Risky sexual practices and prevention of sexually transmitted infections among urban dwelling elderly Yoruba people in southwest Nigeria

By

Ojo Melvin Agunbiade
Department of Sociology, University of the Witwatersrand, South Africa
Department of Sociology and Anthropology, Obafemi Awolowo University, Ile-Ife, Nigeria

A Draft Paper presented at the 7th African Population Conference

Johannesburg South Africa

November 30 – December 4, 2015

Abstract

Risky sexual practices exist in diverse forms as social categories move along the life course. Such practices are sometimes normatively justified as social actors situate their actions within contexts. The paper focuses on the notions of risky sexual practices and prevention of sexually transmitted infections in old age. Twelve Focus Group Discussions with vignettes were conducted on gender basis among elderly Yoruba men and women in three age categories (60-69years, 70-79years and 80 years above). Also, 18 (elderly men and women 60 years and above) and six (traditional health practitioners) semi-structured interviews were held. Concurrent sex with multiple partners has spiritual and physical risks; yet, elderly men could have multiple sexual partners. Sexually transmitted infections are preventable through traditional measures and the use of condoms. However, condom reduces sexual pleasures and satisfaction. Thus, efforts are required to address risky sexual practices and responsive prevention of sexual infections among elderly people.

Introduction

Sexual risk-taking behaviour refers to those sexual activities that predispose individuals or social groups to contract sexually transmitted infections (Gott, 2004). Within and across social categories, risky sexual practices vary with psychological, socio-demographic variables and with structural factors such as poverty, economic, religious, and environmental factors (Luke, 2005). Involvement in risky sexual practices occurs in a web of relationships involving individual, social structural and environmental factors within a particular context. The dynamics and meanings associated with risky sexual practices in old age have received minimal attention in the literature. Nevertheless, such studies have provided useful information in understanding risky sexual practices and prevention measures among adolescents and young and middle-aged adults (Wellings et al., 2006).

Sexual Risk Taking in Later Life and Possible Implications

Despite the plethora of studies on sexual risk-taking and vulnerability, there are few such studies on old and older people (Minichiello, Rahman, Hawkes, & Pitts, 2012). A few of the studies that focus their attention on elderly adults are primarily concerned with younger people up to 40 years of age as their target category (Gott, 2004; Wood, 2013). Available evidence shows that 498 million persons aged 15 to 49 are infected each year with chlamydia, gonorrhoea, syphilis, or trichomoniasis (WHO, 2013). With emerging evidence on sexual involvement and its importance in old age, there is a need to understand further the existing risky sexual practices and associated challenges in later life. Such studies will provide more information that could aid understanding, the formation of policies, and the provision of healthcare services relevant to health ageing promotions within contexts.

Gott (2004) from a postal survey in the United Kingdom also shows that 7% of older people engage in activities that could predispose them to contract sexually transmitted infections (STIs). Commonly reported risky practices include regular engagement in extramarital affairs, unprotected sex, and casual use of condoms. The study also showed gender differences as more men than women engage in risky sexual practices. In a single gendered study among old and older men aged 49 to 80, Cooperman, Arnsten, and Klein (2007) found that older men who are with or without risk of HIV infection and are sexually active use sildenafil—a drug for sexual performance.

In Ibadan Nigeria, King and Olaseha (2012a), in a cross-sectional study on sexual practices among the older population aged 65 years and above, found that older men engage in extramarital affairs. In rural Malawi, Freeman and Anglewicz (2012) also reported the indulgence of older males (i.e., 50–60 years) with multiple sexual partners—a risky practice that might have influenced the prevalence of HIV in the study population.

Furthermore, the use of sexuopharmaceutical drugs for sexual enhancement is growing among different social categories including the elderly, despite possible health implications (Grace, Potts, Gavey, & Vares, 2006; Marshall, 2010). Findings from Agunbiade (2013) on the use of medication for sexual performance in old age among the Yoruba people reveal more negative perceptions of health care providers than among the older people themselves. Inclusive and Responsive pharmacovigilance might help in renegotiating existing gaps between the objective health implications and subjective benefits of pleasures from the aphrodisiacs. In a setting like Nigeria and other countries in the sub-Saharan Africa, abuse of aphrodisiacs is gradually increasing and becoming complex. More substance, multivitamins supplements, and alcoholic beverages claiming to address the growing burden of sexual dysfunctions across the life course are accessible with easy. Based on empirical evidence, Aytac, McKinlay, and Krane (1999) made an estimate of a burden of 320 million people with sexual dysfunctions by the year 2025 across the globe who will need some therapeutic attention. With free access to various types of aphrodisiacs and growing burden of sexual dysfunctions, the possibility of abuse in the consumption of sexual pharmaceuticals is growing in Nigeria(Aderinto, 2012). Engagement in extramarital relations constitutes a level of risk especially with the view that condoms were more useful for younger people than for older men. Nevertheless, policies on post-reproductive sexual health and services are still low and worrisome especially in the sub-Saharan Africa (Aboderin, 2014).

