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Barriers and facilitators to accessing sexual health services for older LGBTQIA+ adults: A global scoping review and qualitative evidence synthesis

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ABSTRACT

Background

The number of older adults identifying as lesbian, gay, bisexual, transgender and other sexual and gender diverse identities (LGBTQIA+) continues to grow as populations age and social environments become more accepting. This study uses a global evidence synthesis to understand perceived barriers and facilitators to sexual healthcare service access globally for older LGBTQIA+ adults.

Methods

We used a scoping review and qualitative evidence synthesis. Embase, PubMed and PsycInfo were searched with terms related to LGBTQIA+ populations, adults aged 45 years old, and sexual healthcare. We used the Cochrane Handbook and the review protocol was registered. Primary and secondary textual data were coded and grouped into themes using PRISMA-SCR and the Minority Stress Model. The certainty of review findings was assessed using the GRADE-CERQual approach.

Results

The scoping review identified 19 studies and 15 were included in the qualitative evidence synthesis. All studies were from high-income countries. Heterocentricity and male-centricity of sexual health care services contributed to feelings of exclusion for older LGBTQIA+ adults (13 studies, moderate certainty of evidence). Both anticipated and enacted stigma from healthcare providers resulted in older LGBTQIA+ adults, especially those with chronic conditions, avoiding health services (seven studies each, low certainty). Older LGBTQIA+ adults have unique sexual health needs and may feel their age empowers them to access appropriate care (four studies, low certainty).

Conclusion

This review highlights the need for additional research and interventions to improve sexual health services for older LGBTQIA+ adults. Practical strategies to make sexual health less heterocentric (e.g., gender neutral signage) may increase uptake of essential sexual health services.

INTRODUCTION

The percentage of individuals identifying as lesbian, gay, bisexual, transgender, intersex, asexual, and other sexual and gender diverse identities (LGBTQIA+) has increased over the past 50 years across the globe [1, 2]. LGBTQIA+ people have unique sexual health needs and experiences, which are often influenced by lifetime discrimination, informal support networks, and sexual behaviors which fall outside of hegemonic heteronormativity. This highlights the importance of visibility and accommodation for older LGBTQIA+ adults in all health services, especially sexual health services.

Older adults, or adults aged 45 years old or older, are often neglected in sexual health services [3]. There is also a paucity in disaggregated data for LGBTQIA+ adults in this age range and many are excluded from studies. Menopause and related biological changes at mid-life provide a rationale for this age cutoff. Older adults are likely to face barriers in accessing sexual healthcare given that many sexual health services do not focus on this subpopulation [4-7]. Older adults are more likely than younger adults to be affected by chronic illness, disability, or co-morbidities which have consequences for sexuality and sexual function [4, 8-11]. The overall prevalence of HIV among people aged 50 and above doubled in the last decade [6, 12]. Older LGBTQIA+ adults are more likely to live with multiple diseases than older cis-gendered and heterosexual adults [13-15]. Additionally, sexual dysfunction is more likely among older adults [8, 16]. Sexual healthcare for older LGBTQIA+ adults may be accessed through general practitioners (GPs) and specialist healthcare providers in lieu of sexual health physicians. Therefore, it is pertinent that these such healthcare providers are aware of the sexual healthcare needs and priorities of older LGBTQIA+ adults in order to provide well-rounded care.

The historic pathologizing of advanced age in sexual health has led to increased hesitation seeking professional help compared to younger cis-gendered and/or heterosexual people [17, 18]. Additional factors such as inclusion in minoritized ethnic and religious communities may lead to further barriers to access to care [19]. Sexual health research has historically focused on youth and fewer sexual health programs target older adults, yet older adults have diverse sexual identities and many continue vibrant sexual lives [20]. Given that older LGBTQIA+ adults are likely to have familiar, longitudinal relationships with healthcare providers and to have experienced compounding microaggressions and heteronormativity in during interactions with these providers, they provide an especially important perspective when considering the inclusivity of sexual healthcare [21, 22].

Few research studies focus on older LGBTQIA populations [23-26].There are limited quantitative data that have rich, nuanced details about their sexual lives [27]. A limited number of studies consider barriers and facilitators to sexual health care and even fewer discuss how morbidities and disabilities affect the sexual health of sexual and gender diverse older people. Qualitative analyses allow for direct and personal narratives about older LGBTQIA+ adults' experienced barriers and facilitators. A qualitative evidence synthesis can capture social determinants which may affect service uptake. Qualitative evidence syntheses have been used by the WHO and other organizations to inform guideline development [28].

The purpose of this scoping review was to determine barriers and facilitators in accessing sexual healthcare services for older LGBTQIA+ adults using a global scoping review and qualitative evidence synthesis.

