected quantitative and qualitative data (see Lyons et al., under review, for further details). With regard to the latter, 53 qualitative interviews with older men and women were conducted, and a subset of findings pertaining to interview participants' understandings and use of safer sex is explored in this article. The findings have important implications for informing strategies aimed at stemming the rise of STI rates amongst older cohorts, within policy, health services and health promotion.

Theoretical framework – a life course perspective

Our research is situated within a life course perspective, which suggests that older people's understandings and practices of safer sex are shaped by and "within the context of both generational time and historical time" (Ballard & Morris, 2003, p. 134). Safer sex practices are themselves historically and culturally situated, and vary over time and cultural context (Donovan, 2000a, 2000b). Additionally, a life course approach recognises the diversity within lived experience, and that people of the same chronological age may have different experiences based on their particular social and cultural locations (Ballard & Morris, 2003).

Participants in our study belong to the "Baby Boomer" generation, and this likely shapes their current experiences and understandings of safer sex. The Baby Boomers are frequently credited with responsibility for leading the "sexual revolution" in the 1960s and 1970s across English-speaking Western countries, particularly the U.S., U.K., and Australia. The sexual revolution critiqued and challenged dominant sexual norms of the time, although

the extent to which it actually influenced the sexual lives and practices of our participants' generation is contested (e.g., Fileborn et al., 2015a). For instance, some participants in Fileborn et al.'s (2015a) Australian study commented that the sexual revolution had impacted more significantly on their children's sexual lives than their own, and that their own sexual practices had continued to be shaped by conservative sexual norms. The Baby Boomers are likewise often credited with challenging dominant norms around ageing "appropriately," and in refusing to perform "older age" in the same way as their parents, particularly when it comes to sex (Fileborn et al., 2015a). Again, while there is likely to be considerable variation in the ways that Baby Boomers are actually approaching older age, it is important to situate the findings of our research within particular historical and contemporary contexts.

Method

Participants

Fifty-three semi-structured individual interviews were conducted with Australian women (n = 23, 43.4%) and men (n = 30, 56.6%) aged 60 years and older from August 2015 to January 2016. Two female participants were aged in their mid-to-late 50s; these women were included in the study due to difficulties recruiting women for the interviews. Interview participants were recruited through the online survey conducted in phase one of the Sex, Age & Me study, which had attracted 2,137 participants from all major areas of Australia. Survey participants were recruited through a range of avenues, including an article published in *The Conversation* by two of the authors and subsequent media attention, age-targeted Facebook advertisements, through local and national ageing organisations, local governments, senior citizen clubs, and sexual health clinics. The survey sample was a convenience sample; however, we were able to target recruitment efforts towards specific key subgroups, and the sample was diverse, including participants from all major sociodemographic backgrounds and from all states and territories of Australia. Survey participants who were interested in

taking part in a one-on-one interview were invited to provide their name and a contact email (these details were not stored with their survey responses). A total of 517 individuals expressed interest in taking part in an interview. Every third person who expressed interest was contacted, resulting in 175 individuals being contacted by email and provided with a participant information statement that explained the purpose of the study (to examine the sexual health, relationships, dating and sexual practices of older people, and knowledge of STIs), the general topics the interview would cover, what participation would involve, and the potential risks of taking part. These individuals were asked to contact the interviewer (Author 1) if they would like to participate. Of these 175 individuals contacted, 53 individuals from across Australia responded and agreed to take part. We did not recruit any more participants as data saturation was reached. An overview of the interview participants is provided in Table 1.

[Table 1: Sample profile of Sex, Age and Me interview participants (n = 53)]

Measures. The interview schedule focused on participants' understandings of sex and sexual satisfaction, the importance of sex and sexual satisfaction, their understandings and use of safer sex, their help seeking practices, and background demographic information. As the interviews took a semi-structured approach, additional lines of questioning were taken based upon the unique issues raised by each participant; however, the relevant questions from our interview schedule are included in Table 2.

Procedure. Interviews were conducted by phone (n = 41), Skype (n = 10), or face-to-face (n = 2) depending on the participant's preference and geographical location. While conducting interviews via Skype is a relatively novel approach, research to date suggests that conducting interviews in this way (and via phone) does not negatively impact upon data quality, and in some contexts may even enhance it (Hanna, 2012; Holt, 2010; Sturges & Hanrahan, 2004). On average, the interviews took 30-60 minutes to complete, were audio-

recorded with the participant's consent, and transcribed by a professional service. The transcripts were de-identified, and participants assigned pseudonyms. Ethics approval was received from the La Trobe University Human Research Ethics Committee prior to the commencement of the research.

[Table 2: Interview questions on safer sex]

Analysis. The qualitative data were analysed using the software package NVivo, and followed a thematic analysis procedure outlined by Ezzy (2002) and Braun and Clarke (2006). The first-named author conducted the primary analysis. This process involved an initial close reading and preliminary coding of the transcripts. Notes were made identifying emerging themes, using the interview questions and core study aims (e.g., discourses on sex and relationships, understandings of safer sex) as initial code categories (i.e., a mix of inductive and deductive coding was used). In vivo codes were also identified throughout this process based on emergent themes and patterns within the data. This process was then repeated in NVivo, with the data sorted into code and sub-code categories. Particular attention was paid to the recurrent themes and patterns in the data, but also to cases that contradicted, complicated, or otherwise sat outside of the dominant thematic categories. This enabled us to account for the complexity and nuance in older people's experiences. A random sample of 10 interview transcripts was independently coded by the fifth-named author (WH) to ensure the validity of the coding, with both coders agreeing on the dominant thematic categories.

Results

What is safer sex?

Participants were asked about their understandings and definitions of the term "safer sex," and the types of safer sex they used. There were five main themes identified: using condoms, preventing STI transmission, discussing STI history, STI testing, monogamy,

avoiding certain sexual practices, and self-care. Some participants indicated that they did not have safer sex, and we examine their reasons for this briefly. Many participants offered complex and multi-faceted definitions and practices of safer sex, and their practices tended to evolve over the course of a relationship, although there was variation between participants in this regard. For many participants, "safer sex" referred predominantly to condom use, and these terms were used synonymously at times. The issue of trust often permeated these practices.

Using condoms. Condoms were by far the most common element of participants' discussions of what "safer sex" is. Given the centrality of condom use in STI prevention and sexual health campaigns, this is largely unsurprising. For example, Karen (64 yrs, heterosexual, single) said that condoms were "primarily what I think of when I think of safe sex." While condoms are promoted as a key safer sex strategy, they are not an infallible method, particularly when used incorrectly or in preventing all STIs. Only a small number of participants acknowledged the limitations of condom use as a safer sex strategy. Kane (63 yrs, heterosexual, in a relationship) noted that "condoms are ineffective against some kinds of infections," such as crabs (pubic lice) – although it is notable that Kane learnt this only after embarking on some pre-interview research on Wikipedia "about STIs just in case you asked me." Another participant, Tim (62 yrs, gay, in a relationship), viewed condom use as one component of safer sex strategies. Tim offered a comprehensive and sophisticated definition of safer sex, saying "safer sex is lower risk activities…using condoms, minimising exchange of bodily fluids and skin contact." Tim also believed that as a gay male he had been exposed to considerably more public health campaigns and education on sexual health than heterosexual people in his age group would have, and this likely accounts for his knowledge of safer sex. Tim was particularly concerned about rising rates of syphilis infection within the gay community, and commented that "condoms can reduce the risk but...you can get

syphilitic sores in the mouth or elsewhere in the body." This suggests that condoms may be seen as a safer sex strategy for certain types of sexual practices, with Tim's comments implying that condoms are not used for oral sex. As we discuss below, having a strong understanding of what constitutes safer sex did not always follow through to participants' use of safer sex. Both Tim and Kane acknowledged the limitations of all safer sex strategies, with Tim noting that these practices *lower*, rather than erase, the probability of STI transmission.