Hence, it will be worthwhile to explore gender and age cohort dimensions of consumption, and the subjective effects of such practices on sexuality and sexual health in old age. Thus, this paper focuses on cultural notions of risky sexual practices and prevention of sexually transmitted infections among elderly Yoruba men and women in three age categories (60-69 years, 70-79 years, and 80 years above). Accounting for the types, patterns,

and subjective meanings of other risky sexual practices from the perspectives of older people also will expand the body of knowledge on sexual health concerns and qualitative ageing within a social setting. The greater consistency in reported risky sexual practices in old age among men than among women could be associated with some socio-cultural factors. Further, more men than women are willing to discuss or probably to exaggerate their sexual practices. The social regulation of sexual behaviour through acceptable ways of expression and engagement also favours men over women in some cultural contexts. However, this does not imply the nonexistence or absolute of risky sexual practices among women even in old age (Maxwell & Boyle, 1995).

There are limited amounts of extrapolated data on HIV prevalence in older populations. The literature on aging and HIV/AIDS indicates an increase in new cases of HIV in older populations (Adekeye, Heiman, Onyeabor, & Hyacinth, 2012). In a small-scale study in rural Malawi, the prevalence of HIV in the 50 to 64 years old population was higher (8.9%) than among men aged 15 to 49 years (4.1%)(Freeman & Anglewicz, 2012). Also, this might indicate that the older individuals are less likely to practice safe sex because they do not perceive themselves as being vulnerable to STIs. However, the literature is lacking when it comes to adequate information on context-based risky practices that might predispose the elderly to sexually transmitted infections (McCord, 2013; Negin & Cumming, 2010).

The use of a predetermined or restricted framework in investigating risky sexual practices in old age could blur the possible variations that might exist between objective and subjective dimensions of risk involvements and outcomes. Reproductive and post-reproductive sexual practices and outcomes are quite dissimilar, because they are governed by different rules of engagement and expectations. Thus, subsuming the post-reproductive sexual health of these social categories and cohorts creates gaps in knowledge. With possible cohort differentials in sexual behaviour and practice (Herbenick et al., 2010), studies that

purport to examine sexual behaviour in old age must categorise and separate middle-age adults from old and older populations. Such a focus will create a cohort-relevant body of evidence that could be useful for several purposes, including comparisons with sexual behaviour in mid-adulthood. Thus, evidence becomes distorted when studies focused on sexual risk-taking and engagement in self-reported and unreported risk practices are tailored towards understanding how such acts influence contraction of STIs alone without considering the pleasure dimension of such commitment.

Method

The findings presented in this paper are preliminary results from my ongoing research entitled: Socio-cultural constructions of Sexuality and Help-Seeking among Urban Dwelling Elderly Yoruba People, Ibadan Southwest Nigeria. The study was anchored on a sequential mixed methods research design(Creswell & Plano Clark, 2011). An exploratory sequential mixed method research design entails collecting and analysing qualitative and quantitative data within a single study (Hesse-Biber, 2010, p. 3). This study is divided into two phases consisting of qualitative and quantitative research methodologies. The qualitative phase of the study was dominant with relevant data captured through focus group discussion (FGD) with vignettes and semi-structured interviews. The goal here was to explore the significance of old age, sexual health, and sexual risk practices among elderly Yoruba people (60-80+). The everyday practices, sexual experiences, patterns, and pathways of seeking information among the Yoruba elderly were the issues of interest. Only the findings from the FGDs and face-to-face interviews are presented in this paper.

Specifically, 12 FGDs with vignettes were conducted as a function of gender among the elderly Yoruba men and women in three age categories (60-69 years, 70-79years, and 80 years above). Across the three age categories, 107 elderly Yoruba men and women featured in the FGDs. In consonance with the literature(Krueger & Casey, 2000), an average of 9

males participated in the 6 FGDs held with elderly men while an average of 8 participants featured in the 6 FGDs with women. Also, 18 (elderly men and women 60 years and above) and six (traditional health practitioners) semi-structured interviews were held.

The 12 vignette-based FGDs and semi-structured interviews were transcribed in Yoruba Language and then translated into the English Language. Two experts in Yoruba and English languages conducted a back-to-translation of the transcripts. Areas of divergence between the two language experts were smoothed out before coding the transcripts. These steps helped to ensure a representation of the participants' views. A thematic approach was adopted in the analyzing the data at two levels. The first stage was a quick analysis of the data based on the themes that guided the data collection. At this point, salient themes and subthemes emerged from the second stage of the analysis. In the second phase of the analysis, all the translated transcripts were edited and transferred into Nvivo 10 for further analysis. At this stage, further coding was condcuted, with themes and sub-themes that explained the research questions being identified. At all levels of the analysis, both deductive and inductive coding approaches were used to analyse the data until a saturation level was achieved. Three salient interrelated themes emerged. The themes are: awareness of sexual infections and normative beliefs on sexual practices and infections; prevention of sexually transmitted infections; and awareness and perceived usefulness of condoms in old age.

Awareness, Perceived susceptibility to, and Prevention of Sexual infections.

The desire for penetrative sex and the social expectations of suppression as a mark of exemplary elderly necessitated further probes on participants' awareness of sexually transmitted infections, their susceptibility and prevention of these infections. The findings from the FGDs and IDIs revealed different opinions and positions on awareness of sexual infections. Some of the participants demonstrated their awareness of sexual infections

through reference to personal experiences, aetiology and the vulnerability of engaging with multiple sexual partners. However, there were variations in perceived susceptibility to sexual infections among elderly men who reported recent sexual intercourse.

