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# Risky sexual practices and approaches to preventing sexually transmitted infections among urban dwelling older Yoruba men in Southwest Nigeria



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ABSTRACT

Social and cultural norms and beliefs shape how men, as social actors, perceive and engage in sexual activities. Little is known about risky sexual practices and prevention strategies among older Yoruba men. As a growing concern in Nigeria, this paper explores risky sexual behaviours of older Yoruba men living in Ibadan, a metropolitan city, and their strategies for preventing sexually transmitted infections in old age. We held six focus groups and nine semi-structured interviews, with a total of 65 participants. The findings show that social norms allow older men to engage in multiple sexual relationships, which exposes them to sexually transmitted infections (STIs), and to use potent traditional medical protective and preventive measures to mitigate their vulnerability to sexually transmitted infections and the consequences of having sex with women under "magun." Such measures include "magun" on men, incisions, amulets, and *aseje* (a traditionally prepared concoction). Additionally, the findings revealed that protective measures are against serious consequences of risky sexual behaviors, like sexual pleasures and death. The findings point to the need for more inclusive sexual health and HIV campaigns and strategies addressing the sexual health challenges of all men and women and must be culturally sensitive.

## 1. Introduction

Sexual activities persist into old age for a high proportion of older men at varied dimensions and frequencies of occurrence. Apart from biological factors, older men have ascribed some social privileges that permit them to express their sexual desires and needs to some cultural notions of masculinity (von Humboldt, Ribeiro-Gonçalves, Costa, Low, & Leal, 2021).

The literature depicts that in heterosexual relationships, men focus more on enhancing their sexual performance and personal satisfaction than that of women, because mistakenly male sexual satisfaction is equated to female partner satisfaction. The universality of such masculine beliefs differs for those with a preference for same-sex relationships. Nonetheless, evidence of how heterosexual males deal with these ideas and become more prone to risky sexual practises in late adulthood is growing (Mutanda & Odimegwu, 2017).

Conceptually, sexual risks are constructed interpretatively to include experiences, actions, and practises that have the potential to cause harm to those involved and their sexual partners (Fileborn et al., 2015). How sexual risks are perceived and interpreted is embedded in social contexts and relationships that inform actions and decisions. Risky sexual behaviors like having multiple sex partners starts in childhood and across spaces in their life cycle (Gore-Gorszewska, 2021; von Humboldt et al., 2021).

With emerging evidence on sexual involvement and vulnerability to sexual infections in old age (Mojola, Williams, Angotti, & Gómez-Olivé, 2015), there is a need to further understand existing risky sexual practises and preferred prevention strategies among older people. The lack of research on sexual risks in old age has resulted in a limited understanding of how sexually active older men negotiate associated risks, preventive measures they use and why, and other available options for reducing vulnerability to sexually transmitted infections (Sinković & Towler, 2019). A focus in this direction will highlight the sexual subjectivities and the peculiarities of the interpretations around risky sexual practices and heterogeneity in old age. Contextualization of such research will provide insights useful to guide future interventions on sexual health promotion and well-being in old age within a given social setting.

Thus, this paper takes a cultural and contextual framing of sexual risks and possible ways older men negotiate the complexities around sexual behaviour with implications on sexual health promotion. This focus contributes to the literature on what constitutes healthy or risky practices and the measures that could reverse the risks and ensure optimal

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beneficial outcomes in old age. It also adds to how indigenous knowledge and practices could perhaps improve the contextualization of sexual health promotion amongst older men in urban spaces in Nigeria.

## 2. Gender, sexual risks and preventive measures in old age

Studies on the vulnerability of older men to sexually transmitted infections are gradually emerging, with more of such a pattern in the global north than in the global south. In contrast, available evidence from the sub-Saharan region shows that a high proportion of older men are sexually active and engage in risky sexual practises like having unprotected sex with multiple partners and having an aversion to the use of condoms (Mutanda & Odimegwu, 2017). Despite being involved in such risks, apathy towards opening a conversation on such behaviours and practises exists, including their susceptibility to contracting sexually transmitted infections (Syme, Cohn, & Barnack-Tavlaris, 2017). As such, cases of sexually transmitted infections such as gonorrhoea, syphilis, chlamydia, and HIV are emerging, with predictions of a possible increase (Harvard Health Letter, 2018; Kularatne et al., 2018). Surveillance data from 31 European countries Tavoschi et al. (2017) have shown how new HIV cases are emerging among older adults (50 years of age and older). Similarly, extrapolated evidence from Sub-Saharan Africa predicted an increase in HIV burden among older adults aged 50 and up (Negin & Cumming, 2010). As the population of older people (those aged 50 and up) grows, so will the number of cases of sexually transmitted infections. Thus, there is an urgent need to focus on older people's sexual health and well-being alongside other health dimensions in later life.

Globally, the sexual health of older people has attracted limited attention. Similar dispositions can be observed in Africa and Nigeria, where older people's sexual health is craving the attention of researchers, health practitioners, and policymakers. Because of this neglect, most sexually active older people are on their own to meet their sexual needs and treat any sexual infections that may arise. Such neglect also occurs in spaces where these older men are actively involved in intergenerational sexual relations and multiple sexual relations among peers (De Wet, Alex-Ojei, & Akinyemi, 2019). Reasons for engaging in intergenerational sexual relationships are embedded in a web of structural and cultural factors. Houle et al. (2018) argue that intergenerational sexual relations also exist between older women and some younger men for sexual and financial gains. Based on notions of hegemonic masculinities, men are more adventurous and at risk due to sexual networking, which makes them prone to sexually transmitted infections (Agunbiade, 2013; Fleming, DiClemente, & Barrington, 2016). Men enjoy high social approval of sexual activities that extends into their later lives (De Wet et al., 2019; Hoss & Blokland, 2018). Hegemonic masculinities also present the woman's body as more valuable and sexually gratifying during her reproductive years. This view is common among older male adults in Africa who prefer younger females as sexual partners or spouses (Hoss & Blokland, 2018; Tener, 2021). Similar preferences have been observed among the Yoruba ethnic group in Nigeria, where older males prefer and engage in sexual and intimate relations with younger females. The age gaps between husbands and wives are more overt among men who are in polygynous marriages. Multiple reasons have been advanced for the practice. Among these factors are the men's sexual networks, their abilities to attract young women, their socioeconomic status, and other cultural values and practises that favour such men. There are other factors such as preference for large family size, previous sexual experiences with multiple women, and a somewhat higher value placed on multiple sexual relations as a form of masculinity for such men.

The consequences of engaging in multiple sexual relations are well acknowledged among the Yoruba people (Aderinto, 2012; Akin-Otiko, 2013). Such consequences are sometimes classified into psychosocial, physical, and spiritual forms. The physical consequences include all forms of sexually transmitted infections, and the psychosocial consequences are the emotional damages, stigmas, and relationship consequences of breaking partners' trust and love. The intersection of these consequences is observable in the negative effects on the well-being and general health of partners that are involved in such intimate relationships. The spiritual consequences of engaging in multiple sexual relations include loss of valour, possible loss of personal ambition, and the inner strength to persevere when faced with challenging life events. Traditional healers among the Yoruba people acknowledge the fluidity of these dimensions and the consequences of engaging in multiple sexual relations (Akin-Otiko, 2013; Alaba, 2004). The healers share common aetiological explanations that accommodate the three types of consequences and the treatment options. Healers within this tradition rely on history taking, questioning, symptoms and divination to discern aetiologies and possible remedies (Jegede, 2010). Among the traditional healers that are of the Yoruba extraction, *Ifa* divination becomes a last resort when treatments are ineffective, patient is struggling to recuperate or symptoms are unknown or strange to the healer (Akin-Otiko, 2013). There are occasions when divination is considered in an effort to understand a root cause and deploy remedies or treatments that could yield desired results. Preventive and treatment measures for STIs exist are common traditional healers among Yoruba traditional healers. However, more emphasis is placed on prevention, especially for the folk STI called magun (Akin-Otiko, 2013). Generally, magun can be contracted through sexual relations, and there are no treatments except antidotes that are ingested, worn, or in the form of armlets prior to a sexual interaction or provided on the spot by an experienced healer (Agunbiade & Togunde, 2018).

