

PEOPLE AGED 50 YEARS AND OLDER



The ageing of the world's population is one of the most significant demographic trends of this era, and there are a growing number of people aged 50 and older living with HIV in the world today (1). With the size of this demographic growing, there will be an increased need for long-term access to HIV and other health services.

This group includes men, women and transgender people. A large proportion of people aged 50 and older are sexually active. Like younger people, people aged 50 and older also need HIV services, although their needs are often overlooked, neglected or ignored.

{ PEOPLE AGED 50 YEARS AND OLDER

I am 50+.

I face these issues.



WHY PEOPLE OVER THE AGE OF 50 ARE BEING LEFT BEHIND

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HIV BURDEN

There are 4.2 million people aged 50 and older living with HIV today.

More than 2 million people aged 50 and older live in sub-Saharan Africa, which accounts for 60% of all people living with HIV over the age of 50.

Thirteen per cent of the adult population living with HIV is aged 50 or older.

HIV vulnerability and risk among older adults is found in all regions.

Approximately one out of five people living with HIV who are aged 50 and older live in western and central Europe and North America (2). This demographic is expected to continue to grow worldwide, and, as it does, so will the need for long-term access to HIV and other health services.

The number of people living with HIV in low- and middle-income countries aged 50 or older continues to grow, representing 12% of all adult people living with HIV in 2013. In high-income countries, the sub-population of people aged 50 and older represents approximately 30% of the adult population living with HIV (1). In 2008, about 31% of people living with HIV in the United States of America were aged 50 or older, compared to 17% in 2001 (3,4). The trend is similar across sub-Saharan Africa, where recent modelling projected that the total number of people living with HIV aged 50 or older will nearly triple in the coming years (5).