Condom use was strongly influenced by relationship context. Participants commonly discussed condoms as something that they used in new or casual sexual relationships. Gwen (65 yrs, heterosexual, single) said that she used "the old fashioned condom, particularly with anyone new." However, if these encounters progressed to a longer-term relationship Gwen would say to her partner "well let's go to the STD clinic and then we don't have to use condoms anymore, if we're both clear." A number of participants also discussed being strict with condom use with new sexual partners after either contracting an STI or being exposed to one in the past. For example, Martha (61 yrs, heterosexual, married) had a rule of "no condom, no sex" after she contracted genital warts from her first husband. Likewise, Rachel (64 yrs, heterosexual, in a relationship) insisted on using condoms with new partners after being exposed to hepatitis C, and only ceased using condoms with her current partner on the provision that they both have regular sexual health screenings. While participants such as Gwen and Rachel only phased out condoms after having STI tests, other participants viewed the use of condoms earlier in a relationship as "going through the motions." For instance, Beverly (66 yrs, heterosexual, single) described how she had new sexual partners use condoms early in their relationship:

> But it was more just like a perfunctory thing…because you know they weren't going to use condoms the whole time and so it was just in the beginning

until I knew that I wanted to stay with them and then it was okay for them to stop using condoms.

For Beverly, condom use was only seen as necessary while the relationship was in its formative stages. Progression to a more "serious" relationship rendered the use of condoms unnecessary; however, this decision was made in the absence of any STI testing or further discussion of sexual health. The cessation of condom use either with or without STI testing once a relationship became established appeared to be a common practice amongst our participants.

Preventing STI transmission. Some participants defined safer sex as being more generally about STI prevention. While condoms were often an important part of this, these participants tended to focus more strongly on the prevention of disease transmission, rather than the particular strategies that might be used to prevent this. One participant, Zane (80 yrs, bisexual, married/open relationship), defined safer sex as "preventing somebody else or any two people passing on something that they've acquired God knows where, to another partner." Another participant, Amelia (73 yrs, heterosexual, in a relationship), commented "safe sex these days is more about not getting STDs than anything else." Amelia's remarks suggest that meanings of safer sex shift temporally. Indeed, many participants commented that when they were younger the concept of "safer sex" generally referred to pregnancy, rather than STI, prevention. For heterosexual participants who viewed safer sex as predominantly related to pregnancy prevention, this could render safer sex as an irrelevant concept to them once they (or their partner) were no longer able to become pregnant.

Discussing STI history. Talking to a sexual partner about their STI and/or sexual history was another common component of safer sex. For some participants, this meant having an explicit conversation about their current STI status. For instance, Marty (77 yrs,

heterosexual, in a relationship) said "if I had a conversation with somebody and was assured that they didn't have any sexually related diseases, then I'd probably feel fairly confident."

For some participants, discussions about sexual health with their partner formed a key aspect of safer sex. As highlighted above, this could involve talking about when they would cease using condoms in a relationship, and to arrange for STI tests prior to this. Some participants utilised discussions with partners (or potential partners) as a way to determine whether condoms or other safer sex measures were necessary. Rather than involving explicit discussions on STI testing and sexual health history, these discussions provided opportunities to make a series of judgements about a partner's character and the perceived likelihood that they would have an STI. For example, Ivy (62 yrs, heterosexual, single) commented that "it's a whole new world compared to when I was young," and that because of this she always raised the issue of safer sex with new partners. However, in determining whether or not she would use a condom with a new partner, Ivy said:

> I think I'm pretty good at assessing [if] people [are] liars…people I usually go out [with]…they're CEO's or they're barristers…I suppose those people have STIs too but anyway generally they're people who have taken care of themselves all their lives.

Discussing sexual health as a safer sex practice was often based on the premise that participants *trusted* a sexual partner to tell them if they had an STI, or trusted them not to have an STI. Trusting a partner's response appeared to absolve the need to use other types of safer sex such as condoms. As Kane said, "my preference is not to use a condom and if I'm attracted to a woman my inclination is to trust her, and one of the things I trust her to do is not to give me an STI." However, another participant, Dani (71 yrs, heterosexual, in a relationship), highlighted the limitations of trust as a safer sex practice in this regard saying,

"they could even say they've had a sexual test and be lying about it, couldn't you? Unless you saw the piece of paper. Yeah, I think I would be wanting to use condoms."

STI testing. STI testing was mentioned relatively infrequently by participants in their definitions of safer sex. Shane (72 yrs, heterosexual, married) said that he would want to know that a new sexual partner "had their sexual health checked and had the tests [to be]…reassured that they didn't have any sexual disease." However, Shane qualified this by suggesting that he would be more concerned if the new sexual partner was male, or if they had not come from a long-term monogamous relationship. Again, this suggests that safer sex practices are seen as context dependent, and as less relevant to those involved in monogamous heterosexual relationships.

Although only a small number of participants discussed STI tests in their definitions of safer sex, many more indicated that they had used STI testing as part of their safer sex practices – as the preceding discussion has illustrated. Some participants – predominantly women – reported that they insisted on their new partners taking STI tests before having unprotected sex (i.e., without a condom). For example, Tina (60 yrs, heterosexual, married) told her now husband, "either you're going to use condoms or we are all going to have the full suite of tests beforehand. He opted for the full suite of tests…we both had every test that you could possibly have."

Wilma (61 yrs, heterosexual, widow) decided to have an STI test after being involved in a relationship with a man who she "wasn't totally trusting," although they had consistently used condoms. However, her doctor was disparaging of the need for her to be tested, saying he was sure Wilma would be fine. The tests only proceeded because of Wilma's insistence that "I really need to have one." A small number of participants also discussed using blood donations as a proxy for STI tests. For example, Kane (63 yrs, heterosexual, in a relationship) said when he was donating blood regularly "I was being tested…every fortnight, so I was

pretty sure that I was clear." While blood donors in Australia are screened for blood borne viruses, they do not screen for all STIs, making this approach to testing limited and risky. Another participant, Aaron (65 yrs, heterosexual, single), said that he also gives himself "a check regularly as well, so I'm modern in that thinking." Aaron's comments imply that, for some older people, STI tests may be viewed as irrelevant or only of concern to young people.