METHODS

Search strategy and selection criteria

We used a scoping review method for the following reasons: few research studies focused on this specific topic; there was substantial heterogeneity in key operational definitions; identifying research gaps in the literature may be well addressed through a scoping review [29]. We used a qualitative evidence synthesis method to lend a richer, more nuanced interpretation of qualitative results to understand the current situation and to better inform our recommendations [28].

This scoping review used a framework as developed by Arksey and O'Malley to guide the methodological approach and structure [30, 31]. This study used an adapted Minority Stress Model and the Patient-Centered Access to Care framework to map the results from the qualitative evidence synthesis [32, 33]. The Minority Stress Model has been previously used in studies related to LGBTQIA+ adults' sexual health [34]. The Patient-Centered Access to Care framework has previously been used in sexual health research focused on individuals with disabilities [35]. As such, these frameworks were selected because they provide an established and inclusive lens through which we can identify individual, provider and system-level barriers to sexual healthcare access for older LGBTQIA+ adults.

On June 10, 2021, PsycINFO, Medline and Embase databases were searched using the search terms with assistance from a public health librarian (Appendix 1). Synonyms, truncations, acronyms, subject headings, and Boolean operators (AND/OR) were used to combine the search terms. Relevant terms varied between databases given their individual search mechanisms. Additionally, relevant articles were searched manually from references.

All potential studies were exported into EndNote citation software, removing duplicates and were screened for inclusion by one author following PRISMA-SCR guidance. Studies were included if they discussed older adults' views on the sexual health care, the study population was older LGBTQIA+ adults as defined by individuals aged 45 and above or sub-analyses were completed for this age group, and they used qualitative methods or ~~was~~ a review of qualitative literature. Studies were excluded if they did not include a main or sub-analysis for older LGBTQIA+ adults, did not address sexual healthcare access or perceptions of experiences, or the primary analysis used quantitative data. There were no time or geographic restrictions. References from studies identified by the search strategy as well as the manual search were assessed and those meeting the inclusion criteria were included as a part of this review. Grey literature was also included.

Data analysis

For the thematic analysis, one researcher thoroughly read each of the included articles. An initial list of themes was discussed with two co-authors and finalized. Using the Minority Stress Model, deductive themes of heterocentricity, stigma, and disclosure were identified. Text was pulled from the included articles if it addressed one of these deductively set themes. Given the Minority Stress Model did not adequately explain all themes addressed in the selected studies, inductive coding methods were used. During multiple reads of the full included texts, one researcher pulled quotes and concepts related to barriers and facilitators of sexual healthcare access and, if similar, subsequently grouped together. Our inductive analysis captured themes of male-centricity, provider characteristics, increased security in older age and the unique needs of older LGBTQIA+ adults. Text fitting these inductively determined

themes was initially pulled from the included articles when similar ideas were found in various articles and later codified into coherent themes.

Confidence in the Evidence from Reviews of Qualitative Research approach (GRADE-CERQual) was used to assign grades of “Very low confidence,” “Low confidence,” “Moderate confidence,” and “High confidence” to thematic findings (Table 5) [36]. CERQual is recommended by Cochrane and has been used by the World Health Organization and other organizations to synthesize qualitative data for guideline development.

RESULTS

A total of 946 citations were identified. 54 duplicates and 863 unrelated citations were excluded. A total of 19 studies were selected, including four literature reviews, thirteen qualitative studies and two mixed method studies of which only the qualitative evidence was analyzed (Figure 1). A total of 15 studies were included in the qualitative evidence synthesis. Details (lead author, study design, methods, location, population, and age range) are in Table 1. All included studies were conducted in high-income settings including the United States (eight studies), the United Kingdom (five studies), Canada (three studies), Australia (two studies), New Zealand (two studies), Ireland (one study), and Sweden (one study). Seventeen studies focused on cis-gendered individuals, two included transgender people and none looked specifically at trans people. Ten studies analyzed gay and/or bisexual men or men who have sex with men (MSM) and four studies looked solely at lesbian and/or bisexual. Publication year of the articles included ranged from 2006 to 2020. Included studies captured the experiences of older adults seeking prostate cancer treatment (six studies), breast cancer treatment (one study), HIV-related care (three studies), primary care (three studies), sexual

health clinics (two studies) as well as general healthcare experiences (six studies). None of the included studies captured the perspectives of sexual health specialists, with older LGBTQIA+ adults seeking sexual healthcare from GPs and other internal medicine specialists. Only two studies [37, 38] were guided by theoretical frameworks, using the Socio-Ecological Theory and the Health Behavior Model of Health Service Use, respectively. Additionally, we were interested in capturing the intersection between disability and sexual healthcare access for older LGBTQIA+ adults but no studies reported on disability. Access to sexual healthcare services for older people with disabilities is a complex issue and should be explored further.