THE TOP 4 REASONS

01

Low perception of HIV risk

02

Managing HIV and other health issues is complicated

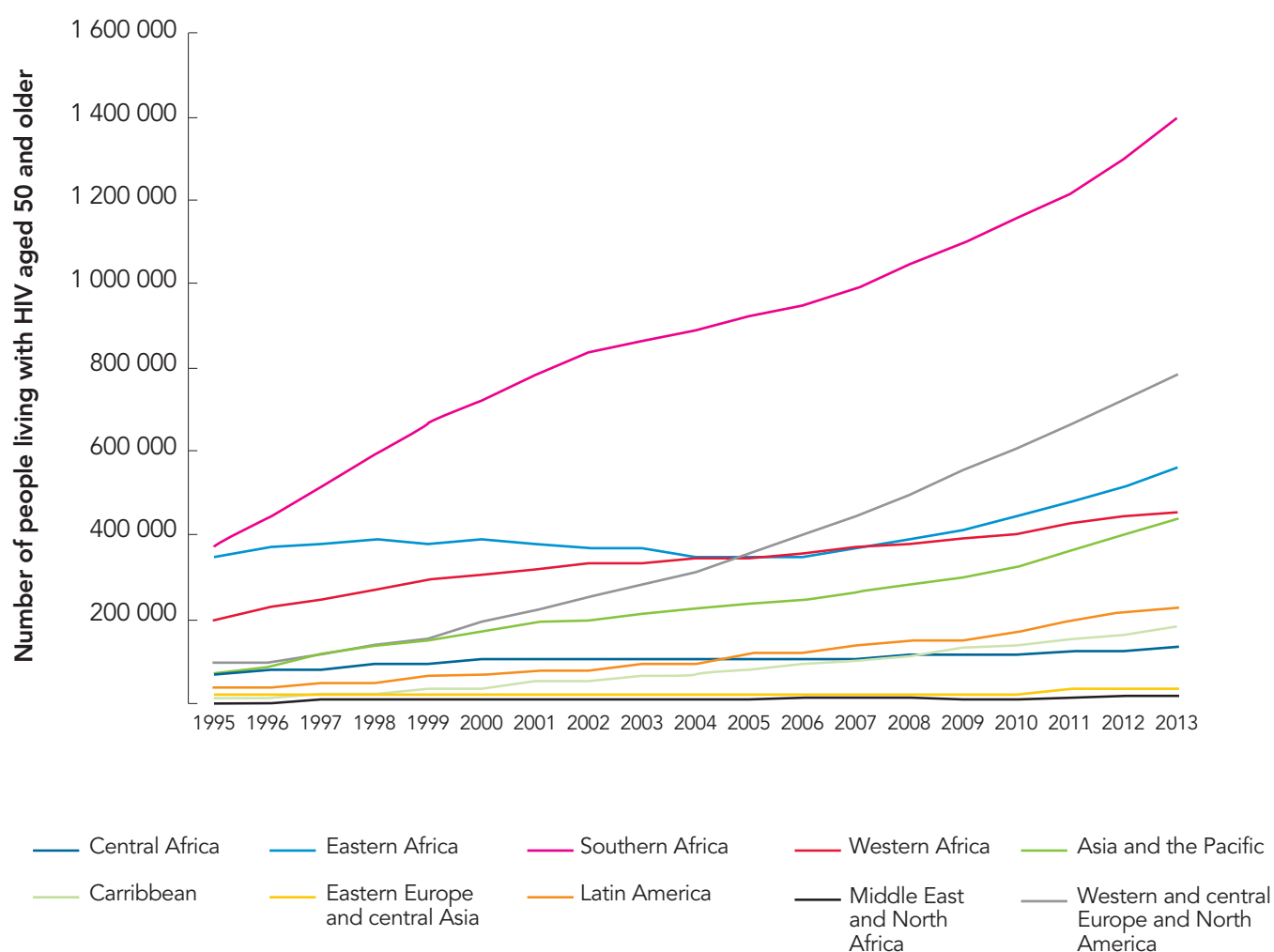
03

Access to services

04

Stigma and discrimination

Estimated number of people living with HIV aged 50 and older by region, 1995–2013



Source: UNAIDS 2013 estimates.

The increasing number of people living with HIV aged 50 and older is largely due to three factors. First, antiretroviral therapy has been successful in prolonging the lives of people living with HIV in high-income countries. Second, the life expectancy of a person living with HIV who achieves and maintains viral suppression on antiretroviral therapy is now similar to that of a person who has not acquired HIV (6). Finally, the trend of decreasing HIV incidence among younger adults is shifting the proportion of disease burden to older age groups.

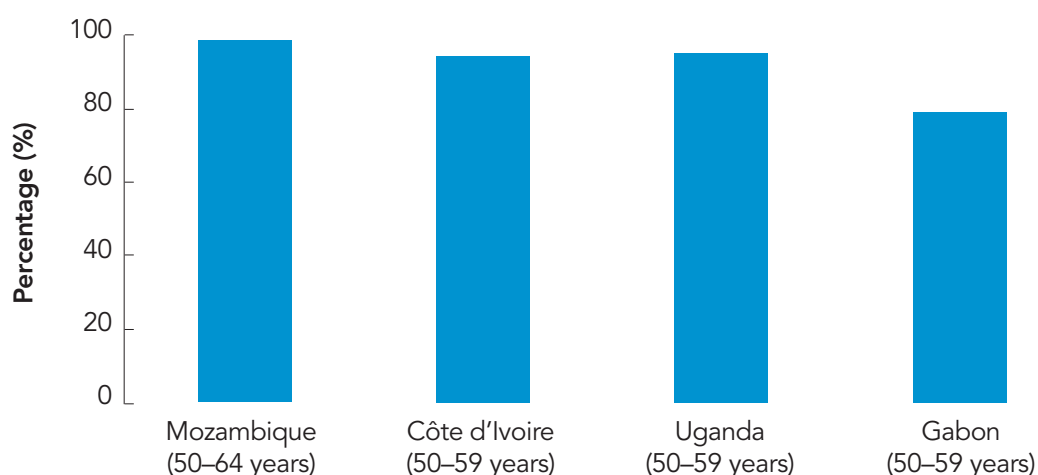
However, few HIV strategies in low- and middle-income countries have caught up with this trend. Many countries are failing to address this increasingly significant dimension of the HIV epidemic.

