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SOCIO-CULTURAL CONSTRUCTIONS OF SEXUALITY AND HELP-SEEKING BEHAVIOUR AMONG ELDERLY YORUBA PEOPLE IN URBAN IBADAN, SOUTHWEST NIGERIA



By

Ojo Melvin Agunbiade
(671975)

A Doctoral Thesis in fulfilment of the requirements for the award of Ph.D. in Health Sociology submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, South Africa

DECLARATION

I, Ojo Melvin Agunbiade, declare that this thesis is an original research work. It is being submitted for the degree of Doctor of Philosophy in Health Sociology of the University of the Witwatersrand, Johannesburg. I attest that this work has not been submitted before in part or in full for any degree or examination at this or any other university.

5th day of September 2016

DEDICATION

This work is dedicated to my Redeemer and Saviour, the only Wise God, the Father, the Son and the Holy Spirit.

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I owe Professor Emeritus Leah Gilbert a high level of gratitude for being a mentor and worthy supervisor in many respects. Thanks a million for demonstrating timeliness with constructive critical feedbacks from the conceptualisation of the research idea and to the successful completion of this thesis. I have learnt tremendously through this priceless tutelage.

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List of Abbreviations

CARTA	Consortium for Advanced Research Training in Africa
FGD	Focus Group Discussion
HINARI	Health Inter-Network Access to Research Initiative
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
JSTOR	Journal Storage
LGA	Local Government Area
OAU	Obafemi Awolowo University
PHC	Primary Health Care
Ph.D.	Doctor of Philosophy
UCH	University College Hospital
UN	United Nations
WHO	World Health Organisation

ABSTRACT

Socio-cultural factors and contexts influence sexuality and associated practices across the life course. Few studies have questioned what constitutes sexuality, sexual pleasure, and notions of risky sexual practices, and how elderly people engage in help-seeking for sexual health promotion and problem-solving. In response to the dearth of such research in Africa, this thesis explores the cultural interpretations, values, beliefs, and embodied practices associated with sexuality and help-seeking behaviour among urban-dwelling elderly Yoruba people (60–80 years and above) in the city of Ibadan, Southwest Nigeria. In addition, it investigates healthcare providers' (biomedical and traditional) perceptions of sexuality and the prevention, treatment, and promotion of sexual health in old age.

The thesis is rooted in Bourdieu's social practice theory, Harré and Langenhove social positioning theory and an anthropological perspective on age-graded sexualities. From an interpretative constructivist framework, the thesis adopts an exploratory sequential mixed design. The design entails collecting and analysing qualitative and quantitative data in a single study. The choice of research design was informed by the perspective that diverse but relevant methodological positions opens the window into contextual understanding of sexuality in old age. The qualitative data consists of 12 vignettes based on focus group discussion (FGD) with three categories (60-69, 70-79 and 80 years and above) of 107 elderly men and women. From a thematic analysis, the FGD findings informed the conduct of 18 semi-structured interviews on equal proportion with elderly men and women (60+) and 11 semi-structured interviews with healthcare providers (biomedicine and traditional medical systems). Subsequently, the thematic findings from the FGDs and interviews informed the development of a structured questionnaire. The questionnaire was administered among 252 elderly Yoruba people (60+).

The findings reveal a dominance normative beliefs and cultural expectations around bodily changes characterised the gendered differences in sexual experiences and expectations in old age. From the exemplary perspective, the 'good old age' connotes compliance with normative sexual orientations, beliefs, and practices. The qualitative and quantitative results affirmed the existence and engagement in penetrative and pleasurable sex at differentiated degrees for elderly men and women. The qualitative findings reveal a lack of consensus regarding the age elderly women or men should disengage from sexual activities. The survey shows that more women (75.8%) than men (54%) agreed that elderly people of their age should stop having sex. The qualitative findings also reveal that health challenges, psychosocial satisfactions in marriage, differences in sexual prowess, and financial independence affect engagement and desires in sexual activities. Two-thirds (60.3%) of the survey respondents also agreed that elderly men and women should engage in sexual activities if their health allows.

The body as a 'site of moral action' places elderly women and men at differentiated positions within heterosexual normativity. From a disadvantaged stance, sexual intercourse with a menstruating woman can result in a folk sexual dysfunction known as *idakole* (poor erection and quick ejaculation) for men. Furthermore, sex with menstruating or menopausal women could cause loss of spiritual powers for men. These views resonate with some taboos on sex and efficacy of some traditional medicine. As a form of contestation, bodily changes during menopause represent a period of abstaining, suppressing or disengaging from obligatory sexual duties. It also affords women the avenue to avoid the experience of *oyun iju* (a socially constructed folk pregnancy). As a counter reaction, menopause also provides valid positions for some sexually active elderly men to seek new intimate relations with younger women. By expounding on the privileged position of men, the findings portray a normative view that elongates men's sexual retirement until death. Without doubting the possibilities of losing

sexual prowess with age, the use of traditional aphrodisiacs was perceived to improve sexual performance and pleasures. Such measures are scarce for women, except those that could aid male's sexual pleasures when used by women like *ado dun* (pleasurable and irresistible vagina sex). In this light, the thesis argues that the differentiated gendered framing of bodily changes and sexuality take the body as a moral and health site to arrive at an interpretation of old age that could influence ageing experience as 'good' or 'miserable'.

The findings also show that the premium on penetrative sex and pleasures create differentiated opportunities for elderly men to contract sexual infections. The possibilities of contracting sexual infections among sexually active elderly people was not doubted. Gonorrhoea, syphilis and *magun* (a folk sexual infection) emerged as common examples of sexual infections among old and young in the study settings. Gonorrhoea and syphilis can be treated via biomedicine and traditional medicine. *Magun* and HIV are untreated sexual infections but are preventable through sexual abstinence and use of traditional medical measures. Traditional preventive measures such as *onde* (amulet), *ajesara* (incisions and digestible concoctions) perform dual functions: prevent disease and guarantee pleasurable sex. Both qualitative and quantitative results reveal that condom use can prevent sexually transmitted infections. However, condom use was also conceived to reduce sexual pleasures for men and women. In this direction, the survey results affirm that condom use can reduce sexual pleasures for elderly men (77.8%) and women (22.2%), respectively. More than average (55.7%) of the female and about one-third (44.3%) of the male respondents also perceive the condom as more useful for younger people.

With the possibilities of contracting sexual infections, the qualitative findings affirm that aetiological explanations around a sexual health problem can act as a constraint and also

facilitate medical help-seeking. Also, shameful feelings, stigma, and unstable or poor financial conditions inhibit responsive help-seeking. More than one-third (49.6%) of the survey respondents perceived doctors' indifference as a constraint. This was followed by shame (22.6%), neglect from other family members (10.7%) and neglect of children (10.3%). Contraction of sexual infection in old age can also lead to withdrawal of quality support from significant others. The thesis argues that the social framework of the exemplary elder influence post-reproductive sexual health outcomes within the study context.

Healthcare providers from the two medical systems acknowledged the need for post-reproductive sexual health care services. Such services were, however, perceived along the gender divide as more elderly males than females expressed and sought help from both systems. The provisions of post-reproductive sexual health services within the biomedical system attracted some pluses. A few of the female participants acknowledge the efforts of biomedical trained physicians and nurses in creating awareness on how to overcome menopausal challenges.

The findings highlight that socio-cultural understandings of the intersections among ageing, sexuality, and gender influence framing of sexual health needs and unequal sexual health outcomes in old age. The possibility of such influences lie in cultural conceptions of the ideal body and the appropriate timing of sexual activities. Such normative views therefore influence how elderly people make sense of bodily changes, their sexuality, help-seeking, and response to sexual health needs from health care providers. Healthcare professionals from both medical systems are also prone to the influence of normative social frameworks in responding to post-reproductive sexual health needs. With the need to achieve a healthy ageing population and the existing gaps in post-reproductive sexual health services, this thesis argues that normative beliefs, values and practices around sexuality influence sexual

experiences, practices, dispositions to sexual infections, availability and access to post-reproductive sexual healthcare services within the study settings. Public enlightenment around sexual rights across the life course are needed to complement a review of existing sexual healthcare services in Nigeria. It will also improve the therapeutic relations between professional healthcare providers and their elderly clients. These initiatives can position professional healthcare providers for responsive diagnosis, prevention and management of post-reproductive sexual health needs and a possible realisation of healthy ageing population in Nigeria.

Keywords: Exemplary elder, ageing, sexuality, condom, sexually transmitted infections, help-seeking, biomedicine, traditional medicine, Yoruba people, Nigeria.

INTRODUCTION

The global growth of the ageing population has stimulated extensive multidisciplinary research into varied aspects of health outcomes (Lloyd-Sherlock et al., 2012). Ageing has linkages with different phases of life, including sexuality (Hillman, 2012). Studies have shown that continuous involvement and diversity in sexual practices and experiences exist among elderly people (DeLamater, 2012; Gott & Hinchliff, 2003; Parker, 2009; Yan, Wu, Ho, & Pearson, 2011; Yang & Yan, 2016). Over the last decade, studies on sexuality in old age in developed countries have increased steadily (Ward, Jones, Hughes, Humberstone, & Pearson, 2008; Woloski-Wruble, Oliel, Leefsma, & Hochner-Celnikier, 2010). Such research efforts are grossly lacking in Africa (Freeman & Coast, 2014), and specifically in Nigeria (Adeoti, Ojo, & Ajayi, 2015; Agunbiade, 2013). Currently, there is lack of evidence and inadequate social policies that could help improve sexual health in old age and address emerging health challenges among the elderly people in Africa (Aboderin, 2014; Freeman & Coast, 2014).

Studies with a focus on post-reproductive sexual health will increase our knowledge of sexual health in old age, improve the design and quality delivery of post-reproductive sexual health care services, and address the growing incidence and prevalence of sexually transmitted infections among elderly people (Freeman & Coast, 2014; Gad et al., 2013; King & Olaseha, 2012; Nappi et al., 2014). Nonetheless, such research requires sensitivity to the heterogeneous intersections between ageing and sexuality. Post-reproductive sexual health is gendered and fluid even within gender and age categories. In this regard, this thesis took a contextual interpretation of the notion of post-reproductive sexual health. To achieve a contextualised understanding of sexual health needs and challenges in post-reproductive age,

the thesis relied on the participants' descriptions and culturally dominant views on the intersection between bodily changes, gender and sexuality.

Hence, this research explores the cultural interpretations, values, beliefs, and embodied practices associated with sexuality and help-seeking behaviour among urban-dwelling elderly Yoruba people (60 – 80 years and above) in the city of Ibadan, Southwest Nigeria. In addition, it also investigates the conceptions of sexuality held by biomedical and traditional healthcare providers, and how they deal with sexual health issues in old age.

The research aims to increase knowledge related to the understanding of ageing and sexuality within an African context, which requires a focus on cultural interpretations around ageing and sexual health. Culture influences what it means to be old, and interpretations of old age vary depending on the particular context (González, 2007; Gullette, 2003). In many cultures and historical contexts, restrictive and erroneous conceptions of sexuality among the elderly abound (Adeoti et al., 2015; Arrington, 2000; Freeman & Coast, 2014; Moore, 2010; Van Der Geest, 2001). Thus, it is critical to explore how cultural contexts influence engagement or non-engagement in post-reproductive sexual activities. The rationale for such engagement could be for pleasure purposes as to whether such sexual activities are risky or non-risky in orientation. It is presumed that exploring the help-seeking behaviour of elderly Yoruba people (60-80+) would provide a context and relevant cultural understanding. The study takes cognisance of patriarchy, cohort, and gender differentials as critical and possible points of differentiating sexuality and ageing experiences in study settings. Accordingly, it investigates gender and cohort similarities and differentials in the importance attached to sexual health and help-seeking behaviours in later life among Yoruba people (60+) in Southwest Nigeria.

In health studies, 'help-seeking' behaviour is often used interchangeably 'with 'health-seeking' behaviour (Cornally & McCarthy, 2011). In this research, I prefer the term 'help-seeking' behaviour. The rationale is that the term refers to the social process of defining a health situation and a commitment to seek medical or nonmedical guidance based on perceived aetiology and recognition of symptoms (Cornally & McCarthy, 2011; Hinchliff & Gott, 2011). Similarly, the term elderly[2] is interchangeable with 'old age' and both terms are preferred to the term the 'aged'. For cultural reasons and the lack of consensus on what constitutes old age (WHO, 2012a), 60 years is also taken as the chronological starting point for old age in this study. Thus, the social category of the elderly is sub-divided into three cohorts that consist of 60-69 years, 70-79 years, and 80 years and above. This categorisation is in line with empirical and theoretical positions in ageing studies in social gerontology (Lodge & Umberson, 2012). It also captures the similarities and differentials in embodiments (Laz, 2003), sexual behaviours, and help-seeking within and across cohorts (DeLamater, 2012).

The study relies on an exploratory research design consisting of qualitative and quantitative methodologies. This will facilitate an in-depth and wider context-based understanding of how cultural beliefs, attitudes, and practices influence age, cohort, and gender differentials in the interpretations of sexuality and help-seeking in old age. This context-based knowledge is important in fashioning sexual health strategies that are culturally sensitive and sustainable and will contribute to a successful ageing agenda. Such understanding is a timely contribution to the global effort to achieve age-friendly primary health care systems. I hope this research will make relevant theoretical and methodological contributions to the on-going discourse

[2] The terms 'elderly' and old age were chosen to indicate the target group in this study mainly because of the contested nature of the term the 'aged'. As such, both terms might be used interchangeably in this thesis.

about the sociology of health in later life – an emerging area within the field of health sociology.

In terms of theoretical orientation, I drew on Bourdieu's social practice theory (Bourdieu, 1992), Harré and Langenhove social positioning theory, and an anthropological perspective on age-graded sexualities (González, 2007). The theories and concepts were synthesised to form a conceptual framework that is situated in the concept of age-grading in the Yoruba cosmology of time and sociation as espoused in Akiwowo's contributions to indigenous sociology (Akiwowo, 1983, 1986). All these efforts facilitated a contextual and cultural analysis of the intersection between ageing, sexuality, and gender among the Yoruba people.

Starting with Bourdieu's social practice theory, the constructs of *habitus*, *capital,* and *field* are useful in challenging dichotomised understandings of the relationship between structure and agency (Bourdieu, 1992; Webb, Schirato, & Danaher, 2002). Harré and Langenhove's social positioning theory (Harré & Langenhove, 1998; Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009) provides additional opportunity to explore further how the moral domain within local context creates normative constraints and opportunities. Moral domains (involving the rights and duties of self and others) affect beliefs and practices in relation to perceptions, experiences and continuity in sexual activities and therapeutic relations. In this light, the notion of age-graded sexualities (González, 2007), and Akiwowo's work (1983, 1986) provide an avenue to explore cultural exemplary in relation to sexual desires, expressions, engagement and disengagement in old age. The anthropological concept of age-grading provides a contextual understanding of social positioning and storylines around sexuality and help-seeking behaviour among the Yoruba people. The rationale is that help-seeking behaviour associated with sexual health issues and therapeutic outcomes are

embedded in cultural contexts. These are further elaborated upon in the section dealing with the Theoretical Framework.

Statement of Research Problem

By the year 2050, twenty-four percent of all Africans will be 60 years and above (Pillay & Maharaj, 2013). Within Africa, the proportion of elderly people is growing most rapidly in sub-Saharan Africa (Velkoff & Kowal, 2007). This demographic transition has psychosocial, economic, and health implications for individuals, families, and society. The situation of elderly people in developing nations demands urgent research and policy attention. Emerging evidence shows 70% of all older people now live in developing nations and ageing demographics in the sub-Saharan Africa are growing rapidly.

Against the demographic dynamics, more old and older people are faced with stigma, abuse, and evitable health challenges (Shetty, 2012). These developments are impacting negatively on ageing experiences and with ripple effects on health and social well-being (Alli & Maharaj, 2013; Mberu et al., 2012; Ojagbemi, Oladeji, Abiona, & Gureje, 2013). In response, the World Health Organisation has called for all-inclusive approaches in appropriating the benefits of ageing populations (WHO, 2004). A framework that could help to achieve age-friendly benefits was again initiated at the 2012 World Health Day, with the slogan "Good health adds life to years" (WHO, 2012b). This was a follow-up to an earlier call by the WHO (2004) for urgent reduction of stereotypes, stigma, the marginalisation of the elderly in primary health care delivery.

Ageism has consequences for the quality of life and ageing experience (Westerhof, Whitbourne, & Freeman, 2012). Stereotypes and marginalisation are diverse, which includes sexual stereotypes (Angus & Reeve, 2006). Such stereotypes have noticeable effects on both help-seeking and healthcare providers' beliefs and attitudes toward sexuality (Bauer, McAuliffe, & Nay, 2007; Haboubi & Lincoln, 2003). Sexual stereotypes affect the quality of sexual health and access to responsive healthcare services in the event of any health-related challenges (Minichiello, Rahman, Hawkes, & Pitts, 2012). This, among other factors, increases the need for culturally sensitive care in meeting the diversities in post-reproductive healthcare (McCord, 2014).

Given the dearth of studies in this regard, a more holistic approach in required for a contextualised understanding of sexual health needs and medical systems' responsiveness. Thus, by exploring the perspectives of elderly people and those of health care providers from multilevel perspectives offered by mixed methods we can capture these dynamics. Furthermore, amongst other contributions, a mixed methods approach to sexuality and ageing could help to bridge the theoretical gaps in social gerontology (Marshall, 2011; Parker, 2009).

This study is among the few studies on sexuality in old age within the African context. To date, research on ageing and sexuality in Africa is still in its infancy and the existing studies are restricted in scope and context. Among these studies, some of the issues that have received attention include the practice of sexual enhancement (Agunbiade, 2013), sexual practices involving multiple sex partners (King & Olaseha, 2012), and Human Immunodeficiency Virus among (HIV) old and older people (Freeman, 2012). Few studies have questioned what constitutes sexuality, sexual pleasure, and notions of risky sexual practices, and how older people engage in help-seeking for sexual health promotion and

problem-solving. In this thesis, sexual health among the elderly is defined in terms of the existence of sexual desire, ability to engage in sexual activity, value and meaning attached to their continued engagement in sexual activity. It also includes factors that motivate or constrain their ability to continue engaging in sexual activity.

Hence, this study seeks to understand existing sexual subjectivities and their embodiment among elderly Yoruba people (60 years and above). Furthermore, it questions how elderly people engage lay and professional healthcare providers (biomedical and traditional) in seeking help for sexual health challenges. The data derived from this research contribute context-based insights into how cultural contexts influence engagement or non-engagement in pleasurable, non-risky, and risky sexual behaviour within gender and age cohorts. They also generate similar evidence concerning help-seeking sources, patterns, and the availability and quality of post-reproductive healthcare services.

Overall Aim

The study's main aim is to explore how elderly Yoruba people (60+) articulate and give meaning to sexuality in old age and help- seeking with a specific focus on pleasure, sexual health promotion, and the search for solutions to sexual health challenges in old age.

Research Objectives

To achieve the overall aim, the following objectives guide the present study:

i. explore the socio-cultural understandings and embodied experiences of old age and sexual health in later life among older Yoruba men and women (60-80 years and above);
ii. assess understanding, meaning, and practices relating to sexual pleasure and risk behaviour among older Yoruba men and women;
iii. investigate socio-cultural understandings of sexuality and decision-making processes associated with help-seeking behaviour for sexual health among older men and women in the different age groups; and
iv. examine the healthcare providers' (biomedical and traditional) perceptions of sexuality and the prevention, treatment, and promotion of sexual health in old age.

Rationale of the study

Across the life course, sexuality is highly contested as individuals and social categories are exposed to contextual and cultural expectations on sexual desires and expressions. These contestations among factors influence sexual health outcomes during reproductive and post-reproductive stages of life. Given this involvement, a deep understanding of the connection between ageing and sexuality experiences is better achieved when located within cultural, historical, and everyday experiences of elderly people (Lodge & Umberson, 2012; Sandberg, 2013). Nonetheless, the gerontological literature is lacking in accounting for the particularity and contextual determinants of ageing, sexuality, and the contestations that comes with individual agencies and sexual subjectivities. The heterogeneity in ageing and sexual health outcomes can be observed in the social tension that comes with sensational story lines of individuals whose sexual desires and experiences are considered transgressive. Such social

reactions cannot be divorced from the sexual capital and social positions of those involved. At the individual level, sexual capital encompasses the social worth of an individual including the perceived sexual attractiveness of the individual to other members of his or her social group. It is dynamic and functionally utilisable in acquiring other forms of capital (Green, 2008). How individuals and social actors engage their sexual capitals and social positions also depends on the dominant norms and values governing sexual relations. The uneven distribution of sexual capital and the differentiated gendered dispositions in sexual fields have consequences on the possible achievement of the Sustainable Development Goal three. The emphasis of this goal is to achieve health for all (UN, 2015). The goal boarders directly on the World Health Organisation drive for all countries to achieve age-friendly primary health care system and qualitative ageing population. Presently, Nigeria is far from achieving a functional primary healthcare system that is responsive to diverse health needs. Access and affordability of services are unequal among social categories (Onoka, Hanson, & Hanefeld, 2015). The country also lacks enabling environment for individuals and social categories to express their sexual rights and access sexual healthcare services without fear, discrimination or coercion. Nonetheless, the incidence and prevalence of sexual risks keep increasing amongst divers social categories(Ahonsi, 2015).

Available literature has shown that continuous involvement in extra-marital affairs persist till mid-life (Mitsunaga, Powell, Heard, & Larsen, 2005; Negin & Cumming, 2010; Oyediran, Isiugo-Abanihe, Feyisetan, & Ishola, 2010). A variant of continuous indulgence in multiple sexual practices, even in old age, may be observed in what is popularly known as intergenerational dating between young and old (Ojebode, Togunde, & Adelakun, 2010) in Nigeria and some other sub-Saharan African countries (Longfield, Glick, Waithaka, & Berman, 2004; Nkosana & Rosenthal, 2007). From the standpoint of sexual networking,

opportunities for wider network of sexual relations exist in disproportionate ways for urban dwellers (Jones, 2016). The dynamics of sexual fields and sexual networking in urban areas are also different from what obtains in rural areas (D'Angelo-Scott, Cutler, Friedman, Hendriks, & Jolly, 2015). Recent estimates show a possibility of about a 90 percent increase in the population of urban dwellers in the sub-Saharan Africa by 2050 (Mberu, Mumah, Kabiru, & Brinton, 2014), the sexual fields and normative values and beliefs that regulate sexual networking are likely to become more nuanced and fluid. As such, wider sexual networking and differentiated orientations to sexual risks among social categories may likely occur. Already, unprotected sex with multiple partners and inadequate access to quality reproductive and sexual health care services are widespread among young and middle aged adults in the sub-Saharan Africa Nigeria (Akinyemi, De Wet, & Odimegwu, 2016). With the growing population of urban-dwelling elderly people, more opportunities for sexual networking, including those that portends some risks, are likely. Thus, more attention is therefore needed to post-reproductive sexual health of elderly people in urban areas. Unfortunately, the prevailing social and policy climates in the sub-Saharan Africa place little emphasis on healthy sexual practices in later life. This silence on safe sexual practices in old age within the context of engagement in extramarital affairs and intergenerational dating constitutes an unhealthy situation. Thus, leaving out the elderly in sexuality research and formulation of policies and programmes targeted against the further expansion of HIV/AIDS in Nigeria and other African countries is worrisome.

From anecdotal and media reports, the quest for sexual activities is widespread among some elderly people (Ameh, 2015). Cases of elderly men involved in sexual abuse (Ogbeche, 2016), multiple sexual relations and requests for marital divorce keep on appearing among elderly couples (Daily Post Reporter, 2015). In most of the divorce request, sexual refusal or

inability to satisfy a partner's sexual needs have been given as a premise (Daily Post Reporter, 2015; Opejobi, 2015). These developments have ripple effects on the social image of the elderly and their cultural roles in societies that are largely gerontocracy including the Yoruba culture. The dilemma partly includes the cultural roles of the elderly as care-givers to their grandchildren and their roles as custodian of knowledge including sexual knowledge.

The network for sexual activities has also introduced more challenges around what constitute sexual pleasures and sexual performance across the life course. Without relegating the diversities in what sexual pleasure and performance entail, heterosexuality occupies a central stage. A point in this direction is the presumptions that penetrative vaginal sex can be enhanced for more satisfaction is being reinforced through various sources. The Vanguard, a Nigerian daily newspaper featured a recent interview with some individuals on the influx, use, and perceived benefits of these drinks. Some of the interviewees shared their belief in their energy boosting effects. Other interviewees, a professor and senior lecturer in clinical pharmacy warned again the possible health effects of these alcoholic beverages (Evans, 2014). In line with the potential side effects of these drinks, a recent case-controlled study on the impact of Alomo consumption on the testis of rats showed the potential adverse impact on fertility. Such studies are lacking in human populations. However, it is beneficial to interrogate further these claims from alcoholic beverages with aphrodisiac effects (Salisu, Ihongbe, Anyanwu, Uwuigbe, & Izekor, 2014). The urgency is further necessitated by the growing consumption of these drinks among old and young in different African communities with the perceived effects on sexual performance and pleasure derivation.

The common message from the adverts and names of these alcoholic drinks is that their use has positive consequences for the sexual satisfaction of both partners (Evans, 2014). The

implied assumption around this expectation is that the duration of each sexual episode determines the derivable satisfaction. In practice, this may be far from what female partners expect from their spouse or husbands who use aphrodisiacs like Viagra. The goal of Viagra as a sexuopharmaceutical is to improve penetrative sex by sustaining an erection for a somewhat longer period. It is believed that sustained erection during intercourse will improve sexual satisfactions for mutual satisfaction. The experience may prove worthwhile for the male, and possibly disastrous for the female. The reason rests on the inherent differences between male and female sexualities. Unfortunately, these differences in sexual pleasures and performances including those associated with the use of traditional aphrodiasics are hardly accounted for in the gerontological literature (Agunbiade, 2013; Grace, Potts, Gavey, & Vares, 2006).

The cultural relevance of aphrodisiacs and emphasis on penetrative heterosexual relations also have implications for healthy ageing. In Nigeria, despite the growing trend toward and acceptability of heterosexual prowess and exploits in old age, there are hardly any existing research efforts that seek to account for the possible impact that such cultural values and beliefs could have on individual sexual health, ageing experiences and help-seeking behaviour. Accounting for individuality and possible variations in ageing experiences could help in promotion of healthy ageing as it takes into account the particularity that exists among old and older people within and across cultural contexts (Laumann et al., 2005). Thus, insights into sexual beliefs, desires, practices and engagement in old age have potential implications for promoting context-specific healthy ageing within and outside therapeutic encounters.

Research with a focus on post-reproductive health can promote the production of culturally relevant information with potential applications in reducing sexual health outcomes and

inequalities in later life. The biomedical literature portrays a somewhat homogeneous position that sexual health needs at post-reproductive age are more prevalent for women than men. Sexual health needs and concerns in post-reproductive age are, however, dissimilar for elderly men and women. By skewing attention to sexual dysfunctions in elderly women, medical systems strengthen the reproductive value of sexuality and deemphasise the pleasures and personal fulfilments in it. Such emphasis can be found in the medicalisation of menopause and absence of gendered variations in dominant therapeutic interventions (Ballard & Elston, 2005). Despite the growing body of evidence, concrete research attention is lacking to the gendered variations in post-reproductive sexual health within and outside the medical systems (Cacchioni & Tiefer, 2012; Wiel, 2014). The premise is that dominant cultural beliefs, attitudes, and perceptions of health have a toll on the responsiveness of medical systems to what qualifies as gaps in care delivery and the disposition and acceptability of these services by the final consumer (clients/patients). In a bid to theorise this complexity, Kleinman (1980) espouses that the social forces that influence healers, also affect patients and their help-seeking behaviour. For these reasons, this study aims to explore the cultural interpretations, values, beliefs, embodied practices, and subjectivities associated with sexuality and help-seeking in later life among elderly Yoruba people in Southwest Nigeria.

LITERATURE REVIEW

Cultural bias has long made sexuality in old age invisible (Brickell, 2006). In a number of cultures and historical contexts, sexuality is stereotyped and valued for reproductive purposes only, thereby calling marginal attention to post-reproductive sexual health issues (Agunbiade & Titilayo, 2012; Calasanti, 2004; Gott & Hinchliff, 2003). The dominant approach in the literature is concerned with biomedical explanations and clinical investigations of challenges to sexual functionality or well-being (Lindau & Gavrilova, 2010; Lindau et al., 2007). An implied position in these studies is the relationship between sexual health (measured in terms of interests, satisfaction, and dysfunction using 'objective' clinical indicators) and other health conditions in old age (Marshall, 2011).

Various studies have presented health in old age in terms of the challenge of a series of disease conditions, both communicable and non-communicable, that affect old and older people (Westerhof et al., 2012). Despite the vulnerability of old and older people to certain diseases, political, economic, psychosocial, cultural, and environmental factors contribute a great deal to health outcomes in old age (WHO, 2004). For this reason, studies have examined sexual dysfunctions by investigating the effects of pharmaceuticals, mental health challenges, and the available treatments in old age (DeLamater, 2012). While a rich body of evidence has emerged from these studies, help-seeking behaviour for sexual health concerns in old age has not been adequately studied, a gap this thesis aims to fill.

The notion of sexuality transcends a partial focus on risk reduction as it also encompasses pleasure seeking and sexual health promotion strategies. Despite the focus on risk reduction for healthy reproductive health outcomes, the marginal attention given to post-reproductive

benefits and pleasures has some latent dysfunctionality for the social categories involved and for society. Parker (2009) describes this partial disposition to post-reproductive health outcomes as unhealthy and calls for a paradigm shift and a reprioritisation of the research agenda within the field of sexuality. Hence, given the global ageing population and the marginal consideration given to post-reproductive sexuality, there are calls for more research focusing on understanding sexuality in later life and help-seeking behaviour within a cultural framework (Arber, Andersson, & Hoff, 2007; Avis, 2000; Bauer et al., 2007; de Vries, 2009; Fox, 2005; Gott & Hinchliff, 2003; Hillman, 2008; Moore, 2010). This focus and approach to ageing and sexuality research has the potential for generating context-based evidence relevant for actualising healthy ageing, which is the aim of this thesis.

For these reasons, the review of the literature addresses current discourses and social gerontological research on ageing and sexuality. The focus is on the implications of cultural expectations and value orientations toward responsive help-seeking in therapeutic and non-therapeutic interactions within a pluralistic medical system. The literature review section is organised as stated earlier in themes and sub-themes for a logical and structured presentation. Based on a search of the literature, seven key themes are summarised briefly, linked directly to the key research questions in this study.

First is a focus on **sexuality as an ideological and historical concept**. The goal is to understand how current discourse and research on ageing and sexuality mirror positions that are deeply rooted in ideological frameworks within a historical context. This also applies to the existing theoretical lens on sexuality. There is a dearth of theories in this regard. However, the few existing theories can be classified into two broad categories: essentialism and social constructionism. Both theories have contributed in different ways to sexuality

studies. This is followed by a focus on the notion of **sexual health, limitations** in the existing institutional definition of sexuality, and the omission of post-reproductive sexual needs outside this definition.

The second portion of the review examines empirical evidence on sexual risk-taking in old age and the implications for healthy ageing. Next is a focus on sexual health help-seeking behaviour and the patterns and processes of help-seeking within and outside medical systems. This is necessary in order to understand the phenomenon of risky sexual behaviour and associated practices in old age. As such, efforts that will contribute to a sustainable achievement of optimum post-reproductive health must be cognisant of these dynamics within cultural contexts. In medical care seeking, attention is given to factors and issues concerned with the provision and delivery of post-reproductive healthcare services within both the biomedical and traditional medical systems.

Stigmatisation and stereotyping of post-reproductive health needs could act as constraints on responsive help-seeking, especially within formal medical settings. In sexuality research and help-seeking, the inhibiting power of stigmatisation has attracted much attention. However, other culturally produced realities that have a motivating or constraining influence on sexuality and help seeking in later life have been examined here. The goal is to focus on studies that show diversities and similarities of nature, types, and patterns of cultural influence on sexual behaviour and availability, affordability, and accessibility to responsive healthcare services. In later life, sexual promotion at both individual and societal levels is critical to the realisation of a healthy ageing agenda. The goal is to contextualise the dynamics of post-reproductive sexual health at the individual level and healthcare provisions

within a pluralistic medical setting as an important part of the global agenda for healthy ageing.

The literature research was based on different sources, with a high proportion of recent peer-reviewed journals and a few books. Google Scholar was used for the general search and supplemented by numerous databases such as EBSCOhost, JSTOR, Hinari, ProQuest and PubMed. This was followed by specific searches of dominant publishers in the social sciences, focusing on BMC Journals, Sge Journals, John Wiley Journals, Springer, Science Direct, Oxford Journals, Cambridge Journals, PsycINFO, and PsycArticles for additional peer-reviewed articles. The research began by focusing on the topics of ageing and sexuality, old age and help-seeking, constructionism, healthcare providers, sexually transmitted infections, healthy ageing and medical systems. In addition, it included information on methodological issues, on researching sexuality, and the challenges of conducting studies among old and older people. The search was not exhaustive, but it provided an opportunity to assess the direction of studies and conflicting issues on ageing and sexuality research. Owing to language barriers and inability to access trusted translated sources, some peer-reviewed articles written in German, French, and Chinese were omitted from the research. Access to some of these materials could have provided more context and cultural differences concerning sexual orientation and practices in old age but was practically impossible in the context of the resources of this research.

Sexuality as an Ideological and Historical Construct

Sexuality is both historical and ideological as a construct as well as a field of discourse and research. The meanings and dimensions of its expression are subject to the influence of multiple factors that vary from one society to another. In one of the early anthropological

studies on sexuality in 76 societies, Ford and Beach (1951) provide evidence on how context, age, and gender influence what constitutes sexuality and its expression within and across the societies studied. This study also shows how what is described as acceptable or non-acceptable forms of sexual expression and relevance differs, based on societal positions determined by class, gender, circumstances, ideology, and religious affiliation. More than two decades later, Foucault (1978) conducted an historical analysis of sexuality in the 17th- and 19th centuries and devised a social construction of how sexuality differs in meanings and values across history and cultures. Within historical epochs and contexts, Foucault demonstrated how sexuality changed from a hidden, secret, and unspoken reality to a confessed phenomenon.

Part of Foucault's (1978) argument is that sexuality discourse and expressions occur within contexts governed by asymmetrical power relations embedded in social structures and social interactions. These power differentials define who engages, how, and where sexuality is socially appropriate. The stimulating effects of these structures and social forces are present in some cultural contexts despite the fluidity and variations in beliefs and practices.

Foucault's classic work on the history of sexuality stimulated further academic debates in sexuality research. As a result of his influence, there is an emphasis on the multidimensionality and dynamics of sexuality across cultures (Pollis, 1987). Indeed, the presence of social regulation has been studied as a phenomenon linked to language, norms, practices, and beliefs for different purposes. A dominant position is a focus on positive purposes. The rationale and perceived benefits of regulating sexuality have generated a series of attacks, especially from the right-based political movements (Phoenix & Oerton, 2005). While some achievements have resulted from reactions against normative sexuality, the

social regulation of what is sexual or asexual and the importance attached to sexuality and sexual health remain evident in diverse settings within and across different socio-cultural contexts (Alaba, 2004; Arnfred, 2004; Green, 2008; Van Der Geest, 2001).

Sexual desires, expressions, and practices reflect and respond in crucial ways to power and gender boundaries (Jackson, 2006). While the boundaries are fluid and subject to change, gender relations operate within socio-cultural and economic mechanisms driven by power and ideological positions. Such arrangements are overt and valid, especially in patriarchal settings found in some cultural contexts (Arnfred, 2004). In a qualitative study among Swedish heterosexual elderly men (60 years and above), Sandberg (2013) shows how the ideological view of linking and restricting intimacy in sexual relations to women alone changes with the ageing process and experiences of the men in her study. Through the narratives of these men, Sandberg (2013) reveals how intimacy as a construct offers a full and contextualised sense of sexual subjectivity in later life. The finding represents a sharp departure from the parochial position of intimacy as a more relevant experience for women than men.

Similarly, in an ethnographic study of understanding sexuality in Botswana, Helle-Valle (2004) show how the practice of *Bobelete* - an informal sexual relationship - influenced the sexuality of young and middle-aged women in Botswana. From the account, *Bobelete* emerged as a response to fill a social vacuum created by migration and the dwindling of quality support from men for their wives. Through *Bobelete,* young and middle-aged women were free to receive financial support and gifts from both married and unmarried men who desire more sexual relations. Through this arrangement, the women were free to remain single but with several sexual partners and the ability to shift their sexual allegiances from

one partner to another. With financial support and donations, individual wealth amassment became feasible and predictable.

As one might expect, this practice changed the terrain of marriage in Botswana as middle-aged women entered informal sexual relationships. The decline in formal heterosexual morality provided both ideological and practical space for *Bobelete* to thrive in Botswana. As more husbands migrated to the cities in search of better economic opportunities, an unintended consequence was the emergence of a new social organisation of desires and gradual loss of power for men. Younger women became more economically empowered, as they received various forms of financial support through the social arrangement of *Bobelete* (Helle-Valle, 2004). The ethnographic account of Bobelete in Botswana is one of many examples of how social arrangements, both intended and unintended, could alter existing arrangements and distribution of sexual desires. A similar practice also exists among the !Kung women in Botswana where social opportunities are provided for postmenopausal women to express their sexual needs by forming new intimate relations with younger men (Lee., 1992).

Patriarchy and preference for heterosexual relations have been dominant features of marital relations in a number of African communities including Nigeria. Among the Yoruba people, there are polygynous and monogamous forms of marriages, due to changing religious beliefs and practices, monogamy has become more dominant (Igenoza, 2003). Nevertheless, men and women are socialised differently about what is required to sustain quality marital relations (Alaba, 2004), and whether the marriage is monogamous or polygynous, the husband is the head of the family, and the wife is his subordinate. Through this arrangement, women are placed at a disadvantaged position in many ways, including their sexual health.

The situation is further complicated by cultural beliefs about sexual duties and rights. One such practice is the belief and expectation that wives must respect their husband's authority (Bove & Valeggia, 2009; Olabisi, Aransiola, & Osezua, 2009).

The gender differentials in privileges, rights, and duties in marriage also cut across another sphere of sexual relations (Aderinto, 2001), which exert different demands on husbands and wives within the union. Traditionally, among the Yoruba people, a new wife in a polygynous marriage is junior not only to her husband's other wives, but also to family members born before the date of her marriage (Fadipe, 1970). The woman is also subordinate in the domestic domain, where her unpaid labour is expected by her husband and other extended family members. Sexual submissiveness is one dimension of junior wives' subordination. Women are their husbands' property, and therefore access to them is thought to be unrestricted (Aderinto, 2001). These social arrangements give men power and control over women, including control over women's sexuality. Thus, in heterosexual relations, the need for couples to meet these obligations is regularly reinforced in a variety of ways (Alaba, 2004; Tamale, 2011b). Both women and men share this world of sexual obligations. However, at the individual level, there may be variations in how individuals adhere to cultural norms and values that exert pressure on their sexualities, duties and rights in heterosexual relations (Hollos, Larsen, Obono, & Whitehouse, 2009; Pearson & Makadzange, 2008). However, for a variety of reasons including stereotypes and ideological preferences, how social arrangements of sexual desire affect post-reproductive sexuality, amongst other factors, remains unexplored in social gerontology (DeLamater, 2012).

Not only is sexuality prone to ideological influences, but so is research on sexuality. To date, the biomedical paradigm remains dominant in this field (Marshall, 2011). Sexuality is

multidimensional and transcends just a focus on the body alone without due consideration for embodiment and the fluid experiences of social actors. Based on the gaps in the literature, especially on post-reproductive health needs, and limitations in focus and achievements made so far through the dominance of biomedicine, different scholars have called for an expanded conceptualisation of sexuality (Parker, 2009; Phillips & Reay, 2011; Tamale, 2011b). The presumption is that a wider conceptualisation of sexuality will provide an opportunity to interrogate sexuality as an embodied reality. Within social gerontological research, studies hardly account for existing gendered differences in the way sexuality as an embodied reality is constructed and experienced (Arber et al., 2007). Such gaps also exist in the growing body of evidence on heterosexual relations in old age. In this thesis, cues are taken from Hillman (2011) about the conceptualisation of sexuality as a biopsychosocial phenomenon encompassing knowledge, identity practices, and emotions related to the erotic lives of people irrespective of age.

For analytical purposes and due to the cultural sensitivity of sexuality discourse in the Yoruba culture, the thesis tilt towards heterosexuality. Nonetheless, this is not a denial of a possible existence of alternative sexualities among the Yoruba people. As acknowledged by Ajibade (2013), despite the silence on same sex relations among the Yoruba people, from the *Ifa* oral sources, there are indications that such practices exist in Yoruba culture. Public discourse around same-sex relations has also grown, but the author also recognised the difficulties and biases that are associated with the growing sermonisations and condemnations around same-sex relations (Ajibade, 2013). Given these challenges, a constructivist interpretative approach to same sexual relations in old age will pose some validity challenges. For instance, the depiction and stimulation of conversations around such sexual practices, experiences and responsiveness of existing medical systems could be skewed. Such problems are also possible

even with the focus on heterosexual relations. The limitations in this direction include absence of opportunities to gain insights into other forms of sexual orientation and the challenges of transgressing a dominant sexual orientation in old age. Elderly people with less popular sexual orientation are likely to suffer stigmatisation and discrimination from community members and the medical systems. Despite these limitations, there was a need to couch the intersections between sexuality and ageing within a framework that could produce a contextualised cultural understanding.

With this understanding, this thesis constructs and validates a qualitative vignette in line with the realities of heterosexuality and extramarital relations among elderly Yoruba people. By exposing the research participants to the qualitative vignettes in a focus group, the thesis findings reveal how social actors adopt conflicting ideological positions in judging and assessing the intersections between ageing, gender and sexuality. Such contradictions could be more conspicuous as individuals justify their own decisions even when they condemn similar actions of others. The thesis adopts a social positioning theory alongside an age-graded approach to sexualities to understand the storylines around these contradictions and justifications.

Cultural worldviews and theoretical frameworks for studying Sexual Health and Help-Seeking in Later Life

Available theories on sexuality are broadly classifiable into **essentialism** and **social constructionism** (DeLamater & Hyde, 1998). Essentialism sees sexuality as an innate part of human existence. It places emphasis on biological determinism and instinct as requisite for sexual expression, despite situational and environmental variations. In contrast, the emphasis

in social constructionism is on how social forces including cultural norms, variations in the socialisation process and experiences shape sexual behaviour within a cultural context (Wellings, Mitchell, & Collumbien, 2012).

Essentialism is common within a broad range of disciplines, including evolutionary psychology and socio-biology. As an approach, essentialism supports the social regulation of sexual pleasures and fulfilment to ensure the maintenance of relative equilibrium within social systems. This idea is also central to Freud's Psychoanalytical theory. The emphasis on biological determinism by essentialism has remained relevant to biomedical research. This is evident in the approach to research on reproduction, sexual disorders, and epidemiological infections associated with sexual activities. Despite the rich body of evidence from researchers in this field, biomedical and essentialist approaches remain inadequate to address the emerging epidemiology of sexually transmitted infections in old age (Adekeye, Heiman, Onyeabor, & Hyacinth, 2012; Hinchliff & Gott, 2011). As a quick response, some researchers have combined both essentialism and social constructionism in researching human sexuality. However, this has produced a partial body of evidence due to the inherent epistemological and ontological challenges with each approach, although there are variations within essentialism theory and the same is true for social constructionism (Wellings et al., 2012). Nevertheless, essentialism and constructionism as theoretical and methodological frameworks emphasise a focus on the nature and dimensions of expressing social realities as a valid means of producing a relatively representative body of knowledge (Wellings et al., 2012).

In a similar vein, constructionism within the field of sociology consists of two variants, namely objective and interpretive constructionism (Harris, 2008). Researchers within both

variants maintain similar vocabularies but different arguments in their inquiries. An important point of departure in interpretative constructionism is that the meanings attached to all things and events are not 'inherent' but driven by context and time. Individuals as social actors interact and relate to social realities and other social actors based on interpretations and meanings (Harris, 2008). In objective constructionism, valid knowledge production becomes possible by focusing on the social process of creating realities and not the meanings and interpretations that social actors attach to phenomena. Often, sociologists employed both variants of constructionism in a single project.

Theoretical and methodological divergence persists, with calls for holistic and context-specific approaches to understanding sexuality and sexual health. Such calls have become more relevant to the increasing challenges of meeting the post-reproductive healthcare needs of an ageing population (McHugh & Interligi, 2015; WHO, 2004). A step in this direction is to locate sexuality in later life and to study help-seeking behaviour within a cultural framework (Hinchliff & Gott, 2011; Marshall, 2011; Moore, 2010; Thorpe, Fileborn, Hawkes, Pitts, & Minichiello, 2015).

Furthermore, a shift from essentialism to constructionism in researching sexuality offers the possibility of studying ageing and sexuality as embodied realities, thereby generating contextualised knowledge on sexuality and sexual health in later life (González, 2007; McHugh & Interligi, 2015; Moore, 2010; Parker, 2009; van den Akker, 2012). In this regard, this thesis adopts an interpretative constructivist approach as an epistemological lens to unravel the inherent contradictions and normative beliefs around ageing, sexuality, gender and help-seeking within the Yoruba cultural context. As such this thesis provides a contextualised response to calls for an understanding of the gender dimensions and degree of

variation in ageing and sexuality (Marshall, 2011; McHugh & Interligi, 2015; Sandberg, 2013).

Masculinities and femininities are social categories and frameworks through which males and females engage their gender (Calasanti, 2004). Exploring sexuality within the cultural notions of masculinities and femininities promises rich theoretical and empirical evidence. Towards this end, Twiggs (2004) posits that such efforts must account for the body, gender, and ageing by focusing on the social categorisation and operationalisation of masculinities and femininities within a cultural worldview. An opportunity to interrogate and understand the experiential knowledge and practices of older people is significant in many ways (González, 2007). Such knowledge has important implications for understanding sexuality, sexual health promotion, and the prevention of sexual challenges in old age (González, 2007; Hinchliff & Gott, 2011; Lodge & Umberson, 2012; Wall & Kristjanson, 2005).

Help-seeking behaviour as a social process depends on cultural and individual reactions and interpretations of symptomatic and non-symptomatic changes within and outside the body (Cauce et al., 2002). As a process, help seeking is subjective and varies among individuals and social categories. Therefore, the patterns, timing, sources and expectations around help-seeking are also different. Denials, responsiveness or non-responsive efforts to symptomatic and non-symptomatic changes are possible outcomes among social actors (Cauce et al., 2002; Evans, Frank, Oliffe, & Gregory, 2011). Seeking medical help for sexual challenges in old age, therefore, depends on structural and individual factors and responsiveness of medical systems (Hinchliff & Gott, 2011). This makes help seeking dynamic and reflective of cultural worldviews within space and time. Among other factors, the perceived aetiology of a disease condition has an influence on when and where help is sought (Horng, Chou, Huang, Fang, &

Chou, 2014). Aetiological explanations vary across and amongst medical systems and cultural settings (Kleinman, 1980).

In this study, the realities of sexuality, ageing, and help-seeking behaviours were explored within the interpretative and objective variants of constructionism. The framework's theorisation of agency as valuable and indispensable to valid knowledge production influenced my preference for it. Social structures have a great deal of influence on individuals and social categories. In the same vein, individuals as social actors possess individual agencies, which shape and affect networks of relations and outcomes in social structures. Through various ways and relations, individuals acquire capitals alongside biological factors to support their sexual health in old age. Against this backdrop, elderly people engage or disengage differentially from sexual activities in old age as demonstrated later.

Sexual Health in later life: Contentious issues and probable resolution

Sexual health is a multidimensional social reality that consists of genetic, physiological, psychosocial and cultural (material and non-material) components (Wellings et al., 2012; WHO, 2006). This implies that similar to other dimensions of health, psychosocial, cultural, biological and environmental factors combine to influence sexual health outcomes, including the ability to enjoy optimal sexual health at the individual or group level. Thus, understanding sexual health challenges in old age requires a retrospective investigation of sexual beliefs and practices associated with post-reproductive sexual engagements (Bacon et al., 2003; Bauer et al., 2007; Corona et al., 2010; DeLamater, 2012; Laumann et al., 2005; Lindau & Gavrilova, 2010). A retrospective investigation could provide insights into previous sexual health challenges, measures adopted, and the possibility of engaging in similar practices and actions in old age.

Contrary to a participatory retrospective approach, an exclusive view that portrays old and older peoples' passivity prevails in available definitions and policy focus on post-reproductive sexual health challenges and probable measures of resolution. DeLamater (2012), in a review of the literature, lamented the unfortunate omission of discussion on post-reproductive sexual health in the WHO's reports on Developing Sexual Health programmes and a second one on *Measuring Sexual Health: Conceptual and Practical Considerations and Related Indicators* (WHO, 2010b). This thesis supports the view that the nature and quality of sexual activities and sexual relations constitute essential components of reproductive and sexual health. However, while reproductive health aims at procreation, sexual health encompasses both reproductive and post-reproductive purposes. Given the premium placed on spirituality in later life (Moberg, 2012), it will be useful to investigate the notion and relevance of spirituality in relation to sexuality and sexual health in later life as is the case in here. Thus, this thesis explores the perspectives and experiences of the research participants on the spiritual significance of sexual activities across the life course. The perceived spiritual significance and consequences of sexual activities has implications for sexual health as a right issue and the provision of quality sexual healthcare services.

WHO, in a 2010 report on "Developing Sexual Health Programmes: A Framework for Action," offers an affirmative definition of sexual health as *'rights of all persons to have the knowledge and opportunity to pursue a safe and pleasurable sexual life'* (WHO, 2010a, p. 4). This definition presents sexual health as a fundamental human right irrespective of age, gender, and race. Despite this stance and advocacy for sexual health as a rights-based issue, more than a decade after the Cairo declaration, post-reproductive sexual health is still absent from international conversations on the health agenda (DeLamater, 2012). This in principle encourages partiality and parochial dispositions to research prioritisation and knowledge

production within the field of sexual health. Knowledge production and research prioritisation occur within frameworks prone to biases and sentiments. This makes it logical to push for a reconsideration of what constitutes sexuality and sexual health across the life course. While an all-encompassing definition is still disputed, existing definitions require a re-examination and expansion to accommodate the peculiarity in sexuality and sexual health in later life (DeLamater, 2012; Marshall, 2011).

The influence of the biomedical system on ageing experiences and health outcomes is widely acknowledged (Blieszner & Bedford, 2012; Scharlach & Hoshino, 2012). Against this backdrop, both DeLamater (2012) and (Marshall, 2011) argue that biomedical discourse dominates contemporary research on sexuality through an exclusive focus on medicalisation of sexual health challenges, risk aversion, and emphasis on clinical treatments for sexual dysfunctions. The dominance of the biomedical approach has also contributed to the popularity of the notions of the "asexual old" even among some old and older people themselves (Hinchliff & Gott, 2011; Parker, 2009).

In the same vein, the medicalisation of sexuality continues to thrive with the notion of 'sexy oldies'- a form of social propaganda that encourages sexual indulgence and relevance in old age through diverse means, including the use of sexuopharmaceuticals (Hartley, 2006; Vares, 2009). The use of traditional plant aphrodisiac has a long historical practice in some cultures (Bella & Shamloul, 2014). Close to two decades ago, Aytac, McKinlay, and Krane (1999) predicted a possible rise in sexual dysfunctions to 320million in the year 2025. Gradually, male sexual dysfunctions and desire for sexual enhancements are on the increase with mixed reactions towards available treatment options (Bhagavathula, Elnour, & Shehab, 2015; Hakim, 2015). Given this context, consumers interest in herbal remedies to resolve sexual

dysfunction, especially poor erection and quick ejaculation has also increased with potential dangers and the urgent need for pharmacovigilance (Bhagavathula et al., 2015).

The national survey of sexual health and behaviour in the US confirms the existence of diverse sexual practices among older people. The results show that solo masturbation was common among American men and women, with 46% of the oldest men aged 70 years and above and 33% of the oldest women engaging in this practice (Herbenick et al., 2010). Similarly, a national survey in the US also reported the existence of sexual activities among elderly men and women. Despite the changes in the frequency of engaging in vaginal sex, the respondents affirmed their interest in sex as their health and circumstances permit (Herbenick et al., 2010). In a related study in Sweden, elderly men and women reported satisfactory sexual experiences. However, the elderly men in the Swedish study felt more satisfied with their sexual experiences in old age than when they were younger (Beckman, Waern, Gustafson, & Skoog, 2008).