Beyond being in polygynous marriages and cultural values and practices that support multiple sexual relations, evidence from other cultural contexts have shown that older people engage in sex for diverse reasons, and they also perceive their vulnerability to the risks and benefits of engaging in such relationships differently (Agunbiade, 2013; Ayalon, Gewirtz-Meydan, & Levkovich, 2019). Knowledge of sexually transmitted infections and dispositions towards risk aversion are nested within networks of relationships and the expectations guiding such interactions within a given social-cultural milieu. A study of 31 heterosexually active older adults in a Scottish city showed that sexually active older people indirectly acquire their knowledge of sexually transmitted infections from different sources, including their adult children and the media (Dalrymple, Booth, Flowers, Hinchliff, & Lorimere, 2016). Additional findings from the study revealed that older people's knowledge of STIs revolves more around HIV than any other type. Dalrymple et al. (2016) argue further that the high awareness of HIV might be connected to the hype in the social marketing of preventive measures against the condition.

Despite the emerging body of evidence, there has been less focus on understanding risky sexual behaviour and ways to reduce the vulnerability of sexually active older men. A consensus from the literature is that risky sexual behaviour and sexually transmitted infections are more common among older men than older women. A sexual health promotion initiative such as encouraging condom use among sexually active people has achieved some significant results. While young and older adults engage in sexual activities, there are gaps in these sexual health promotion efforts as older adults are excluded (Evans, Ulasevich, Hatheway, & Deperthes, 2020). This policy blindness has consequences for older people's sexual health and their sexual partners. Abstinence is another strategy that can reduce or mitigate vulnerability to sexually transmitted infections. Unfortunately, practising secondary sexual abstinence can be difficult for some older adults who are sexually experienced and have the financial means to enter new or maintain existing sexual relationships (Irfan, Hussain, Noor, Mohamed, & Ismail, 2020). As such, in old age, the measures by which risk mitigation is negotiated and pleasure or satisfaction is ensured in sexual relationships would differ among older adults even in similar social settings.

A common consensus in the literature is that empirical evidence about what risky sexual practises entail and how older adults are navigating existing gaps in sexual health policies and practises to reduce vulnerability has some public health benefits(Brooks, Buchacz. Gebo, &

Mermin, 2012; Evans, Ulasevich, Hatheway, & Deperthes, 2020). Stereotypical perceptions and restrictive access to quality sexual healthcare services, however, promote misconceptions, low utilization, and high unmet sexual health needs in old age (ore-Gorszewska, 2021). Inequity and exclusion of older adults from sexual healthcare services, for example, foster a sense of stigma and a sense that such services are disconnected from their sexual health needs (Dalrymple et al., 2016). Systemic exclusion of older adults' sexual health needs appears common across many cultural settings (Glaude-Hosch et al., 2015). Growing older and being sexually active in spaces where inequity and systemic exclusion prevail would widen existing unmet sexual health needs (Gore-Gorszewska, 2021). Exploring what older adults consider to be sexual health needs, risky sexual practices, and approaches that are considered useful among their peers in mitigating vulnerability to sexually transmitted infections could yield additional insights, especially in social settings where there is a need for such evidence (Sinković & Towler, 2019).

Cultural and individual factors are constantly interacting to shape attitudes toward risks and perceived susceptibility to sexual infections in the elderly (Zhou et al., 2014). Evidence shows that sometimes the desire for pleasure could outweigh the implications of indulging in unhealthy behaviours, including risky sexual practises (Chao, Szrek, Leite, Peltzer, & Ramlagan, 2015). This study seeks contextual evidence with implications for knowledge building, policies, and practise.

## 3. Theoretical framework

The sexual script theory and the elements of the socioecological theory guided this research. The script theory provides insights into understanding what qualifies as a risky sexual practice, how older adults position themselves in sexual fields with respect to sexual expression and vulnerability, and the protective measures that are considered useful. The sexual script theory, as propounded by Simon and Gagnon (1986), posits that individuals and social categories form their sexualities through interactions, interrogation, and aligning with either prevailing or marginal social frames around what forms of sexual desires are expressed: when, who, how, and where. Individuals as social actors have differentiated capacities to imbibe, reject, or substitute predominant sexualities for marginal sexualities of their preference and vice versa. Each culture has preferences and peculiarities that are socially expected of its members when expressing their sexual desires. The process of learning, questioning, and rehearsing one's sexuality and reactions to others comes through the socialisation process. The theory posits that social actors can dissect sexual "scripts" (Simon & Gagnon, 1986:99) and opt for what represents their own feelings and subjectivities while being accommodating to those around them.

Sexual scripts are gendered among the Yoruba people in southwestern Nigeria. Sexual interactions are considered indispensable within the confines of marriage, and as such, society frowns on premarital sex. Penetrative heterosexual sexual acts also attract high value, with masculinities dominating expressions and engagements. Such framings also provide men with more privileges into late adulthood. In contrast, older female adults are to suppress their sexual desires or disengage from sexual activities in late adulthood since procreation at such periods is almost naturally impossible.

Contexts play critical roles in how sexual scripts are imbibed and enacted. The socio-ecological theory provides additional perspectives on the layers of relationships and structures that reinforce or shape the enactments of scripts within a cultural context. The socioecological theory is premised on the existence of multiple layers of relationships and structures that consist of individuals, relationships, neighbourhoods, and structural factors such as economics, social positions, and cultural beliefs and practices. At the relationship layers, we have the micro level of interpersonal relationships, where older adults spend their daily interactions with friends, family members, neighbors, and their sexual or intimate partners. These layers of relationships are formed within structures like economic conditions that define financial independence, health status and access to quality healthcare services, inclusion or exclusion in sexual health promotion policies, sexual capitals, and opportunities to engage in sexual relations that are culturally defined and approved. Deviations from these structural pressures and non-conformity to societal expectations are normative. Nevertheless, the layers of relationships, community, and structural forces intersect in influencing the personal beliefs and values of older adults by shaping who, when, why, where, and how they engage in or disengage from sexual activities and their interpretations of sexual risks. Furthermore, the theory also helps to understand the layers of constraints and motivating factors, the rationale for engaging in or disengaging from risky sexual practices, and what forms of protective measures are available, acceptable, and adopted on the basis of perceived usefulness or being beneficial.

Individuals can express various sexual identities and fantasies while grappling with or resonating with what is widely accepted as normal or permissible sexual expressions from childhood to adulthood. As a result, the sexual script theory acknowledges the role of individual agencies within the network of relationships and structures that govern sexual interactions, a capability that resonates with Anthony Gidden's structuration theory. In Gidden's view, social actors are active in forming structures and networks of relations around them and are not just conformists to existing norms and values in their social settings.