Themes

Only the fifteen unique qualitative studies were compared to organize codes and derive relevant themes and the results were assessed for quality (Table 2). Our analysis identified five overarching barriers for sexual health care access for older LGBTQIA+ individuals. From the perspective of older LGBTQIA+ adults, anticipated stigma following disclosure of sexual orientations and/or gender identity, and diverse needs as a result of aging as part of the LGBTQIA+ community function as barriers. At the level of health systems and providers, heterocentricity and male-centricity of sexual health service environments and resources, enacted stigma in response to disclosure and insensitive healthcare providers decreased sexual healthcare access for older LGBTQIA+ adults.

Our analysis also identified three overarching facilitators for sexual health care access for older LGBTQIA+ individuals. Increased security in identity in older age as well as intersectional needs as a result of aging as part of the LGBTQIA+ community facilitate sexual

healthcare access for older LGBTQIA+ adults. Empathetic healthcare providers also contribute to increased access for this population.

The inductive and deductive themes identified in the selected articles reflect the perspectives and experiences of the older LGBTQIA+ adults accessing sexual healthcare, which then map to sociocultural stressors, health behaviours within the Minority Stress Model and represent opportunities for intervention as dictated by the Access to Care framework.

Heterocentricity of sexual health services and research (Moderate certainty of the evidence)

Results from thirteen studies [37, 39-50] suggested that heterocentricity of healthcare service environments, intake forms and resources were a barrier for older LGBTQIA+ adults to access sexual health services. Heterocentricity was defined as the assumption of, or default to, sexual relationships between a cis-gender heterosexual man and a cis-gender heterosexual woman by providers. Heterocentricity affected the way that LGBTQIA+ individuals accessed services and interacted with health care providers [51]. Providers with heterocentric attitudes made older LGBTQIA+ adults feel unwelcome and unsupported [49, 50].

Male-centricity sexual health services for non-male identifying individuals

Results from the selected studies indicated that older LGBTQIA+ adults who were male-identifying were researched to a greater extent to those who identified with other genders, evidenced by the lack of studies focused on this population. The male-centric bias translated

into the exclusion of lesbian women from “sexual health scripts” [47]. The risk of sexually transmitted infections for older LGBTQIA+ women was reportedly fully dismissed by sexual healthcare providers due to a lack of adequate understanding of sexual behavior and risks [39].

Anticipated stigma following disclosure of gender identity and/or sexual orientation to healthcare providers (Moderate certainty of the evidence)

Ten studies [39, 40, 42, 44, 46, 47, 49, 52-54] pointed to older LGBTQIA+ adults’ anticipation of stigma following disclosure of their gender identity and/or sexual orientation to their healthcare providers as a barrier to accessing sexual healthcare. Anticipated stigma may have resulted from previous experiences with providers as well as the legal and political setting in which older LGBTQIA+ adults exist which may alienate, or exclude these individuals from protection [39, 44]. These experiences were characterized by overt homophobia, judgement of sexual behaviors, and provider embarrassment when discussing LGBTQIA+ sexual identities [35, 38, 50]. When older LGBTQIA+ adults were disincentivized to disclose their identity or sexual behaviors, to healthcare providers, the less likely it became that they would receive appropriate care or access care at all [39].

Enacted stigma from sexual healthcare providers (Moderate certainty of evidence)

According to eleven studies [37, 39, 40, 42, 45-50, 52], enacted stigma towards older LGBTQIA+ adults by healthcare providers was a barrier to sexual healthcare access. Enacted stigma was reported in the form of homophobic comments by providers, providers not

knowing about sexual healthcare needs of LGBTQIA+ adults, and denial of care following disclosure of gender or sexual orientation, for example [37, 39, 40, 42, 46-49]. Older LGBTQIA+ adults were more likely to experience discrimination in healthcare settings than LGBTQIA+ youth or non-LGBTQIA+ individuals [39]. Experiences of enacted stigma may also contribute to later anticipated and internalized stigma when accessing healthcare. Findings from two studies noted that older LGBTQIA+ adults were likely to delay or discontinue care as a result of such behavior by providers [37, 52]. Two other studies reported that older LGBTQIA+ adults felt they needed to find other means of care and information outside of formal healthcare settings such as personal research or non-medical social support [45, 49].

Characteristics of sexual health providers for older LGBTQIA+ adults (Moderate certainty of evidence)

Results from ten studies [38, 40, 42, 44, 46, 48, 49, 53-55] noted the effects of healthcare providers' characteristics on sexual healthcare access for older LGBTQIA+ adults. Depending on whether older LGBTQIA+ adults perceived the characteristics of a provider as positive or negative affects the way that they view their care experience. Participants in four studies noted that they were more comfortable discussing their needs and concerns with a sexual healthcare provider that was also LGBTQIA+ [38, 40, 49, 53]. Providers who were seen as empathic, compassionate, and open were associated with increased service access and comfort discussing sexual health needs by older LGBTQIA+ adults, particularly older LGBTQIA+ women [38, 46, 48].