Sexual practices differ even within cultural settings. For instance, in the Spanish National Sexual Health Survey, sexual activities among persons aged 65 and above show kissing, hugging, and vaginal intercourse as the most common sexual practices (Palacios-Ceña et al., 2012). Van Der Geest (2001), in an ethnographic study of the meanings attached to old age and sexuality among young and elderly people in Ghana, describes sex as an activity that requires strength, which dwindles with physiological changes. To the participants in the study, power for men implies sexual prowess, while for women it means the ability to act as a sexual partner for men as well as attend to other social activities. While sex was considered more valuable when young, engagement in sexual activities in old age indicates good health and possession of power but requires cautious engagement on moral grounds (Van Der Geest,

2001). This position depicts a life course perspective and an emphasis on how the differences in the meanings attached to activities and events differ from one stage of life to another.

Hence, whether an individual prefers to be 'asexual' or a 'sexy oldie' in the context will create some dilemma for the elderly, especially within an environment where self-medication thrives. Self-medication in old age is a common practice in sub-Saharan Africa (Mba, 2013; Suleman et al., 2009; Waweru, Kabiru, Mbithi, & Some, 2003). A qualitative study on the use of medication for sexual enhancement purposes among polygynous Yoruba men reveals that many of the pharmaceuticals were self-prescribed and based on an idealised notion of sexuality (Agunbiade, 2013). The study, however, did not investigate the dilemma of becoming asexual or the dangers of addiction and over-dependence on sexuopharmaceuticals for sexual performance in old age. There is a widespread availability of sub-standard drugs and a culture that emphasises self-dependence and medication in old age due to the absence of social policy, modernisation, and a dwindling network of informal support for the elderly in a number of sub-Saharan African countries (Aboderin, 2011b; Gysels, Pell, Straus, & Pool, 2011).

In many African countries, formal social security programmes remain largely unavailable to elderly people (Parmar et al., 2014). Ghana and Senegal have initiated health insurance schemes that cater for the financial costs of accessing modern health care services in old age. The programmes in both countries are still lacking in many respects despite setting some standards (Parmar et al., 2014). South Africa seems better as it has a social security programme that has achieved a moderate impact on older women (Zimmer & Das, 2014). South Africa has a non-contributory social security policy for the elderly that is relatively functional. Through this policy, older women could receive the regular old-age grant and

provide support for their families and household members (Lloyd-Sherlock & Agrawal, 2014).

The situation in Nigeria is that the majority of old and older people depend on varied sources of income. Such sources include irregular pensions, support from relatives and children, menial jobs and alms begging (Eboiyehi, 2006; Togonu-Bickersteth & Akinyemi, 2014). Older people with an unstable and weak network of social support are likely to suffer different forms of abuse even from their significant others (Cadmus, Owoaje, & Akinyemi, 2014). The implications could include inabilities to express their sexual desires, delay or non-responsive help-seeking, especially from formal sources when the need arises. Hence, this thesis investigates how old and older people position themselves and engage in self-care practices aimed at resolving or promoting their sexual health.

Against this backdrop, the present study takes a broader view of sexuality and sexual needs in later life. The concept of later life represents a life course effort to depict ageing by demarcating the inherent heterogeneity of the ageing process and experiences (Higgs & Jones, 2009). The life course approach argues for a focus on chronological, biological, physical, and social dimensions of sexuality as a viable approach to a deeper and more robust body of knowledge than biomedicine alone (Featherstone & Hepworth, 2005; Katz, 2005). However, this will require a shift in methodological position from the increasing quantification of sexuality within the context of sexual activities. Reliance on this approach encourages reductionism and limits understanding of sexuality in later life (Marshall, 2011; McHugh & Interligi, 2015).

This thesis looks beyond the biomedical emphasis on medicalisation, sexual dysfunction, and a risk-oriented approach by focusing attention on the pleasure and relevance associated with sexuality and sexual health in later life. For this reason, the study adopted constructionism as a theoretical lens, supported by a mixed methodological stance in investigating the issues of interest.

Sexual Risk Taking in Later Life and Possible Implications

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 according to psychological, socio-demographic and with structural variables 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 environment within a particular context. Investigating the dynamics and context of involvement in risky sexual practices has been useful in understanding and developing interventions to address the vulnerability of social categories such as adolescents and young and middle-aged adults to sexually transmitted infections and to promote sexual health (Wellings et al., 2006).

Despite the plethora of studies on sexual risk-taking and vulnerability, there are, not surprisingly given the 'asexual' stereotype of the elderly, few such studies on old and older people (Minichiello et al., 2012). A few of the studies that focus their attention on older 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). Based on a postal survey in the UK, Gott (2004) shows that 7% of older people engage in activities that could predispose them to contract STIs. Commonly reported risky practices include regular engagement in extramarital affairs, unprotected sex, and irregular use of condoms. Gender differentials also emerged from the results, as more men than women engage in risky sexual practices.

The literature on ageing and HIV/AIDS indicates an increase in new cases of HIV in older populations (Adekeye et al., 2012). In Ibadan Nigeria, King and Olaseha (2012), 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. This constitutes some level of risk, especially given the view that condoms are more useful for younger people than for older men. Similarly, Freeman and Coast (2014) in rural Malawi, also reported the indulgence of older males (50 – 60 years) with multiple sexual partners. The study showed a prevalence of HIV among the male respondents. A higher prevalence of HIV (8.9%) was reported among the respondents aged 50 to 64 years than among men aged 15-49 years (4.1%). The high prevalence that was recorded among the elderly men might be associated with their engagement in unprotected sex with multiple partners. This may also indicate that the older individuals are less likely to practice safe sex since they do not perceive themselves as 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, 2014; Negin & Cumming, 2010).

Furthermore, studies have shown that the use of sexuopharmaceutical drugs for sexual enhancement is growing among different social categories including the elderly, despite possible health implications (Grace et al., 2006; Marshall, 2010). 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. 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. Based on empirical evidence, Aytac et al. (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 a growing burden of sexual dysfunctions, it seems that the possibility of abuse in the consumption of sexual pharmaceuticals is growing in Nigeria (Aderinto, 2012). Hence, this thesis further explores the gender, age-cohort dimensions of aphrodisiacs consumption, rationalisation and the subjective effects of such practices on sexuality and sexual health in old age.

With emerging evidence on sexual involvement and its importance in old age, there is a need to better understand the existing risky sexual practices and preventive measures in later life (Minichiello et al., 2012). Such efforts will provide more information that could aid understanding, formation of policies and the provision of healthcare services relevant to health ageing promotions within contexts. Nevertheless, policies on post-reproductive sexual health, the gendered dimensions and services are still low and worrisome, especially in sub-Saharan Africa (Aboderin, 2014). For this reason, this thesis focuses on cultural notions of risky sexual practices and prevention of sexually transmitted infections among elderly Yoruba men and women in three age categories (60-69years, 70-79years and 80 years above) in order to shed more light on possible variations in sexual desires, expression and perceived vulnerability to sexual infections.

The use of a predetermined or restricted framework in investigating risky sexual practices in old age could blur the possible variations that may exist between objective and subjective dimensions of risk involvements and outcomes. Reproductive and post-reproductive sexual practices and outcomes are quite dissimilar as they are governed by different rules of engagement and expectations. As a highly gendered social reality, post-reproductive sexual health of men and women are varied across and within gender. Thus, subsuming the post-reproductive sexual health of these social categories and cohorts creates gaps in knowledge (Simpson & Morris, 2016). 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. 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.

Like any other social reality, sexual activities in old age could be beneficial or risky to individuals' health and that of the public (Holden, Collins, Handelsman, Jolley, & Pitts, 2014). What constitutes risky or pleasurable sexual activities, however, vary and depends on sexual subjectivities. Conceptually, sexual subjectivities are constructed interpretatively to include experiences, needs, and desires (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015). An interpretative constructionist stance could provide an opportunity to understand what constitute pleasures or risks to individuals. The gaps between what constitute healthy or risky practices and measures that could reverse the risks and ensure optimal beneficial outcomes are sometimes determined outside sexual subjectivities. The practice of

marginalising sexual subjectivities in sexuality studies, among other factors, keeps fuelling the challenge of promoting sexual health across the life course. How individuals understand and respond to possible consequences of their practices has implications for their health, family members and the public. Individuals as social actors act within certain social frameworks of which they are part of, but which has consequences for their individual agencies and health outcomes.

Against this backdrop, Fileborn, Thorpe, Hawkes, Minichiello, and Pitts (2015) call for contextual understanding of sexual stereotypes and prevailing practices associated with sexual subjectivities in old age. A focus in this direction will help to understand the meanings and interpretations around sexual practices, associated risks and their heterogeneities in old age. There are variations in sexual practices and risks taken in old age (Thorpe et al., 2015) that depend on individual experiences framed alongside biological, psychosocial and structural factors. Specifically, gender differences along with psychosocial factors and availability of partners affect sexual experiences (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015).

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. In this regard, this thesis focuses on what constitute risky sexual practices, the rationale for engagement and associated preventive strategies in old age. Empirical evidence was generated through a qualitative approach by focusing on cultural notions of risky sexual practices and prevention of sexually transmitted infections among elderly Yoruba people.

Sexual health challenges and Aetiological Explanations: Implications for help-seeking behaviours

Sexual health challenges are public health issues that affect both young and old. With the enormous burden of sexual-health complications and the availability of treatment options, responsive and appropriate help-seeking behaviour remains vital to the maintenance of good sexual health. Both sexual health challenges and help-seeking occur in a context that influences what qualifies as a problem and obtainable solutions (Moreira et al., 2005; Pearson & Makadzange, 2008; Schensul, Mekki-Berrada, Nastasi, Saggurti, & Verma, 2006).

Medical systems perform active roles in defining symptoms and prescribing treatments and therapies for health difficulties. In the context of plural medical systems, diverse aetiological and treatment options co-exist with possible competitive and complementary quests for patronage (Kleinman, 1980). From an epidemiological standpoint, sexual health concerns could be symptomatic or non-symptomatic (Wellings et al., 2012). Whether such difficulties are symptomatic or not, individual experiences, definitions and reactions to health issues, including sexually related ones are different. The variations could be in terms of the nature of the problematic, causal explanations, cultural beliefs and practices, social categories, and gender and age (Corona et al., 2010; DeLamater, 2012; Lichtenstein, 2008; Moreira et al., 2005).

Using a broad categorisation of aetiological explanations points towards biomedical and non-biomedical explanations of disease causation (Foster, 1976; Lock & Nguyen, 2010), which are applicable to sexual health concerns (Pearson & Makadzange, 2008; Wellings et al., 2012). Biomedical epistemology and ontology emphasises natural causations and resolution of disease conditions by focusing on the body. The search for objective and scientific

knowledge production is valid and achievable by starting with the body, pathogens and associated pathological conditions. The assumption is that the body functions in a relative state of equilibrium of its various components. However, disequilibrium can occur as the body attracts organisms like bacteria, fungi and virus through relations within contexts. A possible and objective resolution will require an understanding of the body as a physiological entity and the various pathogens and pathological conditions. Through this approach, biomedicine aims at eliminating or minimising pathogenic effects, or replaces faulty body parts/organs to resolve disequilibrium (Lock & Nguyen, 2010).

Non-biomedical such as Ayurveda, acupuncture, the African traditional African medical systems amongst others also recognise natural causation by looking at the body and pathogens about disease aetiology and therapeutic measures (Lock & Nguyen, 2010). African traditional medicine is the most popular in Nigeria and offers a crucial source of help-seeking for different health conditions (Omonzejele, 2008). In terms of explanations, the traditional African medical systems transcend the point of stoppage in biomedicine to seek preternatural and supernatural causal explanations for pathological situations that are unfamiliar or defy common therapeutic measures (Foster, 1976; Odebiyi, 1989). Within contexts, the applicability of natural, preternatural or supernatural explanations also depends on other associated factors with the health condition in question. Thus, for sexual health concerns, factors such as the value placed on sexual health, perceived causal factor(s), severity of the condition(s) and availability or non-availability of therapies, and the treatment outcomes are important (Pearson & Makadzange, 2008).

Herbal medicine, as practised by the Yoruba, revolves around spiritual and physical principles in knowledge acquisition as well as preparation of herbal medicines (Agunbiade,

2014). Certain herbs are presumed to be more effective when backed with the right incantations (Jegede, 2010). The use of incantations is central to the practice of traditional medicine across the various Yoruba communities in Southwest Nigeria. The belief is that incantations provide additional powers by invoking certain energies and forces to provide critical support and reinforce the efficacy of a remedy or therapy (Jegede, 2010). The power of incantation requires the appropriate combinations of the right words and associated rituals.

In the traditional African medical system, the availability and use of multiple frameworks for disease aetiologies provide opportunities for differentiating disease conditions and therapies. Some sexual health problems are perceived as having natural causes traceable to biological factors or germs that are transmittable through unprotected sexual activities. In this framework, the search for causal explanations starts and ends with the body as a psychosocial space (Wellings et al., 2012). As such, therapeutic measures are aimed at resolving bodily imbalances by eliminating or suppressing the further spread of germs or infections. This approach does not exclude proximate and distal causal factors in influencing the incidence and prevalence of sexually transmitted infections. However, the emphasis is on the effective diagnosis of causal agents and the provision of therapies to restore relative equilibrium to the body as a mechanical system.

The use of natural explanations is predominant in biomedical research and practice (Vincent, 2006; Wellings et al., 2012). However, as a body of knowledge, natural explanations of disease or illness occurrence is not restricted to the biomedical system alone. Other medical systems also harbour and apply this framework in defining and responding to health challenges (Omonzejele, 2008). Within African traditional medical systems, natural causal explanation occupies a focal position in constructing and resolving a health condition (Oloyede, 2010; Omonzejele, 2008). From the lay person to the professional traditional

healthcare provider, the first form of explanation is the natural causation thesis (Omonzejele, 2008). From this standpoint, disease or illness could occur from everyday activities, as the human body is fallible. Continuing symptoms would suggest more underlying factors than natural causation and the need for additional therapies or treatments.

Preternatural explanations focus on the breaking of oaths, disobedience to ancestors, violation of taboos, and evil machinations and afflictions from evil people as critical sources of disease or illness. Within African traditional medical systems, good health requires a harmonious relationship between the living and the dead. It also entails conformity to certain normative proscriptions and prescriptions (Omonzejele, 2008). Deviance could attract infection(s) or affliction(s) in the form of disease or illness.

Preternatural and supernatural explanations also require different approaches to resolving diseases or illnesses, as afflictions from both sources require the incorporation of physical and spiritual means. Supernatural explanations rest on the belief that diseases or illnesses are attributable to a sinful lifestyle and flagrant disobedience of spiritual principles for healthy living (Jegede, 2002, 2005). This explanation has strong religious roots and adopts similar measures in resolving issues of ill-health (Pearson & Makadzange, 2008). A salient position in preternatural and supernatural explanations is the belief that spiritual laws govern events in the physical world, including health and disease. Hence, concrete and conscious efforts towards obeying the laws will eliminate the occurrence of any disease or illness condition. This binary stance on health, illness, and healing is well-grounded in African medical systems and the dominant practice of a pluralistic approach to health promotion, treatment, and management of disease and illness conditions (Omonzejele, 2008). Prolonged illness or

disease is more complex in terms of explanations and help-seeking; as such, conditions often attract explanations that are within the realms of supernatural causations.

Despite the historical and contextual relevance of supernatural explanations within the African context, few studies have investigated the influence of such explanations on the variations in sexual needs and challenges of men and women across the life coures (Agunbiade & Titilayo, 2012; Agunbiade, Titilayo, & Opatola, 2011; Anarfi & Owusu, 2011; Tamale, 2011a); and no study has examined how such explanations might influence help-seeking behaviour. Post-reproductive sexual health concerns of elderly men and women are dissimilar and can also vary across the life course. Within the African context, no study has explored sexual health concerns, explanations around the occurrence and perceived possible measures that could mitigate the negative influence on ageing experiences and health outcomes.

Nonetheless, a study on sexual health concerns associated with help-seeking behaviour among young and middle-aged men in Zimbabwe, Pearson and Makadzange (2008) describe how prevailing aetiological explanations influence the help-seeking process, sources of help, and expected outcomes of such efforts among men in Zimbabwe. The findings reveal a mix of natural and supernatural explanations in relation to sexual health concerns. Depending on the perceived aetiology and previous experience, participants in the study followed a pathway that recognised the role of natural and supernatural explanations. Conditions and circumstances in the life of an individual at a time when the sexual health concern occurred also proved useful in interpretations of the conditions and the search for help. Despite the pleasures associated with sexual engagement, procreation emerged as critical in the values that men placed on sexual health. In addition, problems that prolonged infertility and sexual

performance attracted preternatural and supernatural explanations as well as the patronage of traditional healthcare providers for help. The findings show how a dynamic and relevant context could assist in investing and appropriating the help-seeking process for sexual health promotion.

Interestingly, the explanations provided by the men in Pearson and Makadzange's study (2008) are similar to what has been found in a number of African communities, especially when sexual concerns are linked to fertility problems (Hollos et al., 2009). However, preternatural and supernatural explanations are limited in orientation and application to post-reproductive sexual health concerns. For instance, in old age, the aetiology of sexual health problems such as menopausal reactions, quick ejaculation, and erectile dysfunction are more explainable by biopsychological factors than preternatural explanations while the time of occurrence and efforts at resolving these challenges may favour treatments or therapies that are embedded in preternatural and supernatural explanations. Overall, both forms of explanation may be useful in negotiating the context of defining and the process of seeking help for sexual health difficulties, even in old age.

Identifying the presence or absence of sexual health concerns within psychosocial frameworks has its limitations. For instance, what is acceptable or unacceptable differs within different cultural contexts by gender, social class, and a host of subjective indicators. As noted earlier, historical epochs and cultural position have a strong influence on what is seen as pathological and on prevailing solutions within time and space (Kleinman, 1980). The implication is that conditions that are symptomatic within the confines of acceptable social connotations receive more attention and resources. Unfortunately, non-conforming conditions or expressions are stigmatised and denied equal access to help or intervention. Thus, it will be

of interest to understand existing cultural explanations of sexual health matters in old age and the associated health practices for resolving them. However, such studies are scarce and, therefore, investigating the aetiology and associated measures of resolving sexual health concerns in old age has some benefits. It could be useful in addressing factors that may combine to inhibit or motivate old and older social actors' capabilities to harness genetic, physiological, psychosocial, and cultural resources for optimal sexual benefits (Avis, 2000; Bacon et al., 2003; Bauer et al., 2007). Post-reproductive health challenges vary based on gender, biological, psychosocial and cultural factors.

The burden of sexually transmitted infections is increasing among older people, especially with the rising prevalence of chlamydia, gonorrhoea, syphilis, and trichomoniasis (Lusti-Narasimhan & Beard, 2013; Pearline et al., 2010). In old age, sexual health problems exist alongside other health issues, thereby creating complexity in understanding and providing appropriate interventions (DeLamater, 2012). This thesis, therefore, addreses the need to focus on the nature of help-seeking behaviours that are associated with certain post-reproductive sexual health concerns, especially within the African context.

Help-Seeking Behaviour and Sexual Health Concerns in Old Age

The concept of help-seeking behaviour is an elusive one. As mentioned earlier, it is often used interchangeably with 'health-seeking' behaviours in health-related studies despite variations in meaning (Cornally & McCarthy, 2011). As a concept, help-seeking behaviour refers to the social process of defining a health situation and a commitment to seek medical or nonmedical guidance based on perceived aetiology and recognition of symptoms (Cornally & McCarthy, 2011; Hinchliff & Gott, 2011).

Help-seeking behaviour is multi-dimensional in orientation. This behaviour is shaped by structural factors such as culture, gender, age and class, as well as psychological factors (Moreira et al., 2005; Walters, Iliffe, & Orrell, 2001). It is located within complex and dynamic socio-cultural contexts and notions of aetiology, experiences, severity of disease or illness condition, availability of treatment options, and networks of support. Like any other health related problems, delay in seeking help for sexual ill-health has implications for healthy ageing.

A global survey of sexual attitudes and behaviour among women and men aged 40 to 80 years shows that more than half the number who were sexually active had at least one sexual problem, but less than half (20%) of them attempted to seek medical help. Self-medication such as the use of drugs and devices for their sexual difficulties was reported among both men (14.6%) and women (12.8%). The idea of talking to a partner was shared among 39% of the men and women. Less than 10% of them had ever shared information concerning their sexual health during therapeutic interaction with a doctor. The study also showed similarities in help-seeking behaviour between genders (Laumann et al., 2005).

A regional analysis of the same data on adults (40-80 years) from an urban population of Asian countries, the United Kingdom, and continental Europe showed that of all the respondents who were sexually active and with reported sexual dysfunctions, less than half (45%) sought no help or advice and only 21% sought medical care. (Moreira, Glasser, Nicolosi, Duarte, & Gingell, 2008; Nicolosi, Glasser, Kim, Marumo, & Laumann, 2005).

Using hypothetical scenarios, as mentioned earlier, Lichtenstein (2008) shows how historical, cultural, and other group factors affect treatment-seeking options for the elderly in the event of an STI. Horrocks, Somerset, Stoddart, and Peters (2004) in a qualitative study of elderly people (65+) living with urinary incontinence shows that normative interpretation of the condition, 'shame, embarrassment, and generational differences in attitudes to disclosure affect the treatment-seeking process, despite regular visits to a physician'.

A review of the literature also shows the interplay of medical setting factors and social, gender, age, among other socio-economic factors as barriers to sexuality and sexual help-seeking in old age (Bauer et al., 2007). However, gender and age are more dominant than other socio-demographic factors in deciding the extent and nature of care provided for sexual health across the life course (DeLamater, 2012; Hinchliff & Gott, 2011).

The exclusive focus on other health issues as they affect the elderly also dominates studies on help-seeking behaviours. Information on what constitutes help-seeking behaviour for the maintenance of sexual health and prevention of sexual ill-health in old age alongside associated experiences is absent within the African context (Agunbiade, 2013; Agunbiade & Titilayo, 2012). This study aims, therefore, to provide context-based evidence by exploring 'help-seeking' by gender, age categories, and perceived sexual health needs and the associated challenges in requesting support from the different systems of lay and professional primary care providers.

Help-seeking behaviour process

From the forementioned, it can be seen that the process and pathways to help-seeking depend on different factors. These range from psychosocial to cultural beliefs, practices, severity and symptoms of a health condition and the availability or non-availability of treatment options. Cornally and McCarthy (2011, p. 282) describe 'Help-seeking behaviour as a process that consists of three distinguishing traits: problem focused, intentional action and interpersonal interaction with a third party'. Within this process, problem-focused research evidence is critical to the help-seeking process (Yousaf, Grunfeld, & Hunter, 2015). This is the stage at which perceived or the real presence of a health problem is given recognition by the individual or by significant others (Moreira et al., 2008). The presence of a problem indicates the need for help and calls for necessary action. The help-seeking could be from formal or informal sources, biomedical or traditional medical systems. As stated earlier, some factors determine the conceptualisation of the problem in terms of its aetiology, perceived form of treatment, and source of help. There are possibilities of problematic health conditions occurring at any stage in life. However, the explanations attached to such conditions and perceived solutions depend on culturally related factors among others.

The intentional action consists of steps and efforts made at resolving ill health or a threat to health (Cornally & McCarthy, 2011). It involves conscious efforts made either by the sufferer or by significant others to address the presence of a problem. In some African communities, the decision to seek help and the source of help might be a communal decision with or without the agency of the sufferer. As depicted in figure 1, this depends on some other factors including the age and social status of the sufferer, and the nature of the

condition or disorder. Whether the decision is solitary or communal, intentional action is a requisite stage in the help-seeking process (see figure 1).

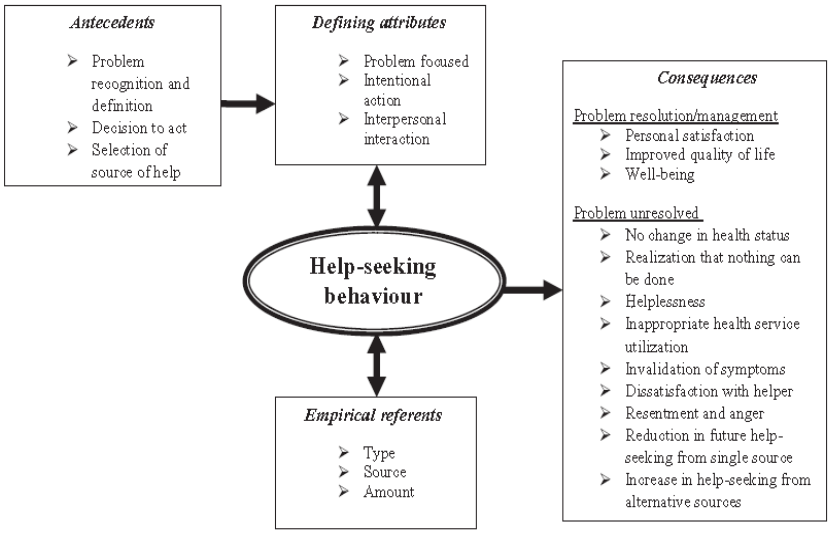


Figure 1: Help-seeking behaviour: An antecedent, defining attributes, consequences and empirical referents. (Source: Cornally & McCarthy, 2011).

Interpersonal interaction help becomes possible when the individual or sufferer is willing to disclose experiences from a problem to the help provider (Scott & Walter, 2010). A level of trust is required in disclosing information to the help provider. Even with sexual health problems, the onus to provide the needed information about the problem is on the help seeker, as disclosure will assist the help provider in delivering the needed care or solution. Distortion and mutilation of information with regard to the nature of the problem will cause a clog in the wheel of healing (Papaharitou et al., 2008).

Help providers, especially those within formal medical systems (either in the biomedical or traditional medical systems), operate with professional ethics that regulate their conduct and ensure confidence and trust building (Schensul et al., 2006). The information made available at this stage requires a level of confidentiality that restricts help providers from divulging the information. The help-seeking behaviour process is a platform for interaction for the help-

seeker and help-provider. However, the help-seeking process occurs within a context capable of influencing the outcomes of the interactions (Griffith, Allen, & Gunter, 2011; Smith, Braunack-Mayer, Wittert, & Warin, 2007). As such, attention to the relevance and influence of context, the social position of the help-seeker and the help-provider, and other contextual factors, require further consideration.

Social positioning theory posits that social actors engage in help-seeking associated with their realities in relation to others (Davies & Harré, 1990). These social interactions and associated meanings have consequences for personal and societal conceptions of sexual health in old age. Theoretically, social actors seek information and negotiate health-related issues within the context of gender and power relations (Fox, 2005). Investigating the dynamics and multidimensionality of help-seeking within and outside the medical setting will improve the body of knowledge on sexual health promotion. The assumption is that decision-making is value-laden and subject to a series of factors involving the problem, the help-seeker, and the help provider (Hinchliff & Gott, 2011; Smith et al., 2007).

The dynamics of help-seeking within formal medical settings differ from other sources of help provision. The philosophical orientations of a medical system change the practice, aetiological interpretations, and the therapeutic measures that are accessible to prevent, promote and provide treatments for sexual ill-health. Hence, the definition of sexual health, its promotion, and treatment will vary within these medical systems. In addition, aetiological explanations of sexual health might be dissimilar between health care providers and older people themselves. As the literature suggests, ageing processes and experiences are culture bound. Thus, a variety of health care providers with adequate knowledge of and promptness in providing post-reproductive healthcare services is crucial to sexual health promotion.

Healthcare professionals represent a diverse group whose attitudes and knowledge of sexual health in old age are relevant (Hinchliff & Gott, 2011; Schweizer, Bruchez, & Santiago-Delefosse, 2013). Healthcare providers' beliefs and attitudes towards sexual health in old age may affect prompt utilisation of post-reproductive health care services - a vital process in addressing sexual health difficulties in old age (Hinchliff & Gott, 2011).

Evidence suggests that professional healthcare providers, even in developed countries, demonstrate partial knowledge and biased positions in terms of information provision and understanding the sexual health needs of the elderly during therapeutic encounters (Hinchliff & Gott, 2011). A qualitative study of general practitioners' attitudes towards discussing sexual health issues with older people during therapeutic encounters showed passive attitudes, stereotypes, and the perception of sexuality as more relevant to younger people (Gott, Hinchliff, & Galena, 2004). Similarly, Schweizer et al. (2013) in a qualitative study among gynaecologists in Switzerland on integrating sexuality in medical consultations with more elderly patients reveals that personal experience and the gender of the doctor dictate their readiness to accept sexuality as part of the discussion during consultations. Similar biases also emerged in an interview concerned with general practitioners' dispositions towards discussing sexual issues with their older patients who engage in same-sex relations (Hinchliff, Gott, & Galena, 2005). The few studies available on help-seeking behaviour of old and older people with sexually transmitted infections have espoused the relevance of context and positioning as important factors in the help-seeking process (Lichtenstein, 2008).

There are various sources of help seeking for sexual health, according to the literature. In a cultural context with plural medical systems, variations in dispositions and responsiveness to post-reproductive sexual health needs are expected. The situation may be more compelling

where individuals and social categories engage in concurrent multiple help-seeking from the available medical systems. In Nigeria, for instance, both biomedicine and the traditional medical systems operate with divergent philosophies and practices aimed at providing healthcare services (Omonzejele, 2008). The divergent philosophical orientations of traditional and biomedical systems are also overt in their theories of disease causation, techniques, and therapeutic approaches (Omonzejele, 2008). These different forms of knowledge, attitudes, therapeutic measures and quality of care could act as barriers and/or motivations for responsive help-seeking around sexual health matters.

For cultural reasons, different attitudes and perceptions towards ageing and sexuality may exist among healthcare providers, whether those in biomedicine or traditional medical system. However, in sub-Saharan Africa, no known study has investigated the perceptions healthcare providers (biomedicine and traditional) have of sexuality and prevention, treatment, and promotion of sexual health in old age. For these reasons, this study places emphasis on understanding the context of participation and the dispositions of both modern and traditional healthcare providers towards sexual health promotion in later life.

Stigmatisation and Stereotyping of Post-Reproductive Health Needs as constraint to help-seeking

Stigmatisation of sexually transmitted infections remains a major setback to sexual health promotion (Aggleton, de Wit, Myers, & Du Mont, 2014). Across the life course, contraction of sexual infections attracts stigma with negative influence on help seeking and quality of care accessible (DeMarco & Lanier, 2014; Dispenza, Dew, Tatum, & Wolf, 2015; Grodensky et al., 2015). Stigmatisation of health conditions can occur at both individual and structural

levels and for different reasons. Stigma causes damage to the patient and the society suffering. As a social reality, stigmatisation can emerge through various social processes and interactions whether overtly or covertly enacted. Stigma becomes enshrined into a wider network of relations through everyday conversation and different forms of interactions including therapeutic relations. Stigma can exist as a personal or perceived reality. The influence of stigma on help-seeking behaviour and treatment outcomes depend on individual, psychosocial and network of support (Eisenberg, Downs, Golberstein, & Zivin, 2009).

Stigmatisation and stereotyping of post-reproductive sexual health needs have significant implications for disposition and access to quality care and support within and outside medical settings. Old men and women position themselves in seeking information for sexual health concerns and positioning influences interactions with health professionals. Among other cultural factors, stigmatisation of STIs creates clogs and delays in responsive health-seeking and sexual health promotion. Stigmatisation as a cultural product affects other responsive help-seeking and access to quality care provision, including that related to post-reproductive health needs (Hinchliff & Gott, 2011).

Historical factors, cultural beliefs, and values influence help-seeking behaviour. Lichtenstein's (2008) study of sexually transmitted diseases (STIs) among older African Americans shows how stereotypes and stigmatisation can undermine responsive health-seeking and sexual health promotion. In a study by Freeman (2012), older adults in rural Malawi depict adulthood in relation to performance of normative responsibilities and avoidance of sexual activities in old age as marks of wisdom and good social reputation. In a review of literature Hinchliff and Gott (2011) identified patient and physician-oriented

factors as possible barriers to prompt help-seeking. The review also revealed a high degree of delay in seeking medical help among older people with sexual health challenges.

Lichtenstein (2008) examined the effects of the Tuskegee Syphilis study and cultural ideation such as the notion of the exemplary influence of elders on the beliefs, perceptions, and dispositions to STIs among older African Americans. The study's hypothesis is that African-American elderly people with sexually transmitted infections are likely to express shame, anger, discomfort, and reluctance to seek treatment for sexually transmitted infections and a sense of betrayal. Some of the respondents felt uncomfortable disclosing their partners' identities for tracing and treatment purposes. Respondents with perceived shame and betrayal due to STIs were likely to delay medical care-seeking. More African-Americans than their white counterparts in the study expressed stigma and stereotypical responses to medical help-seeking. Additional results show gender differentials in the beliefs, interpretations, and attitudes towards medical help-seeking among both urban and rural dwellers in the study.
Lichtenstein's (2008) study highlights the cloud of pressure on sexuality and sexual health promotion, especially the impact of historical and cultural factors. In addition, the article portrays older people as active participants in sexual fields. They have sexual desires, engage in sexual practices, and are susceptible to STIs. Similarly, old and older people are also relevant in the promotion of healthy practices as they serve as exemplars to younger people. However, the exemplary status of the elderly has an impact on their habitus in terms of their beliefs and their practices relating to their sexuality and that of others. Thus, critical engagement in sexuality studies requires a willingness to explore different theoretical and methodological options in generating relevant knowledge. These issues among others are paramount in the research carried out for this thesis, which aims to focus on embodied sexual practices, experiences, and help- seeking in old age.

Promoting sexual health in later life: Policy Environment, medical systems and Individual Responsibilities

Older people occupy distinct social categories but are treated as fairly homogeneous or are left out of development discourse due to misrepresentation and marginalisation of their views and positions (Sharpe, 2004). As stated earlier, a number of factors within and outside the medical systems have skewed health policies towards reproductive health purposes, thereby increasing existing inequalities in the policy environment and provision of equitable quality post-reproductive health care services among the social category of old and older people. The availability and accessibility of cultural sensitivity in post-reproductive healthcare services is one among different alternatives to age-friendly primary healthcare provision (WHO, 2004, 2012b). It is also recognition of the peculiarities of promoting sexual health in old age. At the global and local levels, there are obvious needs to refocus policy and care provision in encompassing ways to harness the benefits of ageing populations. While inequalities and health challenges are common with the social categories of old and older people, the neglect of their sexual health needs remains overt in diverse cultural and policy contexts. With the desire to promote the realisation of a healthy ageing agenda, researchers have called for a cultural approach including policies at the global and local levels to help address constraints within and outside the medical systems and ensure a supportive environment for quality sexual health in old age services (Bustreo, de Zoysa, & Araujo de Carvalho, 2013; Kirkman, Kenny, & Fox, 2013; Lusti-Narasimhan & Beard, 2013; Minichiello et al., 2012).

Awareness of sexual infections, perceived susceptibility and approaches to sexual infection prevention remain crucial to sexual health promotion. Studies have shown how poor

awareness and inadequate knowledge of sexual infections could influence indulgence in risky practices among older adults (Henderson et al., 2004; Maes & Louis, 2003; Negin et al., 2012). Awareness and disposition towards risky practices are embedded in socio-cultural forces (Negin et al., 2012). Cultural and individual factors may influence the dispositions towards risks and perceived susceptibility to enable sexual infections despite current sexual activities (Zhou et al., 2014). Such rationalisations were also expressed in a recent study among older Chinese men. The findings demonstrated how individuals could rationalise risky sexual practices based on their sexual desires, pleasure seeking and cultural notions of risks (Zhou et al., 2014). Thus, sometimes the desire for pleasures could outweigh the risk implications of indulging in unhealthy behaviours including risky sexual practices (Chao, Szrek, Leite, Peltzer, & Ramlagan, 2015).

Nonetheless, epidemiological studies on the incidence and prevalence of sexually transmitted infections are dominant among young and middle aged adults (Minichiello, Hawkes, & Pitts, 2011). Similarly, existing sexual health policies and social marketing of preventive initiatives including knowledge and use of condoms have marginal attention towards elderly people(Poynten, Grulich, & Templeton, 2013). The presumption is that elderly people are asexual and for several reasons they are less susceptible to sexual infections. With recent calls for gerontological studies on sexual practices in old age (Gott, 2004), new cases of sexual infections are emerging among the elderly (Minichiello et al., 2011; Poynten et al., 2013).

The gaps between awareness, engagement in risky practices and responsive adoption of preventive measures remain a critical behavioural barrier to sexual health promotion across the life course. Inadequate knowledge and erroneous perceptions around social realities have

the potential to inhibit the social actor's ability to engage in informed decisions. Excluding the elderly from ongoing campaigns on sexual health promotion, therefore, has consequences on their health, their partners and their society.

Sexual health promotion requires recognition and willingness to commit resources to meet the particularity and variability that exist at the individual, group, and societal levels. Despite the challenges with physiological changes and well-being, ageing experiences differ at both personal and collective levels. Ageing affects men's and women's sexuality differently (DeLamater, 2012; Lindau et al., 2007; Marshall, 2011). The quality and quantity of the context of old and older people's participation and the dispositions of both modern and traditional healthcare providers in post-reproductive healthcare services have significant implications. As stated earlier, medical systems operate with certain ontological and epistemological positions that impact on the forms and quality of the care that is obtainable. The same also applies to the help-seeker (Kleinman, 1980) and, therefore, assessing the existing cultural practices within medical systems and the quality of participation would require accounting for the variability and particularity in age and gender differential in sexual health practices and experiences within medical systems (Parker, 2009).

Effective and power-neutral relations in both therapeutic and non-therapeutic social relations are necessary to encourage participatory post-reproductive sexual health promotion and delivery. By available evidence, factors influencing the quality of interactions in patient-doctor relations (within biomedical and traditional medical systems) are within and outside medical systems. This creates complexity as more holistic efforts and focus are required for deeper understanding and resolution of complexities concerned with patient autonomy and making informed decisions (Foucalt, 1994; Hughes, Rostant, & Curran, 2014; Moore, Titler,

Low, Dalton, & Sampselle, 2015; Rhodes, Harris, & Martin, 2013). Asymmetrical power relations are common in therapeutic encounters, but they are fluid; they depend on the nature of the health problem and other factors involving the help-seeker and help provider(Rhodes et al., 2013).

Inclusive participation in care promotion and delivery is essential in meeting the sexual health concerns of old and older people. Inclusive participation requires the recognition of agency and capacity to make informed decisions without using a predetermined yardstick for all social categories of elderly people (Parker, 2009). This represents a departure from the position that portrays older people as social categories that are relatively homogenous and highly dependent. A passive view like this encourages and affects the decision-making capabilities and prioritisation of needs of elderly people.

The context of participation in defining and accessing post-reproductive sexual health care services is becoming more elusive and complex. The dominant factor here is the increasing flow of anti-ageing medicine supported by an emerging global and traditional consumer culture (Kampf & Botelho, 2009; Vincent, 2006), among other factors. Despite the dearth of studies in this area, the common practice of self-medication among different social categories including the elderly in Nigeria (Afolabi, 2009), and in South Africa (Suleman et al., 2009), for instance, might be expanding over-reliance on pharmaceuticals to feel and look young.

Despite the absence of objective evidence supporting the marketing gimmicks of these pharmaceuticals (Higgs & McGowan, 2013; Kampf, Marshall, & Petersen, 2013), the pressure to succumb to such marketing gimmicks has increased a culture of poor pharmacovigilance. Comparatively, the situation may be worse for the elderly with poor

socioeconomic backgrounds and lack social support in meeting health needs, which leads to a high level of engagement in self-care practices. With more focus on consumerism as markers of proactivity in reversing the ageing process, an avoidable financial drain keeps reoccurring as old and older adults are tempted to spend more to feel young and healthy. So also is the possibility of side effects and addiction to performance-enhancing pharmaceuticals in old age.

There is no doubt that an understanding of the context of participation and dispositions of the elderly as well as both modern and traditional healthcare providers towards sexual health promotion has significant implications. The available forms of knowledge, attitudes, therapeutic measures and quality of care from both modern and traditional healthcare providers could act as barriers or motivations to providing relevant post-reproductive care services. In *Social Construction of Reality: A Treatise on Sociology of Knowledge,* Berger and Luckmann (1966) argue that social actors be active participants in the creation of their realities. This perspective is essential in several dimensions and relevant to creating and sustaining cultural sensitivity in the post-reproductive health care services required in achieving the healthy ageing agenda across cultures (Hillman, 2011; Horrocks et al., 2004; Hughes et al., 2014; Williams, 2009). As such, appreciating the meanings and social contexts of a phenomenon will provide depth and insights specifically at the experiential level. The meaning-making process in physician-patient interactions and the potential implications for therapeutic outcomes are of relevance and therefore they have been taken on board in this thesis.

Summary and Gaps in Knowledge

Ageing and sexuality are complex realities with objective and subjective dimensions that require interdisciplinary conceptualisation. As pointed out by DeLamater (2012), such frameworks possess the capacity to achieve deeper and more holistic bodies of knowledge than relying on the biomedical approach alone.

There is recognition of the richness in investigating sexuality from an embodied position in the literature. However, this recognition is lacking in gerontological studies on sexualities (Twigg, 2004). Dominant studies have employed cross-sectional designs aimed at generalisations. These have made substantial contributions to understanding sexual functioning, the medicalisation of sexuality, and determinants of sexual behaviour, including practices and satisfaction.

Nevertheless, sexuality and ageing are within the purview of individual experiences with group and cultural boundaries. This makes it possible to utilise constructionism as a framework to interrogate as well as provide clarity and understanding. From an interpretive constructionist position, older people as social actors engage physically, psychologically, and emotionally with their environments and their cultures as they construct their embodied subjectivities (Fox, 2005). Knowledge production from this stance has major implications for the realisation of age-friendly primary care and a healthy ageing agenda.

This thesis responds to these gaps by focusing on how old age, gender and sexualities collaborate to form a milieu of segregated gendered opportunities within a given cultural context. In this context, it explores the influence of socio-cultural understandings on the promotion and individual contestation of beliefs and practices that are unfriendly or in

support of sexual desires and expression in old age. Furthermore, this thesis offers contextualised insights into how cultural interpretations of old age worsen the divisions of gender and sexuality as well as health outcomes. In addition, it adds to how social and cultural frameworks shape the way social categories perceive, relate and make sense of ageing, gender and sexual needs and responses from medical systems (biomedicine and traditional) in worsening or promoting sexual health outcomes for elderly men and women.

THEORETICAL FRAMEWORKS

As people age, "Individuals anticipate and deal with the impact of age on their bodies" (Higgs & Jones, 2009, p. 82) and their sexuality (DeLamater, 2012). Sexuality is fluid and varies with age cohort, gender and health status (DeLamater & Koepsel, 2015). As an iterative process, both individual agentic and structural factors influence variations in sexuality (feelings, beliefs and practices) and ageing experiences. Hence, this study is located primarily within Bourdieu's theory of practice and Harré and Langenhove's Social Positioning theory. I developed a synthesis of the theoretical approaches and concepts as presented for clarity in figure 2. The synthesised framework attempts a contextual and cultural understanding of the intersections between ageing, sexuality and gender. The links amongst the three concepts was conceived through an age-graded sexualities approach as discussed by González (2007). Thereafter, I located the possible outcomes from these interactions within the Yoruba cosmology of time and sociation as espoused in Akiwowo's contributions to indigenous sociology (Akiwowo, 1983, 1986). The aim is to gain insights into how sociocultural understandings of ageing, sexuality and gender affect sexual needs, help-seeking and availability of quality support from the medical systems. All these contribute to ensure equal or unequal sexual health outcomes within and across gender in a particular social setting.

The suitability of these theoretical approaches rests on the conceptualisation of human sexuality as a biopsychosocial phenomenon. This therefore opens sexuality to influence from diverse sources. Predominant influences on sexual desires, expressions and practices are, however, traceable to ethics, law, history, and religion along gender, age and individual factors (Masters, Johnson, & Kolodny, 1995; WHO, 2006). The two theories thus provide

unique insights into the web of interactions between structural and individual factors in relation to ageing, sexuality and help-seeking in a social setting. Furthermore, both theories were subjected to an age-graded approach to sexuality and ageing in relation to the notion of time and sex within the Yoruba culture. The aim is to gain insights into how social actors rationalise, respond and make sense of their sexuality and help-seeking in old age, within a given cultural context and the study setting in particular.

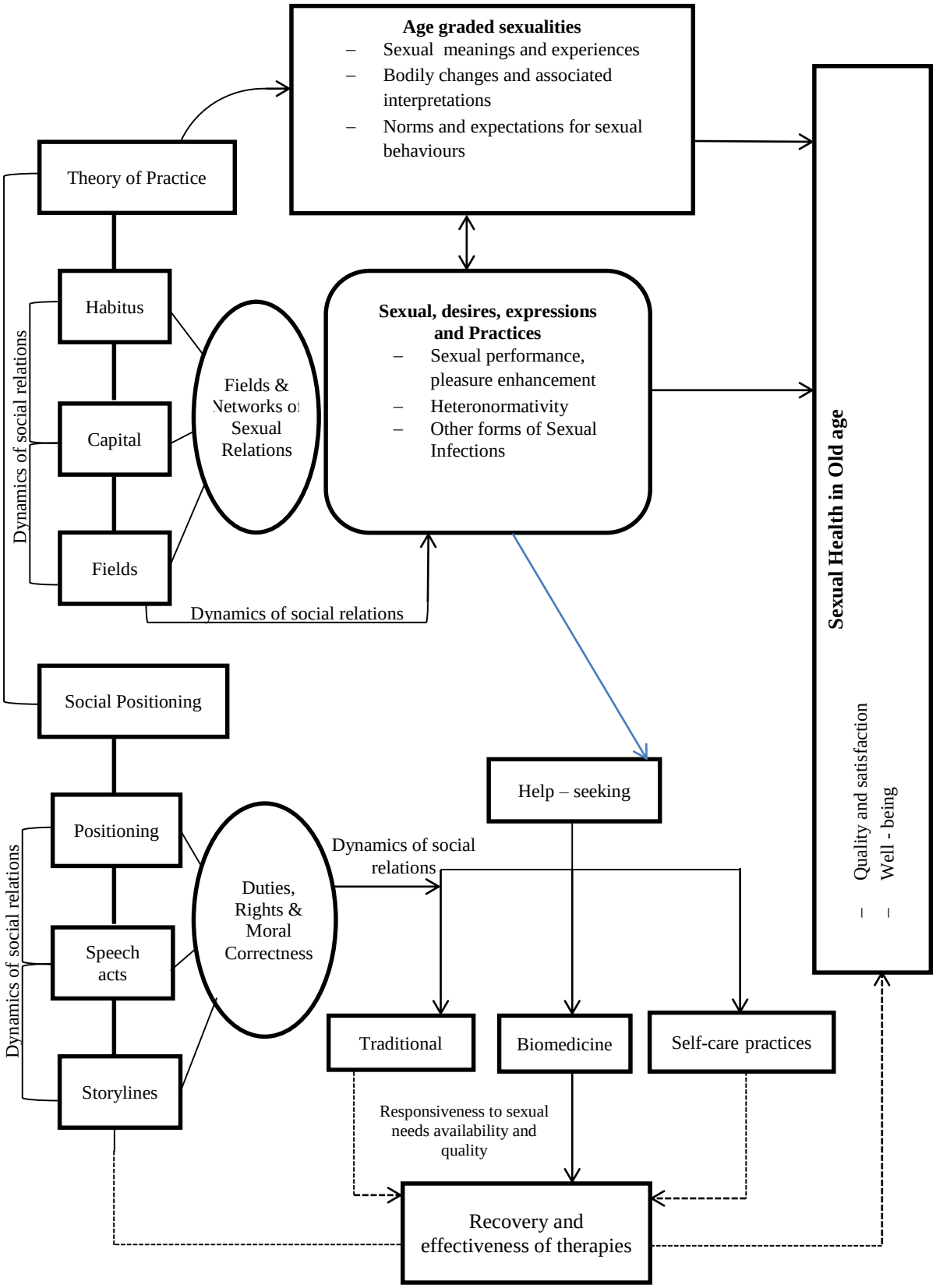


Figure 2: A Synthesis of the Theoretical Frameworks

Bourdieu's Theory of Practice

Bourdieu's theory of practice sets the theoretical scene for this thesis. As a framework, Bourdieu's theory of practice describes how individuals create and are recreated by the cultural atmosphere in which they live. The theory provides an opportunity to delineate the different positions that govern networks of social relations. This theory attempts to articulate the ways in which identity and individual agency rely on and create cultural forms through a network of social relations in everyday life. In sociological parlance, Bourdieu's theory of practice remains significant in exploring the interactions between structure and individual agency. The theory argues that such a focus will produce insights into the objective and subjective dimensions of social realities. As an attestation, scholars from different academic backgrounds have found the theory useful in their quest for generating scientific knowledge. Their endeavours have also attracted criticisms of Bourdieu's theory of practice. Nevertheless, appropriate adoption and extension of the theory partly depend on the nature of the reality of a researcher's epistemology and ontological assumptions.

Interactions permeate the structure, power and agency at individual and group levels. Moreover, the theory of practice, therefore, provides a window into the complex network of relations within social systems through the concepts of habitus, capital and field. Thus, much effort is devoted to the concepts of *habitus, capital, and field* with respect to sexuality and ageing. As demonstrated in Bourdieu's practice theory , 1992; Webb et al., 2002). In Bourdieu's opinion, practice is a function of [(habitus) (Capital)] + Field (Maton, 2008). The triad in this theory provides a context for capturing the prevailing cultural beliefs and attitudes about ageing and sexual health among older Yoruba adults and primary healthcare

providers. Thus, an outline of these concepts is presented and applied with a focus on sexuality and ageing through a sociocultural lens.

Habitus

Bourdieu employs the concept of habitus in accounting for the relevance of individual agentic action in structure formation and change in social systems. This focus was a departure from structuralism, which hardly accounts for individual agency in structure formation and change within social systems. In Bourdieu's work entitled the logic of practice, the notion of habitus represents the basis for understanding the critical influence of social actors within social fields. Thus, he conceptualised "habitus" as a system of durable, transposable dispositions; structured structures predisposed to function as structuring structures (Bourdieu, 1992; Maton, 2008).

In Bourdieu's opinion, the inadequate focus on individual agentic in classical sociological theories limits our understanding of the critical role of subjectivity in the objective construction of social realities (Collyer, Willis, Franklin, Harley, & Short, 2015). Through an iterative process, social agents learn, adopt, deploy and adjust their dispositions and experiences in a manner that affects and shapes interactions within social systems. Thus, habitus is a lens for understanding how experiences in social fields become embodied and how they influence the imaginative capacity of social actors in "forming a feel for the game without reiterating the rules" (Bourdieu 1994:63).

Hence, in everyday life experiences, social actors act in an iterative process but without recourse to their consciousness. Nevertheless, their habitus remains significant as they strategise their interactions and decision making within various social fields. Strategic

appropiration of resources, however, requires experience, time and responsive deployment of capital (Collyer et al., 2015; Wacquant & Deyanov, 2002), which come in diverse forms. As a manifestation of strategic acting, social actors adopt diverse types of habitus that differentiate them from others. The individuality of habitus provides a reflexive opportunity for social actors to engage with other social actors in different social fields. The ability of social agents to engage in this reflexive disposition, therefore, provides a unique opportunity for embodied experiences.

Bourdieu's habitus can, therefore, be applied to the differentiated positioning, beliefs and practices that exist in the sexual field (Green, 2008). During the life course, certain habituses are formed and deployed as social actors engage in or disengage from sexual activities. Through the socialisation process, social agents acquire beliefs, views, and attitudes that are also fluid as individuals and groups interact within a given cultural context (González, 2007). At different levels, cultural expectations, history and traditions emerge as critical examples of habitus. Without gainsaying, habitus delineates individual and group dispositions to what constitutes their sexuality and how this can be expressed and experienced within time and space (Green, 2008).

In the same vein, ageing as an embodied experience differs based on habitus, capital and field. For instance, within the field of marriage, the ageing process presents different experiences and outcomes for men and women, including their sexualities. Through the socialisation process, the notions of masculinities and femininities are acquired as men and women enter into intimate relations. The differences in social expectations that go along with the notion of being a man or woman continue into old age and have implications for ageing experiences, including sexually related ones. Thus, through habitus, social agents define and

experience their sexuality throughout the life course. Often, through conscious or unconscious efforts and structures, social actors spread and promote their sexuality habitus into the minds of generations after them. With time, certain habituses relating to sexual desires, expressions and practices are substituted or modified as social agents realise the uniqueness or deficiencies in prevailing habituses.