The sexual script theory, when applied to sexuality in old age, would help illuminate ageing as a social process that is prone to moral influence, affecting attitudes and perceptions towards sexuality. Society and older adults are constantly framing which sexual behaviours, values, and practises are permissible or otherwise, and this creates contradictions in the process of ageing (Katz & Marshall, 2003). Some older adults may have a healthy status and social capital that puts them ahead of others in terms of attracting sexual partners. Some older adults' sexual networks may also provide them with opportunities to engage in new sexual relationships or strengthen existing ones. Among these possibilities, the chances of being rejected, stigmatised, or suppressing the sexual desire to attain acceptance or conformity are high. Some would also jettison the social benefits of acceptance in favour of satisfying their desires and pleasures. Furthermore, urban life also has a way of mediating and shaping the sexual scripts that are available to different social categories and genders (Collins, 2013). Older male adults with more social capital are more likely to attract quality and numerous sexual partners than older men with fewer capitals.

Interactions in existing sexual fields and optimal appropriation of available relationships will require internalising the norms around old age and contentious positions in the prevailing sexual scripts. As such, older male adults are likely to conceive and perform their sexuality within scripts and frames that represent what is acceptable to them, their circles, or their culture. Within these intersections and framings, notions of masculinity are formed and sometimes modified in networks of sexual relationships. The questions addressed in this study are guided by both theories to gain a contextualised stance in interrogating what constitutes risky sexual practices, how older Yoruba male adults use their agencies, what practises are adopted, and how these measures are interpreted and deployed in accessing personal vulnerability and that of peers to mitigate vulnerability to sexually transmitted infections. Both theories also provides a framework for interpreting how individuals' socialisation and social expectations throughout their lives may influence how older adults perceive their sexuality and express their desires.

## 4. Methods

### 4.1. Design and settings

This paper is anchored on larger research on older adults' sexuality and help-seeking behaviour among the Yoruba in southwest Nigeria. The larger project has a sequential exploratory mixed-methods design that consists of qualitative and quantitative methods. Only qualitative data

from vignette-based focus group discussions and semi-structured interviews with older men are presented in this paper. Combining these methods yields unique insights into the reality of sexuality and ageing that a quantitative approach would not provide (Bauer, Haesler, & Fetherstonhaugh, 2016). This approach is suitable for this study because it aims to gain a subjective, interpretative understanding of risky sexual practises and vulnerability to sexual infections in old age. The study was conducted in six communities in two urban Local Government Areas (LGAs) (Ibadan North and Ibadan Southeast) in the Ibadan metropolis. Both LGAs are among the four most populated areas in Ibadan, the capital of Oyo State. The 2006 population census shows 172,547 males aged 60 to 85+ and 154,754 females within the same age range in Oyo State (National Population Commission, 2009). In these two LGAs, the inner core areas of the communities were purposefully targeted. The city of Ibadan is classified into three subsets: the inner core, transitory, and peripheral (Coker, Awokola, Olomolaiye, & Booth, 2007; Fabiyi, 2004). The inner core represents high-density residential districts with 300 people per hectare. Indigenes are the prominent residents in the inner core areas. Transitory areas are medium-density residential districts with 100–300 people per hectare (Coker et al., 2007). The peripheral regions are low-density residential districts with less than 100 people per hectare. The inner core of the LGAs was targeted.

The city of Ibadan has public and private hospitals, and the University College Hospital is the biggest and only tertiary hospital with a geriatric clinic in Nigeria. Informal care is still dominant in Nigeria, as many older people lack access to geriatric care (Dokpesi, 2015; Ogunshola, 2014). Traditional health-care practitioners' self-care practises and patronage remain high across the various communities in Nigeria (Amzat & Razum, 2014; Isola, 2013). Traditional medicine is sometimes perceived as effective in managing some health problems, especially those with supernatural or preternatural explanations.

### 4.2. Participants and recruitment strategy

The participants are older Yoruba men, aged 60 and above, residing in urban Ibadan, Southwest Nigeria. Among the Yoruba people, those aged 60 years and above are socially expected to have entered old age, especially if they already have grandchildren (Togunu-Bickersteth, 1988). Women of this age are socially expected to refrain from participating in certain activities, including those related to sexuality. The reasons are related to patriarchal dominance and the premium on reproduction as the essence of engaging in sexual intercourse. Within this framing, older men are excluded once they have sexual partners and appear healthy (Agunbiade & Ayotunde, 2012).

Recruitment of FGD participants began with a gradual selection approach that involves community entrance and a strategy to develop good rapport with potential participants. As a principle, the gradual selection approach entails identifying cases or participants based on concrete criteria. It opposes relying on abstract characteristics in selecting cases or participants for focus group discussion (Uwe, 2010, p. 121). In applying the gradual selection principle, the community leaders in the inner cores were identified first through the community relations officers' assistance at the Secretariat of the LGAs. The goal was to make community leaders gatekeepers in terms of recruiting participants. The LGA officials were provided with detailed briefings on the research and its objectives, with opportunities to ask questions and seek clarifications. The research inclusion criteria were also shared with them after receiving their consents to participate in the recruitment process and understanding what the research entails. After that, two field assistants followed the gatekeepers in moving around into the neighbourhoods to identify and recruit eligible participants. The following inclusion criteria guided the process: (1) Yoruba extraction; (2) residents of communities in the two LGAs; and (3) those aged 60 years and above.

In consonance with the literature (Krueger & Casey, 2000), an average of nine males participated in each of the FGDs. In total, fifty-six males participated in the six FGDs and nine in the face-to-face interviews. All the FGDs occurred in public spaces that the participants chose at an agreed-upon time. The location was safe and free from noise and interference.

Based on the research design and aims, face-to-face interviews were also conducted with eligible participants. The recruitment process commenced with a short briefing on the need to follow up with some preliminary findings from the FGD participants. At the end of each FGD, all participants were informed of the individual interviews that would be conducted later. Purposively, some of the FGD participants were approached at this point for possible involvement. The focus at this stage was on participants who shared (1) extremes, (2) popular stereotypes, and (3) subjective experiences of sexuality in old age. Those who volunteered based on their individual experiences were the first set of contacts, followed by those who held extreme opinions and popular stereotypes. Among the FGD participants, seven males who expressed such views or experiences agreed to follow-up interviews and were referred to two others. The interviews also occurred at the residences of the participants, based on their choices. All the FGD sessions and interviews were digitally audio-taped with the consent of the participants.

### 4.3. Data collection instruments

The data collection was done using qualitative vignettes in the FGDS and a semi-structured guide in the interviews. A thematic approach was adopted in developing the FGD guide The findings from the focus group data flagged the issues that were considered in the face-to-face interviews. Each guide was made up of five themes with a series of questions. Only the themes and questions relating to the focus of this paper are presented here. The FGD guide has two contextualised vignettes that were embedded into the questions around the themes. Both vignettes were stories made up of everyday observations, reports, subjective experiences, and other things that showed how the Yoruba people act sexually and what they do to stay safe.

Existing studies have argued that the use of vignettes in a focus group discussion can help participants focus on the characters in the stories, situate themselves in reality as they are portrayed, and gradually divulge their personal experiences and those of others (Easter et al., 2007; Lichtenstein et al., 2017). The vignettes were used in the focus group discussion to stimulate the participants' interest and break some boundaries around the public conversation on the intersections between sexuality and old age. Thus, the focus groups provided an opportunity to learn about the cultural and group influences on sexual practices, risk perceptions, and preferred measures for reducing vulnerability to infection among study participants. Both the vignettes and interview guides were pre-tested and adjusted based on the responses from the participants. But experts in sexuality studies and social research checked the content of the made-up stories to make sure they were accurate.