Increased security in identity in older age for LGBTQIA+ adults (Moderate certainty of evidence)

According to five studies [38, 47, 50, 55, 56], older age facilitated sexual healthcare access among older LGBTQIA+ adults. Older age was linked to resilience in the face of minoritized gender identity and/or sexual orientation [38]. Older age was also associated with a strong sense of self leading some older LGBTQIA+ adults to note that they felt more comfortable discussing their sexual health needs at their current age than they did as young people due to anticipated and enacted stigma [47].

Unique sexual health needs of older LGBTQIA+ adults (Moderate CERQual evidence)

Six studies [39, 42, 45-47, 49] suggested that older LGBTQIA+ adults had unique sexual health needs that affected access to sexual health services. Unique sexual health needs referred to how various social categorizations, such as race, sexuality and gender, intersect to influence discrimination or disadvantage [57]. In particular, older gay and bisexual men in one study felt that their sexual health needs were divergent from that of older heterosexual men in relation to treatment options, consequences from side effects, and sexual relationship dynamics [46]. Conversely, older women who have sex with women noted increased hesitance initiating sexual health screening and providers were less likely to emphasize service access due to deprioritization [39, 47]. Older LGBTQIA+ adults of all genders noted that sexual activity was intertwined with intimacy and maintenance of support networks, which felt more pertinent to them at their current age than when they were younger [45, 47].

DISCUSSION

This scoping review and qualitative evidence synthesis identified multiple barriers and facilitators to sexual health care services for older LGBTQIA+ adults. Our data suggests that heterocentric health services may inadvertently exclude older LGBTQIA+ adults. Internalized homophobia among older LGBTQIA+ adults could exacerbate this process of exclusion, particularly when providers and systems reinforce their "otherness" through unequal access to appropriate information and resources. We found that health system level stressors, such as one-size-fits-all treatment plans and inadequate acknowledgement of diverse sexual relationships, are likely to cause sexual health risks to be misinterpreted, deprioritized, or simply ignored for older LGBTQIA+ individuals. The combined effects of system level stressors and older individuals' health behaviors are likely to result in negative health outcomes for this already underserved population.

Our results suggest that heterocentricity was a barrier for older LGBTQIA+ adults to access sexual health services This is consistent with existing research demonstrating heterocentric biases in sexual health research and practice [18, 58]. Heterocentric sexual health services discourage older adults from disclosing their gender identity and/or sexual orientation. Meanwhile, male-centricity prioritizes the experiences of ~~male-identifying~~ cisgender male individuals, worsening gender disparities in health outcomes. Ensuring that healthcare providers have sufficient training to serve older LGBTQIA+ adults sexual healthcare needs is critical to facilitating high-quality services for all [38, 44]. However, we speculate that training alone may be insufficient to counter heterocentricity and male-centric services. Structural interventions to support diverse genders and sexualities are important [59, 60]. When older LGBTQIA+ adults feel confident that their needs will be met by a provider, they will be more likely to continue accessing their services [55].

The findings in this review provide practical strategies to enhance sexual health services for this subgroup as outlined by the Minority Stress Model and Access to Care framework [32, 33]. The barriers suggested in this study serve as opportunities for interventions and improvements to current sexual healthcare practices while the facilitators represent aspects of successful care access (Figure 3). Our review findings suggested that older LGBTQIA+ adults have different sexual health priorities than younger, non-LGBTQIA+ adults. Providers were not found to adequately acknowledge and address older LGBTQIA+ adults' specific concerns, a complaint observed in other studies [61]. Ensuring that healthcare providers have adequate training and resources that meet LGBTQIA+ needs, particularly when embedded in routine non-sexual clinical services, may improve the acceptability of services. Providers can improve outcomes by clearly signposting support in physical spaces and through provision of LGBTQIA+-specific resources, improving approachability. Gender neutral language could decrease anxiety and distress for older LGBTQIA+ adults during initial encounters [56]. Using gender neutral language in informal health settings (e.g. support groups) may also make these spaces feel more appropriate for older LGBTQIA+ adults [45]. The included texts did not fully address the concept of affordability as laid out by the Access to Care framework. However, there is evidence that older LGBTQIA+ adults are less likely to have health insurance and more likely to experience financial challenges than older non-LGBTQIA+ adults [62, 63].

This review extends the literature by focusing on older LGBTQIA+ individuals, assessing the quality of the evidence and using a qualitative evidence synthesis. Despite the importance of disability among older people, none of the studies focused on disabilities or comorbidities as they relate to accessing sexual health services. Older non-LGBTQIA+ adults with disabilities are similarly underrepresented in sexual health research, particularly related to their

experiences and perspectives related to accessing care. There is evidence, however, that similarly to older LGBTQIA+ adults, their sexual health needs are also not adequately addressed by providers [64]. This is an important topic because conditions associated with older age have implications for sexual function and pleasure. Given that older LGBTQIA+ adults regularly access other specialist healthcare services as part of managing chronic conditions and comorbidities, integrating sexual healthcare into these services could further support this population and address their currently underserved needs. This deserves further research.