With regard to sexual desires, expressions, and engagement or disengagement in old age, certain beliefs and practises are often considered as expected or unexpected among the elderly. This social expectation can generate tensions for the elderly themselves and other members of society. Those among the elderly who have the desire and willingness to engage and express their sexualities may experience disrespect, stigma and marginalisation. This may be overt in instances where such elderly people are in search of new relationships or in need of support to treat an infection or enhance sexual performance. Similarly, tensions may also arise as support may not be provided within and outside medical systems for the elderly who are sexually active. Individual histories and experiences within and outside the medical systems also affect the degree of responsiveness in meeting the sexual needs of sexually active elderly. The ripple effect of these habituses might also include discrepancies between what needs should be paramount in old age and the availability of therapeutic support within prevailing medical systems (biomedical and traditional). There may be delay, denial or non-responsiveness when help is sought. Habitus, therefore, regulates the rules of the game in the sexual field and help-seeking within and outside medical systems. It also affects communication patterns and various forms of outcomes, whether for treatment or to improve sexual performance.

Capital

In Bourdieu's framework, capital can take different forms. Bourdieu's variety of capital differentiates his position from that of Karl Marx and Max Weber. For both Marx and Weber, capital can either be economic or social (Maton, 2008). For Bourdieu, the nature of capital varies according to its utilisation and conversion (Wacquant, 2004). Capital can either be used or exchanged for other forms of capital as deemed fit by the social actor and the field (Maton, 2008; Wacquant & Deyanov, 2002). As such, capital symbolises the power available to an individual social agent to gain an advantageous position within a social field. By typology, Bourdieu classified capital into social, cultural, economic, and symbolic (Maton, 2008).

Social capital refers to the network of relationships that are available to an individual social agent (Collyer et al., 2015). This will include friends, relatives, family members, neighbours and secondary group members. On the other hand, cultural capital includes knowledge, experience, and connections that may be available to an individual. Such capital comes through diverse networks of relation and activities that are available or created during the life course. In a more restricted sense, economic capital consists of assets that could be liquid or fixed, earning capabilities, and investments (Maton, 2008). For symbolic capital, examples include social prestige, the status of being elderly, and the cultural values and recognition that are ascribed to or achieved by an individual within a given context.

Across the life course, any form of capital can be differentially deployed or converted to create advantageous positions (Stephens, 2008). In old age, capital availability can make an individual's sexual and ageing experiences pleasant or unpleasant. Similarly, a sexually active elderly person will deploy an arsenal of capital as deemed fit to either improve or

resolve a sexual challenge. Nevertheless, there are gender differences, and such forms of capital may not be available in equal proportions to both men and women. In the search for pleasure or resolution of a challenge, an elderly person with these four forms of capital may be accorded a different quality of support. In contrast, the inadequacy of these forms of capital may expose an elderly person to stigma, marginalisation and loss of social position in the event of a sexually transmitted infection. Such restrictions or disadvantages may also occur for those interested in forming new intimate relationships. Research has shown how the loss of capital contributes to abuse, exclusion, and vulnerability of some elderly people (Pillemer, Burnes, Riffin, & Lachs, 2016; Sharma, 2013). Similar to this is the neglect and non-inclusion of older people in significant development and health initiatives (Aboderin, 2011a; Parmar et al., 2014; Sharma, 2013).

In medical settings, an elderly person with low or inadequate capital may not enjoy the quality of support when help is sought. In this context, some studies have revealed how power differentials in therapeutic relations affect the quality of attention and dispositions towards clients'/patients' needs. The implications for quality of care and accessibility of care remain enormous, especially in low-resource settings where users of healthcare services are treated based on their purchasing capacity and other forms of capital (Aboderin, 2011b). In Nigeria, for instance, access to modern health care services requires user fees that include the elderly. Efforts at reducing inequalities in accessing healthcare services remain challenging. In the same vein, the use of disease burden in the formulation of public health services, including those that affect the elderly, needs further attention (Aboderin, 2011b). Nevertheless, existing frameworks for prioritising essential health care services for vulnerable groups including the elderly are power dominant (Aboderin, 2011b; Parmar et al., 2014).

Field

The concept of field as used in Bourdieu's theory of practice represents a playing field on which actions and activities take place. It has boundaries where entry and exit rules are defined and regulated by holders of power. Within fields, social agents are the players and occupy differentiated positions with roles and status attached. These positions are not static, however; they are dynamic and subject to change at any period. Bourdieu explains "Field" in terms of structure and power relations. In Bourdieu's opinion, the capital possessed by individual social agents helps in differentiating their relevance and importance in different fields of play. As such, Bourdieu described the structure of the "field as a state of power relations among social agents or institutions engaged in the struggle for differentiated advantage or positions." In other words, it is the state of the distribution of the specific capital which has been accumulated in the course of previous struggles and which orients subsequent strategies (Bourdieu, 1977) .

The field, in Bourdieu's opinion, portrays how complex and contested interactions are produced through habitus, capital deployment and conversion (Wacquant, 2004). With respect to the sexual field and ageing experiences, social agents enter into these fields with different dispositions, beliefs and expectations that can create tensions or fulfilment. As a primary concern for this thesis, sexual desires, expressions and engagements are defined within the habituses that prevail in a cultural setting. Among the Yoruba people, for instance, the field of marriage is seen as a communal entity rather than what belongs to the individual alone. Therefore, relationships that include sexual relations in the field of marriage are influenced by cultural beliefs and practices, history, and traditions. Other structural factors that affect sexual desires and expressions across the life course include religious beliefs and practices, medicine, the media and technology, among others (DeLamater & Koepsel, 2015).

Within medical fields, the beliefs, attitudes and knowledge of healthcare practitioners about sexual health needs in old age have an influence on the quality of care, including the availability of sexual healthcare services (DeLamater, 2012). In addition to biological and psychological factors, relationships and interactions within social structures can alter the desire of social actors to engage in or disengage from sexual activities in old age (DeLamater & Koepsel, 2015).

The use of field as espoused by Bourdieu, therefore, provides insights into the dynamics of power differentials in social fields and the possible influence on sexual health and responsive help-seeking in old age. The context of support provision within and outside medical systems is based on the differentiated positioning of social actors along storylines and exemplary frameworks. Through embodied experiences and network of relations, social actors are inclined to retain (as far as possible) the habits, personalities, and styles of life they developed in earlier years (Moody & Sasser, 2014, p. 462). However, certain particularities and differentials may exist based on habitus and differential deployment and conversion of capital in making sense of sexuality in old age. For exemplification, additional cues are taken from Harré and Langenhove's Social Positioning theory.

Social Positioning Theory

Social positioning theory was developed and popularised by Harré and Langenhove (Harré & Langenhove, 1998)**.** The terms "position" or "positioning" as used in this theory are in contrast with their usage in disciplines like marketing, where they imply competitive advantage and the lexicon interpretation (Harré & Langenhove, 1998). In this context, Langenhove and Harré (1998) defined position "as a complex cluster of generic personal

attributes, structured in various ways, which impinges on the possibilities of interpersonal, intergroup and even intrapersonal actions through some assignment of such rights, duties and obligations of an individual as are sustained by the cluster".

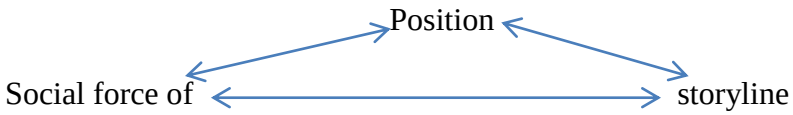


Figure 3: Mutually determining triad (Langenhove & Harré, 1998)

Langenhove and Harré (1998) opined that positioning rather than roles accounts for the dynamics of interpersonal relationships and how social actors develop storylines to make sense of their interactions and conversations with others. In recent advances in social positioning theory, Harré et al. (2009) expanded on positioning theory as a triad (positions, storylines, and speech acts). As portrayed in figure 3, this triad is observable in all forms of social relations whether simple interpersonal, group, or within social structures. The main thrust of positioning theory rests on the following interconnected tenets:

1. Rights and duties are distributed among people in changing patterns as they engage in performing particular kinds of actions.
2. These patterns are themselves the product of higher-order acts of positioning through which rights and duties to ascribe or resist positioning are distributed.
3. Such actions are the meaningful components of storylines. Any encounter might develop along more than one storyline, and support more than one storyline evolving simultaneously.
4. The meanings of people's actions are social acts. The illocutionary force of any human action, if it is one as interpreted by the local community, determines its place in a storyline and is thereby mutually determined. Any action might carry one or more such meanings (Harré et al., 2009, pp. 7-8).

In social positioning, the notions of rights and duties are critical normative frames through which social agents make sense of their everyday activities and perceptions of correctness (Harré et al., 2009). The dynamics and the performance of duties and rights are context specific and vary even among social categories in a cultural setting. Accordingly, Harré et al. (2009) posit further that cultural settings define and appropriate certain duties and rights to social actors in dynamic manners as they perform certain kind of actions. However, these rights and obligations are conceptualised in a different manner from Parson's standpoint. They are non-statutory moral obligations and responsibilities and possess the characteristics of storylines that conform to agreeable behaviour in a local context. Rights and duties are therefore defined based on moral expectations and responsibilities measured against localised and shared standards of correctness. The expected ways of acting, thinking, feeling and reacting frame what social actors can do, or not do, and are brought into how social actors position themselves and others in everyday activities.

In terms of typology, Langenhove and Harré (1998) identified different modes of positioning in interpersonal and group relations. These include first and second order positioning, performative and accounting positioning, moral and personal positioning, self and other positioning, and tacit and intentional positioning. Four of these modes of positioning are adopted in exploring the various forms of positioning and storylines that could emerge in interpersonal, intrapersonal and group discourse on sexuality in old age. In interpersonal conversation, a first order positioning will occur based on how individuals situate themselves and others within a moral space and the kind of categorisations and storylines that follow (Jones, 2006; Langenhove & Harré, 1998). A second order positioning takes place when the first order positioning is contested and being reconsidered. Intentional self-positioning is all

about adopting a particular stance when interacting with others on a specific issue (Harré & Langenhove, 1998).

A discourse concerned with sexuality in old age, for instance, could trigger different positioning whether the interaction is at interpersonal or group level. The variability in positioning reinforces the tensions in social fields and a network of relations, including therapeutic relations. Tension comes in different forms for social actors depending on the nature of the social field and power differentials. For instance, the acceptability of sexual normativity in the growing 'pharmaceuticalisation' of society (Williams, Martin, & Gabe, 2011) might have created various options for sexual relations and practices. Tensions may, therefore, occur as some older people are likely to struggle with social expectations and the pharmaceutical depiction of "sexy seniors" (Marshall, 2010). In Katz and Marshall's (2003) opinion, such plausible contradictions represent "modernity tensions" for the aged. The stance of a particular social actor can inspire or restrict the meanings and assessment of what constitutes (not) exemplary sexual behaviour and practices among elderly people. The existence of gendered and power differentials in sexual expressions and practices in old age can also widen the deployable modes of positioning. These variations and associated meanings have consequences for personal and societal conceptions of sexual health in old age.

In therapeutic relations, healthcare providers and elderly people have been found to exhibit different expectations and dispositions to sexual health needs in old age (Gad et al., 2013; Gott & Hinchliff, 2003; Gott et al., 2004). In relation to these findings, social actors will position themselves differently on a subject in a way that is associated with certain moral correctness and expectations. In such contexts, the quality of care in terms of availability and

support for post-reproductive healthcare services is likely to remain inadequate or poor. Kleinman (1980) opines that both patients and healers operate within a cultural context that influences therapeutic relations, therapeutic measures, and possible health outcomes. The basis is that self-positioning is inherent in all forms of social relations, as social actors would desire to express an individual stance by drawing inferences from personal experiences, beliefs and cultural practices. In all the possible modes, positioning occurs intentionally or unintentionally. Nevertheless, the rights, duties and responsibilities that are associated with various positioning are sometimes accepted and sometimes contested. These contradictions and pressures are extrapolated into everyday practices. The possibility of such contradictions lies in the inevitability of personal understandings and making sense of social realities in interpersonal, intrapersonal and group interactions.

Against this backdrop, Harré et al. (2009) present interactive positioning, a third variant that is of interest to this thesis. In interactive positioning, the stance of an individual could influence how another social actor will position him/herself in a conversation. Like a stimulus, how social actors position themselves will also attract a symbolic response from others. Others, as co-constructors of their realities, are likely to engage reflexively in response or act based on their sense of the situation. As such, positioning theory emphasises relationally contextualised interrogation of the process of arriving at what social actors consider as right and valuable with respect to a particular issue.

Ageing as a social process is prone to moral influence, which may affect attitudes and perceptions towards ageing well, thereby creating some contradictions (Katz & Marshall, 2003). Thus, Harré and Langenhove's Social Positioning theory (Harré & Langenhove, 1998) provides an opportunity to address the question "how do elderly men and women make sense

of their sexuality and that of others at old age." The theory sets a framework for understanding how elderly people position their sexuality and that of others through different storylines. Particularly, the theory provides an opportunity to understand the framing of older men and women as exemplary and how this position is reflected in their assessment of sexual practices among their counterparts. As such, certain defining variables like gender, age, and socioeconomic status, including religious status, are important in terms of ability to conform or deviate from the rights and duties that correlate with agreeable sexual behaviour in old age.

The social positioning theory is also useful in investigating how a dominant explanatory cultural framework, a network of support and embodied experiences stimulate or constrain help-seeking within and outside the medical settings. In this regard, the theory avails the opportunity to explore cultural descriptors associated with sexual behaviour and practices among the elderly. It also provides insight into how elderly people deploy their capital (*cultural, social, symbolic and economic*) in seeking help from medical and non-medical sources. Investigating the dynamics and multidimensionality of help-seeking within and outside the medical setting could reveal the process, pathways, constraints and availability of post-reproductive sexual health care services.

For contextual and cultural understandings of the exemplary correctness of being an elder, I have highlighted a cosmology of time within the Yoruba cultural context along with the anthropological concept of age-grading as discussed by González (2007). In anthropological discourse, 'age-graded perspective to sexuality provides in-depth understandings of sexual desire, pleasure and bodily maturation about embodied experiences and social practices' (González, 2007, p. 32).

Age-graded approach to sexuality and exemplary old age

Age-grading is a social arrangement that recognises and places certain social expectations concerning age in the demarcation of social rights, duties, and expectations. In this sense, Simon (1996) argues that each culture creates an age-graded framework that defines what social actors can do or not do with their bodies within time and space. A noticeable form of social promulgation in this regard is the social control of sexualities and the appropriateness or inappropriateness of sexualities based on individual variables, especially age (Simon, 1996).

Thus, considering sexuality from an age-graded approach helps in understanding the variations in sexualities and bodily changes in relation to issues of inequality and legitimacy or moral correctness among social actors in a given social setting (González, 2007). Therefore, age-grading represents one among other frameworks that helps our understanding and investigation of the interaction between structures and individual agencies, and ageing and sexualities as embodied experiences. Sexuality seen through this lens goes beyond biological reductionism to accommodate the cultural and psychosocial dynamics of ageing and sexuality (González, 2007).

Individuals adapt differently to the challenges of ageing and sexuality. Nevertheless, the embodied experiences of ageing and sexuality are suited to everyday life experience. Through the everyday exercise of moral correctness or deviations, individual experiences and reactions from others in relation to age become clearer (González, 2007). In pushing this view further, Simon (1996) argues that the social reliance on age-graded sexualities ensures differential placement of social actors and formation of hierarchal relationships and

expectations. Through this social arrangement, members of a group or the society observe, monitor and attempt to influence one another to act, behave and relate based on cultural descriptors and exemplars.

The emphasis in the age-graded approach lies in its focus on cultural conceptualisations of duties, rights and moral correctness concerned with age and the social notion of time. Thus, for contextualising insights into age-grading and sexualities within the research settings, I highlighted the notion of time within the Yoruba belief system. Time (*ojo*) in Yoruba cosmology is "merely a point of reference in infinitude" (Akiwowo, 1986, p. 351). In principle, there are three stages. There is the *ojo are* (morning), *ojo osan* (afternoon) and *ojo ale* (night). This categorisation lends credence to the inseparability of time from human activities and eulogises the egocentric approach to the notion of time. Notwithstanding the limitations associated with this approach to time measurement and conceptualisation, it nonetheless depicts the social contestations associated with the correctness of certain duties and rights and the dynamics that exist in the practices and experiences of individual social actors. Such categorisation becomes relevant in deciding the appropriateness of when a person should engage in certain life events, and actualise optimum results with enduring satisfaction - even though there is no certainty whatsoever.

Within this worldview, sexual explorations with enduring satisfactions are seen as part of the activities that should be fully explored in the afternoon period of one's life. Despite the existentialist assumptions in this worldview, the morning period represents the formative part of life when inculcation of social norms and values take place, which is applied in preparing for social responsibilities in the afternoon and night periods. The night-time is supposed to be a moment of reflection on one's morning and afternoon deeds. Each phase is defined

arbitrarily in terms of expected social activities and roles and does not have a fixed chronological age; it changes with context, time, and events.

Superficially, in the *Ifa* oral corpus, proverbs and songs, the cultural emphasis is on good deeds and the urge to act as exemplars as one grows chronologically in age (Abimbola, 1975). Thus, the expectation of this period is on the need to end one's night in peace and with admirable deeds (Abimbola, 1975; Akiwowo, 1986). In reality, while society preaches individual virtues, individuals possess the ability to conform or not to the social norms and values. Sexual choices and practices within cultures are mixed.

Deviations, conformity, or compliance with standards and values by social actors change with sexual fields, social class, and age, among other factors. Thus, from the perspective of social practice theory, my presumption in this thesis is that agency in old and older age could be explored by focusing on lived experiences, everyday practices, and the associated cultural interpretations. González (2007) argued that prevailing norms and cultural practices within a context influence how we express our sexuality and deny our sexual desires and experience.

To this end, behaviour and practices that could compromise such possibilities are monitored, which invariably creates tensions and conflicts in everyday practices and experiences of social actors. These tensions and challenges create inequalities and tensions in the sexual fields of the elderly, in expression and engagement with exemplars in sexual desires, and in pleasures, and help-seeking. The tensions and challenges of negotiating sexuality are inherent in the social positioning and utilisation of sexual capital in different circumstances and for different purposes. Power drives appropriation of prowess, desires, preferences and risk-taking within sexual fields. Within and outside the medical systems, knowledge and sexual

capital are also shaped by the power possessed by social actors, which is further defined by class, age, economic, religion and other social factors.

The associated tensions that individuals and social categories undergo in defining, experiencing, and negotiating their sexualities within the cultural context is thus paramount in this thesis. Both patients and healers operate within a cultural context that influences the construction of health conditions, reactions, therapeutic measures, and possible health outcomes (Kleinman, 1980).

Hence, exploring the presumed consensus of the exemplary elderly, or conflict with changing normative values, will require an understanding of the beliefs and sexuality experiences of elderly people themselves. Such knowledge may offer depth and context-based evidence relevant to address and promote healthy ageing and sexual health within the Yoruba cultural context. Furthermore, I interrogate how cultural contexts influence engagement or non-engagement in pleasurable, non-risky, and risky sexual behaviours within gender and age cohorts. This is premised on the plausibility of individuals manifesting multiple sexual identities across the life course. Using this assumption, I focus on how gender and age cohort differentials may account for the importance and variations attached to sexual health and help-seeking in later life within the existing plural medical system in Nigeria.

Conceptual Framework of the Study

Conceptually, this thesis reckons with three broad categories of variables that shape ageing, sexuality and pathways to help-seeking and decision making. As the core aim is to explore sexuality in old age, the variables of interest are therefore conceived and restricted. The first

category of variables is the individual and particularised factors. These variables are conceptually considered to have a kind of influence on the dispositions of elderly persons towards sexual desires, expressions, practices and problem solving.

Available evidence shows that there are variations in the ways individuals experience ageing and sexuality within time and space. Despite cultural influence, "Individuals anticipate and deal differently with the psychosocial effects of bodily changes" (Higgs & Jones, 2009, p. 82). Prominent factors in this respect include gender, subjective and objective health status, sexual history and experiences , marital status, religious beliefs, economic and financial conditions and the preferences and experiences of their sexual partner(s) (DeLamater & Koepsel, 2015). Within and across gender and age cohorts, the influence of these variables on experiences and disposition towards ageing and sexuality is further influenced by how individuals position themselves in relation to others (González, 2007).

As stated earlier in the theoretical framework (figure 3), the social position has a great deal of influence on embodied experiences and the perceived need for help. Furthermore, this thesis argues further that the individual factors as depicted in the conceptual framework (figure 4) are considered critical in the identification of symptoms, aetiological attribution and possible sources of support and therapeutic outcomes.

With reference to the conceptual framework as represented in figure 4, the thesis postulates that sexual networking goes a long way to influence the availability of sexual partner(s) for the old who desire new or extension of sexual relations. Largely, the prevailing ideological positions, including religious beliefs and practices, provide frameworks that social actors will

adopt when defining sexual correctness. Against this backdrop, the duties and rights of an elderly person revolve around storylines that depict the exemplary elderly from others.

The social framework, therefore, provides diverse opportunities for older persons and others to depict and react to bodily changes and sexuality. In the same regard, contradictions are bound to exist among older persons and others, including health care practitioners, within the traditional and biomedical systems. By cultural injunction, social actors that adhere to normative forms of sexual expressions and practices are rewarded. In contrast, deviants, including the innovators, attract stigma and sanctions of different forms. Condemnation and sanctioning of socially unacceptable sexual behaviours come with explanations that such behaviours are detrimental to the individuals and the public.

Nevertheless, in a diverse and relatively heterogeneous social category such as the elderly, different reactions and practices are possible as individuals deal with their bodily changes and sexuality. There are possibilities that some elderly people will conform to, deviate from or devise alternatives to the prevailing social norms, expectations and correctness associated with sexuality. Similar possibilities can also emerge in the responsiveness of medical systems to post-reproductive sexual health care services. Since healers and patients operate within cultural frameworks that might be dissimilar (Kleinman, 1980), contradictions and tensions are therefore inevitable in therapeutic interactions, especially in sexual healthcare services. Each healthcare giver is a member of a medical system and, therefore, operates within the confines of the cultural beliefs and practices in that system. In the same vein, a patient as a member of a cultural group would seek help based on their judgments and cultural beliefs and practices (Pearson & Makadzange, 2008). Patients' feelings, experiences and knowledge of situation affect/influence perceived needs and solutions to their sexual needs (Hinchliff &

Gott, 2011; Pearson & Makadzange, 2008). Healers or care providers, occupational orientation, and epistemologies also influence the perceived needs of patients and diagnosis (Maimela et al., 2015; Nwoga, 1994; Pearson & Makadzange, 2008). Possible implications amongst others would include a delay in help-seeking, poor therapeutic relations, low or inadequate responsiveness to post-reproductive sexual needs, and poor adherence to or lack of faith in available therapies (Manary, Boulding, Staelin, & Glickman, 2013).

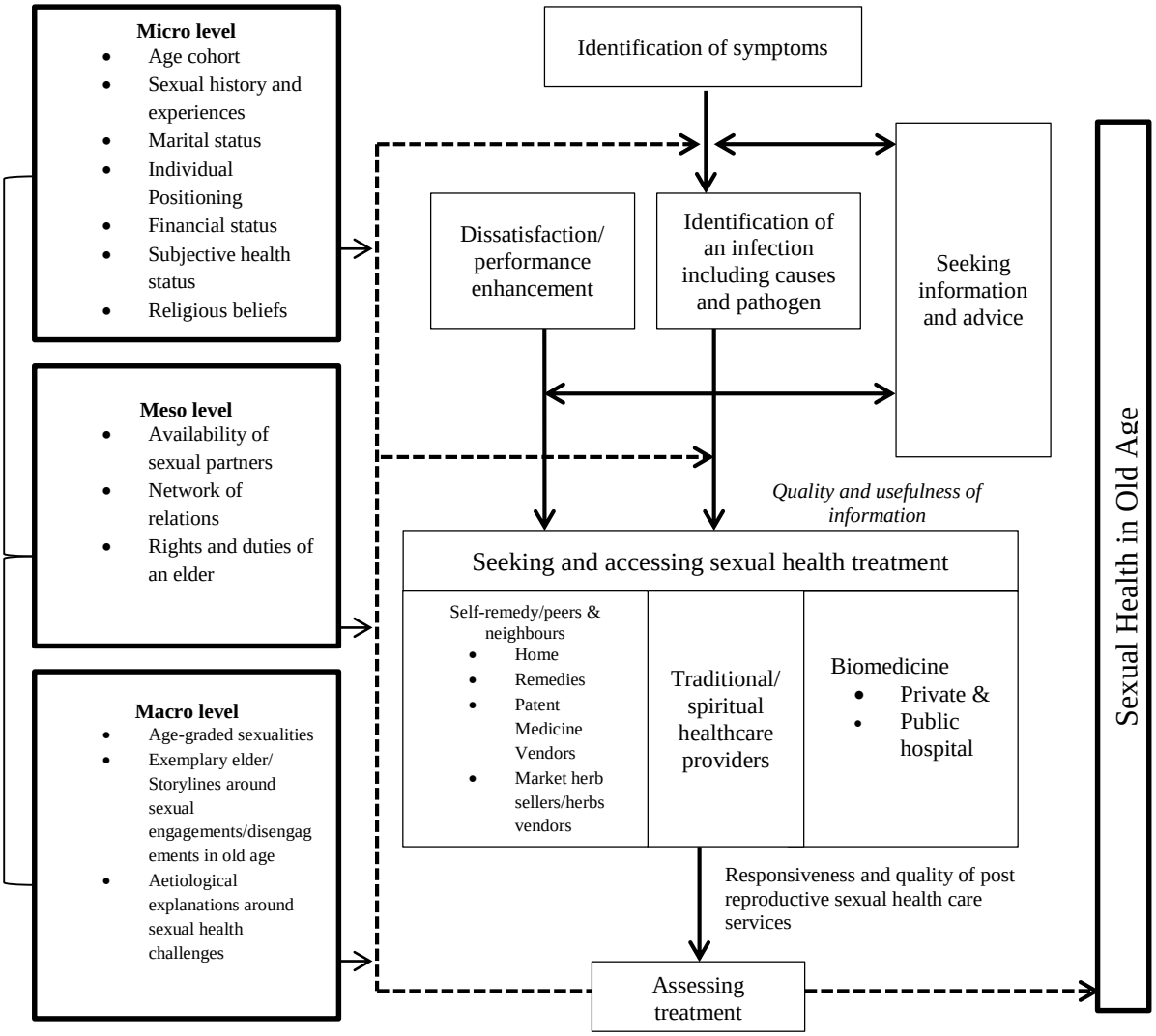


Figure 4: Help-seeking pathways, availability and quality of Post – Reproductive Sexual health care services (Insights from Pearson & Makadzange, 2008)

At the macro level, existing medical systems alongside other structural factors play critical roles in the existence of age-graded sexualities and the availability of sexual healthcare services. Alongside other structural factors such as the political economy, the responsiveness of the medical systems and the availability of post-reproductive sexual health care services affect the quality of care. Within a given context, the forms and nature of post-reproductive sexual healthcare services that are accessible also mirror the interactions between available medical systems (biomedical and traditional) and other structural factors. Tensions may, therefore, occur as older people struggle between social expectations and the medical systems' depictions of "sexy seniors" (Marshall, 2010). These contradictions and pressures are extrapolated into everyday practices. In Katz and Marshall's (2003) opinion, such plausible contradictions represent "modernity tensions" for the aged.

Furthermore, available, accessible and acceptable post-reproductive sexual health care in a given context also depends on prevailing aetiological explanations concerning sexual health challenges. Health from a multidimensional position is holistic and cuts across the diverse spheres of life. In this regard, there are different dimensions of health: mental, psychological, emotional, physical, sexual or spiritual. The literature on Africa has shown the existence of diverse forms of interpretations related to illness, sickness and disease aetiology. Broadly, aetiological explanations are categorised as natural, preternatural and supernatural. Each aetiological source is backed with suitable therapies, as shown in the practice of African traditional medicine. Biomedicine reckons more with natural aetiological explanations as against the preternatural and supernatural. The patronage in terms of care and suitability of available sexual health care cannot be divorced from prevailing aetiological explanations in a medical system. From the literature, sexual health challenges are therefore traceable to any of these sources or a combination of these sources as revealed in a recent study among men in

Zimbabwe. Thus, the patient's beliefs and the judgement of significant others in terms of perceived aetiology would influence help-seeking and therapeutic outcomes.

In sum, this thesis argues that the cumulative effects of factors at the micro to meso and macro level are critical to embodied experiences with ageing, sexuality and help-seeking. Interactions at these levels and the associated meanings have consequences for personal and societal conceptions of sexual health in old age.

THE STUDY SETTINGS

The research was conducted in six communities within two local government areas in Ibadan, the capital of Oyo State in South West Nigeria. As shown in figure 5, Oyo State is one among the five states in the southwest geopolitical zone in Nigeria. Along ethnic and political interest, the geographical space of the Nigerian state is divided into six geopolitical zones. The zones include North-North, Northwest, Northeast, and North Central, Southeast, Southwest, and Southsouth. The Southwest geopolitical zone consists of six States - Ekiti, Lagos, Ogun, Ondo, Osun, and Oyo. Ibadan occupies both cultural and historical relevance in the history of the Yoruba people (Johnson, 2010).

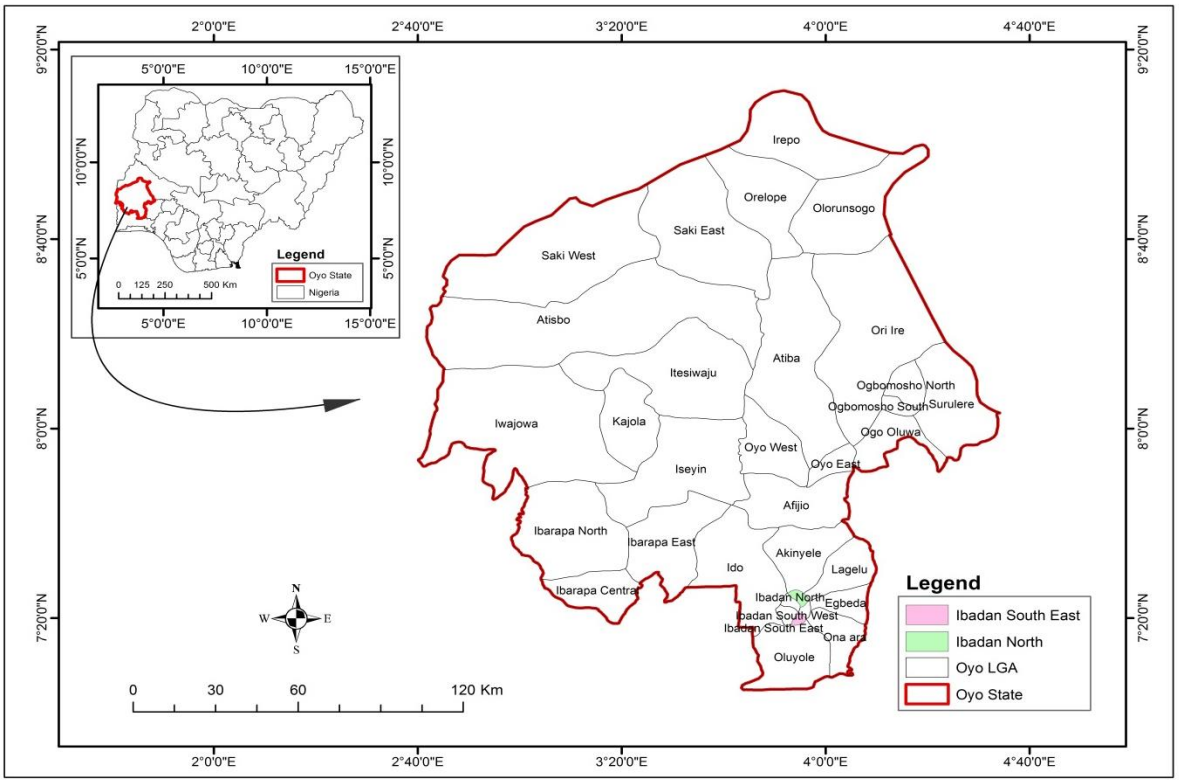


Figure 5: Map of the Study Locations in Ibadan, Oyo State, Nigeria

Ibadan cosmopolitan has 11 Local Government Areas (LGAs). Five of the LGAs are within the metropolis. The remaining six are on the outskirt rural areas. From the 2006 National Population Census, the metropolis has a population of about 1.3 million (NPC, 2009). Two out of the five metropolitan LGAs are of interest to this research. These are Ibadan North and Ibadan Southeast. Residential developments in the southwest Nigeria are broadly categorised into high, medium and low-density areas (Jiboye, 2014). On the average, high-density residential areas in Ibadan have fractions of modern health facilities and a large proportion of traditional health practitioners (Lawal, Taiwo, & Oke, 2015). The house-types in the inner core areas are roomy and often occupied by family members with limited or absence of rooms for rent. Furthermore, the buildings are old and spatially netted together in a way that two buildings share the same fence. These, among other factors, reflect the socioeconomic characteristics of the residents (Jiboye, 2014), and could increase the frequency of interaction and co-residency among the populace. Indigenes and early settlers are mostly found in the inner core areas. A few non-indigenes reside in these areas due to the low cost of renting accommodation and opportunities for survival. The spatial arrangements of residential areas could impact on a network of relations and interactions among community members. The reasons are not surprising; social relations in inner core areas are predominantly informal, with a high tendency to interfere in private matters and lives of others.

Social change and population growth only widen the dimensions of social relations in modern society from *ajobi* to *ajogbe* (Akiwowo, 1983). The notion of *ajobi* signifies social relations that are formed and bound by blood or marriage. With population growth, migration, and other social developments, relationships across *ajobi* are widened to include co-resident relationships known as *alájọgbé*. Social relations and network of relations are therefore built around the variations in these notions of associations. The concepts of *ajobi* and *ajogbe*,

therefore, provide opportunities for relatives, friends, neighbours, and significant others to peep into private relations including sex with others. Urban and rural dwellers may differ regarding their dispositions and involvement in other people's affairs. Nevertheless, the consciousness and value placed on *alájọgbé* (co-residents) are echoed in several ways, especially in religious settings and practices.

Ibadan is a religious city with adherents of the three dominant religions (Christianity, Islam, and traditional) among the Yoruba people. Over the years, missionary activities by both Christians and Muslims have produced remarkable advancements among the Yoruba people of South West Nigeria (Premack, 2015). As such, visible structures are available to announce present and future religious activities, especially prayer sessions targeted at addressing series of social and personal spiritual problems. The need to form good and quality interpersonal relations with co-residents is part of the social process of maintaining harmonious relations and avoidance of evitable grudges or misunderstandings. Effective prayers and acceptable sacrifices are presumed to depend on a quality network of relations with humans and the spirits (Dopamu, 2000).

In the Yoruba belief system, prayers and sacrifices are the main approaches to overcoming personal and social problems that have spiritual undertones (Dopamu, 2000). With emphases on prayers, offerings, and sacrifices in both Christianity and Islam, both religions have won the admiration of many and have increased their following among the young and the old. Nevertheless, a crucial position in both religions is the need to discard beliefs and practices associated with traditional Yoruba religion (Olupona, 1993). Such discontinuation is requisite for the new life that comes through repentance and acceptance of the new faith in Christianity or Islam.

Nonetheless, in practice, social, cultural beliefs and explanations are hardly devoid of the everyday practice of both religions. As a practice, syncretism in Nigeria is expanding in different dimensions among the adherents of Islam (Musa & Ibrahim, 2015), and Christianity (Pruitt, 2012). The practice of syncretism consists of a concurrent mix of elements of a traditional belief system with foreign religions. This version of syncretism is seen in how religious adherents combine traditional Yoruba beliefs with the conduct of prayer sessions and other common rituals (Balogun, 2011). Religious syncretism is also evident in health-seeking behaviour and practices among the Yoruba people (Jegede, 2002).

Nigeria has a pluralistic medical system, with traditional and biomedical systems operating side-by-side (Dime, 1995). Practitioners in the traditional medical system operate largely at the primary level and are well spread and accessible in most Nigerian communities (Abdullahi, 2011). There are specialists of all kinds in traditional medical systems despite their low level of operation and standardisation of care. However, they are professionals in their own right (Adekson, 2003; Omonzejele, 2008; Oyebola, 1981).

The biomedical system of care provision in Nigeria is also organised into three tiers: primary, secondary, and tertiary. Such structures are widely covert in the traditional medical system. In several ways, health practitioners within the biomedical system have the upper hand regarding recognition, organisational structures, and involvement in public health policies, implementation and degree of professionalism (Falola & Heaton, 2006). Despite the uneven playing ground between traditional medicine and modern medicine in Africa, traditional medicine has remained vital in providing primary health care services alongside the modern medical system (Abdullahi, 2011). In Nigeria, the primary level represents the first level of

care with the aim of offering preventive care as against curative services. Basic illness and disease conditions are handled at this level. Qualified health professionals are fewer at this level, with the majority of the care providers trained as generalists. A recent assessment of primary health delivery in Nigeria shows an ailing sub-system where an inadequate and overloaded number of health professionals exists (Timothy et al., 2014).

In the southwestern part of Nigeria, there is only one Geriatric centre, situated at the University College Hospital, Ibadan. The unit was established in 2012 through the philanthropic efforts of a Nigerian, Chief Anthony Anenih. The centre is a multi-purpose unit with the capacity to manage both in-patient and out-patients. As a specialist hospital, the clinic attends to different cases and also refers conditions beyond its capacity to other units of the University College Hospital (Ogunbode, Adebusoye, Olowookere, Owolabi, & Ogunniyi, 2014). The centre is the first of its kind in Nigeria and, therefore, it also serves as the first point of call for elderly clients.

The availability of primary and specialist healthcare services draws referred and non-referred clients to the unit. Such practice is common among other tertiary hospitals in Nigeria. The development is partly due to challenges around access and affordability of well-equipped and functional primary health care service. The attendant consequences include a delay in being attended to, work overload, and possible dissatisfaction with the quality of care. Given this background, healthcare providers and clients are likely to have different dispositions to help-seeking and responsiveness to care provision and available support. With the global drive to operate age-friendly primary health care systems, it will be relevant to understand the dispositions of healthcare providers within the two medical systems and the primary health care providers in particular towards sexual health in later life.

METHODOLOGY

In an attempt to answer the main research question, the thesis seeks to understand existing sexual subjectivities and their embodiment among elderly Yoruba people (60 years and above). Furthermore, it questions the influence of healthcare providers (biomedicine and traditional) on dispositions towards providing quality care for sexual health challenges in responsive help-seeking among the elderly people.

This section provides a detailed account of the methodological stance that informed the generation of relevant data in order to answer the research questions.

Qualitative and quantitative data were collected using an exploratory sequential mixed method approach. The choice of this methodology as most suitable to the aims of the study has been justified in the detailed sections that follow. The qualitative component was the first phase and dominant over the quantitative phase. In the qualitative stage, the method of data collection consisted of focus group discussion (FGD) with vignette and semi-structured interviews. The goal here was to explore the significance of old age, sexual health, and risk sexual practices among elderly Yoruba people (60-80+). The everyday practices, sexual experiences, patterns, and pathways of seeking information among the Yoruba elderly were the target here. Interrogation of the context of care provision focused on the knowledge and attitudes of primary care providers within traditional and Western medical systems concerning sexuality in old age. The presumption and empirical support from the literature were that achieving healthy ageing requires the availability of culturally sensitive health care services and responsive access to quality post-reproductive sexual healthcare services within a social setting.

Through a thematic content analysis, statements and quotes from the focus group and interview data were used as frameworks for developing a structured questionnaire. The aim at this point was to increase the sample size and investigate the interaction among normative beliefs about sexual desires, expressions, and handling of sexual health concerns within formal and informal support systems. The informal sources consisted of help sought or provided by friends, peers, neighbours, relatives, and community members. The formal sources included the biomedical and traditional medical systems as represented by the healthcare providers within these two medical systems. The quantitative data generated through the survey provided additional data to identify convergent and divergent positions that may exist among wider respondents with similar characteristics with the qualitative participants.

Research Design

This study adopts an exploratory sequential mixed design to investigate the cultural interpretations, values, beliefs, and daily practices associated with sexuality and help-seeking behaviour in later life among elderly Yoruba people. Exploratory sequential mixed design entails collecting and analysing qualitative and quantitative data in a single study (Hesse-Biber, 2010, p. 3). Investigating sexuality from diverse but relevant methodological positions opens the window into the complex nature of sexuality in old age (Gott & Hinchliff, 2003).

The richness in exploring sexuality and ageing from a mixed methodological position has been echoed in the literature. However, very few studies have employed mixed methods in exploring sexuality and ageing (Fenge & Jones, 2012; Gott & Hinchliff, 2003). The few studies that have employed a mixed method approach to research on sexuality and ageing are from developed countries. The few available studies in Africa have relied on a monolithic

methodology in interrogating the dynamics of ageing and sexuality (Agunbiade, 2013; Agunbiade & Titilayo, 2012; King & Olaseha, 2012; Okiria, 2011). Therefore, this study employed a sequential mixed-methods approach that consists of qualitative and quantitative methodologies.

As depicted in figure 6, it is noteworthy that at both theoretical and methodological stages, a complementarity process guided the thesis. In mixed method designs, complementarity promotes methodological pluralism and opportunities to understand social realities from different perspectives without relegating the importance of one perspective or presuming superiority of one over another point of view (Leech & Onwuegbuzie, 2009). As a philosophical orientation, a sequential mixed methods designs support the uniqueness and particularity of the various dimensions that form a reality and the need to account for observable variations and similarities relating to the phenomenon of interest within a given context (Greene, 2008).

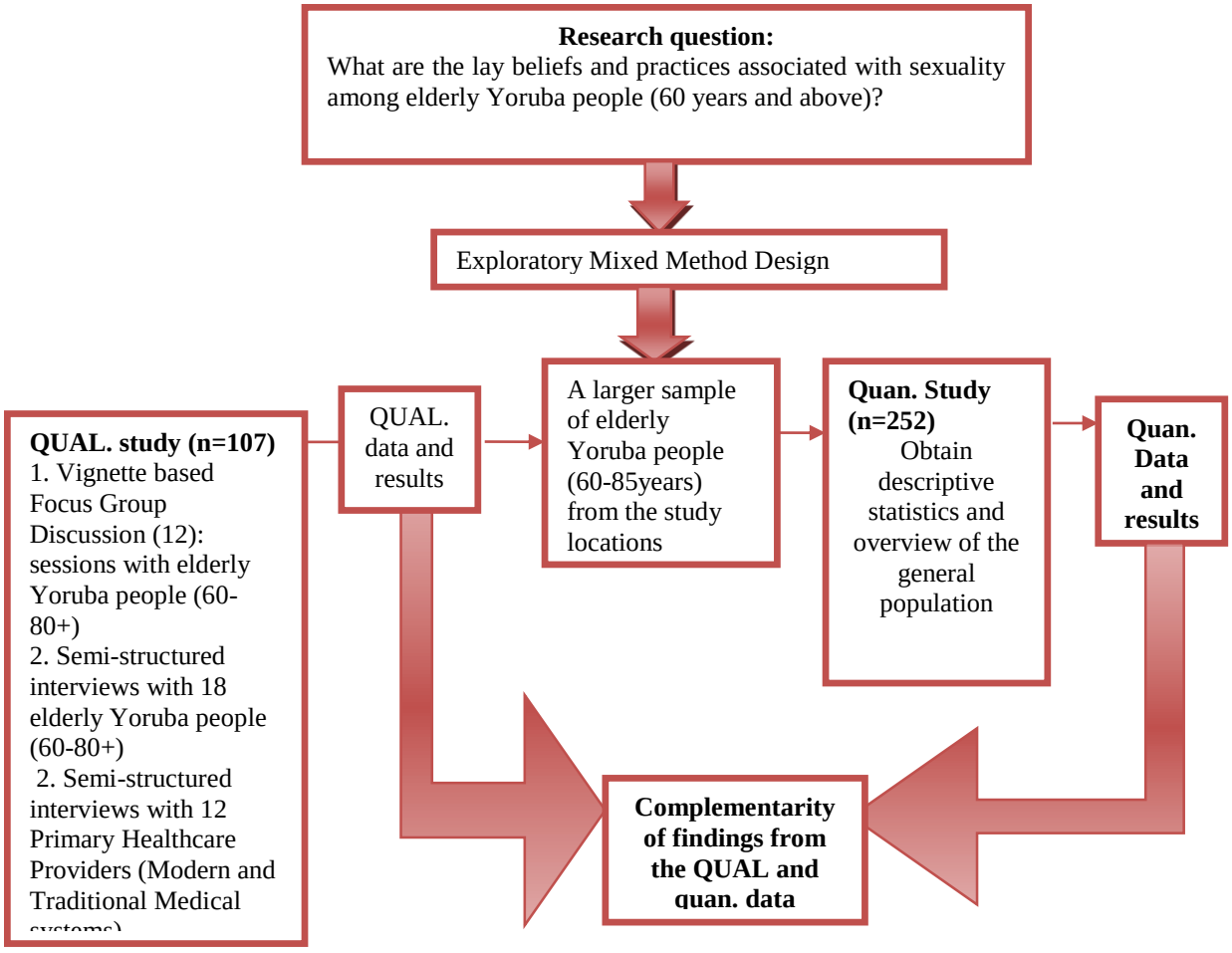


Figure 6: The Research Design (idea from Hesse-Biber, 2010)

The Study Population

There are three categories of participants in this research. The first consists of elderly Yoruba people, defined as 60 years of age and above. The second consists of traditional healthcare providers within the research locations, and the third category is healthcare providers within the biomedical system. The three categories of participants were purposively selected for this research based on their experiences, knowledge and ability to produce valid information on ageing and sexuality.

Among the Yoruba people, the elderly is defined by chronological age and other social indicators. Amongst these indicators are duties, rights, wisdom, understanding and experiences that are acquired through a series of social relations. In everyday activities, the qualities of an elder are tested on his/her ability to relate and resolve issues within a morally acceptable framework. In the process, some elders will conform, become ritualistic, retreat, or deviate from the agreed moral correctness of behaving or living like an elderly.

The second category of the research participants is the traditional healthcare providers. Among the Yoruba people in South West Nigeria, traditional medicine is organised around various areas of specialisations, which makes the healing system complex and diversified (Oyebola, 1980). Although there are various specialists, general practitioners also exist within this medical system. By specialisation, there are experts in the use of herbs (herbalists), herb sellers (those that sell herbal materials or medicinal herbs). There are spiritualists and diviners who are versed in the knowledge and use of incantations known as *ofoo* in the Yoruba language. These practitioners also possess working knowledge of medicinal herbs and combine the power of *ofoo* in effecting the desired change (Jegede, 2010). Faith healers

also exist among the various Christian and Islamic movements in Nigeria. There are also traditional bonesetters, traditional birth attendants, diviners, traditional surgeons, and others (Oyebola, 1980).

The third category of participants is biomedical healthcare practitioners working in the study locations. In Nigeria, biomedical health practitioners are employable in private and public-owned hospitals. They are also licensed to establish and operate private hospitals depending on their qualifications and speciality.

The study inclusion criteria for the Yoruba elderly people were age (60 years and above), gender, residence (Ibadan), and ethnic affiliation (Yoruba). Speciality, patronage and accessibility were the criteria for including the healthcare providers from the two medical systems. For the traditional medical system, the focus was limited to general, traditional medical practitioners, herbalists, herb sellers, and spiritualists. These sets of traditional healthcare specialists are widespread in several Yoruba communities in Nigeria (Adekson, 2003). As community members, practitioners within the traditional medical system are presumed to share similar beliefs with their clients or patients (Adekson, 2003). Such a position would therefore give them deep insights into sexual health needs, care provision and the challenges around post-reproductive healthcare services. In the biomedical medical system, the focus was on general physicians, specialists, and nurses who provide services at any of the three levels of care in the Nigerian hospital system. However, the inclusion criterion for the healthcare practitioners from the two medical systems was based on patronage and accessibility to healthcare services as reported by the elderly people in the qualitative phase. This implies that only healthcare providers who reside or provide healthcare services at the study site locations were qualified to participate in this research.

Healthcare professionals represent a diverse group whose attitudes and knowledge of sexual health in old age are relevant (Schweizer et al., 2013). Their beliefs, views, and attitudes may affect prompt use of post-reproductive healthcare services, thereby compounding the process of addressing sexual health challenges in old age (Hinchliff & Gott, 2011). Hence, the dispositions of healthcare providers and responsiveness to post-reproductive sexual health needs have critical influence on quality of care and equal access to sexual healthcare services.

Sampling Design and Sampling procedure

The early part of this section covers the research procedures undertaken in the qualitative and quantitative stages of this thesis. The section begins with an overview of the sampling design and the rationale, the sampling procedure, and the sample size. The procedure was organised and presented in a sequential approach as informed by the thesis research design.

The Qualitative Strand

Sampling Design

A stratified purposive sampling approach guided the recruitment of participants for the qualitative stage. This approach involves the segregation of participants into sub-groups based on relative homogeneity of characteristics. In this technique, the social category of research interest is divided into strata and then a small number of cases is purposively selected within each stratum for in-depth study (Teddlie & Yu, 2007). For this research, participants were classified and recruited based on gender (male/female), age categories (60-69, 70-79 and 80 years and above) and ethnicity (Yoruba). The second category of participants (health care practitioners) were classified by their affiliations to biomedicine or traditional medicine. The two medical systems, as stated earlier, operate in a parallel manner

in Nigeria. These steps were taken to ensure the recruitment of participants by relevance and uniqueness to the research question. Thus, the principle of gradual selection in sequential sampling procedure was followed in both stages of the qualitative strand (FGDs and IDIs) of this research.

In sequential sampling, the idea of gradual selection of participants is often aimed at generating a theory or broad themes. It is also used to ensure the selection of participants based on their particularity to the research questions (Teddlie & Yu, 2007). The objective of the qualitative phase was to explore the reality of sexual health in later life from the perspectives of elderly Yoruba people (60-80+), and that of the primary health care providers within the traditional and modern medical systems. A stratified purposive sampling technique was therefore considered suitable for the recruitment of participants for the group and individual interviews. Among other benefits, the steps in the recruitment procedure ensure the possibilities of generating valid data that would improve existing understanding of the phenomenon of interest.

Sampling Procedure and Sample Size

The sampling scheme followed a gradual selection approach, as emphasised earlier. The first step was to identify the sampling frame for the recruitment of research participants. This was done by using the 2006 Nigerian National Population Commission enumeration map. In Nigeria, Enumeration areas (EAs) are geographical units demarcated by the National Population Commission, each consisting of about 60-80 household units. Through the EAs, households were identified based on the existing demographic considerations and land use characteristics in Ibadan. The city of Ibadan is categorised into three subsets: namely, inner core, transitory, and peripheral (Coker, Awokola, Olomolaiye, & Booth, 2007; Fabiyi, 2004).

The inner core represents high-density residential districts with 300 persons per hectare. Indigenes are the prominent residents in the inner core areas. Transitory areas are medium-density residential districts with a population of 100-300 persons per hectare (Coker et al., 2007). Peripheral regions are low-density residential districts with less than 100 people per hectare.

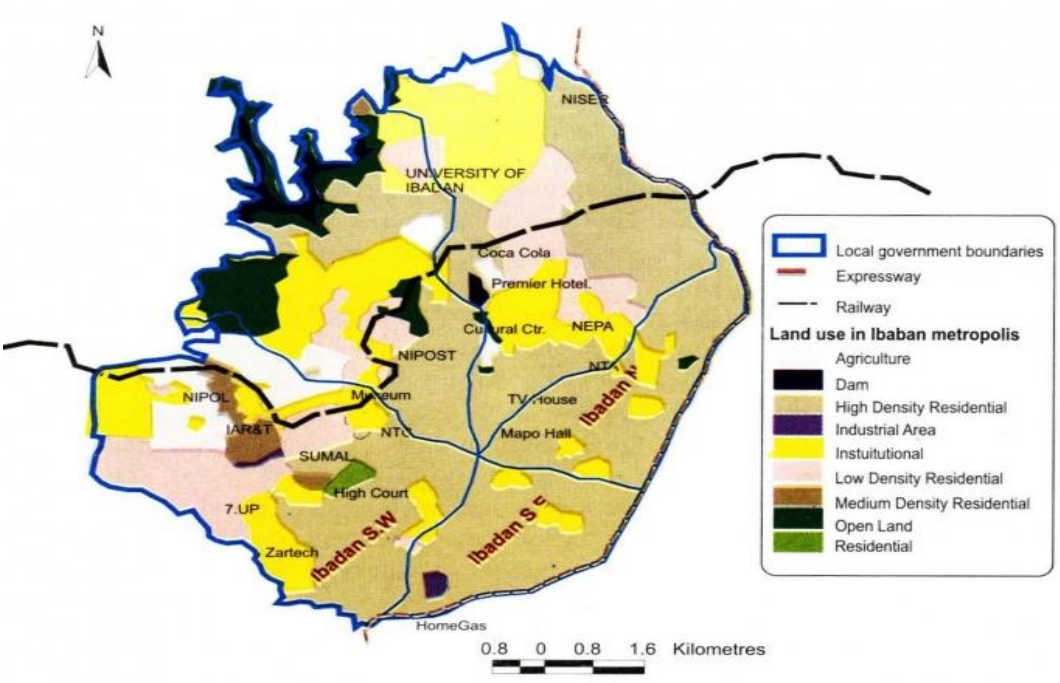


Figure 7: Map of Ibadan Metropolis showing land use classification.