In the same vein, prevention of sexual infections was also approached from different positions. Some of the participants expressed their beliefs and preference for traditional medicine and therapies. These therapies were considered potent and effective in the prevention of all types of sexually transmitted infections. Their argument rests on the cultural beliefs and interpretations that sexual health challenges could emerge from natural, preternatural and supernatural forces. With the absence of this form of explanation in biomedicine, some of the participants expressed a preference for traditional medicine. Similarly, the participants prescribed a limited usefulness of condoms in old age. The subthemes of awareness, prevention and susceptibility are discussed further in an interrelated manner.

Awareness of sexual infections and normative beliefs on sexual practices and infections in old age.

The majority of the participants demonstrated a level of knowledge of sexual infections in old age. Without any prompting, sexual infections such as gonorrhoea, *jeri jeri* (a local terminology for sexual infections believed to be prevalent among the Hausa ethnic group) were predominantly mentioned. In response to the vignettes, sexual infections in old age were described as normative among sexually active elderly like Baba Alamu and Iya Asake. However, a little contestation was raised over the possibility of contracting HIV—unlike the consensus given to gonorrhoea. In this regard, some of the FGD participants denounced the existence of HIV/AIDS popularly known as *arun tii ko gbo ogun* (disease without treatment) as publicised through various local media in Southwest Nigeria. Their denial might relate to

the content of existing biomedical campaigns around HIV/AIDS and the primarily focus on younger people. These campaigns emphasise vulnerability to sexual infections among youths and the middle-aged adults– thereby leaving the elderly out of the loop. This is reflected in the interpretations of the FGD participants, such as the following:

> …old people seldom contract HIV/AIDS. It is more to see cases of such infections among younger people and maybe a few older people who have sexual relations with young people. For older men and women that sleep with themselves, it is uncommon to see HIV/AIDS among them. [FGD with men aged 80 years and above, Oniyere]

> One can contract many sexual risks through sexual relations. Some will appear immediately on the man's body while it takes a longer time for others to manifest. There are also those that lead to instant death after sexual intercourse. Nowadays, there is what you people call HIV/AIDS that one can contract. Whatever you know how to eat, you should also be ready to face the consequences. [FGD with men aged 70-79 years, Sango]

The secrecy and stigma associated with HIV infections and the social projection of AIDS-related deaths also might act as contributory factors. Most of the early campaigns portray the deadly nature of contracting HIV/AIDS to promote safe health practices. The growing campaigns on the HIV prevalence and the secrecy in disclosing HIV status might arouse doubts in the minds of the participants. The possibility of such doubts was expressed as the FGD participants denounced the existence of the disease. Thus, both male and female participants in the FGDs claimed ignorance of seeing an HIV person in their communities and prayed against contracting it in their lifetimes.

Denial or acknowledgement of HIV reality has significant implications for perceptions and attitudes towards voluntary HIV testing, help-seeking, and medication adherence if positive. The temptation to sweep a coming crisis under the carpet could spell doom for individual, households, and the society. Sexual experiences, cultural beliefs, and expectations across the life course also affect risks construction and perceived vulnerability to sexual infections. From the lens of continuity theory of ageing, activities that are habitual are

likely to persist until old age (De Genna, Stack, Serbin, Ledingham, & Schwartzman, 2006). Elderly people with preference for *flesh to flesh* sexual intercourse (i.e.,) are less likely to use a condom (Golub et al., 2013; Zhou et al., 2014). In the same vein, individuals with a history of multiple sexual partners are likely to sustain such practice in old age (Zhou et al., 2014). In consonance with the literature, the FGD participants and interviewees described the sexual exploits of the vignette characters (Baba Alamu and Iya Asake) as products of previous experiences. In the same vein, the FGD participants argued that previous sexual exploits and desires of both Baba Alamu and Iya Askae would have exposed them to different sexual infections. The extract from some of the participants provides further insights and context to dominant narratives around the consequences of multiple sexual partners:

> It is inevitable for Baba Alamu not to contract a disease. You said he had three wives and a concubine making four or five can you see. Each of the wives will have at least one disease or the other. So five of them amount to five different diseases, which he will tap from each of the wives, it is the number of women he has that will determine how many diseases he will have. The common Ones include "*Atosi*" – gonorrhoea, *jeri-jeri* [syphilis] and AIDS. The same applies to a woman. If it were a woman that was engaging in multiple sexes, she would acquire different diseases from all her concubines. [FGD with women aged 70-79, Kobiowu]

> Individuals form the habit of having multiple sexual partners' from youthful age and then sustain it to old age. The only exception is when such individual repent of their sins and ask God for help. [IDI with a Christian male aged 73]

> A polygamist is an experienced person in several ways including sexual infections and the dangers of contracting an incurable disease. [FGD with women aged 60-69 years, Bodija]

> Sexually experienced and active males are conversant with different forms of sexual infections. Shame, stigma, and the fear that it could take longer years to recover from an infection in old age could stand as barriers. [FGD with men aged 70-79 years, Sango]