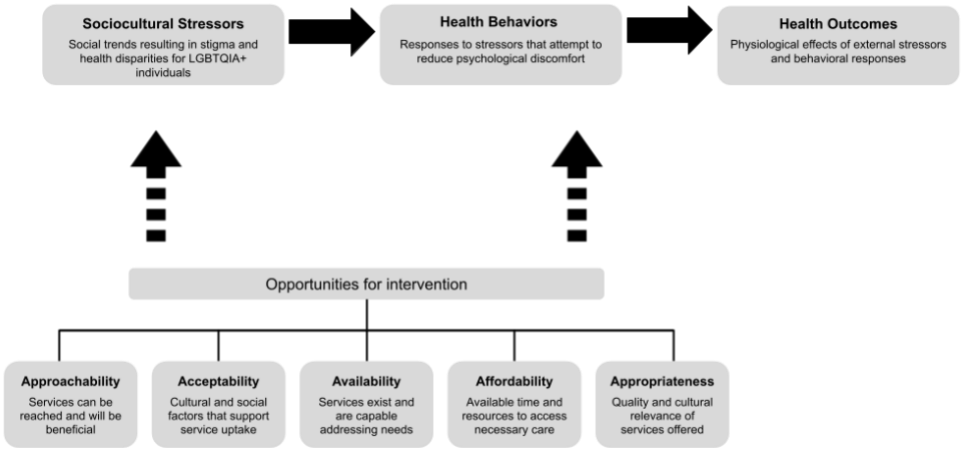
While this study has identified important implications for practice, it also has several limitations. First, this study was not able to capture the full policy and sociocultural contexts of older LGBTQIA+ adults and only captured data from high-income countries. This gap is a reflection of the dearth of research focused on older LGBTQIA+ adults outside of high-income contexts. However, high-income countries are less likely to criminalize divergent gender identities and/or sexual orientations and are more likely to have well-established healthcare infrastructure. High income countries may also provide a more supportive and feasible context for intervention given the increasing visibility of older LGBTQIA+ adults and health system infrastructure. Second, most of the participants from the selected studies were white and middle class. This underlines the importance of further research in other racial and ethnic groups. Third, much research on older LGBTQIA+ individuals is focused on gay men and lesbian women, further marginalizing less visible members of the community such as intersex, bisexual, transgender and gender non-conforming older adults. However, the value of this research is not diminished in that the contexts and individuals considered have intrinsic value.

This review is a rare comprehensive qualitative evidence synthesis of barriers and facilitators to sexual healthcare access among diverse older LGBTQIA+ population. Our findings highlight how heterocentricity, stigma and providers who are not inclusive inhibit sexual healthcare uptake and continuation for older LGBTQIA+ adults while age- and identity-related factors support sexual healthcare service use. Our data on older LGBTQIA+ adults lay the foundation for iterative service improvements. The results of this review demonstrate the need for more expansive provider training and inclusive sexual healthcare delivery, particularly in specialist healthcare, as well as inclusion of older LGBTQIA+ adults in clinical trials to make clinics more inclusive.

From a research perspective, our findings suggest the need to explore sexual healthcare experiences of older LGBTQIA+ women, intersex, bisexual, transgender, and gender non-conforming older adults. Additionally, research which explores the experiences of older LGBTQIA+ adults who are non-white, from low- and middle-income countries and diverse social classes will further add to our understanding and support service provision adaptations to best serve everyone. It is important that these investigations are led by people in these communities so as to not further privilege a heterocentric and male-centric perspective.

This scoping review and qualitative analysis highlights gaps in the literature, and points to individual and system level changes that could improve older LGBTQIA+ adults' sexual health services. For this population, barriers to sexual healthcare access are the result of sociocultural stressors and maladaptive health behaviors older LGBTQIA+ adults develop in response. Heterocentricity and stigma contribute to discriminatory information access and provider behavior as well as anxiety for this population. To address these barriers, our results suggest that providers and health systems need to improve the approachability, acceptability,

401 availability, affordability, and appropriateness of sexual health services. Older LGBTQIA+
402 adults represent an underserved population by sexual healthcare services from the provider
403 level to the health system level and as such represent a flaw in the system to be rectified to
404 achieve equity in healthcare.