Gwen (65 yrs, heterosexual, single) saw the process of having an STI test and revealing the results to a new partner as developing "a whole higher level of trust between you…it actually brings you closer together I think." In this way, STI testing can be used as a mechanism for *producing* trust in a new relationship. Given the centrality of trust in safer sex, this has important implications for the framing of sexual health campaigns targeted towards older people.

Monogamy. Monogamy was often used as safer sex, both within the context of long-term monogamous relationships, and for those who were entering into new relationships with someone who was previously in a monogamous relationship. For example, Xavier (65 yrs, heterosexual, married) said that safer sex was not important in his relationship as he had been with his wife for 42 years, and "safe sex is something you do with people you don't know…If we had any STDs we would've known by now." Another participant, Carl (62 yrs, heterosexual), was involved in three simultaneous, "monogamous" relationships, which he believed protected him from STIs as he believed his three partners did not have other partners. Others were more cautious. For example, Leila (61 yrs, heterosexual, married) said that while "you can relax a little bit" in a long-term relationship, she would "still be very careful…you really never know someone, you just don't."

For those entering into new relationships, serial monogamy (or a relatively "inactive" sexual life) was seen as being protective against STIs. For instance, Dani (71 yrs, heterosexual, in a relationship) said that she did not have an STI test before having

unprotected sex with her partner because "he wasn't having much sex, I don't think." Likewise, Oliver (66 yrs, heterosexual, friends with benefits relationship) said that he "didn't even think about" the issue of safer sex with his partner, because she had not been in a sexual relationship for a very long time. However, monogamy does not always offer protection against STIs, as Elli (59 yrs, bisexual, single) discovered when she contracted herpes after having unprotected sex with someone who had just left a 30-year monogamous relationship.

Sexual practices. For a minority of participants, limiting their sexual practices to activities they viewed as lower risk was an important safer sex strategy. Notably, this strategy was mentioned by two male participants who had sex with men, who both discussed engaging in practices that presented a lower risk of HIV transmission. For example, Fred (60 yrs, bisexual, single/casual sexual relationships) did not have anal intercourse with his regular male sex partner, and said, "we don't do anything that is really hazardous in terms of HIV," though some of his sexual practices may expose him to other STIs. Likewise, Tim (62 yrs, gay, in a relationship) said for him safer sex might involve "lower risk" activities such as "kissing, mutual masturbation, digital stimulation and masturbation, anything that's essentially non-penetrative." Other participants indicated that they would simply not have sex with someone if they believed they might have an STI. As Dylan (65 yrs, heterosexual, long-distance relationship) noted, discussing the fallibility of condoms, "the only perfect one is to not do it, so if I'm worried I'll leave."

Not practicing safer sex. Finally, a few participants indicated that they did not have safer sex in their sexual relationships. For example, Beverly (66 yrs, heterosexual, single), who was casually dating, said:

> I pride myself in looking after myself my mental health and my physical health but when it comes to sexual health you know I've been a bit irresponsible really and it's hard for me to sort of own up to that.

Likewise, Carl (62 yrs, heterosexual, multiple relationships), who had multiple, simultaneous "monogamous" relationships said, "no way, I don't use condoms," while Kane (63 yrs, heterosexual, in a relationship) reported that "post-menopausal women are awfully cavalier" about condom use, so he had rarely used condoms throughout his multiple sexual relationships.

Self-care and well-being. Some participants provided definitions of "safer sex" that extended beyond the prevention of STI transmission to include emotional, psychological, and physical well-being and safety in an intimate relationship. This type of definition was well encapsulated in Rachel's (64 yrs, heterosexual, in a relationship) comment that safer sex is:

> About knowing yourself really well, and understanding all the emotional aspects around sex…understanding…the brain chemistry behind attachment, behind sexual attraction, behind being sexually active…having an understanding of how your thinking works, being a bit mindful about your thinking.

Another participant, Fred (60 yrs, bisexual, single/casual sexual relationships), highlighted an apparent paradox in the relationships between safer sex, caring for one's partner, and the role of trust and stigma relating to STIs. Fred noted that suggesting to a partner that they, for example, use a condom "has two contradictory effects. One is, 'I'm trying to look after you'. It's a positive message to the other person…But the other thing is 'I don't trust you and you shouldn't trust me'." This suggests that the emphasis on "trust" between sexual or romantic partners has the potential to hinder engagement in safer sex and self-care practices.

Importance of safer sex

Our discussion thus far has considered how older adults' understand and define the concept of "safer sex," and the safer sex strategies they used. We move on now to consider how important safer sex was to participants. The importance of safer sex seemed to be closely

connected with relationship context and trust, perceived risk levels, and concern for personal and public health. These factors often co-informed one another, and were not mutually exclusive.

Concern for personal health. For some, safer sex was important due to a concern for their personal health and a desire to avoid any unpleasant symptoms. For example, Sally (71 yrs, heterosexual, widow), who had experienced extensive health problems relating to her reproductive system, said safer sex was highly important to her as "I don't need to get infected with anything, I've had enough problems in that area." A number of individuals who worked in health care settings indicated that safer sex was important to them after being exposed to the early stages of the HIV/AIDS epidemic through health promotion strategies, being employed in the healthcare sector, or having friends or family members diagnosed with HIV/AIDS. Igor (78 yrs, heterosexual, married) previously worked in a HIV clinic and as a result was "determined that I was never going to die of HIV, nor was I going to impose it on somebody else."

For others, avoiding STIs was a matter of "common sense." Juliet (69 yrs, heterosexual, in a relationship) said that although she did not view STIs as shameful, "if it's avoidable, it's just the most sensible thing." Others saw the prevention of STIs as a matter of personal responsibility and commitment to public health. For instance, Norman (69 yrs, heterosexual, married) said "it's obviously important to maintain a healthy population and not to spread disease by sexual means or any other if you can help it."

Stigma. The importance of safer sex was also linked to the stigma attached to STIs and having multiple sexual partners, and the feelings of shame this engendered. Safer sex was important to Ivy (62 yrs, heterosexual, single) because she believed that having an STI "at this age…would ruin any future dating life." However, Ivy did not distinguish between different types of STIs and it was therefore unclear whether she was referring to treatable,

non-treatable STIs or both. Stigma played a somewhat paradoxical role here: it simultaneously increased the perceived importance of safer sex, while also contributing towards a culture in which having an STI is highly shameful and difficult to discuss due to a fear of being ostracised or rejected as a sexual partner. It is also apparent that for Ivy, the stigma or shame associated with having an STI would be further compounded by her age (*"at my age")*.

Safer sex as less relevant in later life. A minority of participants reported becoming more pragmatic about safer sex in later life. For example, Marty (77 yrs, heterosexual, in a relationship) said he was less concerned about contracting STIs compared to when he was younger as he took the view that:

> If I did get an STI I'd probably be able to get it cured fairly easily, and maybe it doesn't matter so much, and maybe even HIV would be less of a threat in that I don't have such a long life ahead that I'd have to live with it.