All the EAs in Ibadan North and Ibadan Southeast LGAs were collated into the three subsets (inner core, transitory, and peripheral). The collation of the EAs was facilitated through the assistance of two field workers attached to the National Population Commission (NPC) Offices in Ibadan North and Ibadan Southeast LGAs. After the collation, a purposive selection of 12 EAs that falls within the inner core was done with the support of the NPC field workers. The selected 12 EAs were then linked with their various host communities. This process produced six communities, which include Bodija, Sango, Oniyere Aperin,

Inalende Oke-Bola, Kobiowu and Odo-Oba. The rationale for focusing on inner core areas from the two LGAs and the six communities is to ensure a considerable recruitment of elderly Yoruba people with relatively homogenous socio-economic environments. Sociocultural and economic conditions affect the way social actors talk about sex (Guest, Bunce, & Johnson, 2006), and how individuals and social categories make sense of their sexuality across the life course. In old age, these factors influence sexual desires, expressions and certain sexual practices (Fileborn, Thorpe, Hawkes, Minichiello, & Pitts, 2015; Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015). Thus, for depth and context of relevant understanding, efforts were made to recruit participants with relatively heterogeneous socio-demographic characteristics and ecological conditions (age, gender, and place of residence).

With the selection of six communities, a decision on the desirable sample size became crucial. Opinion differs on what is theoretically desirable and practically feasible when making a decision on the sample size for qualitative studies (Curtis, Gesler, Smith, & Washburn, 2000; Guest et al., 2006). Critical in this direction is the qualitative tradition that informs a research idea and the nature of the research question. For qualitative studies using FGD as a method of data collection, Krueger and Casey (2009) suggested an average of six to nine participants, whereas Morgan (1997) prescribed a maximum of 12 participants (265) per FGD session. For practical and logistical reasons, the actual recruitment of participants must aim at a 50% over recruitment (Wilkinson, 2004). This suggestion was adopted in the recruitment of participants in this research. The result was encouraging as the smallest FGD group had a minimum of 8 and maximum of 10 participants in all the FGDs (See Section 5).

Besides the average number of participants in an FGD, the question of how many FGDs are sufficient to attain saturation point comes next. To achieve data saturation, I assumed that

three to six focus groups would be sufficient. In line with (Morgan, 1997; Onwuegbuzie, Dickinson, Leech, & Zoran, 2009) suggestions, 12 focus group discussions were considered adequate for this research. In addition to the desirable number of FGDs, it was also crucial to determine the number of individual interviews that could generate data saturation. Opinions differ among methodologists on how many individual interviews are sufficient. However, an informed decision must consider the nature of a research question, the theoretical and methodological orientation and scale of research (Guest et al., 2006). For a relatively homogenous group, Charmaz (2006) suggests a sample size of 25 participants, especially for projects that are of a small scale like this thesis. Similarly, Creswell (2012) suggests a range of 20 to 30 interviews. In expounding on this, Ritchie, Lewis, and Elam (2003) claim that it is common to see samples that are below 50 in qualitative studies. With a reference to experience and the principle of saturation, Green and Thorogood (2013) maintain that new ideas are often difficult to come by after analysing the transcripts of 20 interviewees. Based on the various suggestions and the nature of the key research question in this thesis, 18 elderly Yoruba people (male and female) from the three age categories were interviewed. Similar interviews were held with 12 healthcare practitioners from the biomedicine and traditional medical systems.

The sampling frame for the biomedical health providers consists of general practitioners, specialists, and nurses who provide services at the primary level to all social categories of adults at public and private hospitals within the two LGAs. Similarly, the sampling frame for traditional health care providers includes all general traditional medical practitioners, herbalists, herb sellers, and faith healers/spiritualists in the study locations. From both sets of primary health care providers, 12 participants were targeted for voluntary participation in face-to-face interviews.

Community entry and rapport development

A gradual selection approach was also adopted to gain entrance into the community and develop a good rapport with the research participants. Effective community entry strategy and rapport developments are crucial to high response rate, voluntary participation, and generation of valid data (Harrington, 2003; Suzuki, Ahluwalia, Arora, & Mattis, 2007). Thus, conscious efforts were made to ensure a smooth community entry and cooperation of potential participants.

After the initial identification of the study locations, contacts were made with the community mobilisation officers in the two LGAs. After that, the mobilisation officers then provided links to the community leaders. At this point, contacts were restricted to the communities that fall within the purposively selected EAs, and only the Inner Core residential areas of the selected communities were targeted. The community leaders acted as gatekeepers and facilitated the recruitment of participants for the FGDs. All the community leaders were briefed on the research aims and objectives. They were briefed on their rights to voluntary participation and withdrawal from the research. They were also encouraged to ask questions concerning the research.

The inclusion criteria for the research were also provided and the rationale was explained. In each of the study locations, two community leaders were selected. Each community leader, a male and a female, assisted in recruiting participants of their gender. Each community leader was assisted by a fieldworker in the recruitment of potential FGD participant. The involvement of community leaders in the recruitment of participants contributed to the response rate (see Section 5) that was achieved at the three stages of data collection.

Data collection techniques

Vignette and Focus Group Discussion

As an exploratory sequential mixed-method study, the initial qualitative data generation started with a vignette-based focus group discussion. The use of FGDs has a long history in social research. The technique has produced useful insights into group dynamics in diverse social phenomena. In health research, the use of FGDs has contributed to understanding help-seeking behaviours and how cultural context influence pathways and decision-making (Pearson & Makadzange, 2008; Wong, Awang, & Jani, 2012).

In this research, the qualitative vignette was used to facilitate the FGDs. A vignette is a technique that is adaptable for quantitative (Mojtabai, 2016), qualitative (Jackson, Harrison, Swinburn, & Lawrence, 2015), and mixed-method studies (Anderson-Lister & Treharne, 2014). Vignettes are brief descriptions of persons or social situations, which contain a particular reference to what is thought to be the most influential factors in the decision-making or judgment making of participants (Alexander & Becker, 1978; Jenkins, Bloor, Fischer, Berney, & Neale, 2010). With vignettes, study participants can express their ideas without much fear of divulging personal information to the interviewer or other participants (Hughes & Huby, 2004; Schoenberg & Ravdal, 2000).

In FGDs, the use of vignette provides a context with which participants can relate (Hughes & Huby, 2004). When developed with relevance to the context, vignettes also help in reducing the vulnerability of research participants (Bradbury-Jones, Taylor, & Herber, 2014). As such, vignettes are useful in exploring and stimulating discussions around sensitive issues within context.

In this thesis, the suitability of a qualitative vignette for this research was informed by the nature of the research questions, theoretical and methodological assumptions, cultural and practical considerations, and the study population. Furthermore, based on the literature and my familiarity with the Yoruba culture, six interrelated reasons also provided additional impetus to use a qualitative vignette in structuring and facilitating the FGDs. Thus, the reasons are itemised and explained briefly.

Sensitivity and societal dispositions to public discussion and conversation around sexuality and the elderly **-** Based on cultural values and practices, sexuality, remains sensitive and affects individuals and societal dispositions to public discussion and conversation around sexuality and the elderly. Conversations about sexuality among the Yoruba people are often shrouded in implicit or coded languages that are understood within contexts. Words like *ibalopo(penetrative vaginal sex), ferre awesu(a metaphor that describes heterosexual intercourse), wiwa moo(the missionary style of heterosexual intercourse), bii bara see(sexual intimacy and intercourse), ibasun(a social description that connotes sexual intercourse), mole gun oke mole soo(a social description on penetrative vaginal sex),* a*dunmadeke(a metaphoric description of the pleasures in sexual activities), adun ma le fi fun omo je(the pleasures in sexual intercourse that is not sharable), nti baba nje ti o le fun omo e je(a social description of sexual pleasures and incest as a taboo),* amongst other words are common examples. The list is not exhaustive; however, these are the preferred descriptors for public conversations and peer discussions around sexuality and sexual activities.

Interviewing an elderly Yoruba man or woman and the belief in gerontocracy - the cultural practice and expectations around submissiveness discourages questioning and interrogation of the elderly and more so about private issues like sexual orientation, identity and practices.

A Qualitative Vignette thus lends itself to indirect probe into private matters that are difficult to introduce in a public conversation except among peers and folks.

Cultural exemplary and actual behaviours in old age **-** often variance exists between cultural expectations and actual practices in the everyday experiences of social actors and categories. It becomes useful to engage the research participants in a manner that would not present a probe into the variations between private and public compliance with normative sexual orientation and practices. Qualitative vignettes, therefore, promote a sense of security at the inception of a discussion and with time; it creates rapport as participants develop interests and positions around the topic under consideration (Jackson et al., 2015). Hence, the vignette in this study was developed to stimulate and activate spontaneous responses and beliefs around sexuality in old age.

As a sociological technique, the vignette has been used in diverse contexts with predominance in health-related studies (Jackson et al., 2015). Despite the increasing use of the vignette in social research, the procedure and steps taken in developing qualitative vignettes and the rationale for taking these measures are rarely stated nor detailed enough to replicate (Bradbury-Jones et al., 2014; Jackson et al., 2015). The absence of typologies and procedures for developing and validating vignettes may not imply a lack of growth, but could be a reflection of the variability in research questions and realities of interest. As such, I consider it useful to briefly share the procedure for constructing the vignettes with the FGD guide. In addition, I also present the steps taken to ensure internal validity and facilitation of the qualitative vignette in this research.

As an iterative process, the research questions and the literature guided the development of five interconnected themes for the FGD. The themes are: (a) Cultural understandings of being an older man or woman in Yoruba society. (b) Cultural values and sexual behaviours in old age. (c) Sexual pleasures, risk and health practices. (d) Help-seeking behaviour and sexual health. (e) Sexual health in old age: existing practices, a network of support, availability and quality of post-reproductive care services.

Realism in the Development of the Vignettes

The process started with a focus on the literature on sexuality in old age (Gott, 2001; Gott, 2004; Gott & Hinchliff, 2003; Gutsa, 2011; Lusti-Narasimhan & Beard, 2013; Moore, 2010; Van Der Geest, 2001), and narrowed down to the Yoruba culture (Agunbiade, 2013; Agunbiade & Titilayo, 2012; Agunbiade et al., 2011). Two vignette stories were constructed based on insights from the literature, personal observations, and experiences from diverse sources. The constructed vignettes were then structured and presented based on the specific research objectives of this study. The intention was to stimulate a culturally acceptable discussion on old age, sexuality, and help-seeking behaviour among the participants.

The two vignettes provided specific information on sociocultural beliefs and expectations in old age. Specific information about sexual practices and intimate heterosexual relations were built into the vignettes. It was presumed that a high proportion of the elderly in the study (60+) settings would have had at least an intimate relationship throughout their life course. With this background, the vignettes were couched with information around expected and actual sexual beliefs and practices in old age. Additional issues around help-seeking within and outside the medical systems (biomedical and traditional) were also explored. Lastly, the

vignettes also stimulated discussions around availability, types and quality of support within and outside the two medical systems.

To capture the reality of sexuality and help-seeking in old age, the hypothetical depiction of heterosexual relations was built and suited in polygynous marital relations for men, and monogamous marriage for women. Also, engagement in extramarital relations, which also falls in the domain of everyday intimate relations, was added to the story. Two pseudonyms, Yoruba names, were adopted in drawing the story closer to the participants. Before the pre-test, two common names, which include Baba Segun and Iya Bola, were adopted for the characters in the vignettes. During the pre-test, a participant was Baba Segun, which generated a shift of focus on him when the male character in the vignette was presented. It became necessary to replace these names *(oruko oriki*) with names that are classified as praise-names or cognomen (*oruko abiso*) in the Yoruba culture (Fasiku, 2006; Orie, 2002). This explains the replacement of the characters with the names: Baba Alamu and Iya Asake. Among the Yoruba people, praise-names are attributes given to an individual for the purpose of exhausting good virtues. They also serve as a biographical reference to ancestral achievements or history. Sometimes such names may be adopted by individuals for personal reasons.

Each theme formed a phase in the possible sequence of everyday events around the two characters (*Baba Alamu and Iya Asake*) [See Appendix B]. These efforts provided a comfortable platform for the participants to flow with the discussions around sexuality, old age, help-seeking, and health outcomes. The use of praise-names could have provided a welcoming situation for the FGD participants to discuss the sexual behaviours and practices of the vignette characters (*Baba Alamu and Iya Asake*). Through this process, the participants

had opportunities to react and relate to the sexual orientation and practices of the vignette characters and position their views.

The first theme dealt with issues around what makes an elderly an exemplar in their communities. What forms of behaviours, practices, and relations fall within this axis? Exemplary expectations in intimate relationships, heterosexual relations, tensions and resolutions approach. The theme provided rich insights as participants described cultural expectations, personal confrontations, and experiences with their cultural framework. Sequencing of the vignettes around themes provided the leverage to sustain the tempo around issues that relate to the research questions and the specific objectives. It also ensures a focus on an aspect of the story per time without losing the connection with the whole story.

Face validity of the vignettes

A peer review of the FGD-based vignette guide was carried out among 10 experts (*Anthropologists, Nursing Science, Health Promotion, Health Communication and Sociology*) for internal validity. The process produced a 60 percent response rate, as six out of the ten experts returned the FGD guide with comments. The feedback provided more insights into the choice of words, comprehension, and timing issues. In response, two themes were deleted alongside with some questions.

As laid out in figure 8, the procedure was repeated among the six experts who returned their comments. At this phase, only one among the six experts did not return comments. The aftermath was a reduction in the initial themes from seven to five themes. A revised version was then shared with my thesis supervisor, corrected and pre-tested. The pre-test yielded additional information and a slight adjustment to three questions from two of the themes (one & three). After that, a further revised guide was given to two experts in Yoruba and English

languages to conduct a back-to-translation. Areas of divergence between the two language experts were smoothed out before adopting the guide for the fieldwork.

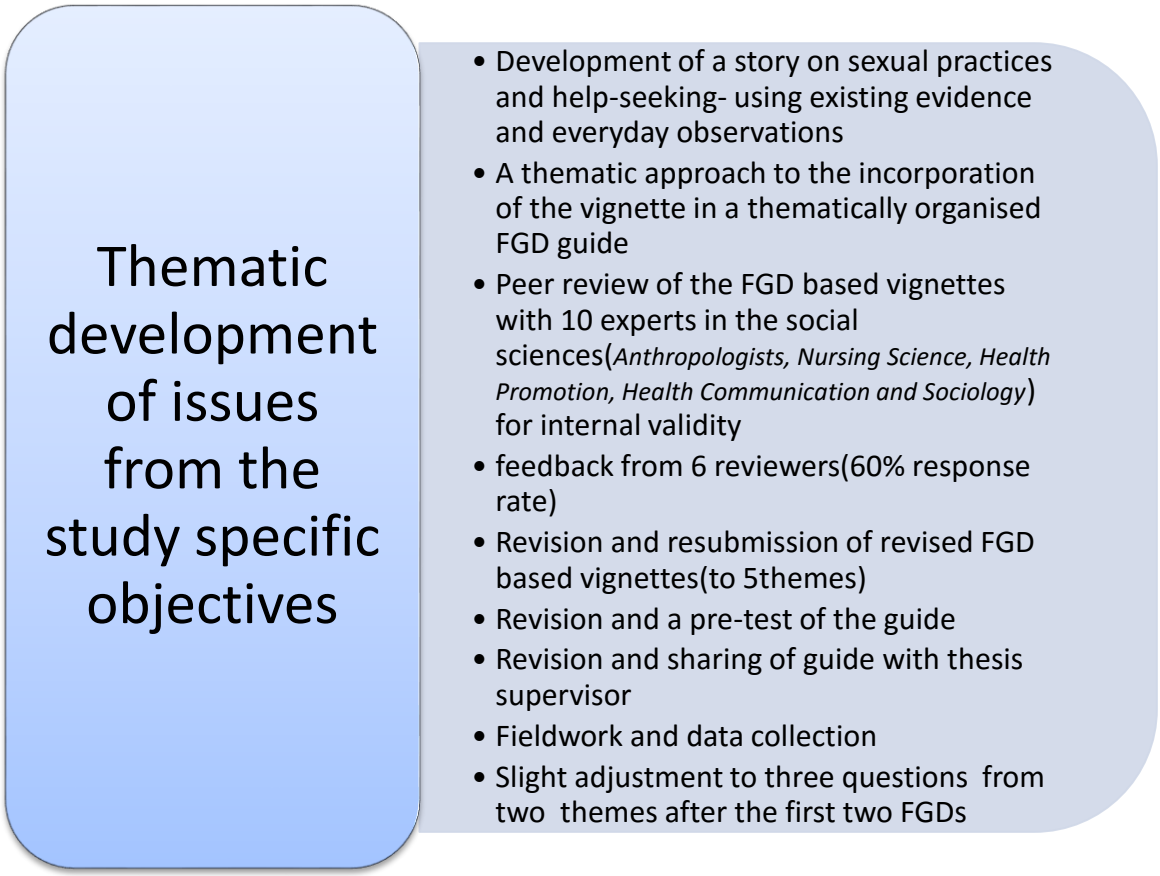


Figure 8: Development and face validation of the vignettes

Facilitation of the vignette-based FGDs

A split approach was used in presenting the vignettes and facilitate the FGDs. Qualitative vignettes can be presented as a single story or multiple stories to research participants (Jackson et al., 2015; Jenkins et al., 2010). For this study, a single story that varied by gender and cultural practices was presented in a sequence in relation to the five themes. The story was divided into short prompts and applied to each of the themes in a meaningful way to facilitate the focus group discussion. Each theme has a series of probes and clarifying questions to avoid erroneous interpretations and complex meanings (Rubin & Rubin, 2011).

The use of probes provided an opportunity to clarify complex meanings, and to make sense of individual and group interpretations that could emerge in response to the vignettes. See Appendices B and C for the sectionalisation of the vignettes as used in the FGD and the Yoruba and English Language versions of the guide.

As an interpretive constructionist focused thesis, it was considered useful to split the vignettes around themes to facilitate the focus group discussions. The sectionalised approach in presenting the vignettes in the FGDs was a slight departure from the literature. Alternative approaches are possible (Bradbury-Jones et al., 2014; Jackson et al., 2015; Jenkins et al., 2010); nevertheless, the split presentation of the story in relation to each theme produced insights and nuances around cultural interpretations and reconstructions of sexuality, old age, and help seeking among the participants.

The FGD fieldwork was conducted in June 2014, and it lasted for three weeks. Two FGDs were organised by gender and age (60-69 years, 70-79 years, and 80 years above) in each of the six selected communities. Each FGD was conducted at an agreed-upon time and location as suggested by the research participants. All the FGDs were conducted in the Yoruba language as preferred by the participants.

Four research assistants (males and females) were recruited, and they were briefed on the study aims and objectives and trained with the FGD guide. The training of the research assistance was facilitated through role plays in repeated sessions. Each research assistant had the opportunity to role play with both versions of the FGD guide. The four fieldworkers were experienced and had engaged in surveys and qualitative research in the Ibadan, Oyo State. To

minimise the gender bias of interviewers, Russell (2007) suggests similarities between the gender and age of the interviewer and the interviewee. The youngest among the

was a female aged 49, and the oldest a male 68 years of age. Given the sensitivity of the topic of interest and cultural emphasis on age within the study setting, I acted as a note-taker only in the male groups with little interference in moderating the discussions where necessary.

Across the three age categories, 107 elderly Yoruba men and women featured in the FGDs. In consonance with the literature (Krueger & Casey, 2009), an average of nine males participated in the six FGDs held with elderly men while an average of eight participants featured in the six FGDs with women.

Table 1: FGD Groups by Communities and some selected information on participants and Duration

Selected communities						
	60-69years		**70-79years**		**80 years and above**	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Bodija						
No. of Participants	10	8				
Average age of participants	65.7yrs	63.75yrs				
Duration	85mins	100mins				
Inalende						
No. of Participants					11	6
Average age of participants					82.7yrs	83.3yrs
Duration					125mins	100mins
Kobiowu						
No. of Participants			6	10		
Average age of participants			76.1yrs	74.9yrs		
Duration			75mins	100mins		
Odo Oba						
No. of Participants	9	10				
Average age of participants	66yrs	63.4yrs				
Duration	65mins	101mins				
Oniyere						
No. of Participants					9	10
Average age of participants					81.2yrs	84yrs
Duration					120mins	57mins
Sango						
No. of Participants			7	7		
Average age of participants			74yrs	71.9yrs		
Duration			84mins	93mins		

All the FGDs sessions were audio-taped with the consent of all the participants. The least FGD session lasted for 57 minutes (FGD with women aged 80 years and above). The longest one was 125 minutes (FGD with men at Inalende). On the average, the FGD session lasted for 92.1 minutes (One hour, 33 minutes).

Analytical aim of the qualitative data

The overall analysis aim of the thesis was to gain an interpretative constructionist insights into the intersections between ageing and sexuality among elderly Yoruba men and women. Biggs, Lowenstein, and Hendricks (2003) maintain that a focus on how old and older people construct their ageing experiences and life outcomes within cultural frameworks is lacking in the literature. Nonetheless, the views and lived experiences of elderly people are crucial to the development of social gerontology as a vibrant critical discipline and research field (Stephens, Breheny, & Mansvelt, 2015). Furthermore, ageing process and the lived experiences of elderly people are fluid and suited within cultural and historical context. Therefore, a subjective and constructivist perspective allows us to situate what ageing experiences and related outcomes imply within a particular context (Schoenberg & Rowles, 2002). With respect to sexuality, this approach, can therefore, account for the everyday contestations and tensions associated with ageing and sexuality within cultural contexts (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015; Moore, 2010). The analysis was therefore aimed at achieving an interpretative constructivist understanding of ageing, sexuality, and help-seeking.

To realise this aim, I focused on both individuals and focus group members as the units of analysis. By taking this stance, it becomes feasible to expand the data and account for divergent and convergent positions and interpretations among the research participants (Onwuegbuzie et al., 2009). I then approached the focus group and interview data using both discourse and constant comparison frameworks.

At the centre of discourse analysis is a focus on everyday conversations amongst research participants, their network of social relations and how social actors make sense of their

realities (Onwuegbuzie et al., 2009). In practice, discourse analysis involves a purposive selection of segments of a conversation and then analyse the chuck of selected lines within a given context (Onwuegbuzie et al., 2009).

Discourse analysis has its roots in social psychology, and with over a decade history of influence in qualitative research. Discourse analysis provides insights into an actor's interpretations and the 'discursive interactions' among focus group participants. On the other hand, constant comparison, therefore, opens up the possibility to gain convergent and divergent understanding of the data and ensure data saturation across and within groups (Onwuegbuzie et al., 2009). As argued by Leech and Onwuegbuzie (2008), the constant comparison method applies to an array of qualitative techniques, the focus group data inclusive. As an analytical approach, the technique of constant comparison as developed by (Strauss & Corbin, 1998; Walker & Myrick, 2006) drives the iterative process for deeper insights into the data.

To use the discourse and constant comparison approach, the 12 vignette-based FGDs were transcribed first in the 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. I proceed with the analysis by focusing on the words and phrases used by the FGD participants and individuls within the groups. At this stage, the words and phrases provided a frame to understand the different positioning that emerged in relation to the vignettes that guided the discussion in the FGDs. These steps helped to ensure a representation of the participants' views in the development of codes.

After this initial stage, I took additional steps to code and recode following suggestions from the literature, (DeCuir-Gunby, Marshall, & McCulloch, 2011; Fereday & Muir-Cochrane, 2008; Onwuegbuzie et al., 2009). Some of these steps were also repeated in making sense of the interviews. A step-by-step presentation is depicted in figure 5 (Procedures and steps in analysing the Focus Group Data).

Procedures and steps in analysing the Focus Group Data

Step 1: Construction of a code manual

From a deductive position, a code manual was developed with cues from the literature and the thesis research questions. Similarly, an inductive approach to codes' construction can also be employed in a single research project. The development of codes is a significant step in setting a framework for a logical and focused analysis of data (DeCuir-Gunby et al., 2011). In qualitative research, codes help in assigning meanings and interpretations to units of information (Saldaña, 2012) [e.g., transcripts of a focus group discussion or interviews], collected in a research project.

Step 2: Face validity and testing of codes

The development of a framework of analysis is crucial in several ways to the generation of relevant and logical analysis of qualitative data. As stated earlier, multiple steps were taken in developing theoretical codes from the literature and the thesis research question. The process was iterative and subjected to a review by a panel of experts as illustrated in figure 4 (*Development and face validation of the vignettes*). The results were compared and areas of divergence were reconciled. After these steps, all the deductive codes were also shared with my thesis supervisor for consideration. The rationale was to depict meaningful categories that capture what research participants could relate with ease (Saldaña, 2012).

Step 3: Summarising data and identifying initial themes

All the focus group transcripts were edited and exported into Nvivo 10 for data management and coding. Through the Nvivo 10 environment, I approached the coding of the focus group data using both open and axial coding. The first stage involves the use of open coding in reducing transcripts into a manageable size. First, the full transcripts of four FGDs (two from the male (60-69 and 80years and above) and (two from the female (60-69years and 70-79years) was read several times, to obtain a sense of the whole. Phrases and sentences of the group members were focused on as the unit of analysis. Through this approach, initial themes were identified and guided the reading and coding of the remaining (8) focus group transcripts. At this level, a descriptor was attached to each unit. The next stage was axial coding, which involves grouping and classification of the codes into meaningful categories. Through this procedure, additional themes emerged. All the initial themes were modified along the line and adopted in making a summary of the data (Saldaña, 2012).

Step 4: Applying the template of codes and additional coding

From the template of deductively created codes, the themes that emerged from Stage 3 of the analysis procedure were compared for merging and adjustment on the Nvivo Windows 10 platform. At this level, the codes that were theoretically developed were further synthesised and constructed as modified nodes in the Nvivo 10 internal environment. The transcripts were thoroughly read with a focus on segments of the texts that matched the identified nodes (codes) (Saldaña, 2012). The procedure was repeated across all the transcripts, and a few segments of the data describing new themes were added (Boyatzis, 1998). At the next stage, all similar codes were grouped into categories to form emergent themes that represent consensus positions among the participants.

Step 5: Linking the codes and making sense of the themes

At this level, the discourse approach helped to locate individual and marginal positions in relation to the themes and sub-themes. The constant comparison strategy then helped to identify areas of divergence and convergence within and across the various focus groups. Through this process of comparison, it was possible to link the codes/nodes, create clusters and situate the themes and sub-themes within context.

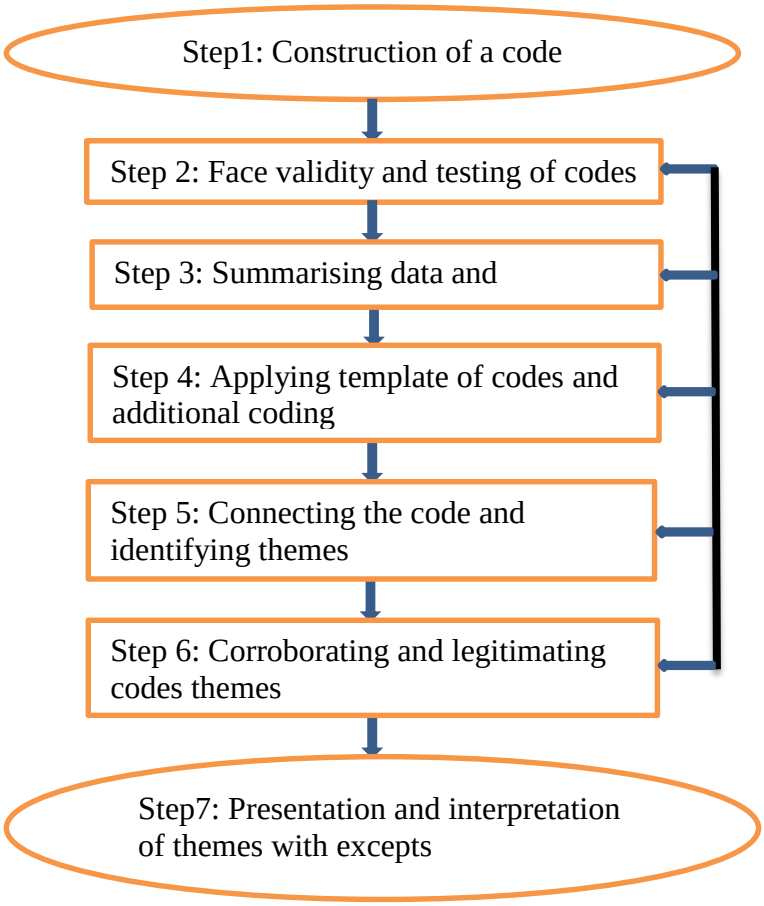


Figure 9: Procedures and steps in analysing the Focus Group Data (Source:Fereday & Muir-Cochrane, 2008).

Step 6: Situating and legitimating coded themes

At this stage, the findings were situated within the study context as identified from the coded text. Through this process, it was possible to make reference to the various phrases and sentences of the individual participants and the groups in forming consensus and marginal

positions. Thus, this requires a revisit to the previous stages of the analysis procedure. As a way of confirming and contextualising the themes, excerpts of individual participants were used to support the summary and interpretations of the various themes and sub-themes.

Furthermore, efforts were made to share a thematic summary with a group of the focus group participants. In qualitative studies, trustworthiness or legitimation are different terms used in assessing reliability and validity in qualitative research (Onwuegbuzie et al., 2009; Smith, Larkin, & Flowers, 2009). In this thesis research, the process of legitimation was iterative and interrelated. From the drafting of the interview schedule to the collection and analysis of the data, the socio-cultural milieu of the participants and the existing literature on ageing and sexuality were noted. Further checks on the validity of the qualitative data were ascertained through "member validation," a process through which participants are given the opportunity to challenge or deepen researchers' thematic representations (Smith, 1996).

In all the focus group sessions, an instant summary of the key positions that emerged from the discussion was carried out. Through this process, a few participants added and clarified some conflicting interpretations, particularly in respect to two proverbs: one on the saying around infidelity of *Ikire* women (a Yoruba town in Osun State) and individuation (*alatise lomo atise ara ree*) (See Section 5).

Step 7: Integration, interpretation and Presentation of themes with excerpts

At this stage, the rationale for employing a mixed method approach in this research was revisited. As stated earlier, the multidimensionality and differentiated gendered nature of ageing and sexuality demand multiple methodological orientations. Thus, with the adoption of sequential exploratory mixed method design, the aim was to understand the realities of sexuality, ageing, and help-seeking from different positions. To achieve this aim, similar themes and sub-themes that emerged from the focus group and individual interviews were revisited with a focus on consensus and marginal themes. Through this step, excerpts from the focus group and individual interviews were aligned with themes and sub-themes that expressed convergent and divergent positions. The seventh stage of the analysis also paved the way for the quantitative stage of the data collection and further analysis.

The Semi-structured Interview

The findings from the focus group data flagged the issues that were considered in the face-to-face interviews. The interviews were held with two categories of participants namely: elderly Yoruba men and women (60+) and healthcare practitioners from the two medical systems (biomedicine and traditional medicine).

The face-to-face interviews with the elderly men and women were focused on their embodied experiences within the contexts of ageing, sexuality and help-seeking. This was neccessitated by the fluidity in the reactions of the FGD participants to the vignettes. Insights into the excerpts and salient themes revealed a constant shift on how the focus group participants positioned old age, ageing experiences and bodily changes. At some point, old age was depicted as a distant reality when discussing certain aspects of their lives. At this level, the focus group participants acknowledged and associated bodily changes to calls for certain

restrictions. However, a differentiated account of bodily changes and ageing experiences including those related to sexuality and sexual practices was echoed in all the groups. Across the FGDs, the participants demonstrated diverse positions and contestations around societal expectations of exemplary and individual compliance or deviations in their sexualities. Thus, the need to probe the lived experiences of elderly men and women from an embodied perspective. It is possible to understand the reality of sexuality through different approaches. However, face-to-face interviews lend credence to an embodied and subjective understanding.

A focus on how the participants make sense of their bodily changes could help to gain insights into what constitutes sexuality and its performance. The body is not the only site for the performance of sexuality, but it represents a major site for an aspect of experiencing and demonstrating sexuality. A focus on subjectivities therefore provides depth and particularised insights the various sites of performance of sexuality from the actor's position within contexts. Notwithstanding, the dimensions of the various sites that influence the performance and experiences of sexuality are thus different across the life course. Thus, five thematic issues were covered in the interviews with the elderly men and women. The issues in these themes were approached differently from that of the focus group. As such, emphasis was on their perceptions of bodily changes, meanings, and interpretations associated with sexuality, sexual practices and help-seeking within a cultural context.

To understand the context and pathways to help-seeking, additional interviews were held with healthcare providers. The aim at this level was to assess the dispositions and views of healthcare providers on the importance of sexual health in old age. Focus was also on their awareness and views on existing sexual practices among elderly people. There was additional

effort to assess the availability of healthcare services to support post-reproductive sexual health needs within the two medical systems. It was also useful to examine their views on possible constraints around responsive care provision and help-seeking.

Pre-test and readjustments on the interview guide

With a thematically framed interview guide, it became necessary to pre-test and adjust the issues and questions. A face validity of the semi-structured guide was also done with three experts drawn from the list of experts who participated in the validation of the focus group guide. For the pre-test, four interviews were held with two elderly males (68 and 76-year-old) and another two females (61 and 80-year-old). One interview took place with a traditional healthcare practitioner aged 94 and a biomedical practitioner aged 56. The pre-tests were all conducted in Ile-Ife, an ancient Yoruba town. At each level of the pre-test, efforts were made to adjust the focus of a theme and some questions. Three out of the initial questions on the theme of sexual pleasures, risk, and health practices were reframed to stimulate discussion around others, before focusing on personal experiences.

A slight difference exists in the interview guides with traditional and biomedicine healthcare practitioners. The structuring of the questions differs and only four themes were focused on as against the five themes that guided the interviews with elderly men and women.

Recruitment of interviewees

The initial findings from the FGDs provided insights on the difficulties around recruiting elderly people for candid conversation around their sexuality without prior contact and good rapport. The recruitment of interviewees was through interpersonal contacts and referrals. Research participants can be recruited through interpersonal networks. The strategy involves

creating a pool of potential research participants through various social interactions. The approach has produced a high response rate and voluntary sharing of personal information in qualitative studies (Browne, 2005). The adoption of an interpersonal contacts approach facilitated rapport and confidence building. However, this was achieved because the research participants were not apprehensive to share personal experiences. Despite the richness of this strategy, it has the potential of recruiting participants with relatively homogenous characteristics that could result in some tilted findings.

With an initial interaction with the focus group participants, it became easier to recruit some of the willing participants for face-to-face interviews. At the end of each FGD, all participants were informed of the interviews that would be conducted at a later date. Not all the FGD participants were approached at this point for a possible involvement in the face-to-face semi-structured interviews. Only participants who expressed some interesting views were approached. By interesting view, I mean whether the expressed opinion was popular or unpopular with respect to sexuality of the elderly people. These two categories of participants were recruited to avoid a skewed representation of views and experiences on sexual behaviour in old age. To increase the inclusion of participants outside the FGD fold, conscious efforts were made to collect the contacts of 12 participants (two from each focus group) to participate in a face-to-face interview.

Consequently, I was able to secure the participation of a diversified category of participants. From a theoretical and data saturation point of view, 18 elderly men and women within the three age categories were targeted. Within this group, five of them were traditional healthcare practitioners and the remaining seven (five males and two females) were participants that shared their sexual experiences during the FGDs. The first sets of participants were followed-

up and approached for face-to-face interviews. Through a convenience sampling, 11 additional elderly participants were recruited from the study locations for interviews. In total, 18 semi-structured interviews were conducted among elderly men and women (60+).

All the five traditional healthcare providers were also interviewed. However, the recruitment of biomedicine healthcare providers was through referrals and information provided by the FGD participants. Four of the healthcare practitioners from the biomedical system were recruited from the Geriatrics Unit of the University College Hospital. The two patent medicine vendors were recruited from two of the communities. The only general physician that was interviewed was attached to the primary health centre at Ibadan Southeast LGA. A total of seven biomedical practitioners were interviewed.

Conducting the interviews

The interviews were conducted in the months of September and October 2014. The 18 interviews with elderly men and women (60+) were conducted in the Yoruba language at locations preferred by the participants. All the interviews were conducted at the participants' homes and efforts were made to minimise interference from partners or relatives. In all the 18 interviews, a minimal interference was witnessed in one of the interviews as a grandchild (about four years old) that lives with the elderly man kept interrupting the session before he was taken aside by a relative. Nevertheless, all the interviews were conducted privately, including the sessions with participants that were still married.

The five interviews with the traditional health care providers also took place in their residence. Only the herb seller was interviewed at her place of business (shop). As preferred, the two patent medicine vendors were interviewed on Sunday evening as this was their period

of leisure or rest. Similarly, the nurses (two) and physicians (three) were interviewed at the place of work. Prior arrangements were made to interview this set of health care providers after their close of shifts. As such, there were repeated visits and re-scheduling of appointments on three occasions.

With the consent of the interviewees, all the discussions were audio-taped. The interviews with elderly males and females were conducted by the male and female research assistant respectively. I acted as an observer in three of the interviews with the elderly males and repeated the same with the elderly females. The decision to act this way emerged from suggestions from the literature on the possible influence of gender and age on interviews with elderly people(Arber et al., 2007). As a sensitive cultural issue, conversation with elderly people on their sexuality can take place when done with peers or those with closer social status. My experience from the pre-field visits confirm the possible power differentials that exists between a researcher and a participant. The power inequalities manifested in several ways. First, some of the participants have participated in some research activities before now. Being a young male, I was perceived as a learner that needs to avoid the errors of the older males. Instance such as marital infidelity and the dangers in polygynous marriages were used as sermons by the female participants. Among the males, I had a different experience as some of the participants eulogised the benefits of having more than a wife and the personal satisfactions of remaining sexually active in old age. The pre-field experiences, my awareness of the Yoruba cultural expectations and suggestions from the literature (Arber et al., 2007) thus influenced my position in delegating the facilitation of the FGDs and the face-face interviews to trained research assistants that were in their 50s.

However, I conducted all the interviews with biomedical practitioners and acted as a note-taker in all the interviews with the traditional health care providers. On average, the interviews with the elderly men and women lasted for (40.6mins), with traditional health care providers (57mins), biomedical health caregivers (64), and patent medicine vendors (36mins). The two longest times spent in the interviews were with a male traditional health care provider (86mins) and a male medical doctor (80mins) at the primary health centre.

Debriefing

Analysis of the interviews

All the audio-recorded interviews were transcribed and coded. However, the interviews with elderly men and women and those with the traditional health care providers were transcribed first in the Yoruba language and translated back-to-back from the English language by two experts in both languages. The analysis of the interviews also followed the steps and procedures undertaken in the analysis of the focus group data. However, the three steps were slightly modified as the interview guide was developed from the focus group findings. Nevertheless, efforts were made to ensure that the themes and excerpts used are linked directly to the interviewees' positions.

The Quantitative Strand

Sampling Procedure

The goal in the quantitative stage was to examine some of the views and expectations around sexuality, ageing, and help-seeking among a larger proportion of elderly Yoruba people (60+). In the quantitative phase, a clustered purposive sampling approach was used. Again, the sampling frame was again restricted to elderly Yoruba people (60-69 years, 70-79 years,

80+) who meet the research inclusion criteria. In addition, the sampling unit was also limited to the EAs that fall within the high density populated areas. In the high density areas, all the EAs were identified and then house listings and households were conducted. Only households with an elderly person aged 60 years and above where listed. On average, an EA in each of the six communities had an average of 115 households with at least an elderly person aged 60 years. In line with previous surveys among elderly people in Ibadan Nigeria (Gureje, Kola, Afolabi, & Olley, 2008; King & Olaseha, 2012), a target of 300 Yoruba elderly people (60-80 years+) was desirable to ensure a relatively heterogeneous selection of respondents targeted in the study locations. At this point, the aim was to select a proportionate sample of 50 elderly people from all the EAs in each of the six communities. In sum, 50 respondents from each of the six communities yielded a sample size above the desired number, but it also increased the response rate.

At the point of enlisting the respondents, only one elderly person was selected per household. Historical events were also used to ascertain the age of respondents who had difficulty in remembering their age. Out of the 300 interviews administered, the quantitative analysis was based on 252 valid questionnaires. This represents a response rate of 84 percent. The fourteen percent non-response rate was due to incomplete provision of basic socio-demographic information (5%) and a few missing questions (9%). Explanations on the respondents with missing information and incomplete questionnaires were provided during the debriefing session after retiring the filled questionnaire from the research assistants.

Data collection and the research instrument

The survey was conducted between February and March 2015. An interviewer-administered structured questionnaire was used. The fieldwork was conducted with support from the four research assistants who participated in the qualitative phase. All the four research assistants were again trained with the structured questionnaire. They engaged in role play on repeated occasions with the structured questionnaire.

The questionnaire was designed in a Likert scale consisting of 1 to 5 dimensions of "strongly agree" to "disagree strongly" (De Vaus, 2002). The 1 to 5 dimensioned scale was considered useful as it has the power to elicit responses that are not at the margin (Revilla, Saris, & Krosnick, 2014). Despite the limitations around Likert scales with agree and disagree responses, it was found helpful in translating to Yoruba language and also suitable for coding and categorisation in making the results meaningful (Liu, Lee, & Conrad, 2015).

The structured questionnaire was shared among five experts for content validity. Through this process, some of the wordings were reframed for clarity. A pre-test of the Yoruba and English versions of the questionnaire was conducted for reliability and validity. The pre-test was conducted in three purposively selected streets in Ile-Ife among 50 elderly people (60+). Respondents with similar characteristics with the study population will be selected from areas outside the study sites. The steps helped in checking whether the questionnaire was understandable and pragmatic. Consistency in responses on the item-by-item basis will assist in checking the overall reliability of the scale. Since the size of alpha is affected by the reliability of individual items, all unreliable items were dropped after the pre-test. Based on the feedback, a further modification of the instrument was carried as two sections were merged and a few questions were deleted. In addition to socio-demographic of the

respondents, the three thematic issues covered include sexual desires and expressions in old age, help-seeking for sexual problems in old age, and support for sexual pleasures and problems in old age.

A *Cronbach's alpha coefficient* was also conducted through a correlation test. The *Cronbach's alpha coefficient* ranges between 0 and 1. A high value of about 0.7 indicates a valid scale (De Vaus, 2002, p. 184). A *Cronbach's alpha coefficient* value of 0.81 was recorded. Since the size of alpha is affected by the reliability of individual items, all unreliable items were dropped after the pre-test. Two selected bilingual experts conducted a back-to-back iterative translation of the questionnaire from English to the Yoruba Language.

Quantitative Data Analysis and Variable Measurement

The quantitative data was managed using the IBM Statistical Package for Social Scientist version 20. Based on the qualitative findings the three thematic issues were examined further in the quantitative phase. These include views around sexual desires and expressions in old age, help seeking for sexual problems in old age, and support for sexual pleasures and problems in old age. On a Likert scale (1-5), respondents were asked to score their level of agreement or disagreement with statements that were constructed from the qualitative findings.

In taking the analysis further, focus was placed on five interrelated themes. These include (a) sexual desires and expressions in old age; (b) normative and stereotypical views associated with sexuality; (c) resolution of sexual health challenges and promotion; (d) perceived barriers associated with seeking help to resolve a challenge or enhance performance; and (e) the use of condoms as a preventive measure. The aim here was to understand the

commonality and wide spread nature of the convergent and divergent views that emerged from the qualitative findings around these issues. In each of the five themes, weights were assigned to selected items and further computations were carried out. A simple frequency was done first and subsequently, a descriptive statistic was computed to determine a level of association among the variables of interest. At each point of the data presentation and analysis, relevant quantitative results were used to complement the qualitative findings.

Positionality and Self-Reflection on the findings

The network of support that facilitated the negotiation of access to the elderly people might not be easily available to an outsider. The same could also be said of the interpretations that I deduced from the qualitative data.An outsider might find some of the views difficult to understand or out of relevance. Being an inisder also does not symbolise that I had a superior understanding of the terrain or the responses of the participants without questionning. By an insider, I mean my understanding of the Yoruba language, my long stay among the Yoruba people, my marriage to a Yoruba woman and the close affinity between my tribal group and the Yoruba culture. To ensure that the meanings and interpretations given by the participants are maintained, I made constant reference to the group by way of sending a note across to the moderator for further probes around certain issues. In addition, there were probes in all the themes and sub-themes to ensure that clarity of expressed views was assertained and not just the assumption that being an insider I understand the worldview of the participants. Despite these caveats, being an insider and with over a decade living and interacting with the Yoruba people and culture, I found it less difficult to position and contextualise the varied gendered reactions to the vignette characters that were presented during the focus group sessions.

As a heterosexually married postgraduate male in his late 30s and with my Christian beliefs, I was also mindful of the difficulties in engaging the elderly in public conversations around their sexualities. I was also careful to yield to the suggestions around the possible influence of gender and age of the researcher on qualitative gerontological findings (Arber et al., 2007; Freeman & Coast, 2014; Gott, 2004). Partly, the construction of the vignette stories provided some leverage in setting the stage for candid conversations. Having done a pre-test of the vignettes and evidence from the literature, I was able to engage the elderly participants in a frank conversation around their sexualities and that of others. The vignettes proofed fruitful in several ways. First, conversation around the sexuality of others was warmly accepted as the participants navigated normative contestations around sexualities in old age. were constructed and relayed to stimulate the group discussion around others. Secondly, through the use of the vignettes, the sensitivity and possible difficulties around discussing personal sexual experiences was gradually eased as the participants shared personal experiences without fear. On the overall, the voluntary sharing of personal information was noticed more among the males than the females. Only a few female vulunteered personal information in three of the FGDs.

Nevertheless, the sensitivity and contradictions that may trail focused conversations on sexuality in a patriachal society was conspicuous in the various groups. This could be observed in the initial reactions to sexual behaviours of the vignette characters. From a gendered position, the majority of the male participants framed and rationalised risky sexual practices among men in old age. As earlier mentioned, the shift in positioning and reactions was gradual. It did not emerge at the beginning of the vignette focus discussion. It came up much later as the conversation became more stimulating around everyday happenings. At the start, the majority of the male (32) and female (43) FGD participants framed and reacted to

the sexual behaviours of the vignette characters (Baba Alamu and Iya Asake) from a normative position of moral correctness and gendered stereotypes. Nevertheless, this was short lived as the male participants in particular vied to disclose their personal sexual escapades in relation to their marital experiences and that of others.

Unequal power relations have critical influence on qualitative findings. To minimise a possible influence of my position as a young researcher, I approached the participants from a passive position. As stated in the sections on the conduct of the FGDs and interviews, I engaged four field research assistants that are experienced with qualitative research. The four research assistants were trained with the research instruments and participated in role plays before the actual field work. Despite the use of field assistants, I was aware of the need for me to have the experience in addition to my previous experiences as an upcoming research. In this sense, I again took a passive but useful position in facilitating the FGDs. In each of the FGDs with the males, I was reintroduced by the moderator as a doctoral student. To an extent, my physical presence as a student researcher, but playing a passive role, perhaps reflected in the enthusiasm of the participants in the male FGD participants. For the FGDs with females, I could not register my presence from the start to the end of each session. I was able to spend an average of 10 minutes in each of the six sessions. The decision to spend an average of 10 minutes was to avoid a possible influence of my gender as a male on their conversation. As stated earlier, my pre-field experience revealed some marital dissatisfactions among some elderly females. During the discussions, some of these female participants sermonised and cautioned me on the need to be faithful and supportive my wife till old age. Such preaching are with good intensions, nonetheless, my presence throughout the focused discussion might make their conversation judgemental. My premonition was confirmed as the majority of the participants shared judgemental views on the sexual behaviour of the

characters in the vignettes. Largely, my presence and declaration of my status as a learner was welcomed and symbolised as a platform for confidential conversation. For instance, in the f focus group discussion among the males, confessional narratives around personal experiences were divulged.

In the light of the above, I had a different experience in the FGDs with elderly women. In the pre-field FGDs with elderly women, I received sermons on being an exemplary male, the dangers of polygynous marriages and the need to support my parents especially in old age. At this point, my background from a polygynous home also helped in a way to resolve the contradictions in the views of some of the elderly women in relation to sexual suppression, asbtinence and disengagement in old age. From three of the interviews and two of the main FGDs (60-69 years), contradictory positions were shared as the participants expressed their decisions to engage or disengage from sexual activities on quality of marital relations. The type of marriage, especially polygynous marriage and the perceptions that some husbands are habitually unfaithful to their marital vows provided such opportunities. Despite these challenges, being an insider and by adopting a mixed method design, I was able to situate the contradictions of individual characteristics, group and societal expectations in the varied dispositions and reactions that emerged in relation to ageing, sexuality, and help-seeking behaviours.

Ethical considerations

Ethical considerations are paramount to scientific investigation on sexuality in old age. Four major ethical issues arose from this research. These include securing informed consent, voluntary participation, confidentiality, protection from harm and respect for participants' views. These ethical issues cut across research among various social categories (Silverman,

2013). Timely resolution and effective management of ethical issues have important implications on overall participation and validity of the research findings.

Among the Yoruba people, the social value and reference to gerontocracy places the elderly in a social position that could make recruitment and voluntary participation in qualitative research somewhat challenging. With consciousness around the cultural value of gerontocracy, I approached the fieldwork from an interpretative constructivist perspective. This stance created opportunities for participatory involvement and sharing of experiences and expression of opinions without any fear or possible damage to the research participants. Ethically informed research recognises and accommodates the individual agency of research participants. In the study settings, social participation in community activities is perceived as a social responsibility. The community leaders that acted as gatekeepers and the research participants were all informed of the study aim and objectives. Questions were entertained and with clarifications provided on issues that were unclear. After this process only participants who had volunteered were recruited. As such, accounting for individual agency in relation to granting of informed consent was somewhat challenging. The point at which individual participants granted informed consent might be difficult to establish.

The situation could have been compounded by involving gatekeepers in identifying and listing of potential participants. Nevertheless, the use of gatekeepers produced high turn- out of participants without compromising the possibility of achieving informed consent. In this context, informed consent was attained through detailed verbal presentation of research aims and objectives at the point of enlisting potential participants and before the commencement of focus discussions and individual interviews. At each stage of the qualitative data collection,

the participants raised questions and sought clarifications around the essence of the research and their involvement. After detailed explanations, the majority of the participants appreciated the opportunity to share their experiences and opinions around sexuality in old age.

The adoption of a constructivist perspective and a participatory approach could have influenced the commendation by some of the participants. At one point, an 81 year-old male participant expressed disatisfaction in how the Nigerian government neglects the needs of elderly people. Although the research was not misconstrued for a government activity, the participant, like others, appreciated the use of vignettes in conniving sexuality among the elderly and therefore shared some personal experiences.

All the participants were able to grant their consent prior to and during the data collection. Close to one third of the participants granted a written informed consent, while the rest of the participants gave verbal consent. A written informed consent sheet (Appendix G) was provided throughout the data collection period. However, some of the partcipants described the emphaisis on written informed consent as demanding and unnecessary. To the participants and within the study settings, verbal audio recorded consent was an acceptable form of consenting within the study settings. These steps amongst other efforts enhanced the voluntary involvement of the participants and improved the informed consent process. It is worthy to note that the disposition towards written informed consent is not particular to this research. Similar observations have been reported within the Nigerian context (Jegede, 2009).

The social aversion around public discussion of sexuality in old age did not restrict the participants from sharing personal experiences and unpopular views on sexuality in old age.

Confidentiality of information provided was therefore reassured at all levels of the data collection. In the focus discussion, all the participants were discouraged from spreading private information given by some of the participants. In practice, this measure would be ineffective as some extroverts might find it difficult. However, participants' identity was concealed at transcription, analysis and presentation of the findings. The photographs at focus groups and individual interviews are transferred and passworded in a secured computer system. The dissemnination of the research findings also did not contain personal identifiers. However, for contextualisation, extracts from focus discussions are supported with names of the communities where the discussion was held. Extracts from individual interviews were also supported with information on age and marital status.