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406 **Figure 1.** An adapted Minority Stress Model using the Patient-Centered Access to Care
407 framework identifying opportunities for intervention to increase uptake of sexual health
408 services among Older LGBTQIA+ adults

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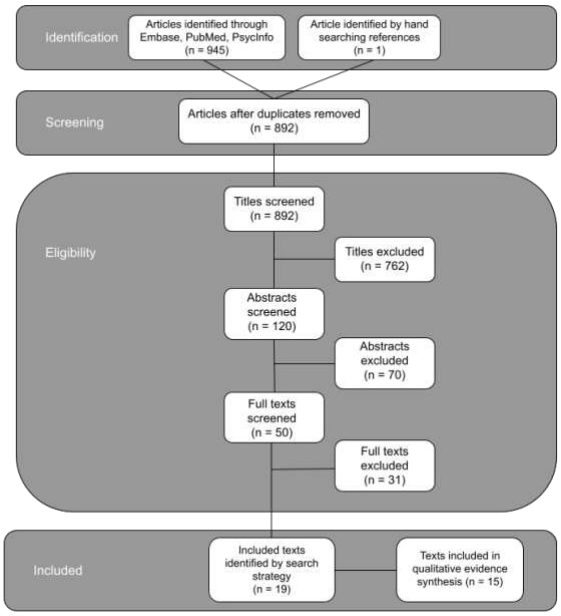

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412 ***Figure 2.*** PRISMA flow chart

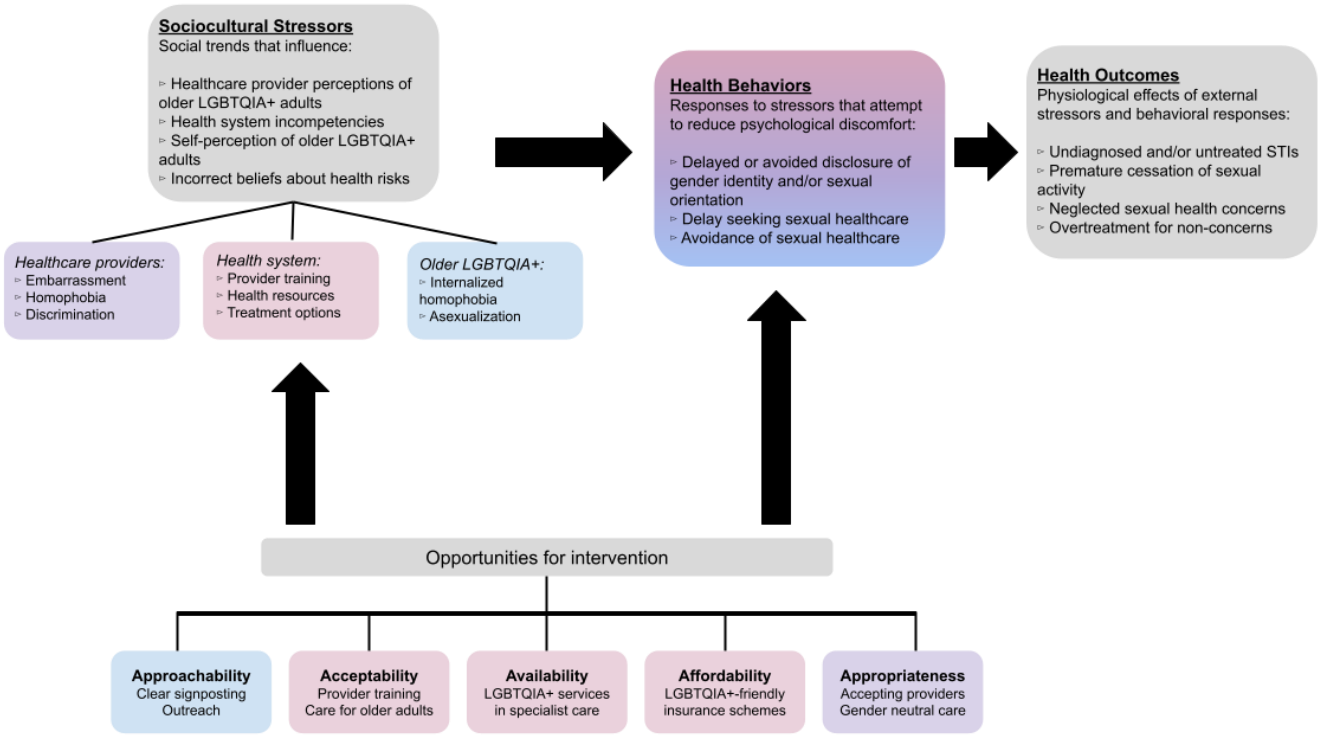

Figure 3. Using the Patient-Centered Access to Care framework to interrupt the pathway to poor health for older LGBTQIA+ individuals as described by the Minority Stress Model

418 ***Table 1.*** Studies included in the scoping review and qualitative evidence synthesis of data
419 from older LGBTQIA+ adults on sexual health (n=19)