The consensus view of the FGD participants and interviewees was that multiple sexual relations are habits acquired through the life course and, therefore, increases the occurrence of sexually transmitted infections. A similar line of thought was extended to the

contraction of sexual infections like gonorrhoea. The consensus was that in the lifetime of every married man and woman, gonorrhoea would have occurred at least once. The practice of multiple sexual partners and polygynous marriages might have informed this position. Thus, the majority of the participants argued that men be more susceptible to gonorrhoea and could infect their wives during intercourse. Similarly, the symptoms manifest more quickly among men than women. The extracts from some of the FGDs provide additional insights:

> Everybody, especially men, is a carrier of gonorrhoea. None that does not have gonorrhoea can give birth, and he is impotent. It is when it is too much that it becomes a problem. Anyone elderly that contracts gonorrhoea must be ashamed of it, just to go to herbs seller, who will prepare concoction for him or her and pass it out through faeces and will urinate it out. [FGD with women aged 60-69 years, Bodija]
>
> Is the dog gonorrhoea that makes one bark like a dog? [FGD with women aged 70-79 years, Sango]
>
> …In women, sexually transmitted infections do not appear instantly but with men, it is spontaneous. [FGD with men aged 60-69 years, Bodija]

These extracts confirm further that unprotected sex and multiple sexual partners could have occurred at one time or the other in their years of marriage. Also, it indicates that the participants were conversant with the biomedical terminology of sexually transmitted infections, especially its relationship and implications of having multiple sexual partners. With background and experiences from polygynous marriages, the majority of the participants interpreted multiple sexual partners as risky and a source for possible sexual infections.

In furtherance of the argument, the FGD participants gave a typology of gonorrhoea. Differentiated by symptoms, three major types exist, and these consist of the excessive pulse (*atosi olo yun*), discharge of blood (*eleje*), and the dog type (*ato si alaja*). Each typology was described based on symptoms, which could have informed the various typologies.

> The main one is gonorrhoea, but it has variants such as "*Elero* because we did not know AIDS in our youth days. Now it is *Eedii* (Aids) that they are contracting now. [FGD with women aged 60-69years, Bodija]

> There is one called *Jeri-Jeri* this one will eat off the penis, people call it syphilis. [FGD with men aged 80years and above, Inalende]

Multiple sexual practice and familiarity with gonorrhoea also have a long history in the Yoruba belief system. An account of multiple sexual relations and probability of contracting sexual infections is contained in the *Ifa* literary corpus (Jegede, 2010). Two (*Oteirunsun* and *Osewejiweji*) of the 216 verses of the *Ifa* are stories on multiple sex partners and possible contraction of gonorrhoea (Aderinto, 2012). *Ifa* as an oral tradition also encourages prevention and responsive help seeking as potent measures for different sexual and other disease conditions (Jegede, 2010). Thus, the majority of the participants took this direction and suggested prompt care seeking especially the use of traditional herbs to eliminate the symptoms of gonorrhoea.

The social desirability of prevention and prompt help-seeking cut across the participants' narratives around *magun* as a *sexual infection*. As earlier espoused, the reality of *magun* is less doubted unlike the logic behind the potency of causing untimely death for the victims. To avoid *magun*-related deaths, prevention and not treatment was given a high premium. The availability of traditional remedies against *magun*-related death also might encourage multiple sexual relations. Nevertheless, the majority of the male participants called for mutual faithfulness in marriage. They argued that unfaithfulness cuts across both genders, but with differentiated tensions and consequences for both men and men. These extracts highlight the dilemma around the dynamics of marital infidelity and sexual infections:

> …it is a woman that will be careful. *Atosi* (gonorrhoea) and *Jeri Jeri* (syphilis) are the common types of infections. The common saying is that you should not blame a husband who places 'magun' on his wife. The safest thing to do is to abstain or avoid other men's wives. [FGD with women aged, Odo Oba]

> Even when you are careful and you do not go after other men's wives, what if other men sleep with your wife, and they infect her? It is possible for a man to avoid sexual intercourse with the wife of an infected husband. However, it is difficult for a husband to know who sleeps with his wife. What if a sexually infected man slept with your wife, what would you do? (*Tii eniyan bay ago fun iyawo asopa, tii asopa ba baa iyawo oluwe lopo kan?*) [FGD with men aged 70-79 years, Sango]

In the event of an inevitable sexual infection, the majority of the participants encouraged prompt help-seeking from competent traditional healthcare providers. Traditional therapeutic treatments were described as natural and caused less harm to the body. They argued that traditional therapies were holistic as they could affect changes at the spiritual, physical levels of a disease or health challenge. In contrast, orthodox or biomedicine treatments work faster but cause more damage and less efficient in cleansing the body from infections like gonorrhoea. Also, biomedical prevention measures like a condom cannot stop a man from dying after intercourse with a magun carrier. In this direction, the participants shared their perspectives on traditional measures of preventing sexual infections and condom use.

Prevention of sexually transmitted infections.

The essentiality of preventing sexual infections cut across the views of the majority of the FGD participants. From varied experiences and interest, the participants suggested possible measures that could reduce or avoid contraction of sexual infections. The suggestions ranged from abstinence for those who can control their sexual urge to the use of traditional medicine and condoms in rare cases. Traditional protection measures include the use of charms to avoid contracting an infection, to avert ill-luck and premature deaths due to *magun* affliction. Individuals with flair and opportunities for multiple sexual relations could, therefore, adopt traditional or biomedical protective measures. Nevertheless, the effectiveness

and relevance of any protective measure depended on perceived aetiological explanations and recovery possibilities if a sexual infection was contracted.