The semi-structured interview guide was also structured around five thematic issues from the FGDs without vignettes stories. For this paper, the thematic sections and questions that explore the subjectivities of risky sexual behaviour, vulnerability to sexual infections, and preferred methods of prevention in old age are considered. The use of vignettes in the focus groups provided rich insights into the patterns and connections in sexual practices, as well as measures to reduce participants' vulnerability to sexual infections in old age. These issues were explored further in the face-to-face interviews using a semi-structured guide.

This study followed ethical standards for qualitative studies. All the participants were recruited voluntarily through gatekeepers that are well known in the various communities. The gatekeepers were approached with information about the study's scope, goals, and benefits for participants, as well as the body of knowledge and implications for health policy and practice. Each gatekeeper was an older male adult, aged 60 years and above. Each gatekeeper was requested to document the details of eligible participants and share such details with the researcher before the agreed-upon date for the group discussion. The approach was fruitful, as more than 12 eligible participants appeared at each agreed-upon

venue. At this point, each eligible participant was further briefed on the objectives of the study and encouraged to ask questions and seek clarifications. Before the group discussion started, the procedure also helped people get to know each other.

In each FGD session, all participants were encouraged to keep information that was shared by others with themselves and with others that were present during the discussions. No personal identifiers of the participants were collected during or after the interviews and discussion sessions. Two institutional ethical approvals were received for the study, one from South Africa and the other from Nigeria. In the vignettes and the presentation of the findings in this study, pseudonyms were used.

### 4.4. Data analysis

The script theory guided the data analysis. The focus was on sexual risks, sexual pleasures, sexually transmitted infections, story lines, social expectations, and social positioning that might help promote the sexual health of older men within the study settings. The approach helped researchers figure out how to interpret the ideas, context, and beliefs that affect older men's sexual risk behaviours and how to keep them from getting sexually transmitted infections in the study settings.

After that, all the audio-taped, focused discussions and interviews were transcribed and translated. All the interviews were transcribed verbatim in Yoruba language before translation. Thereafter, two experts in the Yoruba and English languages conducted a back-translation of the transcripts. The back-translation involves a re-translation of previously translated transcripts to minimise loss of meanings and descriptions that were provided by the participants (Regmi, Naidoo, & Pilkington, 2010). Both transcripts were read and compared by these experts and the first author who also speaks and write in both languages. In the process, areas of divergence between the two language experts were resolved before the transcripts were coded. These steps helped ensure a close representation of the participants' conceptualizations of sexuality based on their experiences and positions. The data analysis was done thematically at two levels, which helps to 'analyse, identify and present findings' from the FGDs and individual interviews (Braun & Clarke, 2006). The first stage was a quick analysis of the data based on the themes that guided the data collection. At this point, the salient themes and subthemes emerged for the second stage of the analysis.

In the second stage of the analysis, all the translated transcripts were edited and transferred into NVivo 10 for further analysis. At this stage, further coding was conducted, with the themes and sub-themes explaining the research questions identified. Throughout the analysis, both deductive and inductive coding approaches were used to analyse the data until a saturation level was achieved. The triangulation of findings from the FGDs and individual interviews provided unique opportunity to further compare the dynamics of sexual health in old age and the experiences that are particular to some older male adults within the study contexts.

## 5. Findings

The findings that emerged from the data revolved around four main themes. These include multiple sexual relations, the normativity of multiple sexual partners, the need for protection, the reality of sexually transmitted infections, including a folk condition, and the availability of traditional remedies that can be adopted in reducing vulnerability.

## 6. Profiles of study participants

Two-thirds of the participants across the three age categories were married, and most of them were in polygynous marriage (See Table 1). A high proportion of FGD participants had no formal education, which supports earlier findings that access to formal education among older people in Nigeria remains low (Olasunbo & Olubode, 2006). Interestingly, two of the participants aged 80 years had up to university education.

**Table 1**
Socio-economic profile of the male focus group participants.

| Variables | N (56) | | |
|---|---|---|---|
| | 60–69 yrs. | 70–79 yrs. | 80+ |
| **No of Participants in the FGD sessions** | 19 | 17 | 20 |
| Age [mean (SD)] | [65.8(2.7)] | [75.2(2.8)] | [82.1(2.6)] |
| Marital Status | | | |
| Married | 19 | 16 | 18 |
| Widowed | – | – | – |
| Widower | – | 1 | 2 |
| **Type of marriage** | | | |
| Monogamy | 4 | 6 | 7 |
| Polygyny | 15 | 10 | 11 |
| **Religion** | | | |
| Christianity | 4 | 2 | 8 |
| Islam | 15 | 15 | 10 |
| Traditional religion | | | 2 |
| **Educational status** | | | |
| No formal education | 5 | 9 | 7 |
| Islamic education | | | 1 |
| Below the primary | 2 | 4 | 1 |
| Primary | 1 | 3 | 5 |
| Below Secondary | 2 | | 1 |
| Secondary | 4 | 1 | 1 |
| Diploma/NCE | 5 | | 2 |
| University | | | 2 |
| **Occupation** | | | |
| Artisan work | 2 | 2 | |
| Clergy | | 1 | |
| Commercial Driver | 1 | | |
| Farming | 1 | 1 | 2 |
| Herbalist/Spiritualist | 1 | | 4 |
| Petty trading | 6 | 5 | 3 |
| Retiree | 8 | 8 | 2 |
| Retired | – | – | 2 |

With slightly less than one-third of the participants having completed secondary school and above, it was not a surprise that some of them had paid employment and are now retirees. Unfortunately, the irregular payment of pensions and the non-existence of a living wage or salary have worsened the situation for older people, including retirees and those in petty businesses.

The socio-demographic characteristics of the interviewees (See Table 2) were similar to those of the FGD participants, as seven of the interviewees participated in one of the FGD sessions. The table indicates that eight of the nine participants were married, and three of them had more than one wife.

### 6.1. Normativity and contestations of multiple sexual relations

The existence of multiple sexual relationships among older people was affirmed as the participants listened and reacted to the sexual behaviours presented in the vignettes. For most participants, such sexual behaviours are found among sexually active males and persist into old age unless there are health challenges or an inability to secure a willing partner or wife. Some participants argued that more men tend to become dissatisfied with their sexual lives, especially with the wives they married in their youthful days. In the FGD with men aged 60 to 69, participants described men as covetous and always desiring more. Such behaviours are acquired through the life course:

> Men are very covetous. They would want to have a taste of everything around them (with a preference for different women). [FGD with men aged 60–69, Bodija]

> After repeated failed attempts to secure my wife's interest, I had to step outside to satisfy myself.[IDI with a male aged 64 years].

From a rational position, the participants argued that men's search for

**Table 2**
Socio-demographic profile of the interviewed older males.

| Participants | Age | Religion | Level of Education | Occupation | Marital status | Type of Marriage | # of wives | # of children |
|---|---|---|---|---|---|---|---|---|
| Participant 1 | 83 | Islam | None | Spiritualist | Married | Polygyny | 4 | 17 |
| Participant 2 | 64 | Islam | None | Trader | Married | Monogamy | 1 | 6 |
| Participant 3 | 73 | Islam | Primary | Business | Married | Polygyny | 3 | 14 |
| Participant 4 | 81 | Islam | Standard III | Retiree | Married | Polygyny | 2 | 12 |
| Participant 5 | 69 | Christianity | Standard IV | Trader | Married | Monogamy | 1 | 5 |
| Participant 6 | 66 | Islam | None | Trader | Married | Polygyny | 3 | 13 |
| Participant 7 | 77 | Christianity | Primary | Retiree | Widower | – | – | 7 |
| Participant 8 | 71 | Islam | None | | Married | Monogamy | 1 | 8 |
| Participant 9 | 80 | Christianity | Higher | Retiree | Married | Polygyny | 3 | 15 |

variety ought to wane with age. However, most men are the culprits in one way or another. As such, participants in one of the FGDs with older men (80 and older) argued and even predicted that it was normal for most men to continue in the practise of looking for different women until they grow old. Their hypothesis was hinged on the belief that habits once formed are difficult to change unless there is determination or sometimes a threat, such as health challenges or a divine touch from a supreme being. As noted by a participant, sometimes individuals with such behaviours would not change until they met a waterloo in their pursuit for sexual pleasures:

> That is just the way it is. 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 continues till one becomes an adult). Extramarital affairs do not begin in old age. It is a behaviour that begins when you are a teenager or a middle-aged adult. As such, there is a chance that such individuals will continue such indulgence even in old age. Even when the stamina for vaginal intercourse diminishes, older men will ask for oral sex or fondling of their penis from their sexual partners. (Laughter and consensus from others). We call it oju koko ro (covetousness), and it starts from childhood to adulthood. [FGD with men aged 80+, Inalende]

In the absence of an effortless route of escape, some participants boldly predicted that married men of their peers would have been unfaithful to their wives at least once throughout their life span. This presumption was also connected to patriarchal orientations and the gendered skewness of household chores that negatively impact women's health and disposition towards sexual activities. According to their argument, once a woman enters menopause or stops childbearing, the chances of reduced sexual activity also increase. The reduced interest in sexual activities also exists for men, but they believe that women are affected more. In the process of navigating the responsibilities of being a wife and growing older, women are caught up as they find it challenging to balance these roles. Unfortunately, for some of their peers, the dilemma of conforming to traditional marriage roles becomes a reason for engaging in extramarital affairs:

> Some wives have exposed their husbands to extramarital affairs through sexual refusal. Due to heavy household chores, some women overwork themselves with little attention and time for their husbands' sexual needs. They will refuse sexual advances from their husbands, and through that, some men will start having concubines or look elsewhere for satisfaction [FGD with men, aged 80+ in Inalende].

As a twist of events, most of the participants opined that older women who are married to sexually active older men are promoting extramarital affairs and multiple sexual practises for some of their peers. Males blamed women, citing how ageing affects women's sexual desires and expression as a reason. They also blame younger women for having multiple sexual relationships or engaging in extramarital affairs. Their position was further motivated by the availability of sex for sale within their communities. Some women are willing to have sex with older men, either for pleasure or for financial gain. For some participants, some young men's poor sexual performance, women's love for material things that might be unaffordable by their husbands, and early sexual exposure contribute to the situation. Hence, most of the participants between 60 and 79 years of age concluded that the situation was becoming more complex as the number of women who are willing to offer sex for free or material gains has increased, and they are now available to willing older men:

> There are women outside who will satisfy any man who is interested in them if there is money to be given to them. [FGD with men aged 70–79 years, Sango Community]

Without much denial, two of the participants in the FGDs with men (ages 60–79) justified how their interest in other women apart from their wives was reactionary. Though the vignette was not designed to share personal experiences, such information became available as the discussion atmosphere became more relaxed. For these two participants, older women enjoy refusing sexual requests from their husbands. As a way out, sexually active men can seek satisfaction elsewhere. Narrating from a personal experience, a man justified his actions:

> My first wife called to tell me she is not interested. What else do you expect me to do? My penis is still alive, and I cannot keep on begging, so I married a younger wife, and I have another younger woman that I see also— [A 79-year-old man, FGD with men aged 70–79 years].

Marriage and age-related contextual factors were partially attributed to this perception and unwillingness to accede to a husband's sexual demand as a social process. Factors such as loss of affection, sex as a laborious duty, and men's unwillingness to support the adjustment period between reproduction and the post-reproduction sexual health needs of women emerged clearly. For most male participants, menopause was a key contributor, along with the view that the woman's body dwindles in sexual value. These gendered positions provide options for some older men to normalise and justify extramarital affairs and multiple sexual relationships in old age.

Despite the slight justifications for engaging in multiple sexual relations and marital infidelity, across the FGDs, there were calls for caution. At this point, the participants appear to have expressed some generative concerns and desires. There was an allusion to older people's exemplary roles, the possible health consequences of risky sexual practises on the self, and the burden on their relationships or significant others. Like a sermon, most participants opined that extramarital relations require discrete interactions and caution on the part of those involved. The participants expressed a consensus that Baba Alamu's[1] sexual exploits and romance with his concubine could attract reactions and cause conflicts with his wives and children if he appealed to the vignette again. To maintain relative peace at home, Baba Alamu's extramarital relations must exist outside his wives' knowledge. For them, the knowledge of his sexual escapades among his other wives could encourage any of these wives to seek equal treatment with their husbands:

[1] The male character in the vignette.

> With three wives at Baba Alamu's disposal and a concubine, there is a chance that some women will be dissatisfied in many ways, including Baba Alamu's ability to meet their sexual demands. The inability to meet the wives' needs will also encourage the women into extra-marital affairs [FGD with men aged 80+, Inalende Community].

Beyond equalisation, another scenario was the possible differences in the sexual experiences of the wives. The participants predicted that women have varied sexual desires and satisfactions that might stimulate favouritism and undue attention from their husbands. For instance, in polygynous marriages, such particularity would negatively impact other wives as one or two of the wives would be treated with preference. For most of the participants, older men who are married to younger women in polygynous marriages would most likely demonstrate such a preference and therefore stand a chance of creating tension between their wives and them.

## 7. Differences in sexual desire and supporting factors

Beyond the reference to the normative view that men are sexually insatiable, the participants also identified factors such as attracting willing partners, level of affluence, sexual prowess of individuals, and health status as critical determinants. In the words of one of the interviewees and a FGD participants, these factors interact to put people in different positions to keep their sexual interests and desires alive as they age:

> 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 individuals repent of their sins and ask God for help. [IDI with a Christian male aged 73 years].

> We are all different; some people have been involved in sexual activities since they were young, and it has become a habit. We still have some who started engaging in sexual intercourse only when they got married. So, someone who began in his youth cannot be compared to someone who began later, so it is dependent on how an individual has lived his life since his youth. [FGD with men aged 70–79, Sango Community]

The participants in one of the FGD sessions with 80-year-old males believed that it would be challenging to adopt a simple explanation for interpreting sexuality over the life course. Nonetheless, there was a consensus assertion that some individuals, whether male or female, can improve their chances of attracting potential sexual partners with diabolic powers. This belief is connected to the cultural view of medicine as anything that has the power to achieve an objective, whether the logic is explicable or not and whether the process can be logically followed through or not. As such, medicine exists in all spheres of human life, including love medicine. The potentiality of such medicines attracts potential sexual partners, thus transcending factors such as affluence, age, gender, or physical features of the individuals. With reference to the male characters in the vignettes, the participants took a guess and are alluded to as thinking that 'Baba Alamu and Iya Asake'[2] were perhaps affluent, have some unique attractions, or have access to medicine that makes them attractive. Additional insights can be gauged from the excerpts drawn from the FGDs:

> Likely, these individuals (Baba Alamu and Iya Ashake) may not have money but have an attractive aura. Once an individual has such an aura, it is natural that everybody will love to have sexual relationships. There was a woman like that from Oyo; she had seven husbands. [FGD with men, aged 80+, Inalende Community]

As captured in one of these excerpts, the belief that some individuals have special hair for attracting sexual partners is not restricted by gender. It is difficult to verify whether an individual has special hair for attracting sexual partners that is not restricted by gender. It is difficult to verify whether an individual has unique, attractive hair or uses love attraction medicine to attract a sexual partner. But those who use the medicine, the traditional healers who make it, and other people who know about spiritual things can give confirmation.