Lead author and year	Study design	Methods	Location	Population*	Age range* (in years)
[39] Addis 2009	Literature review	Meta-narrative	*Not specified*	Lesbian, gay, bisexual and transgender individuals	‘‘*older” not defined*
[40] Alexis 2018	Literature review	Meta-synthesis	*Not specified*	Cis-gender gay, bisexual men who previously had prostate cancer	45+
[52] Clover 2006	Qualitative	Semi-structured interviews	London, UK	Cis-gender, white gay men	60 - 75
[41] Danemalm 2019	Qualitative	Semi-structured interviews	Sweden	Cis-gender gay men who had previously been treated for prostate cancer	58 - 81
[42] Doran 2018	Qualitative	Semi-structured interviews	England, UK	Cis-gender gay men with prostate cancer	49 - 82
[37] Dune 2020	Literature review	Thematic systematic review	*Not specified*	Cis-gender lesbian, bisexual women	55+
[43] Gessner 2019	Qualitative	Semi-structured interviews	USA	Cis-gender lesbian, gay, queer individuals	52 - 59
[38] Green 2019	Qualitative	Semi-structured interviews	Philadelphia, USA	Cis-gender gay men living with HIV	50+
[56] Kushner 2013	Qualitative	Semi-structured interviews	New Zealand	Cis-gender gay men	65 - 81
[44] LaVaccare 2018	Qualitative	Focus groups	Los Angeles, USA	Cis-gender lesbian, bisexual women	65+
[45] Lee 2015	Qualitative	Semi-structured interviews	British Columbia, Canada	Cis-gender MSM	58 – 71
[46] Lisy 2018	Literature review	Systematic review and meta-synthesis	USA, Australia, UK, Canada	Cis-gender lesbian, gay, bisexual individuals who have/had cancer	*Majority of studies included were 45+*
[53] Maloney 2017	Qualitative	Focus groups	USA	Cis-gender gay, bisexual men	40 – 52
[54] Martos	Qualitative	Semi-structured	USA	Cis-gender	52-59

2018		interviews		lesbian, gay, bisexual individuals	
[47] McIntyre 2010	Qualitative	Semi-structured interviews	Calgary, Canada	Cis-gender lesbian women who had previously had a Pap test	43 – 54
[48] Politi 2009	Qualitative	Structured interviews	Rhode Island, USA	Cis-gender lesbian women who were currently unmarried	40 - 75
[55] Pollard 2017	Qualitative	Focus groups	Southeast England	Cis-gender MSM	50+
[49] Rose 2016	Mixed method	Semi-structured interview and quantitative survey	Australia, New Zealand, USA, UK	Cis-gender gay, bisexual men and their partners	45 - 89
[50] Sharek 2015	Mixed method	Semi-structured interview and quantitative survey	The Republic of Ireland	Lesbian, gay, bisexual and transgender individuals	55+

** Included in the analysis of this study*

434 ***Table 2.*** Summary of qualitative review findings using the GRADE method

435

Review finding	Contributing studies	Confidence in the evidence	Explanation of confidence assessment
Heterocentricity* and male-centricity of sexual health clinical services (intake forms, environments, resources, surveys) privilege the perspectives of heterosexual people and men specifically. Older LGBTQIA+ individuals, especially women, report feelings of exclusion and erasure.	[41, 42, 43-45, 47-50]	Moderate	All studies have minor to moderate methodological limitations. Moderate concerns about coherence and adequacy for all 13 studies. Major concerns about relevance due high-income settings of all studies.
Anticipated stigma following disclosure often based on past experiences leads older LGBTQIA+ adults to refrain from addressing identity-related needs. Older LGBTQIA+ often have difficulty identifying providers that they feel will not stigmatize them following identity disclosure.	[42, 44, 47, 49, 52-54]	Low	All studies have minor to moderate methodological limitations. Moderate concerns about coherence and adequacy. Major concerns about relevance due high-income settings of all studies.
Older LGBTQIA+ people reported enacted stigma from healthcare providers in the form of discrimination, rejection, or poorer treatment. This experience of stigma sometimes leads older LGBTQIA+ individuals to avoid primary healthcare.	[42, 45, 47-50, 52]	Low	All studies have minor to moderate methodological limitations. No or very minor concerns about coherence. Moderate concerns about adequacy. Major concerns about relevance due high-income settings of all studies.
Provider characteristics related to gender identity and sexual orientation, amount of experience with LGBTQIA+ patients, and openness may act as a barrier or facilitator	[38, 42, 44, 48, 49, 53-55]	Low	All studies have minor to moderate methodological limitations. No or very minor concerns about coherence for all 10 studies. Moderate concerns about adequacy. Major concerns about

depending on the specific context.			relevance due high-income settings of all studies.
Increased security in identity in older age, especially for older LGBTQIA+ women, leads individuals to advocate for their diverse healthcare needs more confidently, facilitating access to services.	[38, 47, 50, 55, 56]	Low	All studies have minor to moderate methodological limitations. No or very minor concerns about coherence for all 5 studies. Major concerns with adequacy given 2 studies with thin data, 3 studies with thick data. Major concerns about relevance due high-income settings of all studies.
Intersectional needs of older LGBTQIA+ adults related to age, gender identity and sexual orientation interact to drive sexual healthcare priority setting for individuals. As a result, older LGBTQIA+ individuals may make additional efforts to seek sexual healthcare or may be inclined to deprioritize particular services.	[42, 45, 47, 49]	Low	All studies have minor to moderate methodological limitations. No or very minor concerns about coherence. Major concerns about adequacy. Major concerns about relevance due high-income settings of all studies.