In reality, abstinence is a difficult and unsustainable sexual prevention strategy, especially for sexually experienced and healthy people. As argued by Santelli et al. (2006), abstinence from coital sexual activities requires suppression of sexual desires even when there are opportunities for engagement. For health and age-related challenges, it is easier to misconstruing abstinence as an acceptable practice in old age. With age, women are likely to find it easier to abstain from penetrative sex for several reasons. Notable factors include dryness of the vagina, health challenges, unhealthy marital relations, and normative and religious beliefs (Fileborn, Thorpe, Hawkes, Minichiello, & Pitts, 2015; Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015). Relatively, the majority of the participants believed that elderly women would find it easier to abstain at certain periods in life, as reflected in the following extracts:

> A woman that holds on to her husband alone cannot contract STDs except for the one that is having sex with numerous men. However, if the husband has multiple sexual partners, the wife would be at risk. [FGD with women aged 80 years and above, Inalende]

> Once a woman discovers that her husband is very virile and having many sexual partners, she has to be very careful and keep herself. [FGD with women aged 80 years and above, Inalende]

> Some elderly men would find it difficult to abstain and even some women. Those with the habits will always find it difficult to leave it. So abstinence is difficult. [Interview with a 73-year-old woman]

The influence of context on sexual abstinence was emphasized further in the findings from the IDIs and among the FGD participants. The majority of the participants held the view that old age was insufficient to provide sufficient grounds for sexual abstinence. Sexual experiences and quality of marital relations were identified as being essential to sexual abstinence or indulgence in old age. At different points, the interviewees argued that quality

marital relations, health, trust and spouse commitments to family responsibilities could motivate continuity in sex for elderly women. On the contrary, poor marital relations, tensions, suspicion, health challenges, and lack of commitment could promote sexual abstinence. Some of the extracts provide additional insights:

> Sexual abstinence requires mutual understanding. My husband and I have agreed that it will occur just once in a blue moon. We grow old every day and the strength for such activities is no more. [IDI with a 64year old woman]

> Besides health challenges and old age, poor marital relations and lack of commitment to family responsibilities would encourage a woman to abstain from sex. After all, we do not need any child again and the ones on the ground deserve our support even now that we are old. Sexual abstinence is easy for any woman with an uncaring husband not in old age alone. Some men are useless; they will leave their wives and children to suffer and spend lavishly on other women or concubines. [IDI with a 60-year- old woman]

> Sexual abstinence is difficult for healthy elderly men especially those with affluence. They would rather seek pleasures elsewhere than abstaining. It is when their strength and health start failing that abstinence becomes easier. [FGD with women aged 60-69years, Bodija]

The above extracts reveal differentials in sexual abstinence along gender and marital relations. Comparatively, a functional view around abstinence was expressed more in the FGDs among the females than among the males . The pressure and constant demand for sex among elderly married men could have influenced this view. In some instances, the female FGD participants (60-69 years) confirmed that they experienced constant demand for sex from their husbands but expressed their inabilities to fulfil such requests. In sum, the practice of sexual abstinence in old age varied by gender, previous sexual experiences of couples, and quality of marital relations. For instance, two among the female interviewees with somewhat satisfying marital and sexual relations believed that occasional engagement in sexual intercourse was necessary.

In a demonstration of gender differentials in sexual abstinence in old age, some of the male participants expressed concerns over the consequences of sexual refusal from their wives. In support of this view, the majority of the male participants and a few of the females believed that sexual refusal could encourage extra-marital affairs. This assertion also was confirmed in the narratives of the participants:

> *Dani dani kii bani lagba ati kekere ni ti bani* (Misbehaviour is a habit that is formed early in life through the socialisation process, and it continues until one becomes an adult). Extramarital relations start when one is young and continues into old age. It is a behaviour that starts much early in life when you are youth or middle-aged adult. As such, there are chances that such individuals will continue such indulgence even in old age. [FGD with men aged 80yeasr above, Inalende]

With the shortcomings in sexual abstinence, the majority of the male participants preferred strategies that would guarantee pleasure and minimise the risks of contracting sexual infections. Across the various FGDs, the majority of the male participants expressed belief and support for traditional medicine. Their preference resonated cultural beliefs that traditional medicine had the potential to improve sexual pleasures and to prevent the pains of contracting infections. Thus, a few of the males took pride in their sexual adventures and risky practices. They also boosted in their knowledge and use of traditional medicines as a guarantee against infections. Normatively, the majority of the male participants argued that individuals who are fond of having multiple sexual partners also must know how to protect themselves. Their argument was that some of the existing sexual infections are preventable, detectable, and treatable using appropriate traditional remedies. However, access to effective traditional medicine treatments is becoming difficult with less attention to the knowledge and practice among the younger generation.