The protection of research participants against harm is a worthy ethical practice. Discussions and sharing of personal sexual experiences could trigger some discomforting feelings. Prior to the fieldwork, adequate arrangement was made with a psychologist and a Community Health Physician to handle such challenges (See Appendix F). Participants were informed of the availability of these free services and encouraged to disclose their need for such support at any point. Throughout the data collection periods, participants were informed of their right to participate voluntarily and as well withdraw from the study at any stage (Miller, Birch, Mauthner, & Jessop, 2012).

Consonant with good ethical practice in Nigeria (Jegede, 2009), and other African settings (Freeman, 2012; Kamuya et al., 2014), it is socially appreciated to accord elderly people respect and appreciation for sharing their views. Among the Yoruba people, such respect involves respectful conversation, greetings by postrating as a man and kneeling as a woman

(Fadipe, 1970). At the end of each FGD session, I postrate along with the two male research assistants to appreciate the male participants. The two female research assistants also kneel down to appreciate the female FGD participants. Similar gestures were repeated in all the individual interviews. In addition, small gifts, which consisted of plastic buckets, small face towels, laundry soaps and bottled water were presented as gifts to appreciate the participants. The gifts were given at the end of their participation. The gifts were well received, but no evidence that their participation was associated with the gifts.

Despite these challenges, it was less difficult to recruit, achieve consent and solicit voluntary participation and sharing of private information of widely acknowledged challenges with qualitative investigation of sexuality among elderly people. The participants in this research were able to consent and participate voluntarily without public discourse. As a sensitive issue, it is widely believed that voluntary participation in sexuality studies requires ethical considerations and approval. As such, I obtained local permission from the community leaders along with prior institutional ethical approvals from the Research Ethics Committees at the University of the Witwatersrand, South Africa and the Obafemi Awolowo University, Ile-Ife, Nigeria. As highlighted above, conscious steps were taken to adhere to the ethical guidelines as approved by the research ethics committee. Contingent solutions were also sought in resolving the consenting process without violating ethical principles of empirical investigation. I was attentive to the power relations in researching marginal groups like the elderly as highlighted in my reflections and position on the data collection process and research findings. Throughout the data collection process, good rapport was developed with the research participants, which could be observed in the richness of the transcripts and voluntary participation in the quantitative phase of the research.

Written informed consent was also obtained where possible while verbal consent was obtained from some of the participants who could not read nor write due to literacy problems. Information that could reveal participants' identities was avoided in both qualitative and quantitative stages of the data collection. An attempt was made to maintain confidentiality at all levels of the data collection and presentation of findings.

Part of the thesis findings have been presented at two international conferences. The first was at the 12th International Conference on Urban Health in Bangladesh. At this conference, the findings disseminated was centered on an assessment and contextualisation of constraints to responsive help-seeking and preparedness of the traditional and biomedical systems to sexual health needs in old age. The second presentation was entitled 'Risky sexual practices and prevention of sexually transmitted infections among urban Dwelling Elderly Yoruba people, Southwest Nigeria'. This second paper was presented at the 7th African Population Conference in South Africa. In previous and future presentations of the findings, personal information of the research participants and confidentiality of information given by the partipants will be ensured.

ANALYSIS OF FINDINGS

This chapter presents the empirical data generated by a sequential exploratory mixed-methods design. The key research question that guided the data generation and analysis in this thesis was:

> *What are the lay beliefs and practices associated with sexuality among elderly Yoruba people (60 years and above)?*

Sexuality and ageing are social realities that are interwoven with cultural beliefs and practices. As a structural framework, cultural beliefs and practices provide differentiated gendered privileges through which men and women express and engage their sexualities. These privileged positions produce forms of capital that reinforce unequal sexual engagements, pleasures, satisfactions and health outcomes for men and women across the life course (Freeman & Coast, 2014; Gott & Hinchliff, 2003). Despite this structural influence, individual social agencies are employed to various degrees in interrogating structural and other related constraints to promote sexual health or confront sexual health challenges. Thus, the subsidiary questions to the overarching question have also been explored further:

> *What are elderly people's sexual help-seeking patterns and practices? What is the context of involvement and what are the dispositions of professional health care providers within the modern and traditional medical systems with respect to providing quality care for sexual health challenges among the adults?*

In the first stage of this study, an exploratory mixed-methods design that consisted of focus group discussions with vignettes and semi-structured face-to-face interviews was used to answer these questions. The focus was on sexual desire, sexual expression, and normative

views concerning sexual practices in old age. The aim was to understand the influence of normative beliefs and practices on sexual practices in old age and their implications for help-seeking behaviour associated with sexual health and challenges in old age. The details on the empirical approach to data generation are in the preceding chapter. The findings are presented by focusing first on selected socioeconomic and demographic characteristics of the participants at the three stages of data generation. The socio-demographics of the participants also provided insights into the themes and the quantitative results that emerged.

The chapter adopted a thematic approach to presenting and analysing the qualitative and quantitative findings related to sexuality, ageing and help-seeking behaviours. The quantitative results were presented in a complementary manner, wherever possible, with the qualitative findings. At each point, emphasis was placed on convergent and divergent positions taken by the participants. This is in line with the mixed methodological orientation of the research and the nature of the research questions. The findings were analysed and contextualised using Bourdieu's theory of practice (Bourdieu, 1992; Webb et al., 2002) and social positioning theory. Additional analytical insights were taken from the aged-graded approach to sexuality and ageing (González, 2007), and the Yoruba notions of time (Ayoade, 1979), in relation to sexual behaviour. These theories and concepts provided a useful analytical lens for focusing on the complexities around developing storylines concerning sexuality and help-seeking in old age.

Profile of Focus Group Participants

Table 2 offers a summary of the socio-demographic characteristics of the FGD participants. One hundred and seven elderly Yoruba men and women aged 60 years and above participated in twelve age- and gender-based focus group discussions. On average, 9 males participated in the 6 FGDs held with elderly men, while an average of 8 females took part in the six FGDs with women. Across the three age categories and genders, two-thirds of the males were married. Similarly, close to two-thirds of the women across the three age groups were widowed, and only one-tenth of their male counterparts were widowers.

Polygynous marriage was predominant among the participants. Less than a quarter (23) of the participants was in monogamous marriage. A higher proportion of the participants were Muslims (71). Only 24 participants were Christians, and 3 were from the traditional Yoruba religion.

The high proportion of FGD participants with no formal education supports earlier findings that access to and level of formal education among elderly people in Nigeria remain low (Olayiwola & Ketiku, 2006). With the inclusion of the age limit of 60 years for this study, the latest year a participant could have been born at the inception of the fieldwork was 1954. In the colonial era, access to formal education was largely segregated and restricted to very few people. Owing to the many political and economic problems to cope with, issues around access to formal education at different levels emerged only later in the development agenda of the young Nigerian nation (Asiwaju, 1975). The implication is that a majority of Nigerians born within this period had less access to formal education. The youngest participant in this study was born 6 years before Nigeria's independence. With little access to formal education,

a high proportion of the participants (55) across the 3 age categories (60-69 years, 70-79 years, and 80 years and above) and genders went into subsistence trading.

Nevertheless, some of the participants with some form of formal education worked and retired from formal employment. Within this category of participants, more males (18) reported that they worked and retired from formal employment than females (2). With the low level of formal education, working in paid employment would mean working at a low level in an organisation. In Nigeria, the government remains the largest employer of labour, a situation similar to what is found in other African countries. The early independence period in Nigeria provided more opportunities for citizens with minimal educational backgrounds to work in government agencies. However, such individuals were restricted to jobs and responsibilities that required basic education.

Even 50 years after independence, social inequalities remain high, as educated younger generations remain unemployed. Industrial growth and development are still marginal, with a high level of corruption and systemic failures. All these factors affect the quality of life, as the challenges of ageing and survival increase daily (Cadmus et al., 2014; Togonu-Bickersteth & Akinyemi, 2014). Thus, growing old is becoming more challenging in Nigeria. The quality of support for the aged in Nigeria has grown worse, and the cost of living has risen over the years, especially for those dwelling in urban areas (Adeniyi-Ogunyankin, 2012).

As pointed out in the literature review, the high cost of living and low standard of life are common characteristics of urban life in Nigeria. Surviving the hardships of urban life thus requires urban dwellers to search for different alternatives to earn a living. The situation is

worrisome for vulnerable groups, like the elderly, who have struggled through the years to make a living but are left without enough savings or investment to provide a reliable source of income in old age. To date, Nigeria lacks a social security policy that addresses the health and financial needs of the growing population of the aged. As such, many old and elderly people have had to fend for themselves (Adeniyi-Ogunyankin, 2012). A few studies have shown destitution and alms begging to be among the consequences of social and family neglect of the elderly in Nigeria (Eboiyehi, 2006; Fajemilehin, Ayandiran, & Salami, 2007).

Ibadan, the largest city in West Africa, has some destitute elderly people and beggars from mixed ethnic affiliations and different parts of Nigeria (Asiyanbola, 2008). There are those who speak Yoruba and those who speak Hausa and Kanuri among the elderly beggars and destitute in the city. However, none of the participants reported alms begging as a survival strategy. Some mentioned different economic activities, which ranged from petty trading, traditional health care provision, artisan work, to clergy work. Across the male groups, just a few mentioned involvements in strenuous occupations, such as commercial driving (1) and farming (4). Besides retirees, a number of the females reported that they were not working, and a high proportion of women (5) in this category were participants within the age range of 80 years and above.

Regular income in old age has health and social well-being benefits. Recent studies have shown how existing non-contributory pension schemes positively affect the economic and social status of old and elderly people (Salinas-Rodríguez, Torres-Pereda, Manrique-Espinoza, Moreno-Tamayo, & Solís, 2014). Other factors, like social stability, the security of lives and property, and low cost of living, affect economic and social well-being across the life course. However, the absence of social security in old age may worsen ageing

experiences through negative influence on the psychological well-being and self-esteem of the elderly. The effect may be more conspicuous in cultural settings where elderly people provide different forms of support for relatives and neighbours.

Table 2: Socioeconomic profile of the focus group participants

Variables	Male (N=56)			Female (N=51)		
	60-69 yrs.	**70-79 yrs.**	**80 yrs. and above**	**60-69 yrs.**	**70-79 yrs.**	**80 yrs. and above**
Total no. of participants	19	17	20	19	17	16
Age[mean(SD)]	[65.8(2.7)]	[75.2(2.8)]	[82.1(2.6)]	[63.6(3.43)]	[73.7(3.4)]	[83.8(6.7)]
Marital status						
Married	19	16	18	11	5	4
Widowed	-	-	-	7	12	12
Widower	-	1	2	-	-	-
Type of marriage						
Monogamy	4	6	7	3	-	1
Polygyny	15	10	11	8	5	3
Religion						
Christianity	4	2	8	5	1	8
Islam	15	15	10	13	16	6
Traditional religion			2			2
Educational status						
No formal education	5	9	7	8	13	13
Islamic education			1			
Below primary	2	4	1	1	1	2
Primary	1	3	5	6	2	1
Below Secondary	2		1	1		
Secondary	4	1	1	1		
Diploma/NCE	5		2	1	1	
University			2			
Occupation						
Artisan work	2	2		1		
Clergy		1		1		
Commercial Driver	1					
Farming	1	1	2			
Herbalist/ Spiritualist			4			
Petty trading	6	10	3	12	13	11
Retiree	8	8	2	1	1	
Not working				1	3	5

Profile of the Interviewees

Table 2 provides a summary of the biomedical health care providers. Four of the health care providers were attached to the Geriatrics Unit at the University College Hospital, Ibadan. Only two were recruited from the primary health care facilities in the study sites. Three of the health care providers had more than five years' working experience. The two patent medicine vendors had been in business for over five years and were well-known to members of their communities, including elderly people. Both vendors had up to secondary school education. They had no additional training except that both worked as sales attendants in a pharmacy/chemist shop before starting their business.

Table 3: Socio-demographic profile of the interviewed biomedical health care providers

Characteristics	**Physicians (n=3)**	**Nurses (n=3)**	**Patent medicine vendors (n=2)**
Age			
31	-	1	
36	1		
43	1	2	
54	1		1
Highest level of Education			
Secondary	-	-	2
Registered Nurse	-	3	
First Degree	-	-	
Postgraduate	3	-	
Place of work			
University College Hospital (Geriatrics Unit)	2	2	-
Primary Health Centre	1	1	3
Length of years in service			
Less than 5years	1	1	-
Over 5 years	2	2	1

Table 3 provides a summary of the socio-demographics of the interviewees (traditional health care providers). The youngest among the six practitioners was a woman who sells medicinal herbs for various health conditions, including those related to sexual health. The business of herb selling is a predominantly female activity among the Yoruba people (Agunbiade, Opatola, & Titilayo, 2012). Some men are involved in the business as well. All the traditional health care practitioners had been in business for more than five years. Three among them had been providing traditional health care services for their communities for more than ten years.

Table 4: Socio-demographic profile of the interviewed traditional health care providers

Characteristics	**Herbalist (n=1)**	**Diviner/Spiritualist (n=2)**	**Herb Seller (n=1)**	**Islamic Cleric/Herbalist (n=1)**
Age				
46	-	-	1	-
64	1	-	-	-
77		1	-	-
81		1	-	-
83			-	1
Educational level				
No formal	-			
Primary	1	1		
Secondary	-		1	
Length of years in business				
Less than 10	1	1	3	1
Over 10 years	1	1	1	

Table 5 summarises the socio-demographics of the interviewees (elderly men and women). The characteristics of the interviewees were similar in several areas to those of the FGD participants, as the interviewees were recruited from the FGD participants.

Table 5: Socio-demographic profile of the interviewed elderly men and women

Characteristics	**Male (n=9)**			**Female (n=9)**		
	60-69yrs	70-79yrs)	80yrs &above	60-69yrs	70-79yrs	80yrs & above
Age [mean (SD)]	65.7(4.2)	72.3 (2.52)	82.3(2.1)	65.7(4.9)	74.7(2.9)	
Marital Status				3	2	1
Married	3	2	3	-	1	2
Widowed	-	-	-	-	-	
Widower	-	1	-			
Type of marriage						
Monogamy	2	2	-	2	1	-
Polygyny	1	1	3	1	1	1
Religion						
Christianity	1	1	1	2	1	2
Islam	2	2	2	1	1	1
Traditional						
Educational Status						
None	2	1	1	1	2	1
Primary		2		1		1
Standard III			1		1	
Standard VI	1					1
Secondary						
Higher			1	1		

Socio-demographics of the Survey Respondents

A slightly higher proportion of the females (57.14%) than the males (42.86%) participated in the survey (please see Table 6). The gender differential in the percentage of the survey respondents is consistent with the literature. More females than males survive into old age owing to the interaction of biological, psychological and social factors. Close to two-thirds of the survey respondents were in the age bracket 60-69 years. Similarly, more than average of the respondents were married. The majority (68.3%) of the total respondents were Muslims. Islam is a dominant religion in Ibadan, along with Christianity. Each of the study sites had conspicuous religious worship centres that were potentially accessible to members of both faiths. A few such places of worship existed for traditional religions. In other words, both Islam and Christianity are somewhat accessible to new followers. This may be associated more with wider socio-political factors than with differences in doctrines and practices.

Formal education was low among the respondents, as more than one-third had no formal education. Less than 35% had primary education, which cut across the three age categories and gender.

Most (84.92%) of the respondents engaged in various economic activities to earn a living. A similar proportion (75.79%) relied on their children for financial support. This is analogous to the characteristics of the FGD participants. Informal support for the elderly is diminishing, as more elderly people still work to earn a living. As stated earlier, the lack of a social security system to cater for the financial needs of old people and an inadequate level of familial and cultural responsibilities for older people may be compounding the situation (Adeniyi-Ogunyankin, 2012).

Table 6: Socio-demographic characteristics of the survey respondents

Gender	**Freq.**	**Per cent**
Female	144	57.14
Male	108	42.86
Age Categories		
60 – 69	137	54.4
70 – 79	75	29.8
80 years and above	40	15.9
Marital Status		
Married	151	59.9
Widowed/Divorced	101	40.1
Religious Affiliations		
Christianity	80	31.7
Islam	172	68.3
Educational level		
No formal	139	55.2
Primary	78	31.0
Secondary and above	35	13.9
Current source of income		
Children		
Yes	191	75.79
Family members		
Yes	15	5.95
Present occupation		
Yes	214	84.92
Pension		
Yes	15	5.95
Personal investment		
Yes	12	4.76

Cultural Descriptors and Exemplars in Old Age

Cultural descriptors are frameworks through which social actors within a social setting construct and interpret social phenomena. Such frameworks are inseparable from age-grade perspectives on social relations and normative practices. From a social positioning perspective, cultural descriptors are built around exemplars, duties and rights based on a storyline that emphasises moral correctness within a given context. Through various networks

of relations, social arrangements are provided to motivate social actors to live up to these social expectations. On the other hand, individual agencies, experiences and various forms of capital across the life course influence how social actors make sense of these duties, rights, and exemplars within a particular context.

To explore the socio-cultural understanding of old age, the initial questions in the vignette-based focus group discussions concentrated on exemplary elderly people as defined within the Yoruba cultural setting. The participants' perspectives helped in probing further the social desirability, possible conflicts and challenges of acting within or outside the cultural framework of an exemplary elder. With sexuality and sexual activities as part of the core issues raised by the participants when discussing the social correctness of the exemplary elder, it was easier to ask questions about ageing and sexuality. Thus, part of the initial questions were on different forms of sexual relations that are acceptable or unacceptable in old age and how these conceptions could influence the framing of sexual practices and reactions.

From a cultural and moral context, participants in this study expressed concerns and expectations concerning their current stage and future as elderly people. From an interactionist framework, social actors engage others and confront events that could make their lives meaningful or miserable. In this study, the participants addressed both subjective and objective dimensions of what is of value and significant in old age. Regarding context and cultural descriptors, the participants described binary possibilities by contrasting good and miserable old age as life stages. At this level, both philosophical and moral frames of reference dominated the participants' positions in conveying storylines around the moral correctness of an exemplary elder.

With the initial focus on the notion of who is an elder or older person, the FGD participants described an elder as *agbalagba* (older person). In their view, an *agbalagba* is an individual with the requisite wealth of wisdom and understanding acquired through different experiences relative to his/her chronological age. The possession of these virtues would qualify an individual for this status and bring social accolades to an elder at various social spaces. Through social relations, individuals are appraised against these criteria at three broad levels.

The first level rests on personal understanding in the form of life experiences and handling of tensions. Next is the ability to relate and cooperate with others for mutual and societal benefits.The third is whether the public life of an individual reflects mercy, acceptance of others and willingness to mediate or reconcile with others. The cumulative effect is that such virtues are requisite to enjoying good old age and peaceful death in the twilight of life. The multidimensionality of social realities implies that other factors could influence the possibilities of enjoying good old age and peaceful death. Nevertheless, the FGD participants acknowledged the possibility of exception, as some wicked people enjoy long life and successes at different points. In addition, there is a belief that the repercussions of their evil deeds would trail their children. In the words of some of the interviewees, elders must live and act with this consciousness, especially if they have children:

> Most importantly, elderly people should avoid illicit affairs with the wives of those who are younger. The reason is that some senior citizens are fond of descending so low as to engage in illicit affairs with younger women. [FGD with men aged 70-79 years, Sango Community].

Regarding relationships with family members and social actors, the FGD participants argued in favour of harmonious interactions as consequential to favourable ageing experiences. Such efforts are required when relating to household members, neighbours and others.

As expressed in the participants' views, commitment and readiness to maintain quality interactions with neighbours and the community require sensitivity and sacrifices. Relationships with others may attract rejection and frustration, and may also be rewarding sometimes. An exemplary elder, therefore, must be motivated and resilient to overlook such constraints and possible rejection from others. Success at this level was considered critical for an elderly person to assume leadership positions, and to earn the respect and support of those around him/her and community members. These aspects are illuminated in the excerpts below:

> An elder must have patience, tolerance and must always be ready to accommodate insults and provide exemplary leadership. [FGD, men aged 80 years, Oniyere Community].

> Old age calls for tolerance and wider forms of reasoning and ability to ignore some disturbing issues just to maintain peaceful co-existence and a quality network of social relations. [FGD, men aged 60-69yrs., Bodija Community].

Building a quality network of social interactions is an indispensable form of capital, as it affects outcomes in diverse forms of associations. In one of the classic works on social interactions, George Simmel conceptualises 'sociation' as a patterned and observable web of reciprocal interactions between individuals who are 'with-one-another, for-one-another, in-one-another, against-one-another, and through-one-another, in state and commune, in church and economic association, in family and in clubs' (Simmel, 1971, p. 127). The correctness and assumption of eldership require relevance and willingness to conform to socially

prescribed duties and rights. Such conformity must be demonstrated in speech, quality of relations, reactions and disposition in handling challenging life events. Through these meaningful assertions, cultural descriptors and exemplars, the participants affirmed further the local correctness and richness of rights and duties in old age.

> *Ọjo ale là ńtọrọ* –We are praying for good old age
>
> *Agba ki wa l'oja k'ori omo tun tun wo* –The presence of an exemplary elder keeps a child from going astray.
> An elder is someone who stands and defends the truth no matter what. This will encourage younger people to emulate such practice and associate with him. [FGD, men aged 80 years, Oniyere Community]

Explaining the notion of sociations within the Yoruba context, Akiwowo (1983) advocates the centrality and quality of 'co-residentship' relations. Such relations are known as *ajogbe* in the Yoruba language and attracts a higher premium over blood and birth relations as essential components of ensuring the collective cohesion of society. It is on the principle of *ajogbe* ('co-residentship') that society progresses and handles natural and human-designed challenges, especially in the growing network of social relations that characterises post-modern societies. This storyline exists in a common Yoruba saying, where the emphasis is on collective co-existence and communal well-being is superior to individuality and familial relations:

> *Alájọbí, osí mo, alájọgbé ló kù.*
> (Kinship is no longer in fashion, only neighbourliness.)
>
> An older person will try to maintain harmonious relationships with family members and neighbours and encourage the same among those around him. [FGD with women aged 70-79 years, Sango Community].

With the aid of proverbials and wise sayings, the FGD participants described further the instrumental and derivative purposes of cultural descriptors and exemplars in old age within familial and other interpersonal relations.

> An elderly person must be able to forgo and leave some issues to rest. For instance, if you are with you children, you must let go of so many things; otherwise, you will always be having problems. [FGD with women aged 70-79 years, Kobiowu Community].

Social Value and Role Modelling in Old Age

The FGD participants and a couple of the interviewees noted other benefits of exemplary elderly and support from children, relatives and group members. Building a quality network of relations in old age was described as essential in several ways to a person's ageing experiences. Some of the necessitating conditions in this regard are physiological challenges and vulnerability in old age. The FGD participants and the interviewees, except the doctors, spoke about how older people expressed concerns and anxiety about physical mobility and the need for support. Support has different forms and types. As maintained in the literature, the type and quality of the network of support available to old and elderly people within a given context are consequential to psychological, mental and physical health in old age (Stephens, Alpass, Towers, & Stevenson, 2011). An FGD participant asserted that:

> Old men must always think of their later days when they will not be active anymore. Being good to others will reciprocate good gestures from others or attract similar support in their old age. [85-year-old-man, FGD with men aged 80 years and above, Oniyere Community].

From a functionalist perspective, support is earned and, therefore, requires concrete and genuine efforts. Hence, conscious efforts are needed to secure and maintain a quality network of social support in old age. In this regard, conformity to societal expectations regarding

behaving in ways that would improve the quality of social relations was again emphasised. According to the participants, individuals must develop and sustain good relations through behaviour, speech and actions that are morally correct:

> We want our grandchildren to gather around us so that we can take care of them when they come for holidays. We need to be good to our neighbours so that they will not neglect us. Because after we are no more, they will not be saying to hell with our corpse. If you have 'well water' at home, allow people to fetch from it; if you have food at home, give to the needy. By doing so, the young ones too can take care of us. [FGD, women aged 60-69 years, Bodija Community].

> An older person must be less ambitious, and not to be aggressive as he was when he was young. *Agba to roro ko ki nko eniyan jo* –a difficult and troublesome elder will suffer from quality network of social relations. [FGD with men aged 70-79 years, Sango Community].

As earlier emphasised, exemplary old age calls for tolerance and a wider form of reasoning, and ability to ignore some troubling issues, just to maintain peaceful co-existence and a quality network of social relations. If these virtues are lacking, there is a good chance that the elderly will suffer loneliness and neglect in old age, which could also affect their overall well-being. Such a possibility is contained in the following extract:

> People will not go near him and if any benefit is to come his way they may block it as long as they have known him as an evil doer (FGD, Women aged 60-69 years, Odo-Oba).

Despite the willingness and sacrifice from some older people in fulfilling moral rights and duties, some of the participants expressed concerns about neglect and loneliness. Similar to the finding in a study conducted in Ghana (Van Der Geest (2004)), despite the involvement of the elderly in many social activities, the subjective existence of loneliness remains challenging. It seems that experiences and dimensions of loneliness vary within and across

social categories. In particular, gender, religious participation and access to economic resources affect variations and exposure to loneliness (Olutoki, Olagunju, & Adeyemi, 2014; Pettigrew, Donovan, Boldy, & Newton, 2014; Van Der Geest, 2004).

In providing more contexts for the possibility of loneliness despite conformity, some of the participants revealed that past misdeeds of some elderly people earned them neglect and discrimination from their significant others. To err is human, but forgiveness might be difficult, depending on the perceived severity and consequences of the previous evil deeds of an elderly person. As stated by other scholars, there are chances that emotional and psychological disorder associated with neglect and abuse in old age could be misinterpreted as consequences of evil deeds and lifestyle effects catching up with an individual in old age (Lawrence et al., 2006). This is reflected in the participants' narratives, where forgiveness and reconciliation were emphasised as valuable to social approval and recapitalisation in old age:

> The fear of how others will treat you when you become frail is present. As a middle-aged adult, you have more strength to move around, earn a living, sleep with many women and raise many children. However, we are humans and can make mistakes in life, which can be difficult for others to forget and forgive. [FGD men aged 60-69 years, Odo-Oba].

> People easily forget that their actions of today have consequences on their tomorrow and the generation that will come to them. We once had a tough *baba* (elderly man) in our area who was tough and bent on seeking revenge on others. Unfortunately, he had a terrible illness that affected his memory and became very dependent on others. Due to his past behaviour, many of his neighbours avoided him and treated him with contempt. [FGD Women aged 80 years and above, Aperin Community].

As contained in the participants' discussions, a social actor that considers the consequences of his/her current actions on others would likely experience fulfilment and social recognition

more than the nonchalant individual. In the Yoruba cosmology, the evening in an individual's life is a time of accountability, personal reflection and sacrificial living. The value of this social expectation was noticeable especially among the female participants through the emphasis placed on the cultural notion of exemplary motherhood.

Dimensions and Particularity of 'Good Old Age'

Opinions differ on what constitutes or qualifies as 'good old age'. These different positions are present in the gerontological literature (Martin et al., 2015). For some scholars, 'healthy ageing' or successful ageing are terms that describe, contextualise, and provide an interpretative dimension to the notion of good old age (Liang & Luo, 2012). Cultural values, beliefs, and practices reflect on what and how social categories and individuals make sense of their ageing experiences in relation to the notion of 'good old age'. Examples include wise sayings, proverbs, myths, and religious injunctions that are brought to bear to emphasize the richness and expected duties that are associated with good old age. In Yoruba parlance such cultural beliefs and expectations that are associated with the notion of good old age is encapsulated in a common proverb:

> *Pípe láyé lèrè ayé.*
> 'Longevity is the reward for having lived a good life' (Owomoyela, 2005, p. 289).

The attainment of good old age was a possibility, as the FGD participants described four interconnected dimensions of experiencing good old age. These dimensions were health, material security, children's' well-being and peaceful death. Starting with health, the participants described health with reference to physical, emotional, spiritual, and social balance. Material security was viewed in relation to the availability of money, food, clothing and housing. Children's well-being was also described in terms of success in life, longevity and capability of reciprocal quality support in old age. The fourth dimension was associated with a normative notion of peaceful death defined by limited health challenges or death

through sleep and a befitting burial by one's children and relatives. This section gives additional details on the various dimensions and particularities of old age and what constitute good old age from the position of the participants.

Health- Physical, Mental, Emotional, Spiritual, and Social Well-Being

Old age comes with challenges, including health-related ones. For the participants in this study, being in good health does not imply the absence of illness or disease, but conscious efforts that are required to enjoy good health in old age. Part of these responsibilities include making efforts to regulate what to eat and drink, prevent disease occurrence, and seek prompt help in the event of any health challenge. Offering various examples, the participants in the various FGD groups mentioned the need to avoid or reduce certain activities, especially those that drain the energy, to enjoy good health in old age, as reflected below:

> Older people must avoid strenuous activities if they desire to live longer, must avoid eating sweet things; older people that want to live longer, say from 60, 70 years upward must avoid frequent sexual intercourse. [FGD with men aged 60-69 years, Bodija Community].

> Both men and women are supposed to reduce sexual activities, most especially women who have a shorter sexual life than men do. [FGD with men aged 60-69 years, Bodija Community].
> Alcohol intake is appalling for old people; it is only blood tonic (reddish) alcoholic beverages that are suitable for older men. [FGD with men aged, 80 years and above, Inalende Community].

> A regular medical check-up is also imperative. Moreover, as one grows older, there is a limit to everything, including sexual intercourse with women (*wamo ti san obirin*). [FGD with men aged, 80 years and above, Inalende Community].

> What one should avoid in old age, firstly is *oko* (penis). Secondly, we should be eating wheat and 'semo'. We should avoid eating '*amala lafun*' (cooked cassava flour) *eba* (cooked cassava flakes), and egg. Such foods can no longer nourish our body. We should be taking tea, beverages (like Milo) and powdered milk because liquid milk cannot nourish our body. We can consume a small quantity of rice and '*amala gidi*' (cooked yam flour) with good soup (a participant added *efo* – vegetable to the list). [FGD with women aged 80 years and above, Inalende Community].

Some of the above excerpts indicate the influence of a gradual indoctrination of biomedical initiatives associated with active or positive ageing. Also, they echo an awareness of biomedical construction and lifestyle modification to enjoy good health or successful ageing.

The need to look after oneself was expanded further in the interviews, as implied in the following narratives:

> As we get older, we should always take care of ourselves so that we do not experience a burdensome old age (*Agba inira*) by going for medical check-ups. [Interview with a 74-year-old woman, Oniyere Community].

> Many are the activities that elderly people should avoid – eating canned or processed foods in the body usually cause a problem for old people. Elderly people need to avoid eating such food to enjoy good health and well-being [Interview with a 64-year-old woman].

The emphasis on avoidance of perceived lifestyles that mortgage well-being and activities that require physical strength was anchored to the irreversibility of ageing. With chronological increase in age, bodily changes and mobility challenges are inevitable, as noted by the participants. This makes health a critical component of the ageing process. Several health challenges are common in old age (Christensen, Doblhammer, Rau, & Vaupel, 2009). However, available evidence indicates insignificant association between ageing and illnesses or diseases (Marengoni et al., 2011). A complex of bio-psychosocial factors account for the

different health-related experiences of elderly people and susceptibility to certain health challenges (Marengoni et al., 2011).

In line with the above position, the FGD participants supported the preventive philosophy of African traditional medicine. Medicine in the African cosmology includes any substance that can affect a change anyway, anyhow and anytime (Geest, 1997). The vague and broad definition of African medicine differs distinctively from what medicine entails in the biomedical system. Some of the participants described the uniqueness and relevance of some traditional anti-ageing therapies that work differently from the biomedical remedies. Such forms of anti-ageing medicine are characterised by a broad Yoruba descriptive expression *s'agba d'ewe* (a therapy that makes you look younger than your age). *S'agba d'ewe* operates as a magical or spiritual form of traditional Yoruba medicine. The participants argued that individuals with the knowledge and use of *s'agba d'ewe* would always look younger than their peers. There are different forms of this and the procedure of administering them differ. As alluded to by a participant in the FGD with men aged 80 years and above, this medicine is fading away among younger generations, but the knowledge is still accessible to those who are willing:

> The use of *so agba d'ewe* is a common practice in those days, and it works like magic. Certain rules must be followed when using this medicine and most men and women do use it though it has its repercussions. Unfortunately, younger generations are unware of this knowledge and the few who should know are patronising foreign religions and beliefs.[A 83-year-old participant, FGD with men aged 80 years and above, Inalende Community].

In support of the existence and usefulness of *s'agba d'ewe*, another interviewee called for more research on anti-ageing therapies among other available remedies in traditional medicine. In the opinion of this participant, such therapies are not just cultural, but are also

less expensive, potent and effective in coping with everyday challenges in old age. In the words of the participant, *s'agba d'ewe* are different from what exists in biomedicine and can be in the form of incision, concoction or amulet. The practice, however, is to combine different forms of *s'agba d'ewe* to achieve lasting effects. In the narratives of this participant, the benefits in traditional medicine are hardly appreciated until an individual has suffered much in different ways:

> It is common not to appreciate what you have until you lose it. Many of the available traditional remedies are neglected and have not been appreciated. This also affects individuals. To grow old could be interesting if we follow certain steps and use some different traditional remedies as prescribed by those with the knowledge. From personal experience and interactions with others, when you combine such remedies in the right proportion, you enjoy good health even though we will die eventually. [Interview with a male herbalist aged 83].

Despite the existing traditional anti-ageing therapies, the participants argued that interventions only affect the physiological symptoms of bodily changes. The potency of these interventions is commendable in this regard. However, the impact is limited, as the participants observed that organs, systems, and other tissues that make the whole body would grow old and not younger:

> Therefore, we need to be mindful of all these natural physiological challenges. [An 83-year-old man in the FGD with men, Inalende Community].

The FGD participants again reiterated the need to observe certain cultural beliefs, values and practices that emphasise collectivism, truth and harmonious relations with neighbours, relatives, friends, ancestors and God. In building on the thesis for harmonious social relations, the participants asserted that some health conditions are preventable through quality social relations. According to them, some health challenges, especially the medically

inexplicable ones, can emanate from poor relations with others, envy, bitterness and evil machinations. Being in good health, therefore, requires building and sustaining harmonious relationships with others and ancestors. A life full of rancour was described as stressful. Possible sources for chronic illnesses were also classified as *amodi*. In such circumstances, the search for solutions must shift from the natural to the preternatural and the supernatural. Such shift could determine the survival, recovery, and reintegration of the individual with such experience. In the FGD among men from Inalende community, there was a critical focus on quality social relations, especially with family members and couples. Bitterness and rifts among close people were described as a critical source of inexplicable health conditions. The argument was that such health challenges are untreatable using biomedicine.

In the FGD with men, an 83-year-old traditional health care practitioner shared a personal experience of handling an inexplicable health condition. His experience was corroborated by four other participants. He started by drawing on the need to resolve rancour and bad feelings in relationships. Such resolution of rifts and misunderstanding, according to him, would produce harmony and quick recovery from some health challenges. In the same vien, the participant expressed the need for both the sufferer and the care provider to be courteous to avoid recurrence or transfer of the disease or illness to another person.

This view expressed is embedded in the cultural belief and the storyline, that harmonious relationships with significant others and neighbours are essential to enjoying good health. Against this backdrop, the participants in this study perceived health as something not given. To enjoy good health in old age, therefore, requires personal responsibility. This includes physical and dietary intake, interpersonal relationships, good morals, responsive help-seeking in the case of a health challenge, and the fear of God.

While extending the social relevance of good morals and quality interpersonal relations, the participants averred that the fear of God could also promote good health in old age. Their explanation of this position rested on religious beliefs and social expectations. From the stance of Yoruba belief, some individuals are endowed with the privilege of enjoying good health based on their inner *ori* (head) in predestination (Jegede, 2002). The belief here is that individuals are made with good inner heads before sojourning to earth. However, at a point before conception, there is an opportunity to select the type of inner head by choice. Some will select the good one, which is difficult for the enemy to conquer, including ill health as an enemy. For others, their destiny will attract a bad inner head. Upon arrival into this world, steps are required to look into the kind of inner head selected at the place of destiny. Whatever the outcome, the belief is that, through sacrifice and prayers, the type of inner head selected can be modified (Jegede, 2002). On this, the FGD participants called for individual responsibilities, which include the idea of taking ownership of their health and associated consequences.

The participants expressed the need for moderation in life, the need for harmonious relationships with humanity and adherence to some spiritual principles as laid down in their various religious beliefs and practices. Through sacrifice, prayers, and moderation in lifestyle, an individual may enjoy good health even in old age. However, the fear of God and truthfulness are required before these efforts can yield good health and take evil far from one's life in old age:

> This world is full of evil and only the prayerful ones can survive the challenges of life. There are some people who do not want your children to succeed in life. If eventually they succeed, then they would visit you with chronic health conditions so that your old age would be miserable and difficult to enjoy the fruits of your children. [FGD with women aged 70-79 years, Sango Community].

> It is common to see many elderly people going to church and mosque. They are there to pray for good health and a peaceful old age. It requires prayers and sacrifice to enjoy good health in old age. [FGD with men aged 80 years and above, Oniyere Community].

The emphasis on morality and belief in spirituality was expected, as all the participants expressed deep belief in the benefits associated with obeying spiritual principles. To live in peace with others opens the door for mercy and divine protection from all evils. Such efforts, as observed by some of the FGD participants, would guarantee a long life for one's children and their protection from everyday evil. Some of the interviewees also believed that, through such efforts, diseases and illnesses that are medically inexplicable or untreatable would not afflict them, as captured below:

> Some individuals have good and strong heads and such people would enjoy good health and see less of evil in life. However, the wicked people of this world could make life miserable save for prayers, sacrifice and alms giving and good relationship with God. [Interview with a male spiritualist aged, 74]

> Many bad things will happen, including health challenges when individuals prefer to do things their own way. The fear of God protects against strange diseases and untreatable conditions that could drain your income and make your life difficult. [FGD with elderly men aged 70-79, Odo Oba].

To this category of interviewees, the increasing occurrence of medically inexplicable health conditions could be a divine way of forcing humanity to acknowledge the supremacy of God and keep spiritual laws. Violations of spiritual laws and flagrant disregard for God bring

inexplicable conditions that can make life miserable, especially in old age. As a way out, adherence to religious beliefs and practices, fear of God and constant prayers are trustworthy measures.

A common prayer that captures one amongst the critical expectations in old age is to pray against becoming an *agba inira*. This represents a situation when an individual is in a stage that is socially defined and accepted as old, but with a series of challenges that makes the period miserable. *Agba inira* also includes the occurrence of mysterious or untimely deaths of children or grandchildren, loss of property to natural or human-originated events, and poverty. Thus, old age remains a period to appraise and focus energies on measures that could avert becoming an *agba inira,* especially for one's children or relatives. The notion of *agba inira* was tied to well-being of children and quality of support in old age. More emphasis was placed on this notion, as the participants described the pains of poor support and unsuccessful children and ill-health in old age.

Well-being of Children and Family Members

> *Eetán lelégbè ẹyin; ọmọ bíbí inú ẹni lelégbè ẹni.*
> Young palm fruits are the support of ripe ones; one's children are one's support(Owomoyela, 2005, p. 304).

The cultural belief is that children are social investments that should start yielding returns in old age. This social hope for support is normative and cherished. The participants discussed the values and relevance of having successful children. This position was articulated in different ways among the FGD participants:

> You know, with old age comes dependency and the need for support and care in diverse ways. The expectation at this level is that one's children will be financially independent and be in good health so that they can also provide the needed support for their aged parents. [FGD with women aged 60-69 years, Bodija Community].

> It is important for a man to live long and not die when his children are young. Once this prayer is answered, he will aspire to bring up his children well, sit back and expect his children to take care of him in old age. [FGD with men aged 70-79 years, Sango Community].

By socialisation and cultural expectations, the exemplary mother and father must exhibit unconditional support and desire for the well-being of their children and relatives. However, the core responsibility of being there for one's children belongs more to mothers than fathers. Within the field of marriage, Yoruba women are culturally expected to provide diverse forms of care to their husbands, relatives, and children, in particular. These include caring and provision of physical, emotional, and spiritual support to ensure the well-being and survival of a child to adulthood. In this positive direction, parents (especially mothers) have acted responsibly by providing both quality and quantitative support for their children while growing up. Thus, the notion of motherhood among the Yoruba people entails sacrificing personal privileges and rights for the well-being of others, children in particular:

> The focused type of woman would know that she must not just be a mother but a caring mother (*ko ma je iya*, *sugbon ki oje abiyamo nii tooto*). There is a difference between a mother and a caring mother. *Iya* (a mother) is the woman that can give birth, but *abiyamo* will not stop at that, she will always be concerned with what children will eat, she will be guiding them, and she will not only depend on the husband to care/provide for the children but rather be hard working. You know a wise saying is that only the lazy one can be made to suffer. [FGD with women aged 70-79 years, Sango Community].

Motherly support and care of this nature is valued as a sign of good motherhood in the Yoruba culture. The provision of such care and support extends to spiritual issues. The consciousness of this social responsibility can be seen in the practice of Christianity, Islam, or Traditional Yoruba Religion among the Yoruba people. Prayers and making sacrifices are part of the exemplary forms of support from mothers in particular to their children. In some instances, this could include joining secret cults or fraternities, as enunciated in these excerpts:

> Women are so much more concerned with children than some men are. If there is nothing to eat, the father may go out but the mother will always be concerned. Even if it is what she will eat, she will give her children to eat. [FGD with women aged 80 years, Inalende Community].

> Mothers are at the centre of receiving all the blame when things go wrong with their children. The expectation is that a true mother must go the extra mile to save her child (ren), especially when they are in need even as grown-up adults. [Interview with 61-year-old woman, Bodija]

> I personally, I always pray that whatever would happen to my children should happen to me and not them. [FGD with women aged 80 years and above, Inalende Community].

Playing the sacrificial role of *abiyamo* comes with the social expectation of reciprocal care and support from one's children. Such reciprocity is much expected in the evening period of life, when the physical strength to work and earn a living has dwindled. Through wise sayings, proverbs, and religious teachings (Christianity, Islam and Traditional Yoruba Religion), especially in wedding ceremonies and the media, children are reminded of the blessings in reciprocating the gestures of good motherhood. Across the various FGDs, this expectation was widely shared:

> What is important is that the children are to be taking care of us, and we will be praying for them. A good elderly person will pray, for the children, those children that that are not his or her own, and the neighbours as well. [FGD with women aged 60-69 years, Bodija Community].

The participants, at diverse points, lamented the dwindling quality of financial and non-financial support from children. This development was described as disheartening and a likely source of hopelessness for middle-aged adults to live with until older age. In the participants' view, the willingness to fulfil this social obligation still exists, but many adult children are at a disadvantage. Despite the rewards and cultural values of this reciprocity, both parents and children are confronted with different challenges in meeting these obligations and expectations (Adeniyi-Ogunyankin, 2012). The larger socioeconomic and political challenges were described as inhibitors and demotivators in the sustainability of this form of social obligation of supporting aged parents.

Illustrating a demoralising development, a male FGD participant asked a provocative question about whether becoming old was a punishment or a sin:

> We desire social security for older people. On the other hand, is it a sin to be an elderly person? Why can't the government come up with social security policies to support the elderly in Nigeria? [An 80-year-old man in the FGD with men, Oniyere Community].

The rationale for asking the question was clearly understood and expected. The perception might have been influenced by systemic failures in Nigeria and the absence of any concrete strategy for a focused improvement in the quality of life. The health situation of elderly people in Nigeria is pathetic, as there is no formal support, such as the availability of health

insurance for the aged (Adeniyi-Ogunyankin, 2012; Togonu-Bickersteth & Akinyemi, 2014). This leaves the burden of care and financial responsibilities for accessing health care service on children and other significant others. What then becomes the fate of those without children or with children that are financially incapacitated? The narratives of some of the participants with supportive children pointed to some possibilities:

> My children have tried, the good Lord will continue to bless them and prosper their ways. I would have been dead by now if not for their support. [Interview with a 65-year-old woman].
>
> My husband that was very active some years ago has been totally dependent on me. I cannot go out for long because he is on medication. No house help; I do almost everything just to support him. [Interview with a 73-year-old married woman].

Social neglect and marginalisation have ripple effects on expectations in old age. First, there are possible psychosocial effects on the elderly themselves. Second, their well-being and anxiety over their inability to maintain a healthy ageing experience might increase. Some of the participants lamented government's unpreparedness and paying lip service to addressing the plight of the elderly in Nigeria. In the words of an 83-year-old participant in the FGD with men in Oniyere Community, the government has failed us in several ways:

> While I am not waiting for them to eat or drink, I wonder what are the sins of the elderly in Nigeria… There are no plans whatsoever and the art of politics and deceit of the electorate dominate Nigerian politics at different levels. When will there be policies to assist old and older people in coping with health challenges that come with age, feeding and shelter? When will this come? [83-year-old male participant, FGD Oniyere Community].

The provision and footing of health bills rest on children, family members, and, in some cases, religious bodies. Total dependence on others, fending for oneself and poverty are also probable sources of loss of hope for living. Such conditions would only amount to what the

FGD participants earlier described as *agba inira*. The emotional challenges of neglect and loneliness in old age could compound individual assessments of their ageing as *agba inira.* This can also increase the likely occurrence of suicidal thoughts and intentions and psychological disorders, like depression.

Some of the participants expressed sympathy with their significant others over their daily struggles in providing them with support. The increasing difficulty that children, family members, and neighbours experience in providing for their dependants has an effect on the type and quality of support accessible to the elderly depending on such sources. Against this background, some of the FGD participants lamented the increasing difficulty in enjoying their old age. These challenges are complicating ageing for participants who described the difficulties of negotiating an ageing experience that is far from *agba inira*.

The notion of *agba inira* centres on life events and challenges that make old age a miserable period in the life of an individual. Although socio-political and economic challenges remain dominant, the events and challenges that could make old age experiences miserable and result to *agba inira* are traceable to multiple sources, which range from personal, natural, to preternatural and supernatural sources. Whatever the perceived source, reliance on plural and concerted holistic efforts is considered effective in minimising the possible psychosocial effects of these events or challenges to subjective well-being and health outcomes in old age.

From the perspectives of the participants, adoption of holistic approaches will produce the needed relief and succour when they are confronted with challenges that could make ageing a stage of *agba inira*. In consonance with previous views shared by some of the participants, a holistic strategy requires moderation, a healthy lifestyle, and harmonious relations with

neighbours and God. Good morals before and in old age are seen as fundamental in creating situations that could make life in old age interesting and fulfilling. Possession of such standards provides a social advantage, authority, and boldness to engage in constructive interrogation and appropriation of specific strategies in the face of challenges and events in life. Such virtues also provide opportunities for individuals to experience relatively harmonious interactions and relations with humans and the spirit world. Departure from these standards could compromise and expose individuals to events capable of making old age experiences miserable and full of *inira* (pain/misery).

The bottom line, according to the participants, is building a network of relations that could provide the needed support in old age. Such networks also increase the relevance of old and older people as they are positioned to provide support, including material support for those around them, especially their children. A burning desire among some of the participants is the opportunity to leave a material inheritance for their children. The belief is that challenges and events that could make old age miserable and become *agba inira* are linked to quality and quantity of social relations in realms of existence. The challenges of surviving independently with frail bodies could create further stress in old age.

To avert these possibilities, the FGD participants emphasised self-reflection and appraisals that would improve personal commitment to the social correctness of good old age. The gendered responsibility of praying for children and other family members was expressed more among the female participants. This is consistent with cultural values and practices that position women as caregivers by providing support, especially in emotional terms, for their households and relatives. The well-being of women and their health, in particular, often suffer as they struggle to fulfil certain social obligations (Courtenay, 2000). Nevertheless, the

aim is to increase the cultural and social capital that comes with old age and recapitalise to increase social support and acceptance. Through this process, rights and privileges are sacrificed despite the possible effects on personal well-being and self-esteem in old age.

Recapitalisation to Avoid Stigma and Stereotype in Old Age

As active social constructors of their social realities, elderly people also adopt strategies and positioning that are considered effective in reducing marginalisation. The literature stresses the fact that social inequalities, including the exclusion of the elderly from development and empowerment initiatives, have doubled the vulnerability and poor quality of life for the elderly. Accordingly, some elderly people have suffered series of abuse, have become destitute, or are accused of witchcraft or sorcery for reasons related to poverty or ill health conditions (Sharma, 2013).

From a gendered position, the participants in this study posited that behaviour that fails to observe proscribed normative values and practices could generate negative attitudes from others. Such negative attitudes include the stereotypic perception of the aged as 'old fogies', 'witches' or 'unproductive,' especially older women, similar to those documented elsewhere (Ajala, 2006). The ageist perception is strengthened when such an aged person witnesses the death of her children or much younger people around her, even if those children die at a time when they have become aged. The cultural belief is that parents must not bury their children. Burying one's parents, especially the aged ones, is one of the subjective indicators of peaceful ageing experience. The social relevance of burial of the aged by their adult children could trigger anxiety among aged parents when they lose an adult child. The situation may be more troublesome for poor elderly parents with a history of premature deaths and recurrent mishaps. Explanations of such misfortunes often rest on the bosom of the aged, as they are

labelled as witches or wizards and assume responsibility for the predicaments around their children or family members.

> *Ojo* ale is crucial, and one must pray for children's wellbeing and family members. It is a primary responsibility in old age for women to pray constantly for their children and relatives. Such efforts would save an aged woman from being called a witch. [FGD with women aged 70-79 years, Inalende Community].

The participants prayed that they would be spared experiences and events that could attract ageist labels and neglect in old age. They noted that some unfortunate elderly people with unpleasant life events around them suffered neglect, stigmatisation, and all forms of abuse from their significant others, including neighbours. Cases of death by stoning of old and older people were mentioned as examples of how some elderly women were mistreated some years ago. The women were described as having confessed at some point to their evil deeds and involvement in different mishaps to their families and friends. The fear of being labelled as witches and sorcerers can be disturbing, which affects the well-being of the aged.

The possibilities of labelling older women as witches came up in four out of the six focus group discussions with men and women. Such allegations depend on the frequency of negative life events around them, their households, and their children's well-being, as evident in these comments:

> Some children have neglected their mothers in particular due to beliefs that their mothers are using spiritual powers to hinder their achievements and successes in life. [FGD with women aged 80 years and above, Aperin Community].

> Some elders are not good; they are possessed with witchcraft. They are the type they usually stone to death [FGD with women aged 80 years and above, Inalende Community].

> It was common some years back to stone old and older people to death for witchcraft. In recent times, both Christianity and Islam have preached forgiveness and life in eternity. Also, many old women and men are becoming more religious and less involved in witchcraft. [(FGD with women aged 80 years and above, Inalende Community].

To date, the possibility of accusing older women of witchcraft and death by stoning still persists. However, some of the participants claimed that death by stoning was decreasing. They associated the decline with the increasing acceptance of Christianity and Islam. Belief in witchcraft and sorcery still exists and receives particular attention in religious circles among the Yoruba people who are Christians and Muslims (Balogun, 2011). Recently, a 72-year-old man was tortured to death in a community in Bauchi on the allegation that he was a wizard. The orders to execute this old man came from the village head who believed that torture would make the septuagenarian confess to wizardry (Gbadamosi, 2014). This case is just one among many various forms of abuse of the elderly. Some old people have been abused in diverse forms, even without fair hearing or evidence, except on the accusation of possessing perceived or real spiritual powers for evil purposes (Ashforth, 2015; Crampton, 2013).

Beyond witchcraft, actions and activities that could lead to stigmatisation and stereotyping among men are linked to public or community-related issues. For the FGD participants, such activities could include taking other people's wives, alcoholism, and the illegal or dubious sale of landed property and provision of spiritual support or weapons for armed robbers.

These practices were described as common and often resulting in stigmatisation by others, especially younger people:

> Old men that are involved in adultery and reckless alcohol intake will lose their social value and respect. They will call them derogatory names. [FGD, men aged 80 years and above, Oniyere Community].

> Old men should avoid cheating other people by confiscating other people's property. Many old people have taken possession of other people's landed property. An elder must be distant himself from such acts. [FGD, men aged 80 years and above, Oniyere Community].

> Old men aged seventy years and above should abstain from sexual relations because sexual relations can reduce the lifespan of old people indulging in the activities. [FGD, men aged 80 years and above, Oniyere Community].

Poverty and neglect in old age could also encourage engagement in socially unexpected behaviour in old age. Some of the participants admitted that some older people in their communities had engaged in shameful acts, which were unexpected:

> An elderly woman was caught stealing seasoning and locust beans at the market some weeks ago. Those who knew this woman said she steals a lot within the neighbourhood. [FGD, women aged 60-69 years, Bodjia].