Marty's position in the life-course clearly influenced his views about sexual risk taking and living with disease. Others reported that safer sex was relatively unimportant to them because they did not think it related to older people. Amelia (73 yrs, heterosexual, in a relationship), for example, thought that safer sex "possibly wouldn't even enter most people's mind to even do," as most of her generation grew up in the pre-AIDS era where "safer sex" related primarily to pregnancy prevention. As a result, Amelia said that even when she was exposed to safer sex messages "you sort of think, well it doesn't apply to me; that applies to young people." Likewise, Karen (64 yrs, heterosexual, single) commented that many people in her age group would hold the view that "they're in the safe category, that STDs is only something that [happens to] younger people who have…more than one partner," as a result of social norms when she was growing up that STIs were only an issue for sexually "promiscuous," "bad," or "dirty" people.

Relationship context. The perceived importance of safer sex was also related to the relationship context. For instance, Amelia commented, "if you're in a more or less steady relationship and you trust the person you're with, it's not so important…it depends a lot on the relationship, what's safe and what's not." Likewise, many participants commented that safer sex would be important if they were to start a new relationship or dating casually should their current relationship end. Oliver (66 yrs, heterosexual, friends with benefits relationship) saw casual dating as being a particularly "high risk" time where safer sex would be more important, "while you're trying to find a more stable place to express your sexuality." Interestingly, Elijah (63 yrs, heterosexual, single), who was a long-term client of a sex worker, also viewed trust and relationship length as essential to the importance he placed on using condoms. For instance, if a sex worker offered to have unprotected sex at an early encounter "well, obviously she is doing that with everyone" making it a higher-risk decision. In contrast, Elijah said, "if it happens over a relationship period…you develop a trust."

STI risk. The perceived risk or likelihood of contracting an STI also influenced the level of importance some participants placed on having safer sex. As noted above, many participants viewed monogamous, long-term relationships as "low risk" – and in many respects this is a fair assessment, given that older people are indeed less likely to have an STI in comparison to their younger counterparts. Likewise, other participants made judgements about the perceived likelihood a partner had an STI based on their number of sexual partners or social standing. For some participants the perceived risk of contracting an STI was deemed to be low based on their past experiences. For example, Vaughn (71 yrs, heterosexual, in a relationship) reflected on how when he was young there was a "plague" of gonorrhoea. Vaughn said that "at the time I was having about 10 different women in a month…and I only caught gonorrhoea once…and I went through hundreds of people, literally." For another participant, Fred (60 yrs, bisexual, single/casual sexual relationships), the risks presented by

unprotected sex were also a component of sexual pleasure and excitement. Fred admitted that while he had "taken more risks than any rational person would," these risks were "part of the 'fun at the fair.' And when you get away with it and then you go 'wow! That was a rush'." Dylan (65 yrs, heterosexual, long-distance relationship) believed that "the unsafe sex thing is a beat up in many of the same ways we beat up other safety things," and argued that the risks of unsafe sex were relatively trivial and easily addressed through medical treatment. Because of this, Dylan believed that safer sex was largely unnecessary.

Barriers to safer sex

Embarrassment. For some participants, negotiating safer sex with a partner was viewed as an embarrassing endeavour for a number of distinct reasons. Elli (59 yrs, bisexual, single), who had herpes, said that she felt daunted at the prospect of having to raise the issue of safer sex with any new sexual partners for the first time in her life. For Elli, this was daunting because of "the interference with spontaneity and just the embarrassment of having to tell somebody that I'm carrying the herpes virus, which just feels completely bizarre in terms of the amount of sex I've had." This embarrassment was linked to the stigma associated with having an STI, as well as the implications Elli believed this would have for her sexual reputation.

Embarrassment about using safer sex was also linked to the fact that for many older adults, safer sex has not been a core part of their sexual repertoire. This was expressed by Jack (64 yrs, heterosexual, married), who said "I think it may be a little more confronting and embarrassing for older people…young people would probably…do it as a normal course of events." Vicki (73 yrs, heterosexual, single) believed that many older men were not knowledgeable about condom use because they had never (or rarely) had to use condoms growing up. Vicki commented that it "takes a really confident man to say 'I don't really

know how to do this,' especially in bed," suggesting that embarrassment about ineffective condom skills may form a barrier to some older men having safer sex

A number of participants commented that older adults were still influenced by the social norms and taboos surrounding sex when they were growing up, where "frank and fearless communication wasn't a big part of it" (Marty, 77 yrs, heterosexual, in a relationship). The lingering effects of these attitudes made discussing safer sex challenging for some older adults. For instance, Rachel (64 yrs, heterosexual, in a relationship) commented that norms around sexual "promiscuity" meant that for some older women admitting to being sexually active by, for example, requesting an STI test could be "deeply humiliating." However, some participants challenged the notion that embarrassment about safer sex was age-specific. Instead, embarrassment about sex was viewed as related to individual proclivity or personality traits, but, as Leila (61 yrs, heterosexual, married) argued, "that can apply at any age."

Erectile difficulties. Erectile difficulties were a significant barrier to many men in using condoms as a form of safer sex. Participants with erectile difficulties frequently commented that using a condom would cause them to lose their erection – or they were unable to successfully put a condom on due to an insufficient erection. This suggests that safer sex education for older adults must extend beyond simply encouraging condom use, as for many this was simply not an acceptable avenue of protection. This also points to the importance of decoupling the often synonymous use of condoms with safer sex. Such thinking can limit the identification of alternatives to condom use that may reduce the risk of STI transmission. If safer sex is linked solely to condom use, then in the event that condoms can no longer be used, having safer sex becomes impossible.

Lack of skills, experience, and safer sex culture. As many within the current older cohort did not receive comprehensive sexuality education when growing up, a lack of

knowledge regarding STIs and safer sex practices was raised by participants as a major barrier to having safer sex. This was particularly the case for those who had been in long-term, monogamous relationships who had had no perceived need for safer sex other than to prevent pregnancy. For example, Elli (59 yrs, bisexual, single) said that safer sex is "just not part of the frame of reference with a lot of people over 55." Similarly, Edwin (66 yrs, heterosexual, married) commented that "our age group aren't equipped, we don't have the culture…for dealing" with safer sex. As a result, some older people may be lacking the knowledge, skills, and awareness to have safer sex.

The assumption that "you know everything because you've reached this age" (Wilma, 61 yrs, heterosexual, widow) or that you should "know better" as an adult could also function as a major barrier to seeking out information on safer sex. Wilma commented that some people may "feel humiliated and they don't want to ask those questions of the doctor" due to the perception that they should *already* know about safer sex. This assumption and stigma around a lack of knowledge was actively perpetuated by some participants. For example, Dan (63 yrs, heterosexual, married) said that "by the time you get to our age you've been around the block once or twice so you'd be pretty stupid if you didn't know what it was all about." Another participant Gwen (65 yrs, heterosexual, single) believed that while older people did know about safer sex and had learnt about it when they were young, this knowledge was not being reinforced as they got older. Certainly, Gwen's comments reflect current evidence that safer sex education is targeted almost exclusively towards younger people (Kirkman et al., 2013).