Low perception of HIV risk

Every year, 100 000 people in low- and middle-income countries aged 50 and older acquire HIV (1). Seventy-four per cent of this population lives in sub-Saharan Africa.

People in this age group exhibit many of the same HIV risk behaviours found in younger age groups (7). However, HIV prevention and other services, including tuberculosis screening, rarely mention older people or reflect their specific realities and needs (8). Data from countries show that the majority of people aged 50 and older with multiple partners do not use condoms.

Percentage of men aged 50 and older with multiple partners who did not use a condom during last sex in selected countries, 2009–2012



Source: Demographic and Health Surveys (further analysis by UNAIDS).

Sexually active women aged 50 and older are at high risk of acquiring HIV, owing to biological changes. The thinning of the vaginal wall after menopause, for example, increases the chances of lesions and tears, thereby increasing the risk of HIV transmission during sex (9).

People aged 50 and older generally have a low perception of their own risk of acquiring HIV and HIV awareness.

Managing HIV and other health issues is complicated

People aged 50 and older need specialized care for HIV and other chronic conditions.

Providing treatment can be challenging if the person living with HIV also has one or more chronic conditions (17). In a South African study, 30% of the people living with HIV aged 50 and older were found to have two or more chronic medical conditions (18).

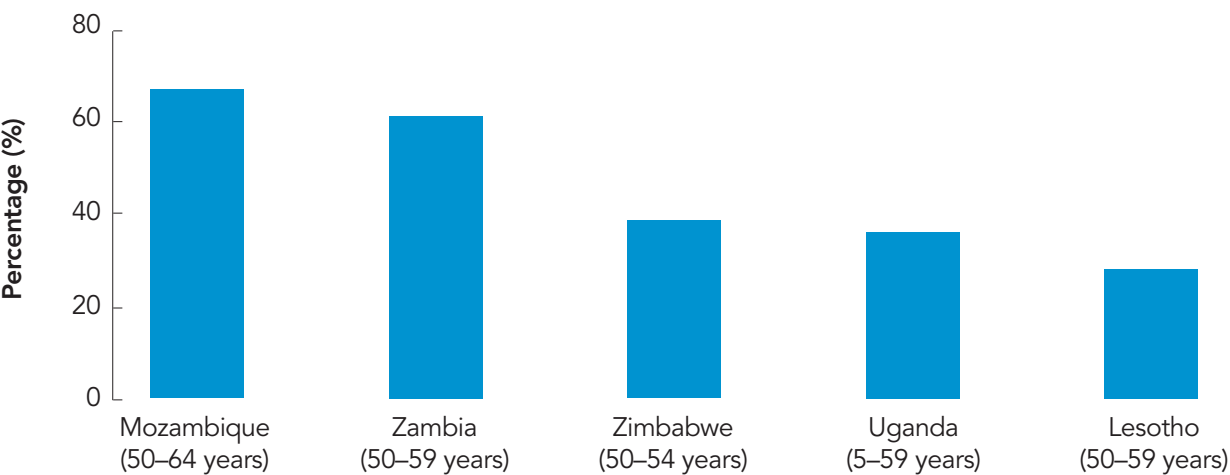
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In countries with a high HIV prevalence, the large number of AIDS-related deaths tends to mask the nation’s potential burden of noncommunicable diseases among older people since large proportions of this population do not survive long enough for non-AIDS-related illnesses to manifest (5).

The demographic shift may have consequences for health systems more generally, especially in sub-Saharan Africa. Increased life expectancy is likely to increase the relative burdens of other diseases in this region, notably noncommunicable diseases.

People aged 50 and older are more likely than their younger counterparts to remain on antiretroviral therapy (12,13). But adherence can suffer when individuals are experiencing several chronic conditions simultaneously or facing poverty and food insecurity (19–21). In addition, people aged 50 and older do not respond to antiretroviral therapy as well as younger people (14).

Percentage of men aged 50 and older living with HIV who have never been tested for HIV in selected countries, 2007–2011



Source: Demographic and Health Surveys (further analysis by UNAIDS).