> Some elderly people are into kidnapping and providing support for criminals just for something to eat. We have some in my area whose names I wouldn't mention. You cannot trust them with anything. They are chronic liars and cheaters. [FGD with men aged 80 years and above, Oniyere Community].

The male participants averred that survival challenges and greed are factors promoting such behaviour among elderly men. Surviving material challenges in old age has led some elderly people into providing support for criminals and engagement in the dubious sale of farmlands and landed property. While an economic deterministic perspective may be useful, it is partial,

based on its focus on material deprivation. Chances exist that such actions might be motivated by a desire for social relevance, such as acting as *baba isale* (godfather). *Baba isale* is a social, political and economic position that provides opportunities for men to create values around them (Omobowale, 2008). Being a *baba Isale* could also mean providing support for legal and illegal activities like supplying arms or charms to robbers and others that are involved in criminal activities. Such elderly people (*baba Isale*) can sometimes provide charms or traditional medicines that are ineffective or lack potency just to earn a living (Fourchard, 2008).

Despite the presumed benefits and systemic frustrations that could motivate the involvement of elderly people in illegal activities, a social call for caution was made by the participants. Such caution was considered necessary for an elder to avoid stigmatisation and neglect. In this regard, some of the male participants expressed their desire for financial independence and good health status. Personal investments and direct earnings when possible could provide succour against dependence on others and freedom to enjoy some privileges. In the words of three male FGD participants, regular income in old age and at least a personal house will provide some comfort and privacy as against depending on others for all things:

> May God give us money, as we grow older. Money is another important thing one must have in old age. As one is growing old and older, you will need money to eat on time, drink on time and eat whatever you like, have a regular bath and put on any clothes of your choice. If you lack any of these basic needs, then old age is miserable and burdensome. [FGD with men aged 60-69 years, Bodija Community].

> I have worked hard so that I can earn a living even in old age. I have some inheritance for my children, and I have shared my property to all my children because I don't want any conflict among them after my death, especially one among them that is lazy and unemployed. [81-year-old man in the FGD with men aged 80 years and above, Oniyere Community].

> Some among us are into trading and selling of subsistence goods at home. There is joy when you can earn a living and feed yourself in old age. The addition that comes from children will be an extra blessing as mothers. [FGD with women aged 70-79 years, Sango Community].

Concern for the regular source of income in old age was expressed more among the male participants than the females. This may be associated with the inclination towards the male performance of the responsibilities of breadwinner at the household level. For the female participants in the FGDs, the provision of social, moral and spiritual supports for one's children or significant others has derived benefits. Providing such support while still very active could be a source of reducing loneliness in old age, as aptly reflected in the following narratives:

> The most important thing for old people is for them to be kind, and they should be exemplary so others can emulate them. [FGD men aged 60-69 years, Odo-Oba Community].

> Women are to protect their children using prayers and sacrifices. Depending on your religious beliefs, *abiamo tooto* (real mother) will involve you going to any length to protect or save your children and grandchildren in the case of trouble. [Interview with a 67-year-old married woman].

Among the females, the inclination towards children's well-being and support for family members was more common than among the males. The male participants expressed a desire for independence and control, while, for the females, the concern was towards dependence and support from others. Physiological changes and personal experiences of frailty may have provided opportunities for the participants to engage in instrumental reflection and desire to observe certain cultural rights and duties. Avoidance of overdependence occupied a focal point, as some participants had to engage in different economic activities for financial and non-financial reasons.

To some other male participants, marrying a new wife or attracting new forms of relations was also a possible way to reduce stigma and subjective loneliness:

> Many healthy elderly men have married younger women in old age to keep themselves warm and reduce loneliness. [FGD men aged 70-79years, Sango Community].

> While active engagement in penetration is less frequent in old age, it is a way of maintaining your masculinity as a man. [FGD Men aged 80 years, Aperin Community].

> Money is imperative in old age. Once there is money and good health, you will be free to have whatever you want. There might be variations in experiences, for instance if an older man marries a younger wife. However, peace of mind is guaranteed when there is money, and you know, with health and money, women will come. [FGD with men aged 60-69 years, Bodjia].

A new wife in old age will require some level of financial responsibility. As an embodied reality, the cultural and individual interpretations of the notion of good old age would reflect on how social actors locate and describe their ageing experiences with respect to beliefs, values and practices that are helpful or otherwise to enjoying longevity, minimising disease or illness experiences in old age (Martin et al., 2015).

Bodily Changes, Duties and Rights in Intimate Relations

Bodily changes occur across the life course, and the psychosocial effects vary among individuals and social categories. Seen through a theory of practice lens, the body, as a dynamic psychosocial field, attracts diverse habituses that affect social relations and outcomes in diverse ways. This influence also occurs as social actors define and attach different sexual values to bodily changes. In this regard, the participants discussed bodily changes and how they affect duties, rights and moral correctness that govern marital and sexual relations. The characters in the vignettes stimulated the discussion and provided possible contradictions that confront social actors in their sexual desire and expression in and outside morally correct contexts.

The initial focus was on duties and rights in intimate relationships and marriage in particular. Irrespective of age, certain duties and rights are inherent in intimate relations. Deviation and inability to observe cultural norms and values that dictate duties and responsibilities associated with marriage could create tensions. The participants acknowledged the existence of gendered roles and expressed the need for couples and partners in intimate relationships to be committed to these roles. In marriage, husbands and wives must commit themselves to some basic responsibilities without which a home would be in disarray. A husband, for instance, must provide food, clothing, and shelter and satisfy his wife/wives sexually. Similarly, a wife must reciprocate by timely preparation of food for members of her household and willingness to satisfy her husband's sexual needs.

The FGD participants emphasised the crucial role of sexual satisfaction in harmonious marital relations. In one of the FGDs with women, the participants contended that sexual satisfaction and commitment to a husband's sexual demands depend on his performance of other duties. Such efforts are often appreciated and reciprocated where possible. This view was also corroborated in the narratives of four interviewees who believed that commitment to a partner's sexual needs also depends on performance of other responsibilities. Once a woman has such assurance, commitment and willingness to satisfy a husband's sexual needs could be assured:

> A woman that is loved by her husband will find it easy to respond to sexual demands even in old age. It is usually difficult when your husband flirts around and hardly provides for his children and wife at home. [An elderly woman aged 79 years, FGD with women, Kobiowu Community].

The female FGD participants noted that most women, especially those in polygynous marriages, have mixed experiences. The cultural view that a woman must submit her body to

her husband has caused much havoc for some women. The argument of these participants centred on the egocentric attitudes of some men who are fond of claiming ownership over their wives' bodies while failing in their responsibilities as breadwinners and giving support for their wives. Such failure creates an unnecessary burden for women and could compromise their well-being in some instances. In fact, in two of the FGDs with women aged 60 to 69 years, the argument was that some men were unfair to their wives, including those in monogamous marriages. Similarly, a worse situation was described for women in polygynous marriages characterised by unequal and unhealthy rivalry and competition for a husband's attention; and inadequate material resources often prevail. The difficulty in surviving polygynous marriage may also be found in a common Yoruba proverb, which says:

> *Obínrin tí ko lórogún ko tii màrùn tí ńṣèun.*
> (A woman who does not yet have a co-wife does not yet know what disease she has (Owomoyela, 2005, p. 308).

In reacting to the vignette characters, the participants based their arguments on the difficulties and partialities that are associated with marital duties and responsibilities. To balance satisfaction and performance in marital responsibilities is difficult. Each wife is a unique entity, and it could be difficult for Baba Alamu (the character in the vignette) to please or love each of his wives, including the concubine, equally. Nevertheless, a minimum provision of food, shelter, as well as clothing and willingness to satisfy the sexual needs of the wives and the concubines remain essential to harmonious marital relations.

> His sexual behaviour will fetch him disrespect from his wives and children except he takes good care of his home without any favouritism. If he can readjust and start performing the responsibilities of a father, then they will regard him as being a responsible husband. [FGD men aged 60-69 years, Bodija Community].

> He is the one that has the means that he marries three wives, and he must take good care of them. I see the concubine as an extra thing for him, and it depends on whether he can care for all of them. As regards the concubine, Baba Alamu knows his capacity, and since he can take care of the concubine, the concubine might become one of his wives with time. If God allows him, the concubine can have a child for him and even inherit out of Baba Alamu's properties if God blesses him and he lives long to old age. [FGD men aged 70-79 years, Sango Community].

> As we ask God for help, we need to exercise caution. Allah encourages us to have the number of wives we can cater for and satisfy sexually. If the man cannot, then, that is a sin. Some men cannot do more than once, and there are some who are capable and gifted in that area. [FGD men aged 70-79 years, Sango Community].

In principle, Baba Alamu is required to perform these basic responsibilities without favouritism to any of the wives or concubines. However, in practice, equality and fairness are scarce, as most husbands would want to treat their concubines better than their wives and prefer one woman to another.

> The man will focus more efforts on how to satisfy the concubine than on the wives at home. If the knowledge of his extramarital affairs gets to the knowledge of his wives, it will lead to a problem at home, and it may destroy his home. On rare occasions, his wives at home may also imitate him and start engaging in extramarital affairs and through that act Baba Alamu might be infected with sexually transmitted infection by his wives' illicit affairs. [FGD men aged 60-69 years, Bodija Community].

> Baba Alamu will be engrossed with his concubine, and he will do different things with her, such as sex, and provide whatever she demands from him. However, the wives at home may enjoy less of such things from him. For instance, if wives at home should demand four things, hardly will he do two; likewise, the children, as he will be preoccupied with satisfying his concubine. [FGD with women 70-79 years old, Kobiowu Community].

There is no doubt that there are challenges in maintaining several wives, children, and concubines. Each marriage, whether monogamous or polygamous, has its peculiarities and challenges. Understanding the inherent uniqueness and difficulties in heterosexual relations is fundamental in several dimensions to marital satisfaction. The FGD participants commented that polygynous marriages were characterised by inherent tensions and rivalry. Concerning the vignette, the FGD participants opined that Baba Alamu would require patience, wisdom, knowledge and hard work to maintain peace and harmonious relations with and among the women in his life.

To some FGD participants, these behavioural traits are important, especially if one of Baba Alamu's wives was young. For this group of participants, Baba Alamu would prefer the younger wife to the older ones for several reasons. For instance, the younger wife might be more beautiful, sexually expressive and active than the older wives. Thus, Baba Alamu would devote more time to his younger wife at the expense of the other wives. By this action, frequent sexual intercourse would likely occur. However, the consensus was that Baba Alamu's sexual needs might have influenced his interest in a younger woman. A normative position among the participants was that women who have reached menopause must withdraw gradually from sexual activities. On the emotional front, an average woman would be jealous that her husband is having sex with other women. Some of the female participants narrated how the use of a rotational timetable could guide and reduce tensions and rivalry:

> He will be entering their rooms (having sex with them) regularly. He must not say that any of them offends him; therefore, he will not enter her room. No matter their number, he must be doing that. Giving them the same amount and even their children must receive equal treatment, and he must not have preferences. [FGD with women in Kobiowu, 70-79years].

Thus, to reduce the emotional breakdown and unnecessary rivalry among the wives and the concubines, Baba Alamu must be firm in his decisions and avoid favouritism.

The male participants argued that women could be very emotional and reluctant to forgive. This high emotional state of women promotes frequent quarrels and inevitable rivalry among women in polygynous marriages. Under such circumstances, any wife that wants favouritism from her husband could engage in diabolic means to achieve desirable change. The participants claimed that, to reduce unnecessary rivalry, Baba Alamu must satisfy the wives and the concubines with sex, money, gifts, non-financial support, and attention. The participants, however, argued that, owing to bodily changes, the older wives would have retired somehow from sex, while Baba Alamu's ability to satisfy the younger wife was also doubted.

Sex and Sexual Activities in Reproductive and Post-Reproductive Stages in Life

In reacting to the sexual behaviours of the vignette characters, the FGD participants expressed both gendered and normative positions concerning sexual activities in old age. These differences and influence emerged vividly as the participants presented consensual and divergent positions related to sexual desires and expressions from an age-grade position. A similar dimension was also found in the interviews: both male and female interviewees expressed an age-grade position to sexual desires and expression within a normative frame of heterosexual marriage.

In particular, sex was considered as an essential duty and right in heterosexual relations. With age, the performance of sex as a duty and the right attached to it in interpersonal relations changes in a differentiated manner within and across genders. The variation was attached to bodily changes and normative beliefs and values associated with the body. Thus, efforts were made to probe further the perceived effect of bodily changes on sex and sexual activities in old age.

With reference to menstruation and menopause as bodily changes, the participants viewed sex and sexual activities through a binary lens. For a group of the FGD participants, sex and sexual activities are useful and pleasurable in the reproductive stage of life for both men and women. In the post-reproductive period, which was marked by menopause for women, sex and sexual activities become stressful, risky and unbeneficial for women. In contrast, sex and sexual activities could be beneficial for men, though at a degree that varies from one individual to another.

Throughout the qualitative phase of the study, the participants demonstrated how normative beliefs influence sexual desires and expressions across the life course. The normative framework was also employed in differentiating gendered constraints and opportunities for men and women to make sense of their sexuality.

The preceding inter-related sub-themes provide contexts and rationale for possible expression, suppression, engagement, and disengagement from sex and sexual activities.

Menstruation and Sexual worth of the Woman's Body

The participants presented symbolic interpretations of menstruation and sexual activities. First, menstruation was conceived as a negative influence on sexual pleasures and a possible source of contracting a folk disease called *idakole* (poor erection). Second, there was the view of possible spiritual implications that sex with menstruating women could have on their male sexual partners.

The participants described menstruation as what makes the body unclean and smelly. During menstruation, unclean blood and other wastes are forced out of the woman's body. At this point, sexual intercourse was conceived as risky and dirty. Sexual intercourse with a menstruating woman could, therefore, open the male body to sexually transmitted infections. In this view, the woman's body is a platform for sexual pleasure and contraction of infections. To make the body safe, attractive, and appealing for penetrative sex, intercourse must be avoided during menstruation. In addition, personal hygiene and cleaning of the vagina would make the woman's body more attractive to her partners. These extracts from the FGDs with men in Bodija and Oranyan provide additional information:

> A woman that is dirty will have body odour that could become worse with menstruation. Such odour is enough to chase away her husband. She will look so ordinary and sexually useless to her husband. [FGD with men aged 60-69 years, Bodija Community].

> If not for the love for children, I would not have married. Women smell a lot during menstruation, and that makes me feel irritated. They also spread many diseases, as they are exposed to many things. [FGD with men aged 70-79years, Oranyan].

> Most men appreciate women that are clean. Even though many women are busy and work hard to support their families, they must look neat. [FGD with women aged 60-69 years, Bodija Community].

> A woman that keeps herself clean and her bedroom will easily attract her husband sexually. *Obun shosho, oloorun kole faa oju oko ree mora* (A dirty and smelling wife will hardly enjoy her husband's attention). [FGD with women aged 80 years and above, Inalende Community].

The female participants suggested some measures to this situation. Daily hygiene, neat hairdos and cleansing of the vaginal area could improve the attractiveness of a woman to her husband. Items such as lime, orange and alum, also called potash alum, were described as common measures that could improve vaginal hygiene. However, with age, the washing and cleaning of the vagina for attractiveness becomes irrelevant. Their argument was that vaginal secretion reduces with age. In line with this position, an interviewee opined that the practice of washing and keeping the body clean continues in old age, but vaginal washing has benefits for women of reproductive age. In her opinion, such measures also tighten the vagina, which some believe affects sexual pleasure and satisfaction during intercourse. In her words:

> Elderly women that are sexually loose may indulge in some practices to keep their vagina wet and neat. However, it is a practice that is common among younger women. People believe that childbearing women are likely to have wide vagina opening. [Interview with a married woman aged 64 years].

Within the study location and other Yoruba communities, lime and alum are used for different purposes, including cleaning and removal of grime from snails, fish and the human body. The availability of these items and their everyday use for food preparation may have increased their usefulness for vaginal cleansing among reproductive age women. As widely expressed by the FGD participants, daily routine and domestic chores can be burdensome for most women and could increase body odour and make personal hygiene challenging.

> Menstruation and too much work can make a woman smell. Thus, personal hygiene and regular baths will make her body fresh and attractive. [FGD with women aged 70-79 years, Sango Community].

The acceptability and expectations concerning hygiene during menstruation were further situated in a constructivist framework. In this frame, menstruation was construed as a possible source of sexual infections, *idakole* in particular. A folk illness, *idakole* symbolises weak erection and quick ejaculation. The participants acknowledged the possibility of contracting *idakole* and other forms of infections through different sources, including multiple sexual partners. The participants pushed their position further, lamenting the growing prevalence of *idakole* among young men. In their opinion, early exposure to sexual activities promotes promiscuity and sexual indiscipline. Such habits are difficult to change once formed and could continue into old age. However, there was confusion, as some of the participants also linked *idakole* to poor treatment of previous sexual infections and heavy consumption of sugary substances. In any case, the participants stressed that sexual intercourse with menstruating women can increase susceptibility to varieties of infections:

> There are chances of you contracting urinary tract infections (*iseto*) when having intercourse with a menstruating woman. [FGD with men aged 80 years and above, Inalende Community].

> Some men have complained of contracting infections during sex with menstruating women. However, they often come down with different symptoms. [FGD with women aged 60-69 years, Bodija Community].

> There are risks for a man to engage in sexual intercourse with a woman during her menstrual period. It can cause infections and at the same time lead to weakness of the male organ. [FGD with men aged 60-69 years, Bodija Community].

With the construction of a folk illness like *idakole*, the male participants again appraised and supported the need for a variety of medical treatments, especially with the growing burden of

sexual infections. They asserted that *idakole* is hardly treated or seen as a disease in the hospital. But some of the participants also linked *idakole* to poor treatment of previous sexual infections and heavy consumption of sugary substances. Irrespective of the divergent views, the consensus was that the availability of traditional remedies to some of these infections should motivate those suffering from such conditions to seek help. For *idakole*, traditional herbal remedies are available from herbal vendors and herb sellers, as noted in this excerpt:

> *Idakole* is a common condition among men of this generation, and it is because they sleep (have sexual intercourse) with women during menstruation. You can see that so many herbs sellers are in town selling different medications on *idakole* and many young men patronise them. [FGD with men aged 80 years and above, Aperin Community].

These remedies are potent and accessible, as articulated by one of the herbalists and diviners:

> Herbal remedies can help in several ways and *idakole* is one among the infections that herbal remedies can cure. People must appreciate the potency of these remedies and use them regularly.[(Interview with a male diviner/herbalist, aged 83 years].

While the psychological effects of flowing blood might be offensive and influence the chance that a male will suffer from *idakole*, the availability of treatment options makes it concrete. Thus, as *Idakole* is a folk illness, traditional remedies would receive more acceptance and suitability in the study location.

Periodical sexual abstinence could prevent *idakole*. According to the male FGD participants, abstinence from sexual intercourse should take place some days after a menstruating woman has finished her monthly period. The normative belief is that any man that defies this warning may suffer from *idakole*, other forms of sexual infections, and possible loss of spiritual powers. The perceived spiritual implications of intercourse during menstruation were well explained by the male participants.

The participants lamented that, despite the warnings and beliefs about sexual intercourse with a menstruating woman, there is indulgence in indiscriminate sex among young men, even during menstruation. In their opinion, early exposure to sexual activities promotes promiscuity and sexual indiscipline. As opined by the FGD participants, such practices, among other things, affect sexual performance and leads to erectile dysfunction:

> People have thrown caution to the wind through their lifestyle, and this is affecting their sexual performance and ability to satisfy a woman sexually. This is one of the reasons some young girls prefer sex with old men. [FGD with men aged 70-79 years old, Oranyan Community].

> We cannot rule out that some women have sex during menstruation, but it is not good practice. [FGD with women aged 60-69 years, Bodjia Community].

> Some useless men do not mind having sex with any woman whether such women are menstruating or not. [FGD with women aged 70-79 years, Sango Community]

Some of the female FGD participants described some men as unconcerned, as they would have intercourse with a menstruating woman.

In the FGDs with women aged 60 to 69 years, the participants described menstruation as a messy period and a stage to abstain from sexual activities because the flow of blood will affect pleasure. They observed that intercourse during menstruation was unhealthy based on taboo, but it does not expose men to infections.

Beyond the implied effects of menstruation on sexual health, sexual intercourse during menstruation could result in loss of spiritual powers or produce setback in life. Similarly, menstrual flows can render traditional charms for luck, protection, and favour powerless. The perceived association between menstruation and spirituality was widely shared among the

male participants. For the males, menstrual blood has some spiritual significance and caution must be exercised. In this regard, sexual intercourse was again described as an activity that has spiritual implications:

> Normatively, a man that sleeps with a menstruating woman would experience backwardness and slow progress. [FGD with men aged 60-69 years, Bodija Community].

The above view cut across the different FGDs with the males. This view is linked with some taboos on sex and efficacy of some traditional medicine. Some traditional charms that are worn for certain reasons must be removed from the body before engaging in sexual intercourse. Similarly, there is a cultural belief that a menstruating woman must not touch some charms or medicines to protect their efficacy (Makinde, 2004). Some of the participants affirmed that a man with spiritual understanding would avoid sex during periods of seeking divine intervention, preparation for rituals or during spiritual warfare:

> In life, there are occasions when you need to seek divine intervention for things to turn around. At periods of *muyiba* (seeking divine help), some of the rites you will undergo need abstinence from sex, especially with menstruating women. [FGD with men aged 80 years and above, Inalende Community].

> Sex with a menstruating woman brings bad luck and retrogression in life. Avoidance is the watchword. [FGD with men aged 60-69 years, Bodija Community].

In advancing the relationship between menstruation and spirituality, some of the female participants asserted that sexual intercourse with a menstruating woman would bring bad luck to the man alone. Only a few of the male participants failed to describe menstrual flows as a substance that can neutralise diabolic powers over a man. For the woman, there was no such effect, except that menstruation could be messy for sexual activities.

Sexuality in Post-Reproductive Stage in Life

From an age-grade perspective, the FGD participants expressed their positions on four interconnected views on sex and sexual activities in old age. These views emerged from the focus discussion on the sexual behaviour of Iya Asake vis-à-vis the possible reactions that may trail her involvement in extramarital relations. Convergent and divergent positions also emerged in a subtle manner from the face-to-face interviews.

The first view affirmed sex as a duty and right in heterosexual relations. This social expectation portrays the woman's body as the man's sexual and reproductive field. The emergence of menopause changes the terrain for sexual activities. In menopausal period, the vagina becomes dry, as it produces little or no lubricating substance. The dryness makes penetrative sex painful for women and less enjoyable for men. Thus, some of the female participants considered menopause as an escape route from sexual duties. However, the reaction was dissimilar for some other women who had previous pleasurable sexual experience, in a monogamous marriage and with quality marital relations.

As a counter reaction to sexual retirement, some of the male participants capitalised on the situation and rationalised the need for extramarital relations or getting a new wife. Menopause provided different opportunities for both men and women to make sense of their sexuality.

Vaginal Dryness and Painful Sex

As stated earlier, in menopause, occasional and infrequent engagement in sexual activities was considered normal for women. There are consequences along the line. These include pain, discomfort and possible contraction of sexual infections. The participants described the dryness that comes with menopause and other changes as challenging and discouraging for sustained interest in sexual activities. They explained that the body had gone through a series of expansion and contraction through childbirth and frequent penetrative vaginal sex. All these activities make the body less receptive to pleasurable sex in old age. As a woman grows older, the vagina shrinks and becomes less accessible to the penis. These changes and the discomforting effects emerged in the participants' reflections on the intersection between bodily changes and sexuality of Iya Asake (the character in the vignette):

> At Iya Asake's age, the vagina dries up and brings out little secretions. The dryness of the vagina is a warning and a call to adjust her sexual desires. [FGD with women aged 70-79 years, Sango Community].

> Once a woman stops menstruating you will discover that her private part will be dry. That is why they will ask them to buy grease to cream the surface otherwise if a man should just insert this penis it will be painful unlike when menstruating. [FGD with women aged 70-79 years, Sango Community].

In a slight shift of position, some of the female participants acknowledged contextual influence on how women react to vaginal dryness and painful sex. Among this category of participants, other factors within and outside the marriage could alter the disposition of some women to painful sexual activities. The quality of the relationship with a spouse over the years could determine the preference and value placed on penetrative sex, as noted below:

> Though men demand sex more often than women, as they grow old, they still want each other, keep each warm, and talk together. It's not only sex…even talking together, sleeping together and then reasoning together…it goes along way. [Interview with a 73-year-old woman].

Similarly, an interviewee commented about the differences that exist among elderly women in relation to pain during intercourse. In the interviewee's opinion, some women have a peculiarity of having pains during intercourse. This only becomes worse and common in old age. Despite the inherent pains, some elderly women still engage in sexual activities. She acknowledged the indulgence of elderly women in sexual activities despite the chance of pains. In her view, such discomfort can be endured just to satisfy a partner:

> Despite their age and dryness of the vagina, some elderly women still engage in sex with their husbands. Dryness of the vagina makes sex difficult, but a woman can still endure if the husband satisfies her needs and does not keep other women. [Interview with a nurse aged 43].

> Haa!!! In old age, people engage in sexual activities at a much reduced degree. You see, in old age, the fluid that makes the body ready and sensitive to sexual arousal would have dried up. This makes sex stressful and causes displeasure compared to when a woman is still young in marriage. [Interview with a 73-year-old married woman].

Personal and relationship qualities could influence disposition to the perceived pains and discomfort. From her personal experience, a 68-year old woman described sexual activities as part of normal life in old age. She described how caring her husband was before his death and how they both engaged in sex even after she turned 60 years. According to her, personal satisfaction in marriage depends on many factors and no relationship is perfect. However, she agreed with the view that some women have good reasons to refuse their husbands' sexual requests. One such includes perceived flirting and unfaithfulness of their husbands. A

woman that knows her husband's sexual behaviours would want to avoid sexual relations once she enters menopause. Such action is premised on the need to avoid contracting sexually transmitted infections, especially HIV. Secondly, women in polygynous marriages would also find it difficult to sacrifice their well-being for their husbands. The reality that a man has more than one wife is sufficient enough for a woman to guide her loins in this period of sexual infections. The excerpts below explain further:

> Despite the pains that come with vaginal dryness, a woman would endure intercourse with her faithful husband. She can also think of other ways to satisfy his sexual needs rather than pushing him outside. [Interview with a 68-year-old widow].

> …even before menopause, it is always painful for some women to have sex. Therefore, once they enter into menopause they have good reasons to stop sexual intercourse. [FGD with women aged 70-79years, Sango Community].

The particularity and variability in response to vaginal dryness and sexual pains was also affirmed by a participant in one of the FGDs. The participant acknowledged the pains that come with vaginal dryness. But she noted that personal willingness and commitment to a marriage could make the difference. In her opinion, there are options to make a vagina wet and reduce the dryness that come with age. These include synthetic creams and local oil from coconut. The use of coconut oil has a long tradition among the Yoruba people. It is known locally as *adin agbon*. Women and men use the oil for several purposes, including the preparation of medicinal herbs. The choice of using a vaginal cream or *adin agbon* depends on other factors. The effects are similar, as the vagina becomes lubricated. In her words:

> Dryness of the vagina can be reduced by using a local or foreign lubricant. In hospitals, nurses have told me how the use of lubricants can reduce dryness in old age. Natural coconut oil works well, and it can be combined with other items for more pleasant odour. [A participant in the FGD with women aged 60-69 years, Bodija Community].

In contrast to the personal position and experiences of this FGD participant, some of the female participants in the FGD weighed the pains against the perceived lop-sidedness of sexual pleasure and satisfaction, as captured below:

> All the good things in her body would have gone by now. Even the concubine will not enjoy her sexually. A woman's body is more useful for sexual satisfaction when they are still procreating. [FGD with men aged 80 years and above, Oniyere Community].

> There are no benefits in such sexual activities. It brings satisfaction only to the man while the woman remains in pains and unsatisfied [Interview with an elderly woman aged 66].

As elaborated in the discussion on individual and gender differences in sexual desires and expressions, the quality of marital relations and experiences in marriage could aid the readiness of women to use menopause as an escape route from sexual obligations. Participants who shared this position asserted that the dryness and perceived pains associated with menopause could motivate women in such relationships to invoke their individual agencies and abstain from their sexual obligations.

Depreciation of the Woman's Body and the Need for Sexual Retirement

Sexual activities, pregnancy and childbearing, amongst other multiple responsibilities, reduce the social desirability of a woman's body. The participants described pregnancy and childbearing as activities that make women age faster than men do. To bridge the gap, the FGD participants appealed to a normative view that suggests quick and optimal appropriation of the benefits (sexual and reproductive) of the woman's body before menopause. A Yoruba common saying that supports this exploitation of the woman's body is 'Ile *obinrin kii pee suu*' (the night comes early for a woman). With stereotypical descriptors, participants explained further, how menopause shapes and devalues the sexual worth of the woman's body:

> When a woman is young and sexually active, her body attracts much value with both young and old trying to have a share. The moment a woman starts childbearing, depreciation sets in and then becomes useless once menopause starts. [FGD with men aged 60-69 years, Bodija Community].

> Women cannot afford to delay unnecessarily when it comes to marriage and childbearing. A man can marry and become a father in his 50s, but it is rare among women. [FGD with women aged 70-79 years, Kobiowu Community].

> Women are better positioned when they marry men that are older. Both of them will grow old together. In contrast, a woman that marries her age mate would grow older; while the husband remains younger and likely to have a younger woman as a wife or sexual partner. [FGD with women aged 80 years and above, Oniyere Community].

The bodily changes that come with childbearing and sexual activities affect both genders. The impact, nevertheless, was perceived more on the female body than on the male body, as noted below:

> Once a woman reaches menopause, it is all right for her to stop sexual relations. The good things already resulted, such as male and female children. [Interview with an elderly woman aged 83].

> Iya Asake has ‘run down’. Most women at age 60 to 70 are almost gone sexually. The only thing a woman can do is to keep the company of her concubine and husband. [FGD with men aged 70-79years, Sango Community].

The female FGD participants accepted bodily depreciation that comes with age, but affirmed the existence of sexual desires and occasional intercourse. As described earlier, interest in, and circumstances that influence sexual desires and expressions are dissimilar for both men and women. Relationship qualities, which include intimacy, perceived faithfulness and health, were critical for the female participants. The argument was that women that are happy in their marriages would likely endure the pains. In their view, each marriage has its own peculiarities. Within each type of marriage, satisfaction, challenges and tensions are inherent, but couples in such marriages would also react differently. Both the male and female

participants emphasised that women in unhappy marriages or those with health challenges would consider bodily depreciation as a route of escape from sexual duties. The male participants emphasised bodily changes, shape and sexual satisfaction that come with penetrative sex. The physiological changes that come with menopause would be reacted to differently by women and men.

The participants were asked to specify the age that elderly people should disengage from sexual activities. The age at which a woman reaches menopause differs and thus depends on individual experiences and circumstances within individual marriages. Some of the participants opined that, once a woman becomes a grandmother, then it becomes a moral responsibility for such a mother to disengage from sexual intercourse. A possible explanation for this could be found in the exemplary roles of mothers and their duties to their children. A participant cited a recent scenario involving a friend and how the child's disapproval of her mother's sexual relationships with a concubine was halted. This scenario is related below:

> Recently, one of my friends was humiliated as his relationship with a concubine came to the attention of the woman's son. What happened was that many people already knew my friend as Alhaja's concubine, and he visits her regularly. During one of his visits, my friend was unfortunate to meet one of Alhaja's sons who just returned from overseas and got the information that her mother has a concubine. Immediately he saw my friend, the boy became furious and nearly threw my friend down from the staircase. [FGD with men aged 60-69 years, Bodija Community].

The excerpt below is also informative:

> You see, once a woman reaches her menopause, she has just stopped sexual relations and is taking care of her children if she wants to eat /benefit from her children once there is no sickness. [FGD women aged 70-79, Kobiowu Community].

Parental responsibilities include acting as a role model to one's children in all spheres of life. The consciousness of living as an exemplary mother and the reciprocal support from children could serve as a barrier to sexual liberation in menopause. The participants expressed the view that mothers in polygynous relationships would need to support their children rather than struggle for sex. More pronounced competition and marginalisation of resources dominate interactions amongst wives and children. Elderly women from such backgrounds would, therefore, strive and commit themselves to their children's survival and avoid losing mutual support in old age owing to moral issues. Mothers would be constrained further in their sexual expressions, as such actions might be misconstrued as a misplaced priority. Children's approval or disapproval of sexual or intimate relationships in old age has implications for women's sexual rights and expression in old age. The loss of economic power and dependence on children for support and survival counts in collaboration with gender and relationship qualities.

The male participants found it difficult to place an age limit on men's involvement in sexual activities. The extracts below offer a picture of the varied suggestions given by females and males:

> The age of 60 years is enough for a woman. I cannot say specifically because around 80 years they may still be performing I mean 80, or 70 years, if the husband is still alive (not someone that has lost her hubby too early) and the man did not marry another woman. If they still get to sixty (60 years) it is still good. However, after 60 years, if the man still wants sex, she may tell him that she allows him to get it elsewhere so as to live long and eat from the children (FGD with women aged 60-69 years, Bodija Community).

> I know of a man at the age of 92 years, he is still sexually active, so for this reason, I don't think anyone can say the age limit to stop sexual activities (FGD with men aged 70-79, Odo Oba Community).

For the male participants, men's biological make-up places them at an advantage over the women. However, there are variations even among men. Some men are also at an advantage over other men. A critical rallying point for both male and female participants was the intention behind sexual activities in old age. To a reasonable point, a man that desires or has no child and has good health can continue to engage in penetrative intercourse. Citing several examples and personal experiences, a majority of the male participants and a few female participants rationalized this social justification:

> We had a father, who was very old, but even at 80 years, he still married a young woman, and she was carrying a baby by the time *baba* died. For men, a father may be up to 100 years, but for women, a mother must not be more than 50 years. Also, if a woman has stopped to menstruate, it is somehow dangerous to be having sex (FGD with women aged 70-79, Odo Oba Community).

> I was moved by this discussion as it reminds me of my personal experience. One cannot determine the exact age to stop as a man. Let me give you a personal life experience. I lost my firstborn who could have clocked 43 years by now. Unfortunately, he died and after much struggle and search for help from different sources, it took me 10 years to have another child. After having another child, I had to marry another woman after another delay. Events like this create difficulties in setting a time limit for men. Now, I am no longer trying to become a father. However, if I had stopped sexual intercourse after that incidence despite my age, maybe I would be childless by now. [A participant in the FGD with men aged 80 years and above, Inalende Community].

> Naturally, men, till they die, can be having sex except for those that have been engrossed with religion, but if he is not religious, and he has not contracted the disease, till he dies, he can still have sex. My father at the age of 100 years fathered a child, and that child was of marriageable age before my dad died. That is what is responsible for the act of having concubines (FGD with women aged 70-79 years, Sango Community).

Sexual Engagement and the Possibility of Becoming Pregnant with 'Oyun Iju' in Old Age

Continuous engagement in sexual activities, especially with multiple partners, will increase sexual pains, infections and the occurrence of *oyun iju* – another form of folk illness. Unlike *idakole*, *oyun iju* (fibroid) can occur in reproductive or post-reproductive age. In the FGDs, the participants described *oyun iju* as the consequence of indiscriminate or frequent sexual activities among elderly women. They claimed that the sperm deposited during intercourse resides in the womb due to lack of menstruation. With frequent deposit of sperm, fibroid would occur. The female participants reiterated their call for retirement from sexual activities to avoid *oyun iju.* The excerpts below reveal this:

> A woman that has stopped her menstrual period needs to abstain from sex to avoid a type of pregnancy called *oyun iju.* There are no neither traditional nor modern medicine drugs, vaccines for such conditions. [FGD with men aged 80 years and above, Inalende Community].

> After menopause, she should stop, if not she will contract sexually transmitted infections. [FGD with men aged 60-69 years, Bodija Community].
> In menopause, the male sperm becomes useless. It is only for reproduction that the woman's body requires sperm to function properly, especially for her menstrual flow. [FGD with male aged 80 years and above, Inalende Community).

From divergent positions, it could be concluded that both the male and female participants employed menopause to frame, interpret and demarcate women's sexuality and their subjectivity. Some of the male participants described menopause as a sign of the depreciation of the woman's body for pleasurable heterosexual relations. The women considered menopause as a route to refusing sexual demands from their husbands and avoidance of fibroid. The men interpreted women's sexual refusal as an additional rationale to engage in extramarital relations.

Extramarital Relations: Normativity and Contradictions

Because of the emphasis on sexual refusal, additional efforts were made to investigate the perceived implications and contradictions that trail such decisions. At different points and in reaction to the vignette characters, the FGD participants acknowledged and confirmed the reality of multiple sexual partners in old age. However, more males opined that extramarital relations are common among women in their reproductive age. The female participants observed that many men indulge in extramarital relations in old age and might have been unfaithful to their wives at least once in their lifetime. An individual's background could also influence the possibility of having multiple wives or engaging in extramarital affairs. The possibility was expressed in one of the interviews:

> You know for a man that may be the father had 6 or more wives, when he grows up too, even if he couldn't marry up to that 6, he will continue to have extramarital affairs till old age. [Interview with a doctor at a PHC, aged 54].

Viewing the issue through a normative lens, some of the female FGD participants (60-69 years) averred that an average married Yoruba man would desire sexual relations with at least two women rather than sticking to one sexual partner in a lifetime. The acceptability of the assertion that men prefer varieties and would desire extramarital relations or multiple sexual partners cuts across the FGDs with women. In one of these FGDs, the female participants described men as sexually insatiable:

> Men are covetous. Their libidos always push them; just as if one is being intoxicated by alcohol, so is their desire for sex. However, for the wives, they must have known him and, therefore, be taking care of themselves. [FGD with women aged 80 years and above, Oniyere Community].

In an effort to refute the assertion that men are inherently greedy for sex, the male participants shifted the blame to women and dissatisfaction with partners. They noted that

some wives enjoy refusing sexual requests from their husbands. As a way out, sexually active men can seek satisfaction elsewhere. Besides sexual refusal, poor sexual performance and unwillingness to improve was also cited. In some instances, some wives would oblige their husband's request for extramarital relations. Such was the case of a male participant in one of the FGDs:

> My first wife called me and told me she does not have the interest again. What then 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].

The position of the FGD participants is in consonance with the earlier position shared by the same category of the female participants. This perception and unwillingness to grant a husband's sexual demand were partially attributed to contextual factors, such as loss of affection, sex as a laborious duty, and perceived flirting of a spouse. For the male participants, menopause was identified as a key contributor, along with the view that the woman's body has dwindled in sexual value. Such contradictory positions open alternatives for elderly men and women to suppress or engage in sexual activities despite the consequences. For men, help and sexual satisfaction could be sought with willing married or unmarried women. Similarly, willing men can also patronise sex workers in the communities:

> There are women outside that would satisfy any man that has interest and the money to give them. [FGD with men aged 70-79 years, Sango Community].

> We have seen some elderly men who would visit brothels and sex workers to satisfy themselves. Such men are still better than those who molest and sexually abuse young girls in the community. [FGD with men aged 60-69 years, Bodija Community].

With regard to sexual satisfaction, some of the participants also blamed women and their wives for seeking pleasure outside. For this category of men, the ability to sexually satisfy a partner differs, but remains important in keeping a man at home. A similar view was also shared among the female participants, that some men lack the ability to sexually satisfy their wives and that could also encourage marital infidelity.

Despite the rationale for marital infidelity or multiple sexual relations, extramarital relations require discrete interactions in order not to attract a partner's bitterness. The particpants asserted that married couples must be discrete in their involvement if they had reasons to engage in extral intimate affairs. The need to avoid being noticed by one's partner has a series of benefits for the individuals involved and those around them. In expounding on this position, some of the participants claimed that Baba Alamu's sexual exploit and romance with his concubine could attract reactions and cause conflicts with his wives and children. To maintain relative peace at home, Baba Alamu's extramarital relations must exist outside the knowledge of his wives. This is because of the possible implications of such awareness for the women's sexual behaviour. It could encourage retaliation, as a wife may also seek revenge by having a concubine. However, such actions are culturally sanctioned and also depend on other factors, like the age of the woman, her social status (income, education, religion and the woman's parity) and the availability of spaces for secretive extramarital affairs (Delius & Glaser, 2004; Orubuloye, Caldwell, & Caldwell, 1991).

In the Yoruba culture, a man is socially allowed to engage in multiple concurrent sexual activities with little retribution from society (Caldwell, Orubuloye, & Caldwell, 1991). Both male and female participants in the FGDs (70 to 79 years old) condemned and criticised Baba Alamu for being in a polygynous marriage and his involvement in extramarital affairs. Their

opinion centred on the position that three wives at home should be enough for a man of his age and the demerits of extramarital relations. The female participants noted that, despite the long history of extramarital relations, the practice has more shortcomings than benefits. The core benefits of such relationships were attached to emotional satisfactions and sexual gravitation. These benefits are, however, subject to previous pleasurable sexual experiences, aversion to risk taking, and the availability of hidden physical spaces where interactions can take place without interruptions.

With affluence, the availability of partners and health status would help an individual who has the desire. In expanding on the availability of a partner, some of the FGD participants believed that some individuals, male and female, get natural attraction from the opposite sex. Based on cultural beliefs, some men and women would require diabolical means or spiritual support before they could attract an opposite sex mate for intimate relationships (Olatundun, 2013). This belief also holds in old age. Some of the participants argued that, while some old and older people are lonely and neglected, others are natural attractors, as they enjoy warm interpersonal relations with people around them. In the opinion of this category of participants, Baba Alamu and Iya Asake are individuals of affluence and sexual prowess. Such individuals attract the opposite sex with ease.This peculiarity might have paved the way for their extramarital relations:

> Baba Alamu has his secret that helps him out. If it is not, he cannot be doing that; if not that he has so much money that makes women fall in love with him. It is because he has a natural attraction (hair) for it (*o ni irun re lara*) anybody with such hair even if he has no money, of which some are tiny in age and women will always be after them to marry. [(FGD with women, Inalende Community].

> But sometimes, the younger lady does not have any husband at all, nobody is there again and time is going, you understand. You see, ladies that are 42, 43 years these days, no spouse at all, nobody to even call them. You know the population of female to male is $^{2}/_{3}$:$^{1}/_{3}$ by demography. So many ladies are just outside there, nobody to even beckon them; so it's an opportunity. Once they see a man, they wouldn't even mind the age; they would want to go for such a man and settle for their life, someone to call their own. [Interview with a doctor at a PHC, aged 54].

> That man you are talking about may not give them a dime, but it is because he has his hair. Once he has it, it is natural; every woman will love him. There was a woman like that from Oyo; she had seven husbands. [FGD with women, Inalende Community].

In addition to the divergent positions regarding predisposing conditions to extramarital relations in old age, some other factors also emerged from the various FGDs. These include subjective health status, regular source of income, secured meeting spaces and the availability of a willing partner. Some of the men argued that individual health and financial (in terms of income) status are important determinants. Once these conditions are satisfied, on average, the decision to have a younger wife or enter into extramarital relations becomes easy. There are consequences and benefits from engaging in multiple sexual relations. The participants again reiterated the possibilities of contracting sexual infections and chances of dying from *magun* (thunderbolt).

Social Risks of Contracting 'Magun' through Extramarital Relations

There are different types of *magun*, and each one has its remedy, which also differs from one medical practitioner to other (Ogunsakin-Fabarebo, 1998). The make-up and antidotes to each *magun* are different from one medical practitioner to another despite the similarities in symptoms and outcomes. In the Yoruba belief system, *magun*-related deaths are ways of

punishing sexual immoralities in marriage (Alaba, 2004; Esonwanne, 2008). *Magun* is a magical substance placed on a woman for her sexual partner to contract (Alaba, 2004). It can be put by any man on any woman to eliminate her sexual partner or as a form of warning to the woman:

> Once *magun* is placed on a woman and she knows it, she goes to the traditional doctor to give her an antidote. If she is not aware, and had sexual intercourse with any man, it is instant death for the man. If she doesn't receive any antidote and no sexual intercourse within a given period, death still remains the ultimate for a woman with *magun*. [FGD with women aged, 70-79 years, Sango Community].

> …such thing is still common among Ikire women because they do not stay in their husbands' homes. Their men do not like people to have affairs with their wives. Hence, they always put *magun* on their wives; one should be very careful unless one has a preventive measure for it. Ikire women hardly stay in their husbands' homes and are promiscuous, so their husbands often place *magun* on them. [FGD with men aged 60-69 years, Bodija Community].

> If *magun* should be put on a woman and that man too is a good adulterer, there are antidotes that he will use to draw it up (render it impotent) until he finishes. Some have immunized themselves against it; these are purely local and not Western drugs as such. [FGD with women aged 70-79 years, Sango Community].

Depending on the contexts, religious beliefs and social position or status, a man can decide to place *magun* on his wife, even when there are unconfirmed facts, to eliminate her supposed concubine or sexual partner. The social expectation is that within a short period, any man who has sex with such a woman would die immediately or within few days. Unlike the biomedical prognosis of disease, *magun* and associated symptoms defy empirical evidence and hardly provide any allowance for recovery (Agunbiade & Titilayo, 2012). The antidote to *magun* is avoidance of sexual relations with the woman-carrier or possession of a remedy that would seize the power of *magun* during intercourse (Aderinto, 2012; Moloye, 1992).

Only certain individuals possess the antidote and the knowledge of manipulating the power of *magun* before and during intercourse with a *magun*-carrying woman. This procedure is only temporal, a permanent removal and neutralisation of the *magun* effect often resides with the person that implants it. The woman carrying the *magun* is still capable of causing sudden death for whoever sleeps with her. The argument of the participants is that, once *magun* is placed on a woman, if not removed within a stipulated period, death is inevitable for the carrier. If a woman with *magun* also sleeps with her husband who lacks the knowledge and power to curb *magun*, his death is also inevitable. This explains the practice of shifting the potency of *magun* in an infected woman for sexual intercourse without the power to remove the *magun* completely except by the person who planted the *magun*. In principle, men that 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 infection. For instance, there is *magun* – a form of infection that kills immediately. 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 60-69 years, Bodija Community].

Based on the aetiology and symptoms associated with *magun*, the participants commented that only traditional medical means can effectively eliminate the effect of *magun* on an adulterer. The use of biomedical means, such as condoms and vaccines cannot remove the effects of *magun*:

> Condom cannot prevent an individual from contracting *magun.* The only prevention is for a man not to mount or climb a woman that is infected with *magun.* [FGD with men aged 80 years and above, Oniyere Community].

> An individual that has the knowledge and the antidote can have intercourse with a woman that has *magun.* This requires the use of charm to render it feeble for the man during intercourse. He will have enjoyable sex with the woman conveniently without any harm since he has the antidote. However, if another man tries the same without using the right antidote, death is certain. [FGD with men aged 80years and above, Oniyere Community].

The logic behind *magun* is inexplicable. It is magical in its operation. The fear that some married men, including the elderly ones, engage in extramarital relations clouded the discussion among the female participants. As a form of protest, the female participants declared their support for women who would avoid sexual intercourse, especially in menopausal age to curtail being infected. Having worked and sacrificed their individual agencies during the reproductive period, the post-reproductive stage demands vigilance, as all efforts must be in place to avoid being beaten twice. Similarly, some of the female participants also approved of the use of *magun* as a practice to enforce fidelity and punish marital infidelity.

Gender Differentials and Individuation in Sexual Desires and Expressions in Old Age

Individual factors, such as gender, previous sexual experiences, sexual beliefs and orientations alongside subjective health status affect sexual desires, expressions and engagements in old age (Gott & Hinchliff, 2003; Zeiss & Kasl-Godley, 2001). The FGD participants added biological differences and a normative view, that some individuals have the divine providence to outperform others in different human endeavours, including sexual activities. In this regard, the participants argued that Baba Alamu and Iya Asake might have

such privileged backgrounds that give them the opportunity to remain sexually active in old age. The view is presented in these extracts:

> God usually endows individuals differently with sexual strengths. One of our friends even had 18 wives before his death. Our friend and some other people like him are endowed with unique strength to satisfy women. Nevertheless, if a man is not endowed with such strength even if he had a wife he would perform on the average or below, especially in old age. [FGD with men aged 60-69 years, Bodija Community].

> For some men, after being with a woman it will take about ten or more days before he can think of doing such again. Among Baba Alamu's three wives, we may see one who does not like sexual intercourse like the other two wives. Some husbands engage in extramarital affairs because of their wives' attitudes and unwillingness to meet their husbands' sexual demands. [FGD with men aged 60-69 years, Bodija Community].

> There are some men with one wife, but who can have sex with five women in a day. We have different abilities and there are some women like that who cannot do without having sex in a day even in old age. Any man that marries such a 'dog' will not be able to satisfy her sexually. We are not equal; some men are so strong that they cannot do with having sexual intercourse. [FGD with men, aged 80 years and above, Inalende Community].

> Some women can do it every day and might fall ill if there was no opportunity for them to do it. For some other women, they can stay without sex for months and years. [FGD with women aged 70-79 years].

The argument in favour of biological factors and divine positioning was more dominant among the male participants than their female counterparts. From personal experiences and those of others, some men and women believed that they are sexually active because God created their genes that way. This privileged position gives them an edge and the opportunity to enjoy good health and their sexuality. In the FGD with men aged 60 to 69 years in Bodija Community, the argument became heated in response to the suggestion that one of the

participant was proud to talk about his sexual prowess and how the note-taker (in his late 50s) and the author (mid 30s) would find it difficult to match his sexual performance.

In furthering the argument, a 79-year-old participant in one of the FGDs boasted of his sexual activities and performance. He shared a recent experience of how a young female undergraduate in the community was satisfied with his performance and has become a regular partner:

> I'm proud of my ability to satisfy a woman sexually and I pray for more strength and good health to enjoy my old age. No woman, young or old, can take me for granted when it comes to sexual satisfaction. [FGD with men aged 80 years and above, Inalende Community].

To buttress the issue of individual differences in sexual prowess and indulgence, another participant shared how recent health challenges forced him to reduce the rate at which he engaged in sexual activities. He enjoyed frequent sexual intercourse until there was a health challenge. Now, he had to reduce his sexual activities to avoid the risk of breaking down owing to over-indulgence:

> I used to have sexual intercourse on a daily basis with my three wives; they are menstruating. Most of my friends warned me to reduce it but I did not listen to them but continued until 65 years, eventually I became sick and was on admission at the University College Hospital. Now I have reduced it; I do it few times in a month and I feel much better now with good health even now that I am 67 years old. [FGD with men aged 60-69years, Bodija Community].

The FGDs with women also confirmed the individual differences that exist in the desire and engagement in sex in old age. From a biological position, a biomedical practitioner emphasised the role of genetic influence on sexual desires and expressions:

> Even as a youth, the drive differs. Even to a woman; there are some women that are very, very active. It is not a fault of theirs. It is not because they are loose. It is just their biological make-up; you understand? You put your finger there and I mean they go crazy, you know, they are just maniacal about it. And the same thing goes for the men. Once they are just with their spouse, they could have it daily in a week. Some men can even have it twice in a day. So, it differs from man to man, whereas some men, I know of a patient that I just saw today who shared her experience with me. She narrated that, for 9 months, the husband did not see her at all. They didn't have any sex, you know, for 9 months. So you see that; and the woman is just 53 years. Taken, the husband will be about 60 years of age. [Interview with a doctor at a PHC, aged 54 years].

However, there was a shift from biological explanations to cultural stereotypes and misconceptions about female sexuality. In one of the FGDs, the emphasis shifted as the women appealed to a normative myth around cutting the umbilical cord of a girl child:

> Before biomedicine, we had our way of cutting the umbilical cord of a new-born. The umbilical cord of a new-born (female) must be cut beyond the knee cap. Failure to follow this measurement will make a girl child promiscuous when she grows up and will be promiscuous even when she grows old. [FGD with women aged 80 years and above, Inalende Community].

The above view was premised on the fact that improper handling of the umbilical cord would stimulate early sexual desire and engagement in sexual intercourse for such a girl child. This myth about sexual promiscuity in women is similar to the cultural myth about cutting of the external female genitalia. The belief is that when cutting the umbilical cord, it must not go beyond the knees. If it does, such a girl child would be sexually promiscuous to old age.

Similarly, once a girl child is circumcised, the external female genitalia must be buried. If not, once a dog picks it, such a girl would also grow up to become sexually promiscous. Some of the participants averred that the female character in the vignette (Iya Asake) could have had her external genitalia eaten by a dog or the umbilical cord cut below her knees. One of the ways to insure the absence or non-occurrence of any of the incidents (external genitalia and the umbilical cord) is to conform to societal recommendations around female sexuality and suppress the desire for sexual pleasure in the post-menopausal stage in life.