Traditional medicine works better when a practitioner has the right knowledge and the appropriate remedies for each health challenge (Omonzejele, 2008). A common saying

among the Yoruba people is that any *oogun* (medicine) that is less potent can be attributed to the incomplete knowledge and the inappropriate combination of ingredients (Jegede, 2010). In the words of the participants, traditional medicine has some peculiar virtues and strength:

> There are several traditional medicines that can increase sexual pleasures as well as reduce the chances of contracting sexual infections. The use differs from one person to another as I mentioned earlier. In recent times, westernisation and belief in foreign religions are making younger people to lose interests in traditional values and practices, and that partly explains the growing trend of evils and different diseases among youth. [A male participant in the FGD with men aged 80 years and above]

> Traditional medicine is all encompassing and has great value for those who have the knowledge. I'm aware that many charlatans are claiming to be traditionalists and are deceiving people; yet, there are some genuine practitioners. With the right remedy and judicious use, an individual can [have] good health including sexual health and be free from sexual infections by depending on traditional medicines. [IDI with a Traditional Health Practitioner aged]

The emphasis on the efficacy of traditional medicines in the prevention, treatment, and enhancement of sexual health could stimulate over optimism and possible risky practices. For instance, the polygynous men who reported recent sexual activities relegated their susceptibilities to sexually transmitted infections. Thus, a few of the male FGD participants took pride in their sexual adventures and risky practices. Two male FGD participants and another male interviewee boasted in their knowledge and use of traditional medicines as a guarantee against infections:

> Once you are sure of the efficacy of your medicine [traditional medicine], you can take some risks and go free. [A 63-year-old man in the FGD with men, Bodija[

> I have slept with someone that was infected with magun. I only pushed the magun since I have the remedy from the lower abdomen to the chest of the woman. Immediately we ended the intercourse; I pushed it back again. [A participant in the FGD with male aged 70-79 years, Sango]

> I have slept with several women without the use of a condom, and I have no sexual infection to date because I am sure of the traditional medicine (*Saa run domi*). [83-year-old male herbalists and spiritualist]

Their beliefs informed their assessments and judgements of the protective powers of traditional medicines. Common types of traditional medicines mentioned included *ajasara, onde, and incisions*. These types of traditional medicines function in a manner that provides users opportunities to avoid contraction of sexual infections. With a wider cultural interpretation of traditional medicine and its applicability to diverse spheres of life, it was easier for the participants to arrive at such conclusions.

Prevention of infections and ability to abstain from having sexual intercourse with an infected woman depends on self-control and willingness to obey prescriptions and taboos. For the use of incision and amulet to work effectively, users are required to observe certain taboos without which the medicine might lose its powers. Each medicine has its material and spiritual components. These properties ensure the potency and effectiveness of the medicines against losing as well performing their functions. With the right incision on the body, an individual would have a sign that will reveal whether a woman has an infection or magun before intercourse.

> He could wear a medicinal or magical ring. It could be incision, or it could be Amulet (*onde*) [herbal belt] could be made for men when he gets to a woman that has sexually transmitted infections his male organ will not [become] erect. Also, it could be performed on women so that it is only her husband that could have fun with her. [FGD with men aged 70-79years, Kobiowu]

> We have traditional rings, herbal concoction, and incisions to prevent contraction of different sexual infections. Even when there is *magun* on a woman, a man can move the magun and sleep with the woman without the man suffering the consequence. Once done, the man will return the *magun* with the woman again. [FGD with men aged 80 years and above, Inalende]

> Also, some incisions will stop a man penis from erecting when about to have sexual intercourse with a woman with infections. [FGD with men aged 80 years and above, Inalende]

> He will be using drugs such as *"marugbo ta kebe"* to make him have the energy to perform sexually. [FGD with men aged 70-79years, Kobiowu]

Largely, the males expressed more beliefs in the protective powers of traditional medicines such *as ajasara, onde,* and incisions. Such traditional medicines provide users an edge over possible contraction of sexually transmitted infections. These types of traditional medicines function in a manner that provides users opportunities to avoid contraction of sexual infections.

> We just need to make incisions around his navel. That is *his pathway to this world; he will not take that pathway back*. Alternatively, we can make three different incisions here and there on his body. Whenever he wants to have sex with a woman, he will draw it up towards her chest, with this statement that *a la soke ni aja n la omi;* because part of the ingredients is a dog's tongue, and it is the nature of dogs whenever they want to drink water to lick it up. With that, he cannot contract any STI including gonorrhoea. Then after sex, he will draw it back. Otherwise, she will be having stomach upset. [Interview with an 83- year-old Herbalist]

The availability of remedies for sexual pleasures and protection against sexual infections might have encouraged a kind of confidence to engage in multiple sexual encounters. However, a caution to this perception was echoed by the majority of the participants on the non-availability of traditional medicine for the treatment of HIV/AIDS except prevention. Prevention is fundamental in African traditional medicine. Through divination and performance of rituals and sacrifices, evils and calamities could be avoided before they manifest themselves (Omonzejele, 2008). The same principle was applied to the perceived efficacy of traditional medicine in the prevention and protection against all forms of infections:

> Prevention can take place in three ways. There is one of injection, the one of rubber [male condom], the nurses also propagate this, that they should use if they want to plan their family. That is why [they use rubber]. If they sense that it may tear, they will double it. Even if the woman has stopped, menstruate, once the rubber is used, man will not drop anything into her body. As you have known the matter with "Mr. & Mrs." That is complex. [FGD with women aged 80 years and above, Inalende]