Access to services

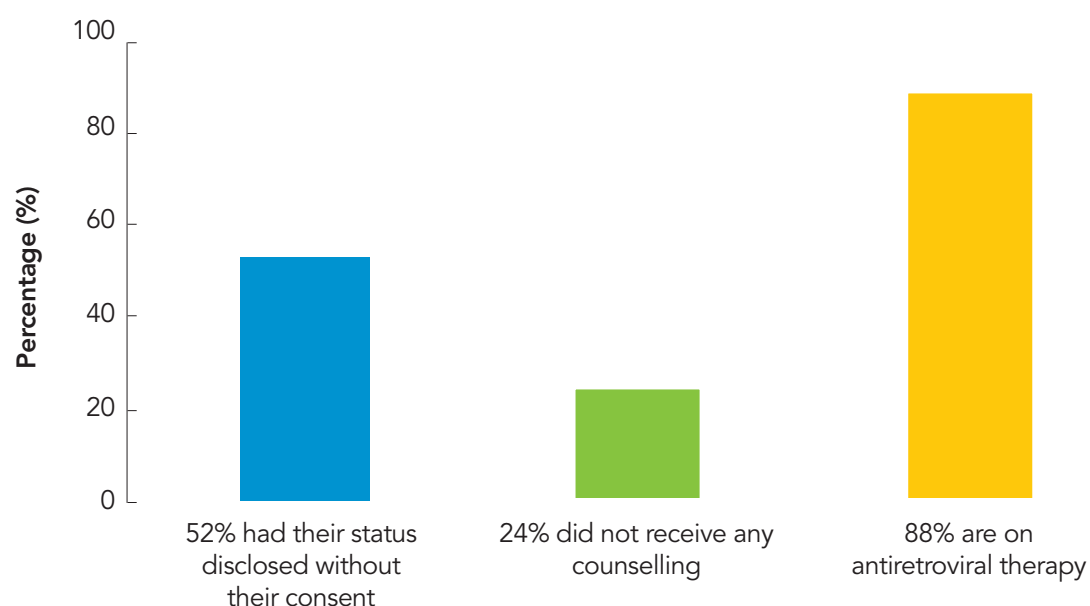
Health communication and health services are not geared towards people aged 50 and older living with HIV. Clinicians are less likely to be trained on the specific needs of people 50 and older living with HIV (22). As a result, this population is likely to be diagnosed late in the course of HIV infection and often after their health has deteriorated considerably (23).

Health services are not geared towards people aged 50 and older living with HIV.

Stigma and discrimination

For people living with HIV aged 50 and older, the consequences of stigma and discrimination are potentially devastating. In addition to the psychological impact of being shunned by family, peers and the wider community, poor quality and delayed services in health-care settings significantly reduce the potential for positive outcomes from HIV treatment.

Experiences by people living with HIV aged 50 and older in Cameroon



Source: People Living with HIV Stigma Index Report, Cameroon. HIV Leadership through Accountability Programme, GNP+, and RéCAP+, 2012.