From the foregoing examples, it is evident that the existence of gendered dispositions to sexual activities in old age provided a ground to test the influence of individual variables, like gender, age, marital status, education and religious affiliation on sexual desire and expression in old age. The survey questions were aimed at understanding the individual variables that could also account for the variations in sexual desire and expression among elderly men and women.

Table 7: Socio-demographic Characteristics of Respondents and Differences in Sexual Desire and Expression

	Low SDE	Moderate SDE	High SDE	Test of sig.
Gender				
Women	72.9%	24.3%	2.8%	$\chi^2 = 58.94$ Df= 2
Men	31.5%	34.3%	34.3%	P= 0.000
Age				
60-69	50.4%	29.2%	20.4%	$\chi^2 = 6.29$ Df= 4
70-79	58.7%	26.7%	14.7%	P= .179
80 years and above	65.0%	30.0%	5.0%	
Marital status				
Married	44.4%	29.8%	25.8%	$\chi^2 = 29.30$ Df= 2
Divorced/Widowed	71.3%	26.7%	2.0%	P= .000
Education level				
No formal education	58.3%	30.2%	11.5%	$\chi^2 = 8.05$
Primary education	56.4%	24.4%	19.2%	Df= 4
Secondary and Post-Secondary	40.0%	31.4%	28.6%	P= .090
Religious affiliation				
Christianity	57.5%	27.5%	15.0%	$\chi^2 = 0.28$ Df= 2
Islam	54.1%	29.1%	16.9%	P= 0.87

As seen in Table 7, more men (34.3%) than women (2.8%) expressed high sexual desire and more willingness to engage in sexual activities. The test of significance also shows gender as statistically significant in terms of differences in sexual desires and expression. Such significance was not found based on age. A significant difference also occurred based on marital status. The significance of gender and marital status in the variations in sexual desire and expression has some cultural inclination. Within and across genders, such variations also emerged in the narratives of the qualitative participants. By appealing to biological and psychological variables, some elderly men and women were perceived to have certain peculiarities in terms of sexual desires and expressions.

The thesis about mishandling of the umbilical cord is a confirmation of how normative beliefs influence the sense men and women make out of their sexuality in old age. For the female FGD participants, the ability to supress sexual desires and engagement in sexual activities would imply moral correctness and acceptability of their womanhood. Conversely, sexual prowess signifies masculinity and healthy ageing for men. With bold categorisation of sexual rights and duties in marriage, a healthy man would possess the ability to satisfy his wife or sexual partner in diverse ways.

Sexual Prowess in Old Age

For men, power implies sexual prowess, while, for women, it means the ability to suppress the desire and control the urge for sexual activities. With beliefs in culture and the potency of traditional medicine, some of the male participants in the FGDs emphasised the gendered differentials in the symbolic interpretations of strength and penetrative sex:

> As said earlier some women grow older than men do. For instance, if our *Bale* here is given a young woman today as a wife, I'm sure he will be touching the woman. *(Interjection from Bale – 'yio kuro ni die (not once in a while, but regularly)).* You see the three wives, there are chances that Baba Alamu did not marry all of them at once, therefore, one among the three wives will be young. With age, women's interest in sex reduces. Therefore, if the first wife is the oldest, there are chances that she could inform her husband that she is no more interested in sex. My first wife once told me she does not want sex anymore; she does not want to have sexual intercourse anymore because she stopped her periodic menses (menopause). I accepted her explanation and faced the second one. [FGD men aged 60-69 years, Bodija Community].

As noted in the above extract, the male FGD participants reiterated the danger in post-menopausal sexual activities for women as against the emphasis on pleasure for men. Continuous engagement in sexual activities was considered harmful to the woman's body

owing to bodily changes, while traditional remedies could aid and improve the male body and readiness for penetrative sex. From different directions, the FGD participants demonstrated their approval of these normative beliefs, as indicated in the following extracts:

> I said that her private part would just be dripping. Don't you know that if a woman continues in sex after menopause, her vagina will be dripping? [FGD with women aged 80 years and above, Oniyere Community].

> There are some young ones like 30 years now that have no strength to walk a long distance; they cannot even compete we people of our age. You will see them shaking. [FGD with women aged 70-79, Odo Oba Community].

The impression that the use of medicine could aid masculinity and sexual prowess was expounded further, as the participants gave examples of traditional medical approaches to sexual enhancement. Starting with incision on the skin and wearing of amulets, participants described the existence and effectiveness of explicable and inexplicable traditional therapies for enhancement of sexuality. In the category of inexplicable therapies, incisions made from a remedy using the tail of *oka,* the Yoruba name for cobra, topped the list. The popularity of this view was also alluded to in one of the interviews with a biomedical practitioner:

> You know in Yoruba land; they make this proverb/adage. They say, 'until a man dies before the tail will go dead.' You see that the tail of a snake you know goes dead, so meaning to say that the man is always there, strong, you understand; but for the woman, it is the converse, okay, but one cannot cheat nature. [Interview with a doctor at a PHC, aged 54].

The idea behind this therapy derives from the notion that the cobra's tail represents a critical source of its power and remains noxious even in death. As evident in the literature, African traditional medicine operates on a binary philosophy that underlines the existence of spiritual

and physical dimensions of all forms of realities. This is exemplified in the African notion of medicine as any substance that can effect a change in any form and anytime without barriers (Van den Geest, 1997). In the FGD with males aged 80 years and above, a participant eulogised the efficacy of an incision prepared with a cobra tail for sexual performance until death and was echoed by others:

> For men, we have some traditional remedies that can boost a man's libido and erection until old age even when a man is 100 years and above. That is why we have a proverb that says *Oka* ko *kii ku de ibi iru* (no matter how lifeless the cobra is, the tail is always potent). We use this to make special medicines for men and any man that uses it will keep on having an erection to death.[An 82-year-old man, FGD with men aged 80 years and above, Inalende Community].

> From what we know and have seen around us, some men could have sexual intercourse with ten (10) women in a day, but with help of a particular locally made beads called *olonde* which prevent sexual infections and longer sex during intercourse. [FGD with women aged 60-69 years, Bodija Community].

With changes and growing modernisation of traditional medicine, some alcoholic beverages with possible aphrodisiac claims are now hawked on the streets and grocery shops. The participants claimed their awareness of these emerging beverages:

> *Osomo, Tesojuee,* and *Pakurumo* are the recent modifications of traditional herbal medicine by individuals like Yem-Kem, Oko Oloyun and others. These herbal products are made with dry gin and other herbal ingredients. The major difference between these herbal mixtures and traditional herbal drugs is their potency, branding, and packaging. [FGD with men aged 80 years and above, Inalende Community].

> At parties, these alcoholic beverages and energy drinks are freely served, and both men and women drink them. [FGD with women aged 60-69 years, Bodija Community].

Some of the participants hypothesised that Baba Alamu and some of his likes would need a few doses of *ale* (any substance that supports penile erection) before they can satisfy their partners:

> Caring for one's body is imperative. A Yoruba adage says *'tiku-tiku l'aawo agba, agba lo mo ise aiku'* (It is the elderly one that knows how he is getting well). Since he has three wives and a concubine outside, he must take good care of his body either by the use of the herbal powder (*agunmu*) or concoction (*agbo*). He can also visit the hospital or get some drugs that will flush out dirt from his body. These efforts are beneficial to maintaining good health in old age. [FGD with men aged 60-69 years, Bodija Community].

> Women don't use such drugs… the few ones available for women are to conceive or protect infections. Men use drugs to stimulate a strong erection and enjoy sex better as men. [FGD with men aged 60-69 years, Bodija Community].

> He will be searching for herbal drugs or orthodox medicines. Since he has interest in sex, there will be the urge to look for support and such medicines are available. *(Chorus response, ki 'ara o le' and other things that will make him sexually active)*. [FGD with men aged 80 years and above, Inalende Community].

> They will be using traditional medicines such herbal concoction, herbal powder even the eating type *(aseje).* They may even use the orthodox types of medicines. [FGD with men aged 80 years and above, Inalende Community].

With the likelihood of real returns on investment, a series of herbal products, including alcoholic beverages, have flooded the markets with claims that they can correct weak erection, quick ejaculation, and low libidos. The possibility of profit motive as a contributor to the growing spread is also indicated in one of the extracts from the FGD with men:

> Some of these branded ones are not very potent and efficient as the ones our fathers used to produce in those days. Most of the people in the production of such herbal mixtures have profits as their primary interest going by the unit price of a 33cl of some of these drinks. Many men, young and old are suffering from quick ejaculation or poor erection and desire a boost to satisfy their wives or sexual partners. The situation is, therefore, lucrative for profit unlike before when an average person has the knowledge of herbs and their uses. Modern religious beliefs and love for the Western lifestyle is killing us. [FGD with men aged 80 years and above, Inalende Community].

Despite the flair for pleasurable penetrative sexual performance, the participants shifted their discussions to the possible dangers in frequent sexual activities. They reasoned that the energy required for intense sexual intercourse could compromise their abilities. Moderation was, however, prescribed to sustain good health and strength for sexual activities in old age. They advocated adequate rest, timely and moderate intake of balanced meals and instructional use of traditional herbal remedies. Some of the extracts provide further insights:

> Moreover, as one grows older, there is a limit to everything including sexual intercourse with women (*wamo ti san Obínrin*). If one does not reduce the frequency of sex with women such an elderly will have waist and back pain and may experience fracture that can lead to sudden death. Thus, it is necessary to be watchful and careful. No medical person can reverse one's age, or have you seen any medical doctor that can do that? Therefore, we need to be mindful of all these natural physiological challenges. [FGD with men aged 80 years and above, Inalende Community].

> The effect will start from the back of one's back and the individual will not be able to walk upright. He will suffer from back pains, and he will be suffering from insomnia, unable to sleep well at night. [FGD with men aged 70-79 years, Kobiowu Community].

> Another effect is that he will be walking in an uncontrollable manner as if something is pushing him as he walks. He might not die. That is why you will see a man that is young but will look like someone that is already 80 years and above. We see many of such men in the community and uncontrollable engagement in sexual activities causes it. [FGD with men aged 70-79 years, Sango Community].

The interviews with the medical doctors and nurses echoed the dangers in over-indulgence in sexual activities. The participants emphasized the need for health and fitness in old age, which requires some modification in lifestyle and everyday practices. In the words of one of the doctors:

> In old age it requires living a life of moderation and self-control to keep fit and move around town with limited support. Individuals who lack self-discipline and engage in frequent stressful activities would jeopardise their physical fitness. Regular physical activities are needed for elderly men and women that earn a living through personal efforts. [Interview with a doctor at a PHC, aged 54].

Among the FGD participants, any elderly person that has physical defects was described as *arugbo* (older person). This description exists outside chronological age and depends on fitness, especially mobility and comportment in speech and other forms of relations. Without physical mobility and fitness, an elderly man becomes an elderly woman that stays at home regularly. The participants opined that over-indulgence in strenuous activities, especially penetrative sex, would compromise the physical fitness of an individual:

> Some elderly men that are younger than us in age cannot walk straight again. We see many of them in the community and it's because they engage in *wamo wamo* (sex) everyday. Now they are not fit again and we are older than them. [FGD with men aged 80 years and above, Inalende Community].

> You can know an elderly woman that engages in too much sex in old age. Just focus on how they walk, their stomach and agility. You will notice how little wind will push them around. It is because they have not retired from sex.[FGD with men aged 70-79 years Sango Community].
>
> Some women have been careless with their bodies and shapes. Just look at them and you will see how haggard some are due to less care and maybe suffering. People judge you and describe you as old by your physical appearance and fitness.[Interview with a 63-year-oldwoman].

The above extracts also show the relevance of physical look and body shape to the females. Many of the perceived health implications revolve around the uterus and the womb as a receptive space for sperm. To keep fit and maintain good look, the female participants suggested abstinence and avoidance of sexual activities in old age. These preventive measures will reduce the danger of penetrative sex and absence of menstruation to flush out the male sperm from their bodies.

Some of the female participants expressed different mobility issues with women and attributed them to sexual intercourse in menopause. As affirmed earlier, the theory of individuation and the myth of the umbilical cord stimulate a high level of sexual activity in old age and compromises women's health in old age. Thus, it was logical to put up a defence and provide health reasons to avoid sexual activities in old age. For some of the women, sexual intercourse in old age, especially when a woman attains the age of 60 years, would result in physiological symptoms that will expose an elderly woman who indulges in too much sex in old age to some health challenges. Regarding the vignette of Iya Asake, some of the participants gave some health implications:

> Once a woman enters into menopause, she must not have sex anymore. If she does, her belly will swell up and, therefore, become a sicklier and create a problem for her children. [FGD with women aged 60-69 years, Bodija Community].
> It is the menstruation that will flush the sperm that men ejaculated into the woman; but once menstruation stops, all further ejaculation stays in the body in the lower part of abdomen and is stored there (FGD with women aged 70-79 years, Sango Community).
>
> That is what is called *iju* (fibroid) which will make her look as if she is pregnant. [FGD with women aged 80 years and above, Oniyere Community].
>
> Sexual activities in old age cause *oyun iju* (fibroid). Truly, because it is that sperm that women use for their menstruation, but once it stopped, the sperm will be stored in them. Go and check those people with a potbelly, they are still engaging in the sexual act, and it is not good, it causes sickness. [FGD with women aged 70-79, Odo Oba Community].
>
> I have told you that those that would not stop having sex after menopause are in UCH; by the time, their womb, uterus and vagina are linked together. [FGD with women aged 60-69years, Bodija Community].

The perceived health implications of the unused sperm in the woman's body could be a reflection of the cultural beliefs and world views that support patriarchal preference and differentiated opportunities for sexual expression that cut across the life course. By re-emphasising the possible health implications, social barriers are propagated and absorbed with little resistance, even among the elderly people. While continuous engagement in sexual activities does not represent successful ageing, the social constraints around sexual desires and expressions in old age could also have some unexplored implications for psychosocial well-being in old age.

Marital Relations and Interests in Sexual Activities in Old Age

Despite the social pressure and the impression that older women should suppress their sexual desires and feelings, there were some exceptions. To some female participants, contexts, especially within marriage, place a huge influence on sustained interest in sexual activities and the meanings women make out of their bodily changes. They stressed the relevance of quality of marital relations to sustained sexual interest. The quality of marital relations was measured based on openness, communication patterns, rapport, and perceived faithfulness. These factors, along with health conditions, account in diverse ways for the sustained interests and relevance attached to post-reproductive sexual activities. Sex within this context was described as beneficial and less harmful if engaged in moderately:

> If it is a monogamous family, I mean, only the wife and husband, even when the wife is around 60 years they may still be having sex *suke-suke* (occasional and slow sex) as opposed to frequent and rigorous sex that take place when the body was much younger. We have some women that are in their 70s who still engage in sex with their husbands. [FGD with women aged 60-69 years, Bodija Community].

> There would be no danger if sex was minimal and limited to an affair between a husband and a wife. I still allow my husband, just that it is occasional and unlike when we were much younger. However, it would have been difficult for me if he was married to another woman or I suspect his faithfulness. I thank God for my husband. He is a good man. [Interview with a 68 year old married woman, Sango Community].

> Some elderly women are still active sexually, and some of those educated and rich women have young men like their boyfriends. [FGD with women aged 60-69 years, Bodija Community].

> We have seen many cases where some *iya ile* (eldest wife in a polygynous marriage) fought her younger wife and accused her of taking their husband totally. [FGD with women aged 70-79 years, Sango Community].

The needed conditions for refreshing and useful sexual activities in old age were doubted in the separate FGD with women, especially those in the 60 to 79-year age category. For several reasons, the commitment desired by women in monogamous marriage is not practicable in polygynous marriages. The natural expectation is that men in polygynous marriages have divided attention and bias towards a particular wife. This creates rivalry and loyalty shifts from marital duties and responsibilities. For instance, the younger wife gets more attention and may be required to satisfy the husband sexually as often as possible. On the part of the older wives, withdrawal from sexual activities prevails. Nevertheless, they still demand their husbands' companionship and care through rotational routines. Dominant among such routines is an agreed roster on who and when to sleep in their husband's room, and preparation of meals for the husband or the family. Given this context, some of the women felt it was normal for them to reduce their stress level as they enter the menopausal stage in life.

Beyond perceived faithfulness and marital commitments, the FGD participants also averred that poverty and the challenges of everyday survival discourage interest in post-reproductive sexual activities. Women of low socioeconomic background engage in energy-demanding activities to support their households. In old age, several women would engage in different economic activities to fend for themselves and their husbands. Such activities could also include fetching of firewood to cook and other household chores. Continuous and rigorous physical activities are energy sapping, make women worn out, and make them look older than their real ages. Similarly, such activities increase body odour and allow little time for rest and leisure activities.

The female participants called for balance in order to enjoy and sustain interest in post-reproductive sex. Support for the husband and engagement in less stressful activities could provide the needed balance. However, for this category of participants, such balance might be difficult to realise at this period of their lives. The explanation was that, over the years, most elderly women have lost interest in sexual activities, as they have to rely on their children's support to survive. Some participants in the FGD with women (60 to 79 years) insisted that approval from one's children is necessary but rarely comes. This is because of the difficulty that elderly men and women can face when entering into new intimate relationships in old age. The fear that one's children could disapprove of such a relationship was considered high for wealthy people. The difficulty could be greater for women, as they would face opposition from their children. Often, such sexual partners are perceived as gold diggers, especially when the children depend more on their parent's wealth. Hence, the derivative benefits of living as an exemplary mother remain high among the female participants.

The qualitative findings supported existing findings on contradictions, tensions, and gender differentials on how men and women make sense of their sexuality in old age. In this regard, it became necessary to investigate the wider acceptability and the influence of individual factors on how elderly men and women view sexual engagement or disengagement in old age. This focus was also on the contexts and expectations that trail sexual activities in old age. For this purpose, the survey respondents were exposed to selected statements on sexuality in old age from the qualitative findings.

Table 8 shows these statements and to what extent elderly people agree with them. A majority (55.2%) agreed that interest in sexual activities is common among the elderly. However, the normative view that sexual health problems are part of the ageing process was widely shared among 79% of the respondents.

One principal finding from the FGDs with women aged 70 and above was the view that sexual disengagement or abstinence is beneficial and necessary to reduce the stress of sexual activities in old age. A probe of the commonality of this view across and within genders showed that more women (75.8%) than men (54%) agreed that elderly people of their age should stop having sex. Similarly, more men (66.7%) than women (27.8%) agreed that people of their age should engage in sexual intercourse at least once in a month.

Several factors, especially subjective and objective health conditions, could trigger or inhibit sexual engagement or disengagement in old age. The relevance of health status was expressed, with two-thirds (63.5%) of the respondents agreeing that elderly people have at least one sexual health challenge that needs medical attention. For instance, about two-thirds (60.3%) of the respondents agreed that elderly men and women should engage in sexual activities if their health allows. A similar proportion (79%) of the respondents agreed that sexual health problems, including sexual dysfunction, require some form of medical attention. The medicalization of ageing and sexual dysfunctionality might have contributed somehow to this view. The qualitative findings revealed how medical interventions in the form of enhancers are perceived as normal pathways to sexual health promotion. More than 50% of the respondents agreed with a gendered view that traditional remedies for pleasurable sex exist more for men than for women.

Table 8: Percent of elderly men and women who agree with some views on sexuality in old age

	Statements on Sexuality in Old Age	Women	Men	Total
2	Sexual health problems are a normal part of the ageing process.	77.1%	81.5%	79.0%
4	Old men/women have interest in sexual activity.	38.9%	76.9%	55.2%
5	Old men/women of my age engage in sexual intercourse at least once in a month.	27.8%	66.7%	44.4%
6	Old and elderly women should engage in sexual activities if their health allows it.	47.2%	77.8%	60.3%
7	There are social opportunities for elderly men to satisfy their sexual desires.	56.9%	58.3%	57.5%
8	There are social opportunities for elderly women to satisfy their sexual desires.	56.9%	58.3%	57.5%
11	Old men engage in extramarital relations.	84.0%	83.3%	83.7%
12	Old women engage in extramarital relations.	78.5%	83.3%	80.6%
13	No woman can claim that her husband has never slept with another woman since they have been married.	77.8%	72.2%	75.4%
14	No man can claim that his wife has never slept with another man since they have been married.	69.4%	71.3%	70.2%
15	Old and elderly men who engage in sexual activities are likely to be in 'good health.'	22.9%	64.8%	40.9%
16	Old and elderly women who engage in sexual activities are likely to be in 'good health.'	23.6%	62.0%	40.1%
21	Elderly people of my age have at least a sexual health challenge that needs medical attention.	52.1%	78.7%	63.5%
47	There are traditional remedies to make sex pleasurable for old men.	37.1%	62.9%	52.4%
48	There are traditional remedies to make sex pleasurable for old women.	33.3%	59.3%	44.4%
49	Men of my age should stop having sex.	65.3%	38.9%	54.0%
50	Women of my age should stop having sex.	88.2%	59.3%	75.8%

A possible variation in sexual desire and expression also emerged in relation to extramarital relations. The result showed extramarital relations as a common practice within the study sites and the likely involvement of different age categories, including the elderly. As shown in Table 8, a high proportion of the participants agreed with the statement that old men (83.7%) and women (80.6%) engage in extramarital relations. The opportunities for extramarital relations may vary within and across genders for elderly men and women. In

part, health status, socioeconomic background and sexual networking opportunities are unequal among both old and older people. This might not be peculiar to elderly people alone. The existence and commonality of extramarital relations were further perceived as normal. A high proportion of the respondents agreed that no married man (70.2%) or woman (75.4%) can claim that his partner has never had sexual relations with someone else since their marriage.

Awareness, Perceived Susceptibility to, and Prevention of Sexual Infections

The desire of the elderly for penetrative sex and the social expectations of suppression as a mark of the exemplary elderly necessitated further probe into participants' awareness of sexually transmitted infections, their susceptibility to, 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.

Prevention of sexual infections was also approached from different positions. Some of the participants expressed their beliefs in 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 about Sexual Practices and Infections in Old Age

The majority of the participants demonstrated a level of knowledge of sexual infections in old age. Gonorrhoea was predominantly mentioned. In response to the vignettes, sexual infections in old age were described as normative among sexually active elderly people, like Baba Alamu and Iya Asake. However, there was some dispute over the possibility of contracting HIV –unlike the consensus about gonorrhoea. The FGD participants denounced the existence of HIV/AIDS, popularly known as *arun tii ko gboogun* (disease without treatment) as publicised through various local media in southwest Nigeria. Their denial might relate to the content of existing biomedical campaigns concerning HIV/AIDS, which primarily focus on younger people. These campaigns emphasise vulnerability to sexual infections among youths and middle-aged adults. 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 common 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 Community].

> One can be exposed to 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 Community].

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 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; the FGD participants denounced the existence of the disease. Both male and female participants in the FGDs claimed ignorance of seeing an HIV-infected person in their communities and prayed against contracting it.

Denial of the reality of HIV has significant implications. It affects perceptions and attitudes towards voluntary HIV testing, help-seeking, and medication adherence for those living with the condition. The temptation to sweep a coming crisis under the carpet could spell doom for individuals, households, and society. Sexual experiences, cultural beliefs, and expectations across the life course also affect risk construction and perceived vulnerability to sexual infections.

From the lens of the 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 a preference for *flesh-to-flesh* sexual intercourse 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 this practice in old age (Zhou et al., 2014).

The FGD participants and interviewees described the sexual exploits of the vignette characters (Baba Alamu and Iya Asake) as products of previous experiences. They contended that previous sexual exploits and desires of both Baba Alamu and Iya Askae would have exposed them to different sexual infections. The statements of some of the participants provide further insights on and context of the dominant narratives of the consequences of multiple sexual partners:

> It is inevitable that Baba Alamu will 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 Community].
>
> 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].
>
> 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 Community].
>
> 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 Community].

The consensus view of the FGD participants and interviewees was that having multiple sexual relations is a habit acquired through the life course and, therefore, increases the occurrence of sexually transmitted infections. A similar line of thought was extended to contracting 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 marriage might have informed this position. The majority of the participants noted that men would 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 a concoction for him or her, who will pass it out through faeces and will urinate it out. [FGD with women aged 60-69 years, Bodija Community].

> Is the dog gonorrhoea that makes one bark like a dog? [FGD with women aged 70-79 years, Sango Community].

> In women, sexually transmitted infections do not appear instantly but, with men, it is spontaneous. [FGD with men aged 60-69 years, Bodija Community].

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

The FGD participants also gave a typology of gonorrhoea. Differentiated by symptoms, three major types exist, and these consist of the excessive pus (*atosi oloyun*), discharge of blood (*atosi eleje*), and the dog type (*ato si alaja*):

> 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 60-69 years, Bodija Community].

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

Multiple sexual practices and familiarity with gonorrhoea also have a long history in the Yoruba belief system. An account of multiple sexual relations and the 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 about multiple sex partners and possible contracting 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). 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 cuts across the participants' narratives of *magun* as a sexual infection. As earlier noted, 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 deaths also might encourage multiple sexual relations. Most 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. The extracts below highlight the dilemma around the dynamics of marital infidelity and sexual infections:

> …it is a woman that will be careful. *Atosi* (gonorrhoea) and *Jeri-jJeri* (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 70-79years, Odo Oba Community].

> 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 ba yago fun iyawo asopa, tii asopa ba ba iyawo oluwa e lopo nko?*). [FGD with men aged 70-79 years, Sango Community].

The majority of the participants encouraged prompt help-seeking from competent traditional health care providers in the event of an inevitable sexual infection. Traditional therapeutic treatments were described as natural and caused less harm to the body; they are holistic, as they could effect changes at the spiritual and physical levels of a disease or health challenge. In contrast, orthodox or biomedical treatments work faster but cause more damage and are 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. The participants shared their perspectives on traditional measures of preventing sexual infections and condom use.

Prevention of Sexually Transmitted Infections

The need of preventing sexual infections cut across the views of the majority of the FGD participants. From varied experiences and interests, the participants suggested possible measures that could reduce or prevent contracting 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 owing to *magun* affliction. Individuals with a flair for and opportunities for multiple sexual relations could adopt traditional or biomedical protective measures. However, the effectiveness and

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

In reality, abstinence is a difficult and an unsustainable 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 misconstrue abstinence as a convenient 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 predicted 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 Community].

> 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 Community].

> 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 FGD participants opined that sexual

experiences and quality of marital relations could influence whether an individual would abstain or indulge in sexual activities 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, tension, suspicion, health challenges, and lack of commitment could promote sexual abstinence. Some of the extracts provide additional insights:

> Sexual abstinence requires mutual understanding. I and my husband 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 64-year-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 pleasure elsewhere than abstaining. It is when their strength and health start failing that abstinence becomes easier. [FGD with women aged 60-69 years, Bodija Community]

The above extracts reveal differentials in sexual abstinence associated with gender and marital relations. Comparatively, a functional view of 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 inability 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 felt 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, most of the male participants and a few of the females believed that sexual refusal could encourage extramarital affairs. This assertion also was confirmed in the narratives of the participants:

> *Dani dani kii bani lagba ati kekere ni tii 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 80 years and above, Inalende Community]

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, most of the male participants expressed belief in and support for traditional medicine. Their preference had to do with cultural belief that traditional medicine had the potential to improve sexual pleasure and to prevent the pains of contracting infections. Four male FGD participants took pride in their sexual adventures and risky practices. They also boasted about their knowledge and use of traditional medicines as a guarantee against infections. Normatively, the majority of the male participants asserted 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 medical 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 some 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, preference for Western lifestyle and foreign religions, are making younger people 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 of traditional medicine, an individual can [have] good health, including sexual health, and be free from sexual infections. [IDI with a Traditional Health Practitioner aged 83].

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 susceptibility 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 about 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 Community].
>
> 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 men aged 70-79, Sango Community].
>
> 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 (*sarun domi*). [Interview with an 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 contracting 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 depend on self-control and willingness to obey prescriptions and taboos. For incision and amulet to work effectively, users are required to observe certain taboos without which the medicine might lose its powers. The FGD participants argued that each medicine has its material and spiritual components. The expectation is that, 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 a man 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 70-79 years, Kobiowu Community]
>
> We have traditional rings, herbal concoction, and incisions to prevent contracting 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 Community]
>
> Also, some incisions will stop a man's penis from being erect when about to have sexual intercourse with a woman with infections. [FGD with men aged 80 years and above, Inalende Community]
>
> 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 Community]

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

> 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 *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 pleasure 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 unavailability 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 menstruating, 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 Community]

> 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 60-69 years, Bodija Community]

> Traditional medicine is active/potent. For instance, we write some verses of the Qur'an (*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 to biomedical practitioners*], 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].

As revealed in the qualitative findings, some sexual infections, especially gonorrhea and syphilis, are treatable either through traditional or biomedical remedies. The contracting of HIV among the elderly was doubted. However, it was described as 'middle' or *aisan tio gboogun* 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 effective treatment or cure. Thus, from the views of the participants, such *aisan ti o gboogun* would create hopelessness and resigning to death, which is inevitable for mortals. The participants argued that contracting HIV in old age could cause feeling of hopelessness , delay, or seeking no help. The excerpts below buttress this:

> Contracting a sexual infection in old age would cause shame and discourage prompt help-seeking. Some elderly people are just marking their time; so a sexual infection in old age brings them nearer to their grave (IDI with a male aged 69, Christain)

> Baba Alamu can take some medications to improve his sexual performance, but once he contracts an infection, it would take more time to heal, compare to when his body was much younger (FGD with men aged 70-79 years, Sango Community)

As a departure from the pessimistic position expressed in the above extracts, the FGD participants expressed a functional interpretation. They reasoned that contraction of HIV either by males or females, owing to multiple sexual relations, could provide an opportunity for self-reflection:

> As you grow older in life, you acquire life experiences in your marriage, relatives, and neighbours. Some of these experiences will shape and make you stronger, wiser, creative, and rational. Similarly, some will destroy you and make you miserable and cruel in some instances, depending on other factors (IDI with an elderly woman, aged 73)
>
> For either Baba Alamu or Iya Asake, contracting a sexually transmitted infection and the associated shame could provide opportunities for sober and reflection over their recklessness (FGD with women aged 70-79years, Sango Community)
>
> Old age is an opportunity to undo some wrongs if possible before dying (IDI with an elderly man aged 69)

The survey probed further the general view on the treatment of sexual infections. The descriptive result in Figure 10 shows that modern medicine (57.8%) was more effective in the handling of sexually transmitted infections. In contrast, traditional medicine received a high rating regarding the perceived treatability of sexual infections.

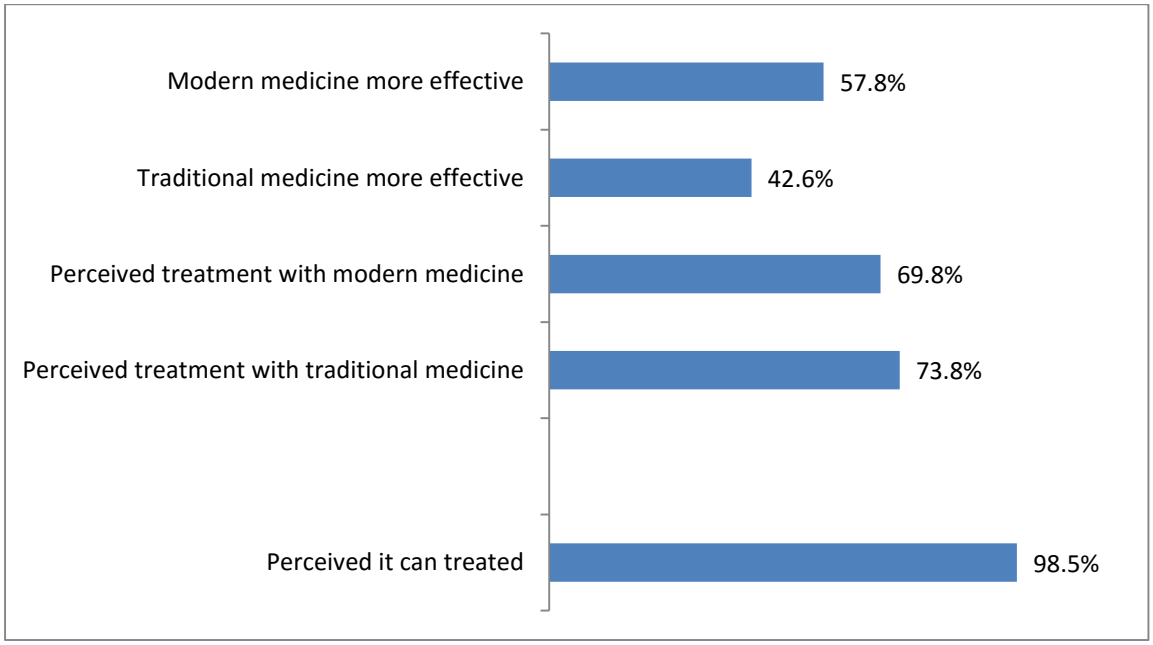


Figure 10: Perceived treatability of sexually transmitted infections among survey respondents

The slight variations in effectiveness and perceived treatment within the two medical systems may be associated with the belief that some sexual health problems are untreatable. Sexual health problems that tend towards preternatural and supernatural explanations would be perceived as treatable by traditional medicine. Those that are considered to be caused by micro-organisms would be considered more treatable by biomedicine. This hierarchical rating or assessment of the effectiveness of the available treatment options within the two medical systems remains highly subjective.

The reliance on this approach in arriving at a decision could increase vulnerability to sexual infections. As noted earlier, the efficacy and potency of amulets and incisions that can assist in making an objective assessment of the presence of infection depended on the user's adherence to the sacredness of a taboo. Under certain conditions, it might be difficult to confirm whether the outcome of an evaluation was not due to the error of the breaking of a taboo. The difficulty in reassessing whether there was a mistake before engaging in penetrative sex also compounds the risks of infections. The ability to recognise a bodily sign can also be impaired under the influence of alcohol.

Awareness and Perceived Usefulness of Condoms in Old Age

Social marketing of condoms seems to be paying off despite the marginalization of elderly people (60+) as part of the target audience. Existing empirical evidence on condom use show that awareness of and association of condom 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 pleasure of sex influence disposition to condom use (King & Olaseha, 2012; 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. The condom was conceived and related with as a method that applies mainly to younger people to avoid unintended pregnancy and sexual infections. For sexually active old men, the use of a 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 below 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 Community].
>
> If a condom is used, it will avoid the spread of disease/infections. [FGD with men aged 60-69 years, Bodija Community].
>
> 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 60-69 years, Bodija Community].

The few male participants (5) who shared personal experiences with condom use shifted into reconstruction of pleasurable penetrative sex in old age. Three among the elderly men between 60 and 79 years of age claimed that 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.

The survey explored further the views of the respondents on the growing evidence around effective condom use as a responsive preventive strategy. The qualitative findings revealed a wide acceptance and belief that some sexual infections are preventable, but there was inadequate faith in the use of condoms. For instance, the male FGD participants felt condom

use reduces sexual pleasure and satisfaction. Hence, it became necessary to investigate the disposition of elderly people to condom use as a preventive strategy against sexual infections among sexually active elderly people.

In Table 2, the survey results showed few of the male (20.4%) and female (2.8%) respondents felt condom use can prevent sexually transmitted infections. A slightly higher proportion of the females (29.2%) and males (25.0%) perceived condom as more useful for younger people. At 0.05 level of significance, gender and marital status influenced the view that condom use can prevent sexually transmitted infections ($p=0.000$). Only gender was significant on whether condom could reduce sexual pleasures ($p=0.000$) (See table 2 for additional information).

Table 9: Selected Demographic factors and some views on condom use in old age

	Gender		**Age**			**Marital Status**	
Statements on condom use in old age	Women (n=144)	Men (n=108)	60-69 (n=137)	70-79 (n=75)	80+ (n=40)	Married (n=151)	Widowed/ Divorced (n=101)
Condom use can prevent sexually transmitted infections Yes	11.1	42.6	27.7	20	22.5	33.1	11.9
Sig. Test	χ^2=32.972; df.=1; p=0.000		χ^2 =1.678; df.=2 p= 0.432			χ^2 =14.707; df.=1; p=0.000	
I can use condoms to prevent sexually transmitted infections Yes	2.8	20.4	11.7	8.0	10	14.6	4.0
Sig. Test	χ^2 =20.643; df.=1; p=0.000		χ^2 =0.714; df.=2 p= 0.700			χ^2 =7.362; df.=1; p=0.007	
The use of condoms can reduce sexual pleasure Yes	6.9	32.4	19	17.3	15	25.2	6.9
Sig. Test	χ^2 =27.279; df.=1 p=0.000		χ^2 =0.354; df.=2 p= 0.838			χ^2 =13.719; df.=1; p=0.000	
Younger people will find condoms more useful than elderly people Yes	29.2	25.0	73.7	69.3	75	74.8	69.3
Sig. Test	χ^2=0.539; df.=1; p=0.463		χ^2 =0.605; df.=2; p= 0.739			χ^2 = 0.930; df.=1; p=0.335	

Experiences Associated with Condom Use

With long years of sexual activities and experiences, elderly men might experience less pleasure using condoms during sex. The male FGD participants described condom use during sex as being less satisfying and undesirable:

> 'No sweet in using condom' and that is why some women will never agree with their husbands or partners to use a condom with them. [FGD with men aged 60-69 years, Bodija Community].

> The use of a condom decreases the pleasure, and it could break when used. The fear of it breaking during intercourse and the possibility of not having adequate pleasure discourage people. [FGD with men aged 70-79 years, Inalende Community].

Concerning the issue of displeasure in the use of male condoms, different experiences and practices were reported among a few of the participants. In some instances, circumvention of the proper use of condoms for pleasure prevailed over contracting of infections. This possibility was narrated by a female FGD participant who eavesdropped on a conversation at the State Hospital between a nurse and a nursing mother that had an unintended pregnancy. In her account, perceived contraceptive side effects prevented the nursing mother from using a contraceptive. Therefore, her husband agreed to the use of condom during intercourse. Unfortunately, the husband circumvented his wife by pretending to use a condom during intercourse. This only became known to the woman after she became pregnant despite breastfeeding a 9 month-old baby. Below is the extract:

> The condom may prevent, but some men are wicked. My experience on the day I took my child to Adeoyo [A state hospital], a woman with a 3-month old baby was crying that the nurse should help her. She was asked to call her hubby, and when he came, he said that the condom is not compatible with his body that is why he would cut the condom. Everybody blamed him that is he is wicked, that he wanted to kill the new baby. That is why some women may try to avoid their man or refuse to use a condom if she does not wish to be pregnant. [FGD with women aged 60-69 years, Bodija Community].

Another narrative came from a 69-year-old elderly male participant who also circumvented the use of a condom. The desire for pleasure would sometimes prevail over the possibility of contracting an infection. He narrated a recent experience that demonstrated such a dilemma:

> Once I'm sure, and I want the pleasure, I will use a trick to cut the condom tip without the woman's knowledge. Through this, I will have it flesh-to-flesh with her. However, if you want to prevent it, you do not need to make holes on it. [A 69-year-old participant, FGD with men aged 60-69 years, Bodija Community].

Sexual engagements and pleasures in old age depend on both relational and contextual factors, which might affect both genders differently (Ménard et al., 2015). In the FGDs and some of the interviews, factors within relationships and contexts were brought to the fore as the participants define and interpret outcomes from sexual engagements. In relation to condom use, mutual agreement and equal participation was conceived as a necessity for actual use of a condom during intercourse. In the absence of consensus, the possible risks of unprotected sex were swept under the carpet as demonstrated in the experiences of some of the male participants. For this category of males, displeasure concerning the use of condoms based on perceived reduction of sexual pleasure ranked higher above possible contraction of sexual infection. Although, the possibility of contracting a sexual infection was given credence, but as earlier stated, experienced polygynous men are to guide against actual contraction of an infection with the use of traditional medicine. Once such preparation is guaranteed, pleasure from penetrative sex was considered vital. The emphasis on pleasure could be observed in the narratives and rationale as exemplified in some of the following extracts:

> There is no enjoyment in using condoms. I will never use it. Rather than using it, to avoid contracting an infection, then I will just romance such a woman and let her go until I get another woman that may be free of infection and also agrees with flesh-to-flesh. [A 63-year-old participant, FGD with men at Bodija Community].
>
> The body contact brings out enjoyment in sexual intercourse. The only enjoyment one derives is when you are about to discharge; apart from that, there is no enjoyment in it. [60-year-old participant, FGD with men at Bodija Community].
> When we engage in sex, we desire pleasure, and it comes from skin-to-skin sex (*chorus response*). Condom use makes it different; the direct experience becomes threatened. [FGD with men aged 70-79 years, Inalende Community].
>
> To me, I dislike the use of a condom. What's the relevance of using it when you will ejaculate and again use your hand to remove what you have released? It is better not to have sex when your semen wasted or not useful for a woman's body. It does not bring any satisfaction, and it is better not to use it since it reduces the pleasure. [81-year-old participant, FGD with men at Inalende Community].

Judging from the extracts above, it will require more efforts to optimise the protective benefits of condom use across different social categories. It is possible that the use of condoms during penetrative sex could have negative or positive effects on sexual sensations and pleasure. On several occasions, the male FGD participants interpreted derived sexual pleasure similar in orientation and expectations to those of their partners.

In reality, sexual subjectivity is gendered, and outcomes from each sexual engagement bring different pleasure and expectations among partners at various periods (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015). Patriarchy and heterosexual normativity might be creating a false sense around males' capabilities to determine sexual satisfaction and pleasure of their sex partners. For instance, wearing a sensational rubber during intercourse might produce different sexual feelings and pleasure for both partners in a sexual episode. As argued by some scholars, experiences of sexual pleasure and satisfaction are fluid and

dynamic even with an individual when situated in episodes of intercourse over a period (Hartley, 2006; Ménard et al., 2015).

Cultural Explanations of Sexual Health Challenges and Help-seeking

The participants described sexual health in terms of the existence of sexual desire, ability to engage in sexual activity, or to suppress sexual desires. The social positioning of the participants was reflected in their description of what makes healthy and unhealthy sexual practices. Positioning also emerged in their views on factors that could motivate or constrain an individual's ability to continue engaging in sexual activity. The participants acknowledged the possibilities and complexities of seeking help to resolve a sexually contracted infection or improve sexual performance. In order to explore the compexlity of the decision-making process as related to sexual health challenges, the next theme and sub-themes examine further the participants' interpretations of sexual health challenges, what help is sought, and how and where such help is accessed, whether from formal or informal sources. All these dimensions are connected to the prevailing explanation of sexual health challenges.

Sexual health challenges are classified into two among the Yoruba: disease- and non-disease-related conditions. Disease-related conditions are infections that occur through penetrative intercourse with an infected person. Such infections were described as *arun ibalopo* (infections through sexual interactions). Through penetrative sex, harmful organisms, like bacteria, virus, or fungi, could be transmitted and shared. The participants asserted that the treatment of disease-related problems could be handled via biomedicine or traditional medicine. Non-disease-related conditions are those traceable to psychosocial and spiritual sources. These are sexual health issues that have explicable and inexplicable causation.

However, their treatment often transcends natural remedies into spiritual therapies as accounted for in the traditional medical system.

In view of the categorisation, the participants further drew from cultural beliefs and provided aetiological explanations of disease and non-disease sexual health challenges with natural, preternatural, and supernatural causations. The familiarity of the participants with existing disease explanations within traditional medicine and partly biomedicine could have influenced their views.

Natural Interpretations of Sexual Infections

From a natural aetiological position, the participants opined that sexually transmitted infections occur through penetrative sex and exposure to germs through other sources. Participants' familiarity with biomedical and traditional medical explanations was also reflected in their emphasis on the germs' roles in disease causation. The consensus was that sexually transmitted infections are contracted and spread through unprotected sex with multiple partners. Infections that are caused and spread through germs were described as *kokoro aifojuri* (microorganisms). These organisms penetrate the body through fluids released during sexual intercourse. To reduce possible contracting and spread of these through multiple sexual partners, social actors must protect themselves. Traditional measures of protecting oneself against sexual infections could be used and possibly also condoms, as explained below:

> Individuals that are sexually active must also know how to protect themselves against infections. With several years of experience in the business of concurrent multiple sexual partners, both Baba Alamu and Iya Asake must protect themselves against infections. [FGD with men aged 70-79 years, Sango Community].

The participants observed further that protection and avoidance of sexually transmitted infections require self-discipline and resilience. However, the derivable pleasure in sexual activities could influence how individuals would position themselves against sexual infections. Some social actors could underestimate the possibilities and indulge in unprotected sex. With the information that the two vignette characters contracted sexually transmitted infections, the participants blamed and called both Iya Asake and Baba Alamu different names. They were accused of negligence and failure to learn from their experiences:

> Since Iya Asake has refused to retire, then younger women will call her *agba iyaa, enitii koo nii it iju* (Shameless old woman). [FGD with women aged 70-79 years, Kobiowu Community].

> *Agba to n se langba langba ni* Baba Alamu (Baba Alamu has lost his reasoning capacity and now behaves like a child). As an experienced elderly with three wives, he has had different experiences and lessons. [FGD with men aged 60-69 years, Bodija Community].

Delay in seeking help for such conditions could have negative health implications. Participants in the FGDs and interviews mentioned untimely death, difficulty in physical mobility and worsening health conditions as possible consequences.

> Infections that are contracted through sexual intercourse can be treated by using herbs or going to the hospital. [Interview with an elderly male aged 71 years].

> Unless the condition is beyond the ordinary, shame, financial constraints and disappointment with self-are always there to stop anyone from seeking help. Each person that has a sexual infection that is explainable must seek help even if the case is HIV/AIDS. [A 56-year-old nurse at a health facility in Ibadan].

The male participants spoke of the normative duties and rights of men to protect themselves and retain their masculinity. Physical fitness, agility, and discrete engagement in sexual activities were described as virtues of masculinity. Thus, the well-socialised man must

demonstrate his possession of these masculine virtues and deploy the same when faced with the risks of contracting a sexual infection:

> Wisdom and carefulness come with age and experiences in life. The willingness to and ability to survive life challenges shows an individual has grown. A man will always be a man. He must protect himself, and if perhaps failed to and contract an infection, help must be sought. Baba Alamu is a man and not a woman. [FGD with men aged 70-79 years, Sango Community].

In terms of responsibilities and duties, the issue of protecting oneself against infections affects both men and women. However, men have more responsibilities to protect themselves. A common Yoruba adage that emphasises men's readiness and presumed responsibility to protect themselves against the risks in extra-marital relations is:

> *E niti o se owo ale ani enii*
> (He who would engage in extramarital relations must prepare well)

With regard to psychological and social constraints, the FGD participants predicted possible difficulties that trail protection against sexual infections. First, the participants argued that previous experiences and habits could act as constraints. Once an individual developed interest in extramarital relations, it becomes difficult for such a person to change. The participants asserted that the derivable pleasure and subjective assessment of risks could compromise protection practices. The consequences of unprotected sex with multiple partners were acknowledged. To minimise the pains, participants called for conscious involvement, appraisal of possible infections, self-control and due diligence to avoid premature death, especially *magun*-related death.

Protection from *arun ibalopo* (sexual infections), especially using traditional medicine, was emphasised. There are remedies to prevent their penetration and those to eliminate them. The rule of thumb is that, once the right proportion and procedures are followed, effectiveness and efficacy are guaranteed:

> There are different types of traditional medicines and treatments for various sexually transmitted infections. There is a particular one called *s'arun domi* (it can reduce the power of an infection to spread to other parts of the body). Often, you have to treat infections gradually because the body recuperates gradually. If you rush a patient to a treatment, it could lead to death. [An 83-year-old male traditional medical practitioner, Inalende Community].

The preventive remedies could also be in the form of amulets or incisions, which are worn in different parts of the body. Proper adherence to the procedure for usage and keeping of associated taboos will ensure continuous effective protection against infections. However, contraction and possible failures could occur owing to human errors and circumstances. Under such circumstances, it would be assumed that a mismatch had occurred and that inadequate steps were taken by the individual to match the risks of exposure.

If preventable *arun ibalopo* (a sexually transmitted infection) occurs, the diagnosis starts by focusing on existing symptoms and client or patient complaints. These include asking questions about bodily changes, fluids, like urine, sputum and body sweat and odour. From observations and patient interviews, practitioners prescribed what remedies could effectively assist in restoring the body to a relative equilibrium condition. The particularity of remedies is a common feature in the practice of traditional medicine. Practitioners' knowledge of remedies, experiences, network of associations and ecology regarding geographical space affect prescriptions or remedies and the material components (Adekson, 2003). This increases possible variations in the materials usable for the treatment of different and similar sexual infections within the same context.

In terms of the composition of materials, herbal remedies vary, but could have some similarities. With years of practice, a traditional health care practitioner would have acquired the knowledge needed to handle different health or life challenges (Adekson, 2003; Omonzejele, 2008). In the event of dissatisfaction with treatment outcomes after and careful adherence to prescriptions, a change in therapies and explanations becomes relevant, as noted in this excerpt:

> As a traditional health practitioner, I advise my patients to visit the hospital for clinical tests depending on their health before placing them in therapy. For instance, if after sleeping with a woman, a man's stomach becomes swollen, that is called ***magun olore***; we use ***epa*** – a traditional remedy for different common diseases). To treat this, you apply the remedy systematically for satisfactory results. Such efforts are precautions to enhance treatment efficacy. There is something we call stomach ulcer whose symptoms including excretion of blood and pains in the stomach. I have the remedy for me. I have treated different conditions like that even those from UCH, and I have treated them with real success. These are our traditional knowledge and wisdom for handling health challenges. [An 83-year-old male traditional medical practitioner, Inalende Community].

In the African traditional medical system, patient referrals, regardless of the frequency or perceived severity of a condition, depend on the healer's network (Konadu, 2007). The submissiveness and trust in such referrals also depend on satisfactory outcomes from previous or similar steps. Within African traditional medicine, referral differs significantly in both epistemology and ontology to what obtains in biomedicine. This procedure or step may occur simultaneously with other activities, such as divination (Konadu, 2007; Omonzejele, 2008)

Once it becomes obvious through various consultations and divination that a condition goes beyond the ordinary (*ejo ni owo ninu – there is more to what is seen),* then shifts in explanation or referral may take place. However, divinations and observations from the client/patient response to treatments are critical indicators to decide a referral or change in explanations.

> Some of us work with rejected patients or those referred to us for spiritual recourse to their problems. Such cases are often determined after repeated failures from treatments, whether at the hospital or with a traditional healer. [Interview with a male diviner/traditional healer, aged 83].

Recovery may or may not occur, depending on the sexual health condition in question. If symptoms matched with treatment options, the response and recovery of a patient would be compared with outcomes from previous and present remedies. The outcomes of this process provide valid options for shifts from natural aetiological explanations to preternatural or supernatural ones. It is worthy of note that the treatments and therapies may not change despite the emphasis of the latter on possible causes from the spiritual sphere. However, certain spiritual procedures are necessary before recommencement of essential therapies for the client or patient in question.

In the category of sexual health challenges defined as psychosocial (*ale sidede nii ibalopo*), wider issues are introduced into this frame of construction. This category provides opportunities for explicable and inexplicable sexual health challenges. The examples given included fertility challenges, especially those without known causes or untreatable causes, *okobo* (erection problem) and *idakole* (quick ejaculation and poor sexual performance) and *magun*, which causes sudden death. According to the participants, critical contributors to this class of sexual challenges include untreated or poorly managed infections, individual

interpretations of aetiological cause(s) and outcomes of the quality of social relations with other ancestors, deities, and the Supreme Being, as indicated below:

> On some occasions, carelessness and unruly behaviour of some men and women have earned them sexual problems that are beyond aetiological explanations. [Interview with a 73-year-old male].

As this participant articulated, some elderly and younger people have sexual disorders because they have a curse on them. Such problems are hardly treated through natural means, except for spiritual means. The FGD participants described some elderly men that sexually abuse young people as living examples of such individuals. They also cautioned that individuals suffering from a spiritually induced sexual disorder would hardly come to terms with the aetiology of their problems. In a somewhat less contestable scenario, the FGD participants also gave examples of inadequate or poor treatment of previous sexual infection as a potential source:

> Poor management and treatment of some infections could make the life of an individual miserable. After treating those who seek help from me, I will also refer such individuals to the hospital for more additional investigation. [Interview with an 81-year Old Traditionalist].

The boundaries between sexual challenges caused by intercourse, untreated infections, and psychosocial relations are fuzzy and difficult to demarcate based on the explanations provided. The FGD participants provided more insights; they emphasised the critical influence of preternatural forces in the causation and treatment of some sexual health challenges.