> I have said earlier that prevention is better than treatment. If one is covetous because women are dangerous regarding infections. One should have prevention against such infection. For instance, there is *magun*- a form of infection that kills instantly. Any

> man that has a desire for extramarital affairs must be prepared so that if he encountered any woman with *magun*, he would survive it. [FGD with men aged 60-69years, Bodija]

> Traditional medicine is active/potent. For instance, we write some verses of the Quran (*hanntu)* into the water for someone that has a headache to drink, and he will receive his healing. However, if he is taken to our counterparts, [*referring biomedicine medicine*], delays due to clinical investigations and confusions would worsen his condition. Look at this child that entered now, he could have been dead by now. He is alive today just by God's mercies. About six days ago he was very sick, the time they would spend on screening the blood, urine and the like, would the patient not give up? Here, by divination and spiritual understanding, we go straight to the source of the problem. [Interview with an 81-year-old Islamic faith healer]

The perceived variations in effectiveness and treatment options within the two medical systems may be associated with the belief that some sexual health problems are untreatable. In this latter category, sexual health problems that tend towards preternatural and supernatural explanations would be perceived treatable by traditional medicine. Those that are considered caused by micro-organisms would be considered more treatable by biomedicine. This hierarchical rating or assessments on the effectiveness of available treatment options within the two medical systems remain highly subjective.

Awareness and perceived usefulness of Condom in old age.

Social marketing of condoms seems to be paying off despite the marginalization of old and older people as part of the target audience. However, awareness and the association of condoms use with the prevention of infections do not imply the proper and efficient use of a condom. Other factors such as the feelings of being old, stigma or shame and the guarantee of the pleasures of sex influences disposition to condom use (King & Olaseha, 2012b; Ludwig-Barron et al., 2014).

Regarding awareness, the male FGD participants claimed that they had seen and were more aware of male condoms than were the female participants. A few of the females also claimed awareness of the male condoms, but none had seen a female condom before despite their awareness of male condoms. As a preventive measure, the condom was constructed as applicable mainly to younger people to avoid unintended pregnancy and sexual infections. For sexually active old men, the use of condom was greeted with mixed feelings. The majority (39) of the elderly men acknowledged the relevance of condom use. However, the bursting of condoms and the possible reduction in sexual pleasures would discourage them from using them except on rare occasions. The extracts exemplified their views on the usefulness of condoms:

> It can prevent unintended pregnancy among young people especially those in schools. [FGD with women aged 70-79years, Sango]
>
> …If a condom is used, it will avoid the spread of disease/infections. [FGD with men aged 60-69years, Bodija]
>
> By using a condom, we know it is for prevention, but no enjoyment can be derived from it. It is a waste of energy. [FGD with men aged 60-69years, Bodija]

The few male participants (5) that shared personal experiences from condom use shifted into a reconstruction of pleasurable penetrative sex in old age. Three among the elderly men within 60 and 79 years of age claimed they had used condoms at least once within the last few months. Within the category of men with recent sexual activities, condom use was rare and described as being less pleasurable, except on very few occasions.

Conclusion

Engagement in multiple sexual relations and unprotected penetrative sex exist among elderly Yoruba people in this study. With the availability and experiences with the use of

traditional medicine, emphasises on traditional measures attracted higher premium than did the utilization of a condom. The aversion for a condom was based on its limitations in the prevention of magun and reduction of sexual pleasures. The confidence in the efficacy of traditional medicine could be a function of perceptions, beliefs, and values. There are possibilities that such judgements are unempirical tested or verified. This is in tandem with the epistemology of African traditional medicine where verification and potency of existing remedies transcend empirical relevance. With poor regulations and acknowledgment of occasional contraction of sexual infections, holistic measures are required in promoting healthy sexual practices and responsive use of preventive measures among sexually active elderly within the study settings.

References

Aboderin, I. (2014). Sexual and reproductive health and rights of older men and women: addressing a policy blind spot. *Reproductive health matters, 22*(44), 185-190.

Adekeye, O. A., Heiman, H. J., Onyeabor, O. S., & Hyacinth, H. I. (2012). The New Invincibles: HIV Screening among Older Adults in the US. *PloS one, 7*(8), e43618.

Aderinto, S. (2012). Dangerous Aphrodisiac, Restless Sexuality: Venereal disease, biomedicine, and protectionism in colonial Lagos, Nigeria. *Journal of Colonialism and Colonial History, 13*(3).

Agunbiade, O. M. (2013). Enhancing masculinity and sexuality in later life through modern medicine: experiences of polygamous Yoruba men in Southwest Nigeria In A. Kampf, B. Marshall & A. Petersen (Eds.), *Aging Men: Masculinities and Modern Medicine* (pp. 138-155). London: Routledge.

Aytac, I., McKinlay, J., & Krane, R. (1999). The likely worldwide increase in erectile dysfunction between 1995 and 2025 and some possible policy consequences. *BJU international, 84*, 50-56.

Cooperman, N. A., Arnsten, J. H., & Klein, R. S. (2007). Current sexual activity and risky sexual behavior in older men with or at risk for HIV infection. *AIDS education and prevention: official publication of the International Society for AIDS Education, 19*(4), 321.