Stigma. The continued stigma surrounding STIs figured as a barrier for some participants in using or negotiating safer sex. While stigma around STIs is also an issue for young people this may be heightened for older people given the conservative norms governing sex when they were growing up. A number of women recounted stories where a

male partner had been "insulted" after they asked them about their STI history. Vicki (73 yrs, heterosexual, single) believed this was because "in the old days…it was prostitutes and…loose women" who used condoms. Indeed, Rachel (64 yrs, heterosexual, in a relationship) shared an experience of a sexual partner refusing to have sex with her after she asked him to use a condom, saying to her "what sort of woman carries a condom…obviously you sleep around with everyone." Fred (60 yrs, bisexual, single/casual sexual partners) also indicated that this association could make discussing condom use "awkward" because it was akin to saying "'well, you must be promiscuous,' and that's not something most women want to think about themselves." It is notable that it was only female participants who reported feeling judged, and only women who were seen to be viewed negatively for raising the issue of safer sex (see also Dalrymple et al., 2016). This suggests that the barriers to using safer sex in later life operate in highly gendered ways.

Reduced pleasure. As has been well documented in the literature on safer sex (e.g., Crosby, Yarber, Sanders & Graham, 2005; Higgins & Wang, 2015), the belief or experience that condoms reduce sexual pleasure was a disincentive to using condoms. Jack (64 yrs, heterosexual, married), for example, said that he "enjoy[s] sex more without a condom." Gwen (65 yrs, heterosexual, single) commented that it could be difficult to negotiate condom use with men who believed that condoms decrease or remove their sexual pleasure, "the usual classic complaint from men." While this is a common barrier to using condoms across all age groups, some male participants indicated that the impact on sexual pleasure was heightened in older age. For instance, Vaughn (71 yrs, heterosexual, in a relationship) said that "we're certainly not as sensitive as we were, so wearing a condom tends to make things very insensitive," and this could make it difficult to achieve orgasm. Vicki (73 yrs, heterosexual, single) believed that older men were "remembering using the old type of condoms, which…were thicker." As a result, older men's experiences of using condoms was potentially

"more unpleasant than it needs to be now," suggesting that overcoming past experiences or assumptions in condom design may be needed to increase willingness to use condoms.

For women who experienced vaginal dryness after menopause or due to various health conditions, condom use could be painful, although younger women have also reported experiencing vaginal irritation as a result of condom use (Crosby et al., 2005). While Sally (71 yrs, heterosexual, widow) acknowledged that use of lubrication could help with this, she doubted "whether I'd find anybody that would be willing to go through all the preparations necessary…it wouldn't be spontaneous." This suggests that while the physiological issue of vaginal dryness can make condom use difficult, beliefs around how sex "should" occur – in this case, as a spontaneous, "natural" process without interruption or the use of sexual aids – also act as a barrier to engaging in practices (such as using lubricant) that would facilitate condom use (see also Diekman, McDonald & Gardner, 2000).

Discussion

While participants in this study discussed a broad range of safer sex practices, there was a strong emphasis on the use of condoms in comparison to other forms of safer sex (such as STI testing or engaging in lower risk, non-penetrative sex) – although data from the Second Australian Study of Health and Relationships (ASHR2) suggests that condoms are not commonly used by older Australians (de Visser et al., 2014). Likewise, while practices such as discussing sexual health and history with a partner were raised, this was often presented as a strategy for making a value judgement on the perceived likelihood that a partner would have an STI. This echoes the findings of Hillier, Harrison and Warr's (1998) earlier research with Australian high school students, who likewise reported that condom use was virtually synonymous with safer sex, while trusting a partner and informally discussing sexual history were key safer sex strategies.

There was great variation regarding the extent to which safer sex was important to participants, and this was strongly mediated by relationship context. For many, safer sex was seen as relevant to new, casual relationships, and in contexts where a sexual partner was not "trusted," extending the findings of Dalrymple et al.'s (2016) research with late middle-age adults in the U.K. While the overall themes identified here are in many ways similar to studies conducted with younger age groups, the context and the ways in which these themes play out in the lives of older people is distinct and shaped by the interplay of ageism, cohort norms regarding sex, and more general stigma around STIs and sex.

When it came to having safer sex, there was again much variation. While some participants placed great importance on using condoms and having STI tests with new partners, for others having safer sex was often context dependent and based upon assumptions about their partner's sexual health status. Trust was fundamental in shaping safer sex, with condoms or STI tests seen as unnecessary with a trusted partner. This echoes the findings of research undertaken with younger samples (e.g., Crosby et al., 2013; Hillier et al., 1998). For example, Crosby et al. (2013) reported that women in their sample aged 25 and older were more likely to believe that condom use signified a lack of trust in one's partner compared to their younger counterparts. Notably, while many of our participants were in what might be considered "low risk" (long-term, monogamous) relationships and were unlikely to contract an STI, even those engaging in comparatively "higher risk" sexual relationships did not necessarily view safer sex as relevant to them. Implicit in these attitudes was the assumption that STIs are visible to the naked eye, and that you can tell if someone has an STI. This reflects the findings of research with younger cohorts (e.g., Barth, Cook, Downs, Switzer & Fischhoff, 2002).

The absence of sex education and a perceived lack of widespread condom use while growing up also meant that some older people may lack the knowledge, skills and

cultural/social norms to have safer sex – and this is more unique to older adults. It was apparent that norms and beliefs about safer sex from when participants were growing up continued to shape the understandings and practices of at least some older people. Some participants implied they were able to predict whether a partner had an STI based on their character and/or perceived number of sexual partners, and a number of female participants had experienced hostile responses from male partners after asking them to use condoms. The embarrassment and stigma associated with STIs and sex continued to act as a major barrier to discussing safer sex with a partner or healthcare provider, and this reflects the findings of research with younger cohorts (e.g., Barth et al., 2002; Hood & Friedman, 2011), though the impact of stigma plays out in different ways for older people. For instance, the stigma of having an STI may be compounded by the widespread cultural assumption that older people do not, or should not, have sex.

Our findings have important implications for policy, practice, and sexual health promotion initiatives aimed at reducing STIs amongst older cohorts. There is a clear need to challenge gendered norms and stigma about safer sex and "promiscuity" held by some members of older cohorts. The belief that only "promiscuous" or "dirty" people have safer sex functioned as a major barrier to having safer sex (and particularly condom use), hindered the ability to negotiate safer sex (particularly for older women), and meant that many older men and women did not view themselves or their partners as "at risk" of, or likely to have, an STI. In many respects, these findings are similar to those from research with younger adults (e.g., Barth et al., 2002; Hillier et al.,1998). Sexual health promotion strategies must clearly communicate that older people are sexually active, susceptible to STIs, that safer sex practices are relevant to older people, and that STIs are a normal (though not completely inevitable) aspect of sexual activity. Relatedly, campaigns must seek to disrupt dominant sexual scripts that hinder safer sex. The notion that sex should be "spontaneous" and

"natural," without interruption or discussion of any kind, could act as a barrier to discussing or having safer sex (see also Diekman et al., 2000; Galligan & Terry, 1993 for similar findings with younger samples) – not to mention discussion of other components of sexual health and wellbeing, such as consent and the negotiation of pleasure (Dune & Shuttleworth, 2009). Such actions may help to shift safer sex cultures amongst older cohorts in a way that facilitates their use.