Across the FGDs, health status was also described in connection to all other factors that could aid or hinder the chances of engaging in sexual activities in old age. Those who were sick were said to be incapable of engaging in sexual activities. The incapacitation might be partial or total. A participant in the FGDs with men aged 60 and above in Bodija recounted how he had to reduce his sexual activities after a health challenge. However, he did not disclose the illness's nature but recounted how he reduced his daily sexual activities. However, the decision was painful, as he initially found it difficult to listen to his friends' advice about his urge for sexual intercourse. In his words:

> When I was between 55 and 60 years old, I used to have sexual intercourse daily with my three wives, except when they were menstruating. Most of my friends warned me to reduce it, but I did not listen to them and continued until I was 65 years old. Eventually, I landed at the University College Hospital. Now I have reduced it; I do it a few times a month, and I feel much better with good health, even now that I am 67 years old. [FGD with men aged 60–69 years, Bodija]

Despite the normative beliefs, individual, relationship, and circumstantial factors highlighted, a sense of being responsible for oneself and others was also shared. For most participants, the leverage to engage in multiple sexual relations also comes with some responsibilities. Such responsibilities must be borne by men for three main reasons: First, men were pictured as being more vulnerable and more likely to experience the symptoms of a sexual infection before their female partners. The second reason centres on the availability of traditional remedies and therapies for sexually transmitted infections, and men should take the lead in ensuring that they are protected as well as their partners. This second role was embedded in the third reason as the participants argued that sexually experienced men must be initiative-takers for them to survive the antics of women and, most importantly, to survive a folk sexual infection called magun. This common sexual infection can be contracted with instant death as the consequence of whether the male partner uses a condom or not. In their views, traditional medicine provides such resources and genuine healers within the system that can succour clients and help respond to the growing incidence of sexually transmitted infections across the life course.

### *7.1. Dilemmas of marital infidelity and risks of contracting sexual infections*

Critical sources of contracting sexual infections, irrespective of gender are multiple sexual relations and unprotected sex. The participants' position might be connected to their polygyny experiences and the practise of multiple sexual relations within and outside marriage. It was normative for the participants to perceive sexually active men as being highly susceptible to contracting at least one sexual infection in their lifetime. However, this likelihood was interpreted in line with their experiences and oral histories around gonorrhoea, syphilis, and magun. These diseases might have been common in the youthful days of the participants, especially gonorrhoea.

> Everybody, especially men, is a carrier of gonorrhoea. None of those who do not have gonorrhoea can give birth, and he is impotent. It is when it is too much that it becomes a problem. [FGD with men aged 60–69 years, Bodija Community].

The above excerpt is somehow connected to the earlier position that men are sexually insatiable and that once the habit of multiple sexual

[2] The male and female characters in the vignettes.

relations is formed, it becomes difficult to fizzle it out throughout the life course. As a result, older people who had a proclivity for such habits in their youth were thought to maintain the habit in their later lives.

Interestingly, the presumption of the participants was affirmed in two of the FGDs with men aged 60–70 years. In both FGDs, two of the participants volunteered their personal experiences and how their sexual habits were very much with them. The second participant, married to three wives, narrated a decline in his sexual activities due to a severe health challenge. The illness reduced his sexual activities. As such, across the life course, the participants postulated that married men would, at one point in time, contract at least one of these three types of gonorrhoea: the one with excessive pus (atosi oloyun), the one with discharge of blood (atosi eleje), and the dog type (ato si alaja).

From the participant's perspective, sexual infections like gonorrhoea were common and treatable using either traditional medicine or biomedicine, or both. However, most of the participants doubted their chances of contracting HIV. The FGD participants and interviewees acknowledged that they have heard of HIV/AIDS, which they described as arun tii ko gboogun (disease without treatment as it is publicised through various local media in southwest Nigeria). Those who reported that they were sexually active, however, denied their chances of contracting the infection. This presumption might be connected to their high trust in the holistic nature of traditional medicine and its ability to address a wide range of health and non-health related issues:

> 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 of traditional medicine, an individual can [have] good health, including sexual health, and be free from sexual infections. [IDI with a male aged 73].

> 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].

There is also the likelihood that such views might be connected to the neglect of older people in existing HIV/AIDS campaigns with a primary focus on younger people. These campaigns focus on the vulnerability of youths and middle-aged adults to sexual infections, leaving older adults out of the picture. The excerpt below provides additional insights:

… *Old people seldom contract HIV/AIDS. It is more common to see cases of such infections among younger people, and maybe a few older people who have sexual relations with young people. It is unusual to find HIV/AIDS among older men and women who sleep with themselves. [Interview with a traditionalist/Muslim aged 80 years]*.

Campaigns around HIV/AIDS appear to have gained ground, even among older people. However, the excerpts show the disenfranchisement and neglect of older people in the ongoing campaigns on HIV and stigma eradication. The neglect of older people might have influenced older people's perceptions and dispositions, as some participants conceived the problem as that of younger people and those in their reproductive age. So, it was not a surprise that some of the FGD participants and interviewees said they had had more than one sexual partner, but were less worried about contracting HIV.

However, HIV was described as "aisan tio gboogun" or "eedi" among the participants. The term "eedi" sounds synonymous with "AIDS," the full-blown effects of a delayed or poorly managed HIV condition. Early dominant campaigns around HIV infection and treatment options qualified the infection as an "aisan ti o gboogun." The term "aisan ti o gboogun" refers to health conditions without adequate treatment or cure. According to the participants, such aisan ti o gboogun would create hopelessness and cause people to accept death as an unavoidable part of life. Like a sermon, the participants admonished the young and old who are in the habit of engaging in multiple sexual relations to adopt traditional or biomedical protective measures. The participants advanced the idea that any remedy or protective measure's suitability and relevance should be informed by the perceived aetiological explanations and recovery possibilities from the contracted sexual infection.

In contrast, magun, a folk sexual infection without symptoms, was less denounced as the participants called for more caution and responsiveness to avoid magun-related deaths through extramarital engagements. The participants explained that they depend on the context, religious belief, and social position or status. A man can decide to place magun on his wife, even with unconfirmed facts, to eliminate her concubine or sexual partner. The social expectation is that any man who has sex with such a woman will die immediately or within a few days. Some participants affirmed the commonality and use of magun across different Yoruba communities and eulogised its functionality in enforcing fidelity in marriage:

> There is a feeling that women from Ikire town (one of the Yoruba communities in Osun State, Nigeria) hardly stay in their husbands' homes and are promiscuous, so their husbands often place magun on them. As a result, men who engage in multiple sexes may contract it unless they have an antidote. [FGD with men aged 60–69 years, Bodija Community]

Despite the acclaimed potency of magun, it can be circumvented by those who possess knowledge of its antidotes. Such knowledge was affirmed as uncommon. Only certain individuals possess the antidote and knowledge necessary to manipulate the power of magun before and during intercourse with a magun-carrying woman. This procedure is only temporary; a permanent removal and neutralisation of the Magun effect often reside with the person who implants it.

The participants argue that, once magun is placed on a woman, if it is not removed within a stipulated period, death is inevitable for the carrier. If a magun also sleeps with her husband, who lacks the knowledge and power to curb magun, his death is also inevitable. This explains the practise of shifting magun's potency in an infected woman for sexual intercourse without the ability to completely remove the magun except by the person who planted the magun. In principle, the male participants emphasised the view that men who engage habitually in extramarital relations must protect themselves against sexually transmitted infections, particularly magun, as indicated in this excerpt:

> If one is covetous because women are dangerous in terms of infections, one should have prevention against such infections. For instance, there is magun,a form of infection that kills immediately. Any man who desires extramarital affairs must be prepared to survive if he encounters a woman with magun. [FGD with men aged 60–69 years, Bodija Community]

Based on the aetiology and symptoms associated with magun, the participants commented that only traditional medical means could effectively eliminate the effect of magun and prevent sudden death.