436 ** Heterocentricity is defined as the assumption of or default to acknowledging relationships, sexual or otherwise,*
437 *between a cis-gender heterosexual man and a cis-gender heterosexual woman for this study*
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SUPPLEMENTAL

Appendix 1. Full search strategies

Embase	1. Queer or lesbian or gay or MSM or WSW or transgender or transexual or intersex or bisexual or LG* or "sexual minority" or "men who have sex with men" or "women who have sex with women"
	2. "Older adult*" or older or elder* or ag?ing or "mature adult*" or "middle age*"
	3. "sexual health" or "sexual healthcare" or "sexual health care"
	4. 1 and 2 and 3
	5. limit 4 to (360 middle age <age 40 to 64 yrs> or "380 aged <age 65 yrs and older>" or "390 very old <age 85 yrs and older>")
	6. limit 4 to aged <65+ years>
PsycInfo	1. Queer or lesbian or gay or MSM or WSW or transgender or transexual or intersex or bisexual or LG* or "sexual minority" or "men who have sex with men" or "women who have sex with women"
	2. "Older adult*" or older or elder* or ag?ing or "mature adult*" or "middle age*"
	3. "sexual health" or "sexual healthcare" or "sexual health care"
	4. 1 and 2 and 3
	5. limit 4 to (360 middle age <age 40 to 64 yrs> or "380 aged <age 65 yrs and older>" or "390 very old <age 85 yrs and older>")
Medline	1. sex/ or sex.mp
	2. sexual health/ or sexual health.mp
	3. sexual dysfunction.mp
	4. 1 or 2 or 3
	5. Healthcare or health care or delivery health care

[redacted]	6. Middle age* or middle age.mp or aged or ag?ing or elderly or elderly.mp
	7. Chronic disease.mp or chronic disease/
	8. Comorbidity/ or comorbidity.mp
	9. Hypertension/ or hypertension.mp or diabetes.mp or diabetes/
	10. 7 or 8 or 9
	11. Qualitative.mp or focus group/ or focus group.mp
	12. 2 or 5
	13. 4 and 5
	14. 6 and 13
	15. 10 and 14
	16. 11 and 15

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Appendix 2. Summary of CASP scores from the systematic review checklist of literature review studies

Lead author	Year published	Focused?	Best sort of studies?	Relevant studies included?	Rigor?	Results appropriately combined?	Overall results clear?	Generalizability?	Imp nt out s co ed?
Addis	2009	Yes	Yes	Yes	Yes	No	Yes	No	Y
Alexis	2018	Yes	Yes	Yes	Yes	Yes	Yes	No	Y
Dune	2020	Yes	Yes	Yes	No	Yes	Yes	No	Y
Lisy	2018	Yes	Yes	No	Yes	Yes	Yes	No	Y

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Appendix 3. Summary of CASP scores from the systematic review checklist of qualitative studies

Lead author	Year published	Focused?	Qualitative approach	Appropriate research design?	Appropriate recruitment	Appropriate data collection	Reflexivity?	Eth cs cle rly

			justified ?		strategy?	strategy?		sta ed
Clover	2006	Yes	Yes	Yes	Yes	Yes	No	No
Danemalm	2019	Yes	Yes	Yes	Yes	Yes	No	No
Doran	2018	No	Yes	Yes	Yes	Yes	No	No
Gessner	2019	No	Yes	No	Yes	Yes	Yes	No
Green	2019	Yes	Yes	Yes	Yes	Yes	No	No
Kushner	2013	Yes	No	Yes	No	Yes	No	No
LaVaccare	2018	Yes	Yes	Yes	Yes	Yes	No	No
Lee	2015	Yes	Yes	Yes	No	Yes	No	No
Maloney	2017	Yes	Yes	Yes	Yes	No	No	No
Martos	2018	Yes	No	Yes	Yes	Yes	No	No
McIntyre	2010	Yes	Yes	Yes	No	Yes	No	No
Politi	2009	Yes	No	Yes	No	Yes	No	No
Pollard	2017	Yes	Yes	Yes	No	No	No	No
Rose*	2016	Yes	Yes	Yes	No	Yes	No	No
Sharek*	2015	Yes	Yes	Yes	Yes	Yes	No	No

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