Creswell, J., & Plano Clark, V. (2011). *Designing and Conducting Mixed Methods Research* (2nd ed.). Thousand Oaks California: Sage Publications Inc.

De Genna, N. M., Stack, D. M., Serbin, L. A., Ledingham, J. E., & Schwartzman, A. E. (2006). From risky behavior to health risk: continuity across two generations. *Journal of Developmental & Behavioral Pediatrics, 27*(4), 297-309.

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

Fileborn, B., Thorpe, R., Hawkes, G., Minichiello, V., Pitts, M., & Dune, T. (2015). Sex, desire and pleasure: considering the experiences of older Australian women. *Sexual and Relationship Therapy, 30*(1), 117-130.

Freeman, E. K., & Anglewicz, P. (2012). HIV prevalence and sexual behaviour at older ages in rural Malawi. *International Journal of STD & AIDS, 23*(7), 490-496.

Golub, S. A., Botsko, M., Gamarel, K. E., Parsons, J. T., Brennan, M., & Karpiak, S. E. (2013). Dimensions of psychological well-being predict consistent condom use among older adults living with HIV. *Ageing International, 38*(3), 179-194.

Gott, M. (2004). Are older people at risk of sexually transmitted infections? A new look at the evidence. *Reviews in Clinical Gerontology, 14*(1), 5-13.

Grace, V., Potts, A., Gavey, N., & Vares, T. (2006). The Discursive Condition of Viagra. *Sexualities, 9*(3), 295-314. doi: 10.1177/1363460706065050

Herbenick, D., Reece, M., Schick, V., Sanders, S. A., Dodge, B., & Fortenberry, J. D. (2010). Sexual behavior in the United States: Results from a national probability sample of men and women ages 14–94. *The journal of sexual medicine, 7*(s5), 255-265.

Hesse-Biber, S. N. (2010). *Mixed methods research: merging theory with practice. New York: US. The Guilford Press.* New York, US The Guilford Press.

Jegede, O. (2010). *Incantations and Herbal Cures in Ifa Divination: emerging issues in indigenous knowledge*: African Association for the Study of Religion.

King, O., & Olaseha, I. (2012a). Perceptions of sexual practices among the old people in Sub-Saharan African largest City, Nigeria. *Retrovirology, 9*(Suppl 1), P120.

King, O., & Olaseha, I. (2012b). Perceptions of sexual practices among the old people in Sub-Saharan African largest City, Nigeria. *Retrovirology, 9*(1), 1-1.

Krueger, R. A., & Casey, M. (2000). A practical guide for applied research. *A practical guide for applied research*.

Ludwig-Barron, N., Wagner, K. D., Syvertsen, J. L., Ewald, I. J., Patterson, T. L., Semple, S. J., & Stockman, J. K. (2014). "When You Get Old Like This… You Don't Run Those Risks Anymore": Influence of Age on Sexual Risk Behaviors and Condom Use Attitudes Among Methamphetamine-Using Heterosexual Women with a History of Partner Violence. *Women's health issues, 24*(6), 620-628.

Luke, N. (2005). Confronting the'sugar daddy'stereotype: age and economic asymmetries and risky sexual behavior in urban Kenya. *International Family Planning Perspectives*, 6-14.

Marshall, B. L. (2010). Science, medicine and virility surveillance:'sexy seniors' in the pharmaceutical imagination. *Sociology of health & illness, 32*(2), 211-224.

Maxwell, C., & Boyle, M. (1995). Risky heterosexual practices amongst women over 30: Gender, power and long term relationships. *AIDS care, 7*(3), 277-294.

McCord, L. R. (2013). Attention HIV: older African American women define sexual risk. *Culture, Health & Sexuality*(ahead-of-print), 1-11.

Minichiello, V., Rahman, S., Hawkes, G., & Pitts, M. (2012). STI epidemiology in the global older population: emerging challenges. *Perspectives in Public Health, 132*(4), 178-181.

Negin, J., & Cumming, R. G. (2010). HIV infection in older adults in sub-Saharan Africa: extrapolating prevalence from existing data. *Bulletin of the World Health Organization, 88*(11), 847-853.

Omonzejele, P. F. (2008). African concepts of health, disease, and treatment: an ethical inquiry. *Explore: The Journal of Science and Healing, 4*(2), 120-126.

Wellings, K., Collumbien, M., Slaymaker, E., Singh, S., Hodges, Z., Patel, D., & Bajos, N. (2006). Sexual behaviour in context: a global perspective. *The Lancet, 368*(9548), 1706-1728.

WHO. (2013). Sexually Transmitted Infections(STIs). *Global Health Observatory (GHO)* Retrieved August 09, 2013, 2013, from http://www.who.int/gho/sti/en/index.html

Wood, A. M. (2013). A Generation Skipped: An Exploratory Study of HIV/AIDS Education and Prevention Services for Older Adults. *Research in the Sociology of Health Care, 31*, 217-246.

Zhou, Y., Ding, Y., Gu, K., Lu, X., Gao, M., & He, N. (2014). Motivations for sexual risk behaviors among older men in Shanghai, China: a qualitative study. *BMC Public Health, 14*(1), 802.