The logic behind Magun is inexplicable. It is magical in its operation. While antidotes were emphasised, some of the male participants called for mutual faithfulness in marriage. They contended that infidelity affects both genders, but with different opportunities and societal dispositions when caught in the act. However, the consequences remain the same in terms of the contraction of sexual infection by men and women involved in multiple sexual relations. These extracts capture part of the dilemma around the dynamics of marital infidelity and sexual infections:

> 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? A male can 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 would you do if a sexually infected man slept with your

wife? (Tii asopa ba ba iyawo oluwa e lopo nko, tii eniyan ba yago fun iyawo asopa?) [FGD with men aged 70–79 years, Sango Community]

As noted above, the reality of Magun can be avoided in some way. The extracts portray the participants as people who have succumbed to circumstances and the inevitability of women and men contracting a sexual infection across the life course. Rather than rescinding, the participants argued that there is potential and knowledge that can be sought within the traditional medical system for protection against all forms of sexual infections, including those with no current treatment options in the biomedical system.

Against the fact that there are consequences to engaging in multiple sexual relationships, the participants called for responsive help-seeking. Such help-seeking would minimise the physical and spiritual risks of having multiple partners. In their narrative, biomedicine can only handle physical consequences such as treatable and manageable sexual infections. Only traditional medicine can adequately manage such risks, particularly the unfortunate ones that occasionally occur in men when they engage in random sex. For most participants, random sex can wreak spiritual havoc on men, especially when, unfortunately, they have sex with the wrong person. For them, seeking help from competent traditionalists provides more assurance and protection. Traditional treatments were described as natural and causing less harm to the body; they are holistic, as they can affect changes at both spiritual and physical levels.

### *7.2. Protection against infection an exemplar and normative responsibility*

Protection against sexual infection is considered a normative and exemplar way of life for sexually active older people. They argued that older men must have developed a sense of what supports, and services are available through experience. More so, all forms of sexual infections are detectable, preventable, and mostly treatable through responsive help-seeking, either from the biomedical or traditional medical systems. Without disparaging biomedicine, the participants lauded the holistic nature and potential of traditional medicine. They argued that traditional protection measures include the use of charms to avoid contracting an infection and to avert ill-luck and premature deaths due to the magun (a folk sexual infection) affliction.

As such, the onus lies on experienced older men who desire to avoid sexual infections. The emphasis on the efficacy of traditional medicines in the prevention, treatment, and enhancement of sexual health might stimulate over-optimism and relegate the consequences of sexual risks.

I have slept with several women without using a condom, and I have never had a sexual infection to date because I am sure of this traditional concoction. It is called sarun domi (thatwhich turns any disease into water for the body; see at that corner; I use it daily). [Interview with an 83-year-old male herbalist and spiritualist].

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. Other forms of traditional medicine within this category include ajasara (all forms of incisions, ingested substances, and initiations in the form of medicine), onde (amulets), and incisions. These types of traditional medicine function to provide users with the opportunity to avoid contracting sexual infections. The participants in the male FGDs at Kobiowu and Inalende argued further that each medicine has its material and spiritual components. These properties are inseparable from ensuring potency and effectiveness. They hinted that unless something was missing, Men with the right incision in their bodies, for instance, will receive a sign that will let them know whether a woman has an infection before intercourse.

He could wear a medicinal or magical ring. It could be an incision or an amulet (onde) [herbal belt] made for a man so that when he comes into contact with a woman who has sexually transmitted infections, his male organ does not [become] erected. It could also be performed on women so that only her husband could have fun with her. [FGD with men aged 70–79 years, Kobiowu Community]

The impression was that these traditional medicines provided users with an advantage over the possibility of contracting sexually transmitted infections. The same principle is applied to the perceived efficacy of traditional medicine in the prevention of and protection against all forms of infection.

## 8. Discussion of findings

The gerontological literature has a fair representation of what sexual health entails, including risky practises and the preventive measures that are found among older male adults. The scarcity of studies, especially those from Africa, on the sexual behaviour of older male adults has widened the gaps in knowledge. This study contributes to the argument that cultural values and practices contribute to what qualifies as risky sexual practices, vulnerability to sexually transmitted infections and protective measures that can be promoted with a view to improving sexual health. Within the study settings, gendered cultural values and notions of masculinities promote sexual activities including risky practices into late adulthood.

The findings revealed that sexual activities continue until old age, and some older male adults engage in practises that could compromise their sexual health and well-being. The older adults in this study have a shared understanding of what it means to engage in unprotected sex with multiple sexual partners and the need for protection. Engagement in risky sexual practises transcends the place of knowledge to include what to do and the possible consequences of failing to act as socially expected. The transmission of sexual infections was normative, especially for men who had multiple partners. This finding is consistent with the literature, which indicates that men who have a history of multiple sexual relationships, such as those in polygynous marriage, are more likely to engage in sexual risks (Zhou et al., 2014). In China, Zhou et al. (2014) found that among older Chinese men with a history of multiple sexual partners, they sustained that practise even though some were in monogamous marriages. The reasoning is that multiple sexual relations are a habit formed across the life course and thus become difficult to discontinue in old age.

In addition to previous sexual histories, growing older in urban spaces could inculcate values that are more permissive of forming new sexual networks and creating opportunities for expressing sexual desires. The sexual scripts as narrated by the older male adults in this study could be mirroring variations and the dynamics of sexual behaviours and practises in urban spaces (Collins, 2013). Older male adults who have high social capital and a quality network might be sexually attractive to any of the inhabitants spread across the nooks and crannies of the city of Ibadan. The literature on intergenerational sexual relations supports the existence and growing involvement of young females in sexual relations with older males in urban spaces in southwest Nigeria (Adetutu, Asa, Solanke, Aroke, & Okunlola, 2021; Ayamolowo, Ayamolowo, & Afolabi, 2020). These relationships are noted for their inherent risks, including the chances of contracting diseases that have different biomedical treatments and explanations.

The findings also revealed sexual risks as conditions or events that transcend the biomedical conception of sexually transmitted infections to include the contraction of a folk sexual condition that responds to traditional remedies alone. There was also a varied sense of susceptibility, a sense that was commonly shared among those who believe that most sexually transmitted diseases are preventable using traditional medicines in diverse forms. What exists as a risk, and the chances of becoming susceptible to a sexually transmitted infection, varied among the participants. This viewpoint echoes Gore-Gorszewska's (2021) findings that older people of all genders have a fluid understanding of what sexual risks and susceptibility entail.

Nonetheless, to the participants in this study, it is shameful and

socially risky when such older men fail to learn enough and adopt traditional protective measures to prevent sexual infections and improve their sexual performance without delay. In this script, the men considered themselves responsible for and in charge of protecting their sexual health, including their partners' sexual pleasures. This perspective is based on hegemonic masculinities, which position men as risk-takers and determinants of what and how their sexual partners can be satisfied (Fleming et al., 2016). This sexual script resonates with the cultural expectations of being responsible sexually and the premium of gerontocracy as a leadership exemplar. Thus, when the scripts of masculinities and the normativity of heterosexuality are well rehearsed and practiced, older adults are valued by their peers and others. For older adults who lack the social capital to shield them from shame and provide access to essential support within and outside the medical system, the risk of stigmatisation and labelling increases.