Vitally, the promotion of safer sex must move beyond a sole focus on condom use to include a multi-faceted and holistic approach to sexual health promotion. For many individuals in this study, condom use was not appropriate due to erectile difficulties or other health issues. This represents a unique challenge for promoting condom use amongst older age groups (Schick et al., 2010), although other studies have also indicated that erectile difficulties can influence correct condom use amongst younger men (Crosby, Sanders, Yarber, Graham & Dodge, 2002; Graham et al., 2006; Sanders, Hill, Crosby & Janssen, 2014). While awareness of condoms as a safer sex strategy was high, there was considerably less discussion on STI testing (see also Hillier et al., 1998), and this coheres with findings from ASHR2 suggesting that participants aged 60-69 were the least likely to have had an STI test in the past 12 months. Regular STI testing – particularly for those with new or multiple sexual partners – represents a more accessible form of safer sex for those who are unable to regularly use condoms. Public health campaigns targeted towards older people could also include guidance on successfully putting a condom on a semi-erect penis. Likewise, efforts to normalise the use of lubricant during penetrative sex may also be of benefit, particularly given that some participants viewed lubricant use as disrupting the "natural" flow of sex.

It is also notable that – with the exception of two male participants who had sex with other men – participants did not discuss engaging in sexual practices that presented lower risk of disease transmission as a form of safer sex (see also Hillier et al., 1998). It is unclear

whether participants did not recognise this as a safer sex strategy (an issue that could be addressed through public health and educational campaigns), or whether heterosexual participants adhered to the idea that penetrative, penis-in-vagina intercourse constitutes "real" sex. Recent qualitative Australian research illustrates that older women hold diverse views of what "counts" as sex, though some still privileged penetrative heterosexual intercourse as "real" sex (Fileborn et al., 2015a; Fileborn et al, 2015b). Participants in the present study held similarly diverse views of what sex "is." Nonetheless, adherence to the view that penetrative intercourse constitutes real sex may prevent older people from engaging in lower-risk sexual practices as a form of safer sex, and suggests a need to continue to challenge and disrupt social and cultural norms that privilege penetrative intercourse.

Additionally, it is important to note that many participants' understandings of "safer sex" were, in some respects, quite narrow. While there was a strong focus on STI prevention, issues such as sexual consent, wellbeing, and ethics were raised by only a small number of participants, despite these being key components of the World Health Organization (WHO) definition of sexual health (WHO, 2006). Given that our participants grew up in a context of limited sexuality education, it is possible that this continues to shape their current understandings of safer sex – and this highlights the importance of situating safer sex within a life course perspective. Our findings suggest that sexual health campaigns for older people may also need to address broader issues such as those identified above, though this warrants further investigation.

Some participants reported negative or dismissive experiences with healthcare providers after requesting an STI test. As previous research has illustrated, healthcare providers are often reluctant to address issues of sexual health with older patients (Gott et al., 2004; Kirkman et al., 2013). Our findings indicate the need for training and education for healthcare providers regarding sexual health in later life. There is a clear role here for

healthcare providers to initiate discussions with older patients regarding sexual health, and to be receptive to this issue when raised by patients.

Educational and other efforts targeted towards older people may also benefit from taking into account the major barriers and facilitators to safer sex reported by participants. Trust was essential to participants' understandings of safer sex, and the importance and use of safer sex. Having trust typically meant that there was no perceived need to have safer sex. However, as one of our participants suggested, having STI tests and discussing safer sex could in fact *build* trust between partners. By reframing safer sex as being fundamentally about trust and trust building, this may encourage older people to have safer sex. It is also important to challenge the notion that monogamy offers protection against STIs, and to encourage older people to have an STI test or to use other forms of safer sex with all new partners.

As concern for personal health and well-being facilitated the use of safer sex, this could also underpin educational campaigns. For example, concern for health could be utilised to encourage older people to have an STI test, though such campaigns should be targeted towards older people in "high risk" groups for STIs, given the generally low likelihood of older people contracting STIs overall. Given that some participants reported that they did not see information about safer sex as relevant to them (see also Dalrymple et al., 2016), it is important that safer sex campaigns or educational resources be clearly targeted towards older people, or at least be inclusive of older populations. Any targeted resources may need to cover the "basics" of condom use and other safer sex practices, and provide a discrete and non-judgemental source of information. Such resources should also cover issues specific to older cohorts. For instance, this may include information on how condom design has changed over time to enhance sexual pleasure.

Limitations

There were some limitations of this study. As a qualitative study we were concerned with generating an in-depth exploration of participants' understandings and practices, and the findings presented here are not generalizable. The participants were generally highly educated, articulate, comfortable discussing sex, and from an Anglo-Saxon cultural background. Future research is necessary to identify any differences in attitudes and practices in more diverse demographic groups. Likewise, the majority of our participants identified as heterosexual, and the experiences of sexuality and gender-diverse older people require further examination. While participants were asked to respond to open-ended questions about what safer sex "is," and the safer sex practices they engaged in, the broader project from which this data stems (and particularly the online survey component of this project) had a strong focus on STIs and STI prevention. It is possible that this shaped our participants' definitions of safer sex and the types of safer sex they discussed. It is notable, for example, that participant discussions of safer sex focused almost exclusively on STI prevention as opposed to more holistic definitions inclusive of issues such as sexual consent and sexual pleasure.

Conclusion

Giving consideration to the sexual health of older people is becoming increasingly important, particularly with an ageing population where older people are remaining sexually active for longer and experiencing an increase in STI rates. This study – the first of its kind in Australia, and one of only a handful internationally – has provided important insight into the complexities and nuances of older peoples' understandings of safer sex and their safer sex practices. Our findings point to a considerable degree of variation in practice and knowledge. Likewise, while there is some similarity in understandings and use of safer sex with young age groups, our findings suggest that there are unique contextual factors and implications for older people. The continued influence of a range of myths and misconceptions about safer sex and STIs was also apparent. Importantly, these findings present valuable insight into the

ways in which we may begin to initiate change to help improve and support the sexual health and well-being of older populations.

References

Altschuler, J., & Rhee, S. (2015). Relationship power, sexual decision making, and HIV risk among midlife and older women. *Journal of Women & Aging, 27*, 290-308. DOI: 10.1080/08952841.2014.954499

Ballard, S. M., & Morris, M. L. (2003). The family life education needs of midlife and older adults. *Family Relations, 52,* 129-136. DOI: 10.1111/j.1741-3729.2003.00129.x

Barth, K. R., Cook, R. L., Downs, J. S., Switzer, G. E., & Fischhoff, B. (2002). Social stigma and negative consequences: factors that influence college students' decisions to seek testing for sexually transmitted infections. *Journal of American College Health, 50,* 153-159. DOI: 10.1080/07448480209596021

Bateson, D., Weisberg, E., McCaffery, K. J., & Luscombe, G. M. (2012). When online becomes offline: attitudes to safer sex practices in older and younger women using an Australian internet dating service. *Sexual Health, 9*, 152-159. DOI: 10.1071/SH10164

Beckman, N., Waern, M., Ostling, S., Sundh, V., & Skoog, I. (2014). Determinants of sexual activity in four birth cohorts of Swedish 70-year-olds examined 1971-2001. *Journal of Sexual Medicine, 11*, 401-410. DOI: 10.1111/jsm.12381

Bergstrom-Walan, M. B., & Nielsen, H. H. (1990). Sexual expression among 60-80 year old men and women: a sample from Stockholm, Sweden. *Journal of Sex Research, 27,* 289-295. DOI: 10.1080/00224499009551558

Bourne, C., & Minichiello, V. (2009). Sexual behaviour and diagnosis of people over the age of 50 attending a sexual health clinic. *Australasian Journal on Ageing, 28,* 32-36. DOI: 10.1111/j.1741-6612.2008.00336.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101. DOI: 10.1191/1478088706qp063oa

Brooks, J. T., Buchacz, K., Gebo, K. A., & Mermin, J. (2012). HIV infection and older Americans: the public health perspective. *American Journal of Public Health, 102*, 1516-1526. DOI: 10.2105/AJPH.2012.300844.

Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2013.* Atlanta: U.S: Department of Health and Human Services, 2014.

Cook, H. (2012). Getting foolishly hot and bothered? Parents and teachers and sex education in the 1940s. *Sex Education, 12,* 555-567. DOI: 10.1080/14681811.2011.627735

Crosby, R. A., Sanders, S. A., Yarber, W. L., Graham, C. A., & Dodge, B. (2002). Condom use errors and problems among college men. *Sexually Transmitted Diseases, 29,* 552-557.

Crosby, R., Shrier, L. A., Charnigo, R., Sanders, S. A., Graham, C.A., Milhausen, R., & Yarber, W. L. (2013). Negative perceptions about condom use in a clinic population: comparisons by gender, race and age. *International Journal of STD & AIDs, 24,* 100-105. DOI: 10.1177/0956462412472295

Crosby, R., Yarber, W. L., Sanders, S. A., & Graham, C. A. (2005). Condom discomfort and associated problems with their use among university students. *Journal of American College Health, 54,* 143-148. DOI: 10.3200/JACH.54.3.143-148

Dalrymple, J., Booth, J., Flowers, P., & Lorimer, K. (2016). Psychosocial factors influencing risk-taking in middle age for STIs. *Sexually Transmitted Infections,* DOI: 10.1136/sextrans-2016-052588

DeLamater, J. (2012). Sexual expression in later life: a review and synthesis. *Journal of Sex Research, 49,* 125-141. DOI: 10.1080/00224499.2011.603168

DeLamater, J., & Koepsel, E. (2015). Relationships and sexual expression in later life: a biopsychological perspective. *Sexual and Relationship Therapy*, *30*, 37-59. DOI: 10.1080/14681994.2014.939506

De Visser, O. R., Badcock, P. B., Rissel, C., Richters, J., Smith, A. M. A., Grulich, A. E., & Simpson, J. M. (2014). Safer sex and condom use: findings from the Second Australian Study of Health and Relationships. *Sexual Health, 11,* 495-504. DOI: 10.1071/SH14102

Diekman, A. B., McDonald, D., & Gardner, W. L. (2000). Love means never having to be careful: the relationship between reading romance novels and safe sex behaviour. *Psychology of Women Quarterly, 24,* 179-188. DOI: 10.1111/j.1471-6402.2000.tb00199.x

Donovan, B. (2000a). The repertoire of human efforts to avoid sexually transmissible diseases: past and present. Part 1: strategies used before or instead of sex. *Sexually Transmitted Infections, 76,* 7-12. DOI: 10.1136/sti.76.1.7

Donovan, B. (2000b). The repertoire of human efforts to avoid sexually transmitted diseases: past and present. Part 2: strategies used during or after sex. *Sexually Transmitted Infections, 76,* 88-93. DOI: 10.1136/sti.76.2.88

Dune, T., & Shuttleworth, R. P. (2009). "It's just supposed to happen": the myth of sexual spontaneity and the sexually marginalised. *Sexuality & Disability, 27,* 97-108. DOI 10.1007/s11195-009-9119-y

European Expert Group on Sexuality Education. (2016). Sexuality education – what is it? *Sex Education, 16,* 427-431. DOI: 10.1080/14681811.2015.1100599

Ezzy, D. (2002). *Qualitative analysis: practice and innovation*. London: Routledge.

Field, N., Mercer, C. H., Sonnenberg, P., Tanton, C., Clifton, S., Mitchell, K. R.,…Johnson, A. M. (2013). Associations between health and sexual lifestyles in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Lancet, 382,* 1830-1844. DOI: 10.1016/S0140-6736(13)62222-9

Fileborn, B., Thorpe, R., Hawkes, G., Minichiello, V., Pitts, M., & Dune, T. (2015a). Sex, desire and pleasure: considering the experiences of older Australian women. *Sexual and Relationship Therapy, 30*, 117-130. DOI: 10.1080/14681994.2014.936722

Fileborn, B., Thorpe, R., Hawkes, G., Minichiello, V., & Pitts, M. (2015b). Sex and the (older) single girl: experiences of sex and dating in later life. *Journal of Aging Studies, 33,* 67-75. DOI: 10.1016/j.jaging.2015.02.002

Foster, V., Clark, P. C., McDonnell Holstad, M., & Burgess, E. (2012). Factors associated with risky sexual behaviors in older adults. *Journal of the Association of Nurses in AIDS Care, 23*, 487-499. DOI:10.1016/j.jana.2011.12.008

Galligan, R. F., & Terry, D. J. (1993). Romantic ideals, fear of negative implications, and the practice of safe sex. *Journal of Applied Social Psychology, 23,* 1685-1711. DOI: 10.1111/j.1559-1816.1993.tb01061.x

Gedin, T. C., & Resnick, B. (2014). Increasing risk awareness and facilitating safe sexual activity among older adults in senior housing. *Journal of Community Health Nursing, 31*, 187-197. DOI: 10.1080/07370016.2014.958390.

Gott, M., & Hinchliff, S. (2003). How important is sex in later life? The views of older people. *Social Science and Medicine, 56,* 1617-1628. DOI: 10.1016/S0277-9536(02)00180-6

Gott, M., Hinchliff, S., & Galena, E. (2004). General practitioner attitudes to discussing sexual health issues with older people. *Social Science & Medicine, 58*, 2093-2103. DOI: 10.1016/S0277-9536(02)00180-6

Graham, C A., Crosby, R., Yarber, W. L., Sanders, S. A., McBride, K., Milhausen, R. R., & Arno, J. A. (2006). Erection loss in association with condom use among young men attending a public STI clinic: potential correlates and implications for risk behaviour. *Sexual Health, 3,* 255-260. DOI: 10.1071/SH06026

Grant, K., & Ragsdale, K. (2008). Sex and the 'recently single': perceptions of sexuality and HIV risk among mature women and primary care physicians. *Culture, Health & Sexuality, 10*, 495-511. DOI: 10.1080/13691050801948094

Grulich, A. E., de Visser, R. O., Badcock, P. B., Smith, A. M. A., Richters, J., Rissel, C., & Simpson, J. M. (2014). Knowledge about and experience of sexually transmissible infections in a representative sample of adults: the Second Australian Study of Health and Relationships. *Sexual Health, 11,* 481-494. DOI: 10.1071/SH14105