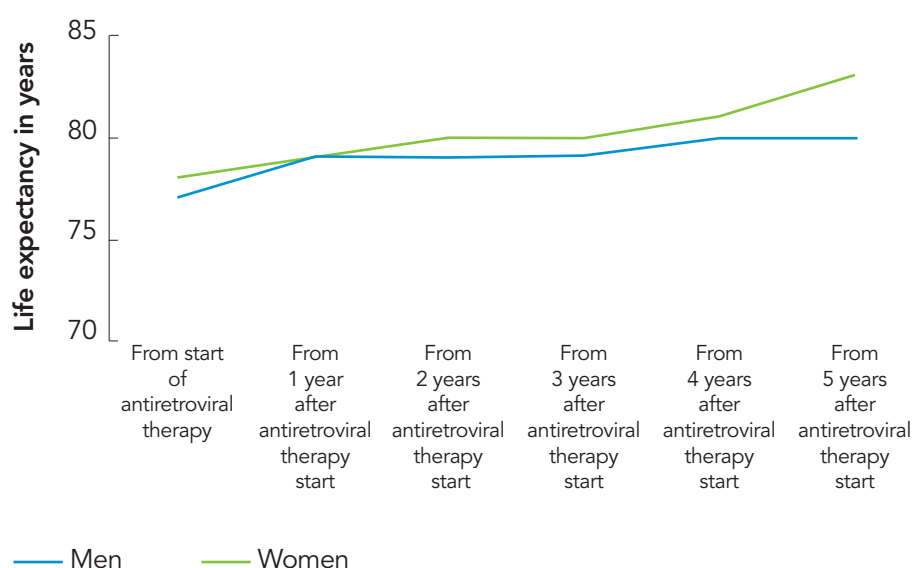
CLOSING THE GAP

As the number of people living with HIV who are aged 50 or older continues to grow, the demand and need for long-term access to HIV and other health services will also grow. A large proportion of this group continues to be physically and sexually active and does not consider themselves to be elderly. Many people aged 50 and older continue to be active in the workplace and in the social fabric of their communities and societies. They are men, women and transgender people. HIV testing and treatment services need to address the distinct needs and realities of people aged 50 and older who are living with HIV. The timely detection and initiation of antiretroviral therapy is especially important, since the immune systems of people 50 and older tend to recover more slowly compared with those of younger people (8,24).

More and more, studies are showing that early HIV treatment has a positive impact on the lives of people living with HIV who are 50 and older. Where the health systems are strong, this population, when taking antiretroviral therapy, can have life expectancy comparable to people who have not acquired HIV.

In order to respond to the varied needs of people aged 50 and older, knowledge about the efficacy of and modifications to treatment regimens in different age groups must improve. At the moment, research and data are sparse. A greater understanding is required around issues related to the body's ageing process, and how the presence of other illnesses may affect HIV-related treatment.

Life expectancy among people reaching age 50 at one, two, three, four and five years after the start of antiretroviral therapy in the United Kingdom



Source: Based on data from Margaret T. et al. Impact on life expectancy of HIV-1 positive individuals of CD4+ cell count and viral load response to antiretroviral therapy. AIDS. 2014;28(8):1193–1202 and UK national statistics.

Twenty-four per cent of people aged 50 and older living with HIV in Cameroon received no counselling at the time of their test or afterwards.

HOW TO CLOSE THE GAP

01

Early HIV detection and treatment

02

Integration of services

03

Psychological and medical support

04

Social protection

To the extent possible, all health services should be integrated to facilitate easy access and supported by linkages to the community. As we move forward and the absolute number of people who are aged 50 and older who are living with HIV continues to grow, data collection systems need to improve and services need to adapt and evolve. Further efforts are required to integrate antiretroviral therapy effectively within care systems for other chronic diseases. HIV services for people aged 50 and older should be managed alongside concurrent health considerations (5), such as diabetes, heart disease and hypertension.

When taking antiretroviral therapy, people aged 50 and older living with HIV can have life expectancies comparable to people who have not acquired HIV.

HIV responses need to account for the sexual rights and evolving family and economic contexts of older people and provide prevention, testing, treatment, care and support services that are accessible and that meet their specific needs.

Increasingly, health and social services for people aged 50 and older should be informed by—and, in some cases, integrated with—broader initiatives to combat inequality and to end extreme poverty. Community-based services and, in particular, the provision of services and support through community and faith-based organizations will be key to the scale up of social services for older people living with HIV.

Health-care providers must be trained to respond to the specific needs and challenges of this population. Special attention must be given to providing psychological and medical support as well as concrete social protection for people over 50.

Even well-planned, integrated and appropriate services are only truly accessible to people if they are affordable. Data disaggregated by older age groups are scarce, but available data indicate that this group is overrepresented among the poor and the extremely poor, especially in the two thirds of the world's countries that do not have social pensions or other social protection for older adults (25).

Social protection instruments, such as non-contributory pensions and health and disability insurance, have been shown to dramatically improve the welfare of older people who are living with HIV themselves or caring for their children and grandchildren affected by HIV. For the urban and rural poor, even small, predictable payments enable them to buy food, pay transportation costs and contribute to their families' expenses.



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Printed on FSC-certified paper



20 Avenue Appia
CH-1211 Geneva 27
Switzerland

+41 22 791 3666
distribution@unaids.org

unaids.org