This study made no assumptions about the consistency of engagement and sustained interest in sex in old age. Instead, participants predicted varied continuity in sexual activities due to a web of factors. The dominant ones mentioned included the absence of life-threatening health problems, partners' availability, and access to social capital to attract potential partners.

With a high proportion of male participants in polygynous marriages, it was not surprising that the majority of the FGD participants did not consider their involvement in polygyny as risky (Zhou et al., 2014). For the participants, couples in monogamous marriages also stand a chance of being vulnerable to sexual infections. While relegating other sources of contracting an infection, the participants dwelt more on trust in marriages, but it also affirmed how difficult it is to ascertain faithfulness across the life course. From their experiences and those of others, trust and faithfulness in marriage can be compromised at any point, irrespective of gender (Tener, 2021). Women can become unfaithful even in monogamous marriages, and vice versa. Reasons and excuses for becoming unfaithful can emerge from any direction, depending on power dynamics and contexts (Tener, 2021).

From a social positioning perspective (Mapp, 2018), the findings showed that personal experiences and other life events could equip sexually active older men with the reality of contracting sexual infections and position them to explore available knowledge and practises within the medical systems around them. From this vantage point, the older men in this study advocated for a script that echoes responsive and consistent interactions with genuine traditional healers, as well as the use of tried-and-true traditional medicines in enhancing sexual health and protecting sexually active older men and their partners from contracting and transmitting sexual infections.

Some of the findings support a widely held belief in the literature that traditional medicine can treat both folk and biomedically defined sexual infections. Only traditional medicine has been perceived to possess the potential to address both dimensions. In extending this view, Omonzejele (2008) argued that most African traditional healers and their clients have a profound sense of confidence that all traditional medicines are effective when prepared with due diligence to the physical and spiritual principles guiding the practice. A common saying among the Yoruba people is that any oogun (traditional medicine) that is less potent can be attributed to incomplete knowledge and an inappropriate combination of ingredients (Jegede, 2010). While this may seem obvious, charlatans and fraudulent traditional practitioners are capitalising on the precarious situation. Hence, the risks of accessing ineffective or fake traditional medicines are high, as more infections are contracted and transmitted to other partners.

The belief that most married people would contract gonorrhoea resonates with the sexual script that being sexually active can sometimes lead to having multiple sexual partners, especially in social settings where polygyny is acceptable and rationalized. From a social positioning lens, older male adults that are sexually active would have had multiple sexual partners across their life spans and would have had a series of sexually transmitted infections, like gonorrhoea, that they contracted and treated. The view that most married men would have contracted an infection like gonorrhoea in their lifetime is consistent with the oral literature of the Yoruba-speaking people. The Ifa literary corpus (Jegede, 2010), an authoritative oral body of knowledge, has two (Oteirunsun and Osewejiweji) of the 216 verses of the Ifa relaying stories about multiple sex partners and the possibility of contracting gonorrhoea (Aderinto, 2012). Those who imbibe a sense of this nature could be carefree about their sexual health and would be more likely to normalise the contraction of treatable sexual infections as normal. With the youngest participant being 60 years old, it was expected that cultural worldviews and beliefs would be advanced. However, Ifa, as an oral tradition, also encourages prevention and responsive help-seeking as potent measures for different sexual and other disease conditions (Jegede, 2010). As alluded to by the participants, the onus lies on the sexually active man to seek help and avoid the contraction of sexual infections, including magun.

Generally, magun is socially perceived as functional and as a deterrent to marital infidelity (Alaba, 2004). Magun's modus operandi is that it works effectively when placed on a woman for her sexual partner to contract (Alaba, 2004). Any man will die instantly after sexual intercourse with a Magun-infected woman. The truth is that men who understand the type of magun and its antidote can still enjoy the pleasure, whereas the woman is still at risk after the intercourse. The antidotes for the diverse types of magun differ from one medical practitioner to another (Ogunsakin-Fabarebo, 1998). Often, the antidote to a magun rests with the practitioner who prepared it. Even when a man escapes death by suppressing the power of magun during intercourse, the afflicted woman remains at risk until an antidote is provided by the person who placed it or an experienced traditional practitioner removes the magun within a limited time (Aderinto, 2012; Moloye, 1992).

## 9. Policy implications

There are important policy implications from these findings. The first requirement is to identify and contextualise the unmet need for sexual health among the elderly. There is clear evidence that older men consider sexual activities and engage in risky sexual practises as part of their daily realities. Public campaigns and efforts that can improve sexual health and responsive help-seeking can be helpful. The cultural worldview and the aetiology of magun would be challenging to alter as much as the knowledge and practise of planting magun prevail amongst the Yoruba people. The publicity that comes with such reports could sometimes reinforce the medicalization and folk construction of sexual infections and help-seeking behaviour. The sustainability of these beliefs and practises around sexual pleasure has implications for risky sexual behaviour among sexually active older men.

Voluntary testing for HIV and other sexually transmitted infections is urgently needed across older people's various social categories in Nigeria. No service is currently in place targeting older people's sexual health needs in Nigeria, and this is common in other African countries (Aboderin, 2014). The exclusion of older males from existing sexual healthcare services implies that the unmet need for sexual healthcare services in Nigeria and Africa will continue to grow as the population ages (Sinković & Towler, 2019).

## 10. Limitations

The findings presented here are rich and in-depth, but only limited to the study settings and not across diverse Yoruba communities. The participants were also recruited within the inner core of urban Ibadan. They were mostly in polygynous marriages and had little formal education. The participants' marital status also implies that they were heterosexuals, which would have impacted their views and experiences on sexual risks and the prevention of sexually transmitted infections. The use of qualitative vignettes in facilitating the focus group discussion might have contributed to the rich information and experiences that were volunteered across the focused groups. A more holistic picture of sexual risks, stigma, and help-seeking might have emerged in a wider, more

heterogeneous group and across the different Yoruba communities in Nigeria.

## 11. Conclusion

The findings show the older men living in Ibadan, Nigeria engage in risky sexual activities, which expose them to STIs including HIV/AIDS. Notions of masculinity and gendered privileges that persist in a cultural setting shape and propel what qualifies as risky sexual practices, perceptions of vulnerability, and measures that are considered effective or potent enough to mitigate the consequences of risky sexual practices. Human nature's fallibility does not absolve sexually active older men of the need to be role models in the implementation of measures that can prevent the transmission and contraction of biomedically defined STIs and folk STIs.

Additionally, the participants noted that the existing sexual health programs and campaigns focuses on younger persons while neglecting the needs of older men. The participants yearn for a more inclusive sexual health and HIV prevention campaigns and strategies. Thus, by embedding cultural values around sexual health and ageing in campaigns and interventions would promote positive sexual health in older males, sexual health promotion within the study settings would be acceptable and sustainable. Sexual health of older persons does matter.

## Ethical statement

Institutional ethical approvals were obtained from the Ethics and Research Committees at the University of the Witwatersrand in South Africa and the Obafemi Awolowo University. All the participants in this research were recruited voluntarily with their consents. The benefits of participating in the research were provided, and clarifications sorted before the data collection commenced. All the participants were assured of their rights to withdraw their participation from the research at any point. No form of inducement was offered; nonetheless, all the participants received a souvenir (Plastic bucket), and transport fare was given to a few participants. The findings presented in this study did not include any personal identifiers of the study participants.

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## Declaration of competing interest

We hereby declare no conflict of interest in the conduct of this research and in the presentation of the findings. The manuscript is original and has not been published elsewhere nor under consideration in any outlet.

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