Hanna, P. (2012). Using internet technologies (such as Skype) as a research medium: a research note. *Qualitative Research, 12,* 239-242. DOI: 10.1177/1468794111426607

Higgins, J. A., & Wang, Y. (2015). The role of young adults' pleasure attitudes in shaping condom use. *American Journal of Public Health, 105,* 1329-1332. DOI: 10.2105/AJPH.2015.302567

Hillier, L., Harrison, L., & Warr, D. (1998). "When you carry condoms all the boys think you want it": negotiating competing discourses about safe sex. *Journal of Adolescence, 21,* 15-29. DOI: 10.1006/jado.1997.0126

Holt, A. (2010). Using the telephone for narrative interviewing: a research note. *Qualitative Research, 10,* 113-121. DOI: 10.1177/1468794109348686

Hood, J. E., & Friedman, A. L. (2011). Unveiling the hidden epidemic: a review of stigma associated with sexually transmissible infections. *Sexual Health, 8,* 159-170. DOI: 10.1071/SH10070

Idso, C. (2009). Sexually transmitted infection prevention in newly single older women: a forgotten health promotion need. *The Journal for Nurse Practitioners, 5,* 440-446. DOI: 10.1016/j.nurpra.2009.02.015

Johnson, B. K. (2013). Sexually transmitted infections and older adults. *Journal of Gerontological Nursing, 39,* 53-60. DOI: 10.3928/00989134-20130918-01

Kirkman, L., Kenny, A., & Fox, C. (2013). Evidence of absence: midlife and older adult sexual health policy in Australia. *Sexuality Research and Social Policy, 10,* 135-148. DOI: 10.1007/s13178-013-0109-6

Lindau, S. T., Leitsch, S. A., Lundberg, K., & Jerome, J. (2006). Older women's attitudes, behaviour, and communication about sex and HIV: a community-based study. *Journal of Women's Health, 15,* 747-753. DOI:10.1089/jwh.2006.15.747.

Lindau, S. T., Schumm, P., Laumann, E., Levinson, W., O'Muircheartaigh, C. O., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *The New England Journal of Medicine, 357,* 762-774. DOI: 10.1056/NEJMoa067423

Lyons, A., Heywood, W., Fileborn, B., Minichiello, V., Barrett, C., Brown, G., …Crameri, P. (under review). Recruitment and sampling strategies for a large mixed-methods study of sexual health and relationships in an older population: The Sex, Age and Me study. *Culture, Health & Sexuality.*

Malta, S. (2007). Love Actually! Older adults and their romantic Internet relationships. *Australian Journal of Emerging Technologies and Society*, *5,* 84-102.

Malta, S., & Farquharson, K. (2014). The initiation and progression of late-life romantic relationships. *Journal of Sociology, 50,* 237-251. DOI:10.1177/1440783312442254

May, J. (2006). Secrets and lies: sex education and gendered memories of childhood's end in an Australian provincial city, 1930s-1950s. *Sex Education, 6,* 1-15. DOI: 10.1080/14681810500508790

Mercer, C., H., Tanton, C., Prah, P., Erens, B., Sonnenberg, P., Clifton, S.,…Johnson, A. M. (2013). Changes in sexual attitudes and lifestyles in Britain through the lifecourse and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). *Lancet, 382,* 1781-1794. DOI: 10.1016/S0140-6736(13)62035-8

Minichiello, V., Plummer, D., & Loxton, D. (2004). Factors predicting sexual relationships in older people: An Australian study. *Australasian Journal on Ageing, 23*, 125-130. DOI: 10.1111/j.1741-6612.2004.00018x

Minichiello, V., Rahman, S., Hawkes, G., & Pitts, M. (2012). STI epidemiology in the global older population: emerging challenges. *Perspectives in Public Health, 132*, 178-181. DOI: 10.1177/1757913912445688.

Nash, P., Willis, P., Tales, A., & Cryer, T. (2015). Sexual health and sexual activity in later life. *Reviews in Clinical Gerontology, 25,* 22-30. DOI: 10.1017/S0959259815000015

Nusbaum, M. R. H., Singh, A. R., & Pyles, A. A. (2004). Sexual healthcare needs of women aged 65 and older. *Journal of the American Geriatrics Society, 52,* 117-122. DOI: 10.1111/j.1532-5415.2004.52020.x

Pilcher, J. (2005). School sex education: policy and practice in England 1870 to 2000. *Sex Education, 5,* 153-170. DOI: 10.1080/14681810500038848

Poynten, I. M., Grulich, A. E., & Templeton, D. J. (2013). Sexually transmitted infections in older populations. *Current Opinion in Infectious Diseases, 26,* 80-85. DOI: 10.1097/QCO.0b013e32835c2173.

Public Health England (2016). *Sexually transmitted infections (STIs): annual data tables*. England.

Reece, M., Herbenick, D., Schick, V., Sanders, S. A., Dodge, B., & Fortenberry, D. J. (2010). Condom use rates in a national probability sample of males and females ages 14 to 94 in the United States. *Journal of Sexual Medicine, 7,* 266-276. DOI: 10.1111/j.1743-6109.2010.02017.x

Sanders, S. A., Hill, B. J., Crosby, R. A., & Janssen, E. (2014). Correlates of condom-associated erection problems in young, heterosexual men: condom fit, self-efficacy,

perceptions and motivations. *AIDS & Behavior, 18,* 128-134. DOI: 10.1007/s10461-013-0422-3

Schick, V., Herbenick, D., Reece, M., Sanders, S. A., Dodge, B., Middlestadt, S. E., & Fortenberry, D. J. (2010). Sexual behaviors, condom use, and sexual health of Americans over 50: implications for sexual health promotion. *Journal of Sexual Medicine, 7,* 315-329. DOI: 10.1111/j.1743-6109.2010.02013.x

Slinkard, M. S., & Kazer, M. W. (2011). Older adults and HIV and STI screening: the patient perspective. *Geriatric Nursing, 32,* 341-349. DOI: 10.1016/j.gerinurse.2011.05.002.

Smith, K. P., & Christakis, N. A. (2009). Association between widowhood and risk of diagnosis with a sexually transmitted infection in older adults. *American Journal of Public Health, 99,* 2055-2062. DOI: 10.2105/AJPH.2009.160119

Sturges, J. E., & Hanrahan, K. J. (2004). Comparing telephone and face-to-face qualitative interviewing: a research note. *Qualitative Research, 4,* 107-118. DOI: 10.1177/1468794104041110

The Kirby Institute (2015). *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2015*. Sydney, NSW.

World Health Organization (2006). *Defining sexual health: report of a technical consultation on sexual health 28-31 January 2002, Geneva*. World Health Organization: Geneva.

Zablotsky, D., & Kennedy, M. (2003). Risk factors and HIV transmission to midlife and older women: knowledge, options, and the initiation of safer sexual practices. *Journal of Acquired Immune Deficiency Syndromes, 33,* s122-s130. DOI: 10.1097/00126334-200306012-00009