Preternatural explanations and treatment options

The preternatural, as stated in the literature, centres on relations with deities, gods and goddesses, ancestors and humans. The applicability of preternatural explanation to sexual health conditions depends on the response to treatments and the recovery period of a client. In the scheme of classification, the symptoms, severity, and availability of therapies or treatment are insufficient to determine the possible preternatural cause(s) of a condition. To unravel causation(s) and options, divination and interview as tools of investigations are channelled towards a holistic understanding of potential linkages, as shown below:

> Health challenges in general and some sexual problems would require a probe into different possible causes if not; solution or recovery will be difficult. As I mentioned earlier, women are involved. Like our mothers, they are powerful and can do anything with the life of a man. [Interview with a male diviner/traditional healer, aged 83].

Investigations at this level were aimed at searching for causes from the client's/patient's network and quality of relations with others, including ancestors and possible keeping or breaking of taboos. It is believed that sour relations breed strife and bitterness among the living. Bad feelings, bitterness and evil machinations could lead to afflictions that will manifest usual symptoms, but will defy treatment against all odds.

In the event that treatments fail, or a client is slow to recover, probing is then extended to preternatural and supernatural levels. Through the process of divination and other modes of investigation, understanding and solution become possible. Different approaches and steps are taken, depending on the spiritual affiliations and network of the health care provider. The narrative shared by this interviewee was similar to his earlier position in one of the FGDs with elderly men. Based on personal experience, the male FGD participant recounted how he negotiated a complex health condition in arriving at the desired solution to the recovery of an

ailing man who suffered an affliction from his wife:

> Let me also share a condition I managed not too long ago with you. Raimi (*a focus group participant)* is my witness. A case of a woman that afflicted her husband with a problem was brought to me. The husband was taken to the hospital several times without any success. The man was brought to me, and I called the wife for private interaction. I made a spiritual inquiry and got to know that she was the one responsible. Therefore, I pleaded with her to kindly free her husband, reluctantly, she agreed. Immediately, I assured her of my cooperation and willingness to give her whatever she needs as the sacrifice. Fortunately, she agreed to some animal sacrifice and that once the sacrifice was carried out she would release her ailing husband. Interestingly, I went to her spiritual colleagues and presented the sacrifice as agreed. I told her colleagues that she has accepted the terms and has collected what she needed to release her husband. However, if she failed to release her husband despite the sacrifice, they should face her and not me. Unfortunately, she accepted the sacrifice as promised, but failed to release her husband. Somehow, I freed myself from the consequences and her husband. Sadly, the woman died because she collected the items she requested including the goat, but never released the man. [FGD with males aged 80 years and above, Inalende Community].

Among the Yoruba people, individuals who perform witchcraft or sorcery are believed to have the backing of their other members when they have an interest in afflicting others with pain or evil. For the participant who shared this experience, appeasement of members of such witchcraft or sorcery groups providing the backing require some experience and skills that a diviner must acquire for successful handling of complex health and non-health related cases. Experienced diviners offer a peace offering, sacrifice (*ebo, etutu*) and appeal for forgiveness of wrongs on behalf of their clients. Such efforts would then improve the efficacy of any sacrifice and the healing process. Defiance and disregard for such groups have brought negative repercussions on practitioners and members of their households. With this understanding, due diligence is a required virtue for excellence and efficient therapies.

The practice of African traditional medicine has a series of drawbacks, which include the

absence of truthfulness, love for material wealth and little regard for serious apprenticeship. The participants argued that the scramble for foreign religions has also contributed to the loss of knowledge of African traditional medicine. Due and sincere consultations with the elders and experienced practitioners in the field were described as a potential source for sustainable and efficient practices:

> With just a little more patience, self-control and willingness to make sacrifices, gifts for divine revelation will come, understanding and ability to see beyond the natural and proffer workable solution but, unfortunately, that is lacking today. Many of today's traditional medical practitioners are interested in their pockets and not the practice of true African traditional medicine that places need ahead of rewards and personal benefits. [FGD with men aged 80 years and above, Oniyere Community].

During interviews and especially after divination, a client may go through retrospection of the quality of relations with the living and possible breaking of taboos or covenants with deities for further clues. An important factor in effective and efficient African traditional therapeutic outcomes is the focus on the particularities of the client/patient as an individual. The presumption is that individuals are unique entities and may sometimes require some level of variation in what will work for them. As earlier stated, in Yoruba cosmology, each person's *ori* (inner head) accepts different remedies per time. Thus, certain remedies may work previously and fail in another moment for the same person unless certain steps are taken.

The emphasis on maintaining a relatively harmonious relationship with others, especially neighbours, relatives and friends, cut across the various groups of participants. Tensions in intimate relations can also cause sexual health challenges, such as erectile dysfunction for men and infertility, both primary and secondary, for women. Confirming the essence of

quality relations in marriage and intimate relations, participants gave different examples of how the conflict of interest, marginalisation and preferential treatments stimulates envy and jealousy in polygynous marriages. An immediately possible consequence from the tensions among women in such marriage is erectile dysfunction and infertility. The erectile dysfunction might be periodic, such that the same husband will have healthy and satisfying sex with a wife and then suffer poor erection with another woman. The incidence of this form of dysfunction is not limited to men in polygynous marriages. Such cases are also possible in monogamous marriages when a wife suspects infidelity of her husband.

However, such cases might be less pronounced for the avoidance of suspicion in polygynous marriages. Such a woman may invoke more lasting and long dysfunction on her husband. This will take the suspicion far from the home since the poor erection persists with all the wives at home or outside. In this latter scenario, an understanding of the probable cause(s), backed with an active search for help, is required. Such efforts will help, if sought from experienced and spiritually powerful healers. Recounting experiences, the FGD participants described the usual occurrence of tension, envy, bitterness, and unfair treatments; these challenges in polygynous marriages facilitate sexual dysfunctions:

> There are some men whose penis may be taken by witches and will not be able to perform sexually. In such cases, we will put some incisions on the man's waist and tie the penis with a particular thread. After taking the affected man through this procedure, the penis will start functioning again. You see these our mothers (wives) are wicked and difficult to relate with when it comes to sexual intercourse. They dislike sharing their husband or partner's penis with others. If you are her husband, for instance, she will try to shield you from other women. [FGD with men aged 80 years and above, Inalende Community].

> There are reasons for taking or rendering men impotent. Men with many wives are susceptible to such problems if they not careful. Rivalry among or between women in polygynous marriages could make their husband's penis weak or suffer erection to their personal advantage or satisfaction. If the younger wife is doing *yanga* ,i.e. showing off in the presence of the other wives, they may use that to punish her because whenever their husband wants to go in for the younger wife he will not be able to perform sexually. For personal satisfaction, a woman in such a marriage can seize her husband's erection and only make it work when having sex with her. Many such cases abound in this community. [FGD with males aged 80 years and above, Inalende Community].

Somewhat similar to the possibility of poor erection for men and infertility (either primary or secondary) can also be invoked on a woman, either by her co-wives, neighbours, or relatives or owing to breaking of taboos. The breaking of taboos, evil machinations of others (neighbours, relatives, and household members, including spouses) could cause spiritual afflictions that will affect health and life outcomes.

> Some women are infertile for several reasons. Some are because they are into one covenant with a spirit or the other. Some cases are caused by the evil machinations of people around. This is the largest category of women with such problems. The reason is that there is so much competition in life especially in *ile olorogun* (Polygynous marriages). The competition is always tense, and it affects the well-being of wives, children, and the husband himself. [FGD with Women aged 70-79years, Odo Oba Community].

A slight emphasis on explanation was observed among the female and male participants. For the male, women are the evil behind tension in polygynous marriages. For the women, it is the insatiable desire and covetousness of men and their flair for several experiences that promote tension. The participants in the FGD with females (aged 70 years and above) decried the inevitable tension men often create by their appetite for sexual exploits. In the view of the FGD participants, once such problems are created, women are not the only ones that will

suffer; their children will also suffer. To minimise possible adverse effects, the majority of the women, as earlier stated, prefer to focus their energies on protecting and caring for their children just to guide against any eventuality. Status in polygynous marriages requires much effort, apart from the position of a wife in the marriage.

Status in polygynous marriages is achieved rather than ascribed. The position of a wife only counts in many respects when she makes herself useful to the husband and can outperform other wives. This could be in the form of her physical look, character, warmth, sexual prowess and care for her husband and children, as well as her acceptability among relatives. Achievements in all these respects count; each wife will work towards outperforming the other wives, as explained below:

> It is possible that other wives are no longer sexually active. In this case, the man's attention would be directed to the new wife. In addition, he might also be using drugs. [FGD with men aged 80 years and above, Inalende Community].

> Polygynous marriages are homes of conflict and intrigues. Even when there is peace on the surface, a war of interests is beneath the surface. Thus, suspicions and manipulations to outshine others and your children matter most. [FGD with women aged 60-69 years, Bodija Community].

The philosophy of *aye ofe kii aru eruo ka* so (A cultural view that acknowledges the inherent strife, bitterness and envy that is embodied in social and interpersonal relations and selfishness to excel at the expense of others) was invoked. Six female FGD participants reiterated the call for spiritual and sensitive decisions in polygynous marriages. However, the women were quick to acknowledge the possibility of sometimes failing as mothers and becoming too emotional and reactionary to tension in relating to husbands and co-wives. A guiding consolation in this regard is the inherent imperfection of human nature. Only knowledgeable individuals with the required skills can bridge the gaps and reconcile the

deviations and associated consequences for health and other spheres of life (*Akii rin ki ori ma mi*). Constant prayers, patience, and faith were mentioned as needed ingredients to continue and cope with the constant changes that go along with marriage. The majority of the female participants argued that most men are always in search of what they have not lost:

> Unfortunately, the consequences of their actions affect everyone in the marriage. Children and wives are not left out. Some women are very diabolical, and once they have entered a home, everybody is in trouble. [FGD with women aged 70-79years].

A strong position in the Yoruba cosmology is the belief in the need for spiritual preparedness to understand and navigate life's challenges. This requires conscious efforts to protect self, children, and household members from all forms of spiritual attack that will come with or without invitation. The belief in the existence of spiritual forces further strengthens the roles of intermediaries between the physical and the spiritual dimensions of life. These intermediaries take the form of deities, gods and goddesses, and ancestors. They also include certain individuals that possess the required expertise and network of spiritual relations to negotiate and reconcile the challenges. Chronic erectile dysfunctions, infertility and pregnancy miscarriages are often attributed to such spiritual afflictions.

Supernatural Explanations and Treatment Options

The search for possible explanations and solutions to disease conditions or infections often gets to supernatural levels when all known therapies and investigations have been observed. At the level of supernatural explanation, all attention goes to the Supreme Being, the creator of heaven and earth. The Yoruba people believe in the existence of gods, deities and the Supreme Being (Olodumare). Lesser gods and deities are perceived as intermediaries between Olodumare, who sits in the heavens and controls affairs on earth (Bewaji, 1998). All humans are expected to live and conduct their lives according to certain morals and

responsibilities. Gross misconduct will attract God's wrath and punishment. In the same vein, adherence to the standards comes with rewards, including satisfactory old age and fruitfulness in life regarding material goods and children. These benchmarks are critical in forming opinions and categorisation of those who are living rightly and those living otherwise.

With an increase in the number of those professing Christianity and Islam, the belief that some infections/diseases and health challenges are caused by sinful living and demonic possession was widespread among the participants. By adopting this framework, infertility or erection dysfunction would sometimes qualify as *afowofa* (consequences of reckless living or lifestyle). The same explanation becomes relevant even in describing the presence of infection, especially sexual infections in old age. The common belief within this framework is that such an individual is enjoying the fruits of his/her labour.

From the context of recklessness and punishment for sins and immoralities, participants spoke further about the possible contraction of infections by Baba Alamu and Iya Asake in the vignettes, as signs of punishment for their extramarital relations. The FGD participants with the knowledge of HIV infections attributed the growing cases of sexual infections to falling moral standards. Using different examples, the FGD participants spoke on indiscipline, and early sexual initiations as contributing to different sexual infections among the younger ones. They further commented on the emulation of loose morals among the elderly, especially those with high social status. The perception is that affluent married elderly men engage in sexual relations with younger girls, through which all sorts of sexual infections are spreading among older people.

Decision-making and Pathways to Help-seeking

Decision-making around the appropriate source of getting the needed help depends on contexts, beliefs, motives, and the availability of the desirable. The diversity in help-seeking within context could be appreciated when situated around the questions of what, how, when and where help is considered needed. The variations also exist within and across health conditions and other individual and structural differences within social settings (Hinchliff & Gott, 2011; Meyer, Hickson, Lovelock, Lampert, & Khan, 2014; Schatz & Gilbert, 2012).

In this study, two critical motives were dominant in the views of the participants, namely: the need to increase sexual pleasure and resolution of sexual health challenges.

The desire to improve sexual performance occupies the centre stage in the narratives of the male participants. Those in polygynous marriages and with reported recent sexual activities were more vocal than others. Throughout the FGDs, the participants identified poor sexual performance, interpreted as quick ejaculation and poor erection, as a cause of misunderstanding at the home. The participants noted that the problem exists more among younger couples than among older couples. The male participants recounted how sexual refusal had caused strains and counter reactions in their marriages. The constant denial of sex motivated them to take another wife or engage in extra-marital relations:

> Some men are too demanding, and women are busy with household chores and the fact that we are already old. It is surprising how some men demand sex from their wives during their reproductive years and still want the same when their wives have reached menopause and were in their 60s. It is not as easy for women as men, and this causes misunderstanding in homes. [FGD with women aged 60-69 years, Bodija Community].
>
> 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].
>
> I married another younger wife when the ones at home started denying me sex, and since the strength was there, I took another woman. [A participant in the FGD with men aged 70-79 years, Sango Community].

As earlier reported under the theme of tensions in polygynous marriages, sexual performance and satisfaction of a younger woman could be a challenge for some elderly men. Besides age differentials, several factors account for sexual dysfunction and sexual satisfaction (Tan, Tong, & Ho, 2012; Trompeter, Bettencourt, & Barrett-Connor, 2012). Poor sexual performance, such as quick ejaculation and poor erection are not exclusive to elderly men and women; these conditions cut across different age categories. The psychosocial consequences of sexual dysfunction create contradiction and differentiated experiences related to gender and relational variables (Ménard et al., 2015). For men, a possible psychosocial effect is loss of ego and masculinity orientation, as individuals move between the traditional binary view of success or failure in sexual performance (McCarthy & Pierpaoli, 2015).

The traditional binary view of success or failure in sexual performance was used by the participants to narrate pleasurable and penetrative sex. On the average, the FGD participants maintained that a typical elderly male in their communities would prefer to seek help and improve penetrative sexual performance. The fear of losing a younger wife to other men owing to poor penetrative sexual performance might be a motivator for help-seeking. As

earlier expressed, Baba Alamu might contend with this possibility by going the extra mile to use traditional or modern medical means to improve erection. Such efforts are perceived as useful in improving his sexual performance and ability to satisfy a new wife. As an alternative, Baba Alamu could shun the psychological pains and just allow the new wife to seek satisfaction if it pleases her elsewhere.

In contrast, the male FGD participants reasoned that old age comes with reduced powers for hard and long-lasting penetrative sex. However, those with working knowledge of traditional medicine contended that elderly men with good health who are willing to seek help could sustain their sexual performance even at its peak in old age. In traditional Yoruba medicine, a few herbal remedies exist for women. The male FGD participants noted that there were no traditional aphrodisiacs for women. The common remedies for women are designed to enable pleasurable and satisfying experience for their male partners or husbands. The expectation is that the remedy will make her partner glue to her and discourage him from having sexual relations with other women. The motive, therefore, is to make the woman more inviting for the man, as shown in this excerpt:

> Women can also use traditional remedies to enhance their partners' sexual experiences with them. Such medicines are called *ado dun* and are aimed at making a male sexual partner glued to them. [FGD with men aged 70-79 years, Sango Community].

Furthermore, the majority of the male and female participants acknowledged the availability of different forms of treatment for performance enhancement. Most of them favoured traditional medicine, believing that the medicine has the potency to address all forms of sexual dysfunction, especially those caused by preternatural and supernatural factors. Yet, the

participants observed that the existence of a plural medical system provides multiple options, whether for sexual enhancement or resolving an infection.

Sexual Infections and Help-seeking Behaviour

A pluralistic approach to help seeking was again advocated in the event of a sexual infection. The FGD participants suggested possible options associated with peer referrals and traditional and biomedical systems. The pathways and the choice of a source of help, however, depend on several factors. The factors include the comprehensive explanations around the infection, network of relations, availability and access to sexual health care services and personal beliefs and practices. With these factors in place, individuals would assess their sexual health condition and then make the decision on what, when, how and where to access the needed help.

In terms of linkages in the process, the FGD participants agreed that a subjective assessment of the challenge is a precursor. The appraisal would require individuals to talk to others, focus on the nature of the infection (in terms of symptoms, whether known or unknown, severity, aetiological causation) and on recovery possibilities. The rationale is that an individual with a health challenge will understand the situation and steps to take better than anyone else. The premise of this argument is the presumption that all realities possess varying opportunities to comprehend and respond. The onus, therefore, is on the individual going through the experience to see these alternatives and complexities around the challenge.

To appropriate this principle, a male participant in the FGDs with elderly men in Sango Community narrated a story about the Yoruba analogy of *alatise ni mo atise ara re* to substantiate the uniqueness of an experience to an individual and responsibility-sharing:

> It is Baba Alamu alone that has the solution for his case among his three wives and concubine (*Alatise ni mo atise ara re*) There is a story behind this statement. There was a man with erection and poor sight. One day the man was standing at the back of his house, and suddenly an agama lizard ran under his trousers to avoid being prey to the hawk. Then the lizard pleaded with the man and asked for his protection from the hawk. In return, the lizard promised to help the man out by restoring his erection problem. So the man agreed. Similarly, the hawk came and told the man to expose the lizard kindly and in return, it will restore the man's sight. Therefore, the man went to his wives and narrated his dilemma. The wives, as you know, told him that they would take care of him if he regains his erection even if he does not regain his sight. Similarly, he called his children and told them the same story. The children suggested that erection problem is hidden and that sight problem was more important. Once he regains his sight, they will take good care of him as his children. He told himself that he knew what to do. He has a chicken in the house with children. Therefore, he went for one of the chicks and showed it to the hawk. Immediately, the hawk descended and took the chick and as well touched the man's sight. That was how he regained his sight. He then went back to the lizard and he got his erection back… [FGD with males aged 70-79 years, Sango Community].

In principle, the analogy in the above extract supports an assumption that as a polygamist and an elder, Baba Alamu has acquired some useful knowledge and experiences that could help in developing a positive and responsive disposition to sexual infection(s). As such, some of the female participants felt, Baba Alamu had the best information and knowledge about what is happening around him, and the steps to take for a possible solution to the infection contracted.

This simple analogy is somewhat distant from what occurs in reality. In reality, collective duties and rights could override the individual privileges that are associated with some sexual health challenges. In circumstances where symptoms are similar to the existing knowledge and everyday reality, individuals would require the support of their significant others. The

shame around sexual infections could hamper the taking of decisive steps and objective appraisal even when the needed help exists. As expressed by some of the participants, individuals differ in their manner of responding to challenges, including sexual health problems. Solutions to some of the common sexual health challenges are accessible when individuals speak out and ask for help. Such knowledge could come without much cost, as affirmed in two of the FGDs:

> Individuals with a sexual infection, like Baba Alamu and Iya Asake, should speak out and ask for help. There is no need to be shy. All they need to do is to speak out and ask for help by visiting the hospital, herb sellers, and people who are knowledge. Such steps would save them from inevitable death. What has happened has happened. It is not strange to have a sexual infection in old age. [FGD with men aged 70-79 years, Sango Community].

> Once there is a problem, just try and move closer to people with the right knowledge. For instance, you can squeeze the mature leaves of *mocuna* leaves (*Ewe yerepe*) for gonorrhea infections. *Ipa (swollen scrotum)* can also be treated using the following: *egbo gbegbe* (bark of *Icacina tricantha*), *eso ado*, and *ireke* (Sugar Cane). All these items should be boiled and regularly drunk. [FGD with men aged 60-69 years, Bodija Community].

While explaining further on the significance of the actors' knowledge and interpretations surrounding a particular challenge, the male participants appealed to how ignorance and unrealistic optimism could motivate or discourage responsive help-seeking. They opined that some individuals, irrespective of their health condition, would still want to deny the reality facing them until it became hopeless to assist them. An herbalist and an Islamic cleric in one of the FGDs with men asserted that some individuals have lost their abilities to relate to their health problems. Such individuals could have lost these abilities as a result of spiritual forces or pride and self-condemnation, especially when the condition is a sexual infection. The

interviewee claimed that religious men that are victims would prefer to hide their true health condition even when they are dying. In his explanation:

> Some individuals, especially those who claim religiosity, would try all efforts to hide and deny any sexual infection in old age. Rather, they would blame others, such as evil machinations, envy and bitterness from relatives or friends, for their health condition. Nevertheless, they know what they do in secret and the consequences. [FGD with men aged 70-79 years, Sango Community].

The thesis is that spiritual forces could hinder how individual appraisal and reactions to a particular health condition are developed further in relation to knowledge and available treatment options. The explanation of preternatural and supernatural causation of health challenges only appeals to the traditional medical system. The FGD participants opined that some health practitioners possess more depth of knowledge and dexterity to heal than others. Within the traditional medical system, some healers are more spiritually empowered than others. Thus, they are powerful and possess insights into complex health conditions that are medically inexplicable. Therefore, their therapies are laced with favourable outcomes when religiously applied by their clients (Omonzejele, 2008). The participants classified some health conditions as non-hospital conditions and others as treatable at the hospital or through traditional medicine:

> I have a brother that was rejected at the University College Hospital, Ibadan. He was bailed N300, 000 for treatment. When he was brought to my place, I told his people to leave him with me. I am happy I have some witnesses here among our people. [FGD with men aged 80 years and above, Inalende Community].

Health conditions that are non-hospital in orientation are those that might have defiled explanations around natural causation or poor outcomes from previous or current medical

help sought. At different levels, the participants argued that individuals and significant others could have difficulties around what was treatable or untreatable at the hospital. The demarcation around the hospital and non-hospital treatable condition was also corroborated in the interviews with nurses and doctors. Two of the health care providers argued along cultural beliefs and practices, that some health conditions will defile treatment whether there are known effective therapies or not. One of the nurses asserted that a defiant health care provider could become a victim by attending or treating a patient that has preternatural forces as underlying factors for his/her health challenge:

> We cannot deny that some health conditions will defy known treatments, and we have seen series of such conditions among old and young. To save the inadequate resources and frustrations around poor or slow recovery and death, you can suggest spiritual measures that are available through other sources. [Interview with a doctor in a hospital in Ibadan]
>
> If after using the hospital, the result is not that good, then traditional medicine or the use of both medicines would be better. [FGD with women aged 80 years and above, Inalende Community].
>
> On the average, a doctor or nurse must have some spiritual understanding even though we do not have such training. Spiritual knowledge and understanding have a saved some healthcare providers. Once you noticed the complexities around a health problem, then you are free to suggest alternative measures without compromising your duties as a nurse trained in the ethics of biomedicine. [A 56-year-old nurse at a health facility in Ibadan].

Five nurses and two of the doctors also confirmed their experiences with such conditions. Under biomedical training and ethics of care provision, clients with such conditions are monitored until the client or their significant others felt otherwise. By sharing cultural beliefs around disease aetiology and treatment outcomes, a doctor, or nurse trained in biomedicine, would suggest alternative treatments and plural medical help-seeking. A shift in this direction

could reassure commitments and empathy of the care provider to the cultural sentiments of the help-seeker.

Constraints to Help-seeking for Sexual Infections in Old Age

Responsive help-seeking was widely acknowledged among the participants as necessary for a healthy ageing experience. For this reason, it became necessary to understand the context, motivations, constraints and experiences with regard to help-seeking for sexual health problems. The Yoruba people, like other ethnic groups in Africa, share a cooperative approach to problem-solving, especially in relation to health challenges. While the common approach to help-seeking for sexual infections may differ to a degree, there are indications that some level of support still exists.

The socio-cultural contexts remain critical to help-seeking. It influences the types, availability, and forms of obtainable support. Furthermore, socio-cultural frameworks provide opportunities for social actors to search for causalities and interpretations concerning health challenges and then act based on available therapeutic measures. Context is, therefore, critical to understanding health challenges, motivations, and constraints to responsive and adequate help-seeking. The views of the participants revealed the interplay of factors about cultural beliefs, medical systems and the patient or client as critical determinants. The interconnectivity and influence of these factors are consistent with the literature on help-seeking behaviour. The participants referred to how cultural beliefs and personal and medical systems-related factors provide motivation or demotivation for responsive medical help-seeking related to sexual infections. A further elaboration of the context and rationale for engaging or disengaging in medical help-seeking could be observed as the participants spoke further about the constraints to responsive help-seeking.

Cultural Beliefs and Help-Seeking Related to Sexual Infections

Cultural beliefs influence what qualifies as help, the desirable form of help, and why and where such help could be accessed. On grounds of human fallibility, the participants excused elderly people who have contracted a sexual infection and called for responsive help-seeking. The saying *eni ba dake tara 're na*a a *ba dake* (keeping a problem to oneself will deny one access to solutions) was invoked. As presented in the sub-theme on aetiological explanations, the views of the participants affirmed how cultural world views influence help-seeking (pathways and decision-making concerning a sexual health challenge and the perceived efficacy of available treatment / therapies, and the source).

Aetiological Explanations as Constraints to Seeking Help for Sexual Infections

From an aetiological position, the participants described what deserves help, why and where needed help could be accessed. Within this framework, a dichotomy between African traditional medicine and biomedicine was also developed, as they emphasised the strengths and weaknesses of each medical system in relation to the treatability of a sexual health problem. The nature, severity and symptoms associated with a sexual condition and possibilities of recovery aided the categorisation. Sexual infections that are within the terrain of natural aetiological explanations were perceived as treatable, and help could be sought from any medical system. Pathways and decisions on help-seeking are predictable and logical to explain once conditions are labelled as natural. As for common sexual infections like gonorrhoea and unirary tract infections, the participants argued that such conditions were treatable:

> There are effective treatments for *atosi* (gonorrhoea). An individual like Baba Alamu or Iya Asake can visit any herb seller for treatment. They can also visit the hospital, depending on their interest and testimonies on the service providers. [FGD with men aged 80 years and above, Oniyere Community]

> All sexual health challenges are somewhat related to natural factors. The first point of approach is to seek possible solutions from what can be seen to that which cannot be seen. [Interview with an 81-year-old spiritualist].

The participants argued that infections with causalities outside the terrain of natural causation are likely to attract mixed patterns and routes to seeking help. For such infections, the difficulty in establishing logical explanations using objective as against subjective criteria may contribute to the mixed patterns and routes to seeking help. Initial help-seeking was predicated on the belief that a sexual health challenge could occur through unprotected sex with multiple partners. An underlying motive behind help-seeking for sexual health challenge was the desire for solution that could aid recovery or improvement in health status:

> Since both Baba Alamu and Iya Asake have multiple partners, it's likely that they are suffering from gonorrhoea. First, they can get help from either traditional people or the hospital. By asking for help, they would reduce their pains, health condition and avoid the troubles that will come upon their family. [FGD with women aged 80 years and above, Oniyere Community].

The outcomes from the help sought influence future decisions and the degrees of confidence of seeking future help from that source. Satisfactory outcomes from a particular source of support would also necessitate a repeat. In the likely event of disappointing outcomes, then a change in direction or search for alternatives becomes likely. The chances of seeking alternatives increase when the testimonies of peers and significant others align with expectations about recovery or improvement.

The FGD participants felt that preternaturally and supernaturally caused sexual infections are treatable using only traditional medicine. This view was based on the epistemology of African traditional medicine, where metaphysics occupies a critical role in knowledge generation and healing processes. By possessing spiritual knowledge and powers, practitioners in the field transcend the physical into the spiritual to provide explanations and solutions to conditions that might have defied treatment.

The absence of such procedures and epistemology in biomedical systems reinforces cultural beliefs and expectations in help seeking. However, not all practitioners possess such powers. Herb sellers and herbalists, for instance, are different in both training and practice. A herbalist will require knowledge and ability to use metaphysical powers in producing and improving the efficacy and effectiveness of prescribed herbal remedies. The herb seller only needs the knowledge of each medicinal plant and the right combination of different materials for different health conditions. The interview with the diviner and herbalist further confirmed the importance placed on this metaphysical knowledge in problem handling and trust in the healer:

> It's not a matter of gainsaying, most of the people around this community have referred and they keep on referring people to me. Complex cases that are rejected at the hospital have been treated here with good testimonies. [Interview with a diviner and herbalist, aged 83 years].

The view that some African traditional health care practitioners are powerful has some social benefits. It increases public confidence and sustained patronage (Omonzejele, 2008). The process of arriving at the classification of a practitioner as powerful is subjective and based on long-term experience and consultation that have produced satisfactory outcomes. From the

FGD with males in Inalende community, such commendation comes through truthfulness and adherence to good practice. Unfortunately, few of the practitioners in the field adhere to the virtues and professional ethics of African traditional medicine. To this category of participants, the drive for wealth as against service to humanity, materialism and impatience have taken over the field of traditional medicine, with just a few faithful ones left. The implication is that precision and accurate assessment and provision of actual service is hard to find. However, the few faithful ones that are available are providing exemplary services.

The direction or pattern of help sought does not guarantee recovery. It depends on the perceived outcomes from available treatment options. The source sought again depends on awareness and knowledge of the available treatments and the perceived effectiveness of these treatments. Even when the awareness level remains high, disconnect between perceived benefits of accessing available treatments could also be a hindrance:

> The body responds slowly to treatments in old age. If an individual believes that treating a sexual infection in old age may produce limited benefits especially when one is closer to the grave, then a passive help seeking practice will be adopted. [FGD with women aged 80 years and above, Oniyere Community].

> …the thought that one was already old and near the grave may be a constraint in going to the hospital. At age 80 years for instance, an elderly person may be fearful because of the unknown that may be met at the hospital, which could cause his/her death. [FGD with men aged 80 years and above, Inalende Community].

> They are just deceiving themselves in looking for treatment, what is left for them is death. [FGD with men aged 70-79 years, Kobiowu Community].

> There is a saying around keeping mute on a disease condition. The saying goes thus, "keep me, and let me kill you". If Baba Alamu keeps it away from elders and makes it secrete, it will kill him. If Iya Asake says she does not want to become an object of mockery, that disease will kill her. [FGD with women aged 70-79, Kobiowu Community].

To refuse treatments or delay help-seeking based on the impression that much could not be achieved from such effort has several consequences. Given this background, help-seeking for sexual dysfunction or infections that are associated with medically inexplicable conditions may produce some contradictions. More confusion could emerge, as alternatives to help-seeking become restricted and biased to the traditional medical system. Since aetiological explanations exist in both subjective and objective realms, the chances of erroneous judgements are certain; the participants spoke on the existence of diverse and unstandardized treatment options and the difficulty in recognising exploiters and incompetent traditional healers.

Medical Systems-related Constraints

Dominant medical explanation(s) and cultural beliefs surrounding a sexual infection also affect dispositions towards help-seeking and response to treatment options (Freeman & Anglewicz, 2012; Hinchliff & Gott, 2011). Across the FGDs, issues concerning misconceptions about medical systems and treatment options, accessibility of available health care services and the attitudes of the health care providers emerged as dominant.

Misconceptions about medical systems and treatment options

Mistrust and misconceptions with regard to a medical system or health condition has effects on help-seeking. It could affect trust and confidence-building in therapeutic relations, adherence to given treatment regimens and the time between symptoms recognition and decision-making. The participants spoke further on the side effects of synthetic drugs and the dangers of standardisation problems with African traditional medicine. They classified different forms of therapies as effective, as against less or non-effective options, depending on medical systems. They maintained stereotypes related to one medical system having efficient and effective treatments.

As mentioned earlier, the participants attributed the cause of sexual infections, like gonorrhea, syphilis and genital warts, to natural factors, such as germs, stress and multiple sexual partners. These conditions were perceived as treatable using biomedicine or traditional medicine. However, they expressed their support for plural medical help-seeking based on the perceived aetiology of the sexual infection and the differentials between both medical systems. For conditions that were perceived as untreatable and aetiologically difficult to explain, traditional medicine was most preferred, as it offers a holistic approach to diagnosis and treatment options. Similarly, treatable and explicable sexual health conditions could be approached via biomedicine and then traditional medicine. Some of the male FGD participants opined that biomedical treatments eliminate the organisms causing sexual infections and also cause some damage to the body. An infected person would then use traditional herbal therapies to rebuild the body:

> Hospital medicine works quicker on the body, but also affects the body and causes other harm. Traditional herbs are slow to relieve the body of infections. However, they are natural and the body absorbs them without harm unless when not used as instructed. [A participant in the FGD with men aged 80 years and above, Oniyere Community].

> To me the difference is that orthodox medicines work faster and act rapidly but leave the disease partially cured. On the other hand, traditional medicines work gradually in a way that helps the body to pass out the infections through urine, faeces, and sweat, and it cures more permanently than orthodox medicines. I am talking from experience. I had a sexual infection at a time, and I used a biomedical drug first, but with a slight relief before I took some *agbo* (herbal concoction) and became free. [Interview with a man aged 78 years, Sango Community].

> There are differences between orthodox and traditional medicines. However, traditional medicine is more effective than orthodox because traditional medicines are many and have no adverse effects. [FGD with men aged 70-79 years, Sango Community].

The existence of a plural medical system could have provided the opportunity for the above submissions and the juxtaposing of treatment options. Awareness of the side effects of drugs could have informed the premise on the perceived detoxifying effects of traditional herbal medicine and the possible side effects of synthetic biomedical drugs. Despite the absence of a clear-cut pattern in help-seeking, the fuzzy and subjective assessments of available treatment options provided clues about the context and rationale for engaging a medical system when faced with a sexual health challenge.

In spite of the perceived harmlessness in consuming herbal remedies, the participants confessed to some challenges in measuring efficacy and effectiveness of some traditional herbal remedies. Some of the participants cited a popular traditional remedy known as *awo-igba-arun* (can cure/treat 200 diseases). The traditional concoction is believed to cure and

treat about two hundred disease conditions. The use of a holistic herbal remedy, like *awo-igba-arun* creates contradictions and tensions for help-seekers in terms of potency and ability to reconcile a particular health challenge to the principle of specifity in biomedicine.

The FGD participants and interviewees also expressed concerns about the side effects of the available therapies, especially those within the biomedical system. These concerns are explicated in the extracts below:

> We have heard different cases of people going to the hospitals and returning home worse than they left due to side effects of treatments. [FGD with men aged 60-69 years, Bodija Community].

> The fear of dying from a treatment or medical error is somehow high in old age. To me, this is very important when talking about treatments and help-seeking in old age. [Interview with an elderly woman aged 62, retiree].

With the preference for a particular medical system, it could then become a problem to switch to more efficient treatment outcomes when necessary. This also creates further constraints around accessing alternative treatment options in the biomedical system. Nevertheless, the participants felt comfortable with plural help-seeking, as it increases access and recovery from complex sexual health conditions.

Accessibility of Available Health Care Services

As urban dwelling elderly people, the participants had the first-hand experience of seeking help at different hospitals. As such, their experiences cut across various categories of hospitals at all the three tiers (primary, secondary and tertiary) of care in Nigeria. Interestingly, the participants expressed more confidence in seeking treatments from public-owned hospitals, especially the secondary and tertiary ones. The participants mentioned

visiting the Adeoyo State Hospital and the University College Hospital (UCH). The State Hospital provides a secondary level of care, while UCH is a teaching and research hospital. In Nigeria, service delivery at health facilities in urban areas is characterised by shortage of qualified professionals, overloaded workforce, long waiting periods and inadequate facilities (Onwujekwe, Hanson, Ichoku, & Uzochukwu, 2014).

The consequences include poor service delivery, demotivation, low utilization, and preference for self-medications. Accordingly, time wasting and long waiting periods at the public hospitals dominated the narratives of the participants. The few available hospitals are often crowded and with inadequate facilities and workforce. From the various FGDs, misconceptions about the hospital, long waiting periods, affordability, and acceptability of available care were the critical constraints mentioned. These factors were interlinked and narrated as part of the systemic factors that could discourage responsive help-seeking. These, among other factors, complicate the quality of care and responsive utilization of health care services. To the participants, a help-seeker must factor in the waiting time and be determined, without which help-seeking in such places could be frustrating:

> Just go to *Oritamefa* (University College Hospital) and see how people are going through pains. Some are half dead and with their legs hanging. [FGD with women aged 70-79years, Odo Oba Community].

> It takes several hours before you see a doctor at the hospital. Anytime I 'm going there, I know I would not do any other thing that day. It could be very painful and time wasting. [Interview with an elderly woman, aged 67 years].

> The Adeoyo Hospital is there for both Baba Alamu and Iya Asake to seek treatment. It all depends on their interests. I have used the hospital several times. [A female participant in the FGD with women aged 60-69 years, Bodija Community].

The FGD participants cited these constraints from their experiences at the public-owned hospitals. Only a few of the participants mentioned seeking care from private hospitals on a few occasions. Affordable health care services is challenging and becoming worse for the poor and low-income earners in urban areas (Deaton & Tortora, 2015). Marginal and vulnerable social categories, like children, mothers, and the elderly, are the most affected (Deaton & Tortora, 2015). In Nigeria, health care programmes are hardly targeted towards addressing the health needs of the elderly people(Fajemilehin, 2009). In light of the challenges associated with accessing quality and responsive healthcare services when needed, the participants described two main constraints. These include high charges of accessing care from private hospitals and the poor quality of accessible care in public owned hospitals. For the elderly, charging high and exorbitant out-of-pocket fees to access health care services was unjustified. The cost of accessing care at public hospitals was cheaper, but time consuming and poor in quality. The participants argued that the time spent at public hospitals and the high fees at private hospitals promote self-care or patronage of patent medicine vendors.

> Going to the hospital, either public or private, is expensive and beyond the reach of many of us. The government has neglected the elderly as if we do not deserve any support. Tell me how I can pay my hospital bills when they refused to pay my pension. [FGD with males aged 80 years and above, Oniyere Community].

> Cost of using the hospital is high and most elderly will prefer going to the chemists for *asapo* (self-medication) rather than the hospital. [FGD with women aged 60-69years, Bodija Community].

The cost of health care services in Nigeria is largely borne by the consumers as clients pay from their pockets (Onwujekwe et al., 2014). The implication is that affordability becomes a critical challenge. The inadequate support available to the elderly in Nigeria, including access to free qualitative health care services, is compounding ageing experiences and delaying

help-seeking. The views of the participants' point further to the urgent need for quality support at all levels of care for the elderly.

Perceived Differences in Dispositions of Health Care Providers towards Sexual Health Needs in Old Age

From the perspectives of the FGD participants, there are differences in attitudes and disposition of health care providers towards post-reproductive sexual health care services. Such variations could be observed during therapeutic encounters. From their descriptions, health care providers in public hospitals demonstrate poor attitudes towards care provision by comparison with those in private hospitals. A related comparison was drawn between the dispositions and attitudes of nurses in private hospitals as against those they know and interact with at the public hospitals.

The confidence and willingness to discuss freely during therapeutic encounters was also reflected in the expectations and actual care received. The FGD participants spoke about some of their encounters with the health care providers:

> Most of the doctors are too busy to listen to your stories. They quickly want you to explain your needs and some elderly people will hardly talk about their sexual challenges. [FGD with men aged 60-69 years, Bodija Community].

> Some of these nurses could make you feel sometimes ridiculed by asking: what do you still do at this age, Baba? If Baba Alamu can bear the shame or this kind of attitude, then he can go to the hospital. [FGD with men aged 70-79 years, Sango Community].

Consistent with the FGD findings, three of the interviewees also expressed dismay at the disposition of some physicians to sexual health needs in old age. A common experience

among the three was their inability to engage in free conversation with their physicians. Two of them attributed the challenge to the lack of privacy and unwillingness of the doctor to probe further. For the third participant, it was both an attitude and a privacy problem. The physician who attended to him was impatient and asked him too many questions in the presence of others:

> You will know when someone has genuine interest in you. With many patients to see him, you hardly get enough time to share your concerns [Interview with a 68-year-old elderly male].

For the interviewees, the perceived difference in dispositions, confidentiality, and trust in therapeutic relations with biomedical health care providers is also traceable to their perception of the hospital as a psychosocial space. The participants described the hospital as an open space that lacks the needed privacy:

> Since engagement in sex is done in secret seeking care openly by going to, an open place like the hospital may be difficult. [FGD with men aged 80 years and above, Inalende Community].

The complaints from these participants' point to the critical usefulness of confidentiality and privacy issues in therapeutic relationships. The inability to secure such an atmosphere hindered their confidence and they preferred to use unclear language to relay their sexual concerns. The inadequate physical space to create privacy may complicate the burden of care and the need to attend to all clients during hospital visits. Negotiating the tension around timely attendance to a patient just to reduce the waiting period of other patients could have a negative influence on rapport and confidence building.

The hospital as space had different meanings and interpretations for the participants. For some of the FGD participants, the hospital represents a psychosocial space where people with critical conditions are treated. It was also described as a place where nurses and doctors would use an individual as an object of sermon and example to others. Within this setting, young people (medical students) would ask questions and use them as case studies to learn and conduct research. Thus, in everyday conversations, these interpretations take the form of prayers and affirmations:

> We pray every day not to have cause to visit the hospital especially *orita mefa*. [FGD with women aged 80 years and above, Inalende Community].

> Old age is much better when you visit the hospital less and not on admission to the hospital. In old age, dying peacefully at home is the best. Just sleep and don't wake up. That is the common prayer, not to go and die at the hospital. [FGD with men aged 70-79 years, Sango Community].

The position of the participants shows that the hospital has different meanings and relevance to the health workers, clinical students and the clients/patients. These different interpretations influence help-seeking and therapeutic relations. Ability to synchronise and bridge the differences, however, varies among health care providers and the clients or patients. Probably owing to closeness in terms of worldviews and expectations in therapeutic relations, the participants expressed possibilities of confidence and privacy when discussing a sexual health challenge with a traditional health care provider.

A physician at the Geriatric unit narrated how, over the years, he has built good rapport and confidence with some of his elderly clients:

> Some of my clients call me *oko arugbo* (husband of the aged), and I am happy to attend to them. I have noticed that some patients would give different complaints during consultations, especially when a significant other is present. Two weeks ago, an elderly man was brought here by his eldest wife. Baba complained of the general weakness of the body and pains. After the wife excused herself, Baba now added poor erection as one of his complaints. [Interview with a doctor at the Geriatric Unit, UCH].

Hence, maximising the outcome of therapeutic interaction would require sensitivity, friendliness, and use of clear language. Unfortunately, work-related factors and physicians' personal biases may act as constraints in allowing for sufficient time with patients during consultations. The interviews with the doctors and nurses confirmed the growing challenges in spending quality time with a patient during consultations. The immediate effect, as earlier mentioned, includes use of unclear language, for instance, when a patient finds it difficult to express personal needs and expectations. Responsive handling of elderly patients' complaints about the side effects of treatment and their sexual health is vital to developing age-friendly care and patient-centred care.

Patient-related Factors as Constraints to Responsive Help-seeking

At different levels of disease or illness, patient-related factors interact and coexist with factors within and outside the medical systems in influencing help-seeking. The client/patient-related factors also act as constraints to responsive help-seeking. These factors include recognition and acceptance of the need for support, gender, socioeconomic status, the locus of control, and perceived recovery possibilities. Similarly, causal explanations from the available medical systems and the perceived effectiveness of the therapies are also important.

This section focuses on participants' descriptions of patient-related factors in line with other factors that could delay or restrict responsive help-seeking.

Error in Appraising Bodily Changes and Communicating Sexual Infections

Ability to identify and relate to bodily changes is essential in reaching a decision to seek medical help. To the participants, contraction of sexual infections would require immediate help. The common view among the participants was that the untreated sexual infection would damage the body, increase susceptibility to other forms of infection and mortgage general wellbeing in old age. The same possibilities were expressed about the delay in help-seeking. Delay in seeking medical help could worsen ageing experiences and the quality of relations with others. Untreated sexual infections, like gonorrhoea, syphilis and genital warts, were believed to cause irritation and foul smells, which would cause shame and social isolation.

Subjectively, social actors appraise bodily changes and respond as they deem fit. The ability to engage in this form of subjective assessment emerged as one of the criteria for measuring healthy ageing among the participants. Social actors react and respond differently to bodily changes, especially when such changes are negative. While achieving precision in assessment is not a concern, objectivity remains critical to reducing possible normalisation of such changes as part of the ageing process. As individuals grow old and older, the precision of and responsiveness to certain changes reduces at different degrees, thereby increasing the difficulties of diagnosing the need for help, as expressed below:

> The body grows weaker with old age, and some individuals may not even understand these changes depending on their psychological state and wellbeing. [FGD with men aged 80 and above Oniyere Community].

Despite the possibilities of an infection, the participants noted that some elderly people might decide to rationalise both objective and significant subjective changes as normal and part of the ageing process. Denial as a subjective outcome could be reinforced by overt symptoms of present health condition of an individual and testimonies of significant others. A spouse's or sexual partner's assessment of symptoms of a sexual infection could alert the sufferer to existing challenges and the need for medical help. The judgement and evaluation of significant others in the classification and labelling of a sexual health challenge could corroborate the need for help. In polygynous marriages, for instance, older wives in the marriage are unlikely to make a valid and critical assessment of their husband's sexual health. Partly, they might have lost interest or have been discouraged by their husbands' interests in other women. Similarly, an elderly man with multiple wives may also deny symptoms of sexual infections just to maintain the social value of being the man in charge.

> Once a man contracts an infection, the symptoms will start within a short period. However, we have heard that HIV takes more time to manifest than other infections. So some men can claim they are healthy because they can sleep (sexual intercourse) with two to four women in a day(FGD with Men aged 60-69 years, Bodija Community)

Communication barriers are common among couples in polygynous marriages. Sharing of information on sexual health status will be minimal, as husbands would prefer to keep some information from their wives. Opening up to any of the wives, especially the older ones, could lead to ridicule of the younger wives as the prime suspects. The common belief among the participants is the view that younger women in polygynous marriages are likely to engage in discrete extramarital relations. The presumption cut across the narratives of the interviewees and the FGD participants. Thus, acknowledgement and disclosure of a sexual infection within polygynous marriages could trigger other issues and confrontation among the wives. Confrontation and shifting of responsibilities could be directed at such younger wives

and their husbands. In other words, the likelihood of strains and refraining from sexual activities is likely to deny older wives access to first experience and awareness of their husband's sexual health condition.

A possible implication is that such husbands may suffer neglect and inadequate support when conditions or symptoms become known as sexually transmitted. Similarly, the likely use of unclear terms during therapeutic interactions may also support the need for confidentiality and privacy in therapeutic relations.

Some of the barriers around individual social actors and households, within and outside medical systems, were explored further in the survey. As seen in Figure 11, doctors' indifference (49.6%) was the most common complaint, followed by shame (22.6%) and neglect shown by other family members (10.7%) and children (10.3%).

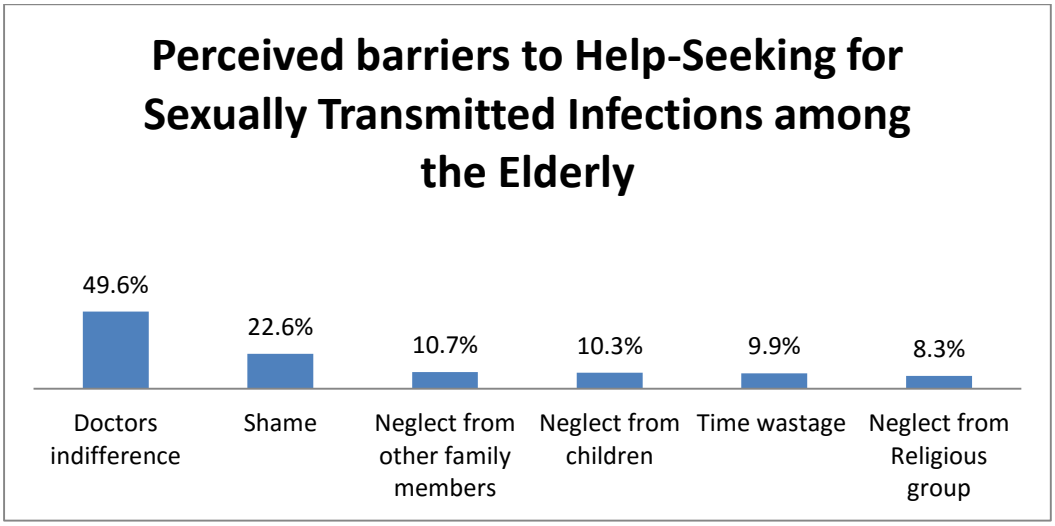


Figure 11: Perceived barriers to help-seeking for sexually transmitted infections

The concern about others and how they perceive sexuality in old age could be seen as underlying these barriers. These barriers are within and outside the biomedical and medical systems that give meaning and interpretation to these factors.

Perceived Dwindling Support and Financial Constraints

A high-quality network of social support plays critical roles in responsive help-seeking and well-being in old age. As expressed in the various FGDs and IDIs, the tensions around ensuring quality support from children and other significant others remain paramount among the concerns about healthy ageing experiences. Partly, a quality network of support and acceptability as an exemplary elder were conceived as enablers of financial support and other forms of assistance in old age. From a moral correctness perspective, the participants argued that contracting sexually transmitted infection could imply loss of financial support from significant others, including their children. The participants decribed possibile loss of support and neglect as potential constraints to responsive help-seeking. With much dependance on others owing to reduced sources of income and poverty, the participants predicted that contracting sexual infection could fast -track the possibility of *agba inira* (burdesome old age).

Buttressing the possible neglect that follows public knowledge of social deviations from the cultural norms associated with exemplary eldership, the FGD participants provided further insights into how sexual infections weaken social relationships and support from significant others:

> Baba Alamu or any elder that contracts a sexual infection would lose the respect of his children and relatives. [FGD with men aged 60-69 years, Bodija Community].
> Their colleagues may not be willing to help them because of their *ise ku se* (promiscuity), which they have been cautioned, but they were adamant. [FGD with men aged 80years and above, Oniyere Community].

The above statements depict some of the struggles and tensions around sexual activities, contracting of sexual infections and declaration of status. As stated in the literature, there is absence of a formal support system for ederly people in Nigeria. The dominant but dwindling

form of support available to the growing proportion of eldery people is the informal support systems provided by significant others. The system survives based on voluntary contributions from significant others. Thus, an elderly person whose entire income and support is only from this source will survive at the mercy of significant others or children. As opined by the male FGD participants, individuals with inadequate support would likely be in poverty and would rather spend their money on food and shelter than improve their sexual performance. Furthermore, contracting a sexual infection would also encourage self-medication and patronage of patent medicine vendors or peers who could help:

> If he has no money, there will be discouragement as neither hospital nor Alagbo will provide free treatments. [FGD with women aged 80 years and above, Oniyere Community].
>
> Money, if they do not have money to treat themselves and their children are not rich enough to treat them. [FGD with men aged 60-69 years, Bodija Community].

As illustrated by the above statements, finance remains a huge challenge for the average elderly person in the study locations. Inadequate social support contributes to poverty and lack of money in old age. Nevertheless, the resilience to survive could be observed, as some of the participants engaged in menial jobs and found other sources to earn a living. The male FGD participants postulated further that life could become misrable for an elderly person who constracts a sexual infection without money to seek help. At this point, it becomes less motivating to seek help or demonstrate much hope for recovery, as exemplified in the following excerpts:

> If he has no money, and the next is death. [FGD with women aged 80years and above, Oniyere Community].
> It will be costing them money to get a solution to their problems, and it will be a waste of money and time. [FGD with men aged 70-79years, Odo Oba Community].

> On the other hand, he may be thinking that going to the hospital for a test could lead to some other problems like money to buy drugs. The knowledge of the health condition and lack of money may even lead to depression since he does not have money to treat himself so he may decide not to go for treatment. [FGD with men aged 80 years and above, Inalende Community].

In such a situation, an individual may give up hope for living and rationalise the situation as an inevitable route to death. Thus, personal interpretations of inadequate finances were considered more important than the reality of not having the money itself. For the participants, the absence of money creates psychological feelings related to help-seeking, thereby compounding personal disappointment concerning contracting sexually transmitted infections.

Across all the FGDs and among the individual interviewees, financial constraints were overt and loud. The survival challenges of everyday life and the need for quality health services in old age became more complicated with the lack of money and inadequate support from significant others. The psychosocial influence of contracting severe sexual infections may be alleviated if the quality network of support becomes available within and outside existing medical systems. However, this becomes difficult and challenging given the stigma associated with sexual infections, even in old age.

Internalised Ageism and Stigmatisation of Sexually Transmitted Infections

The position that sexually transmitted infections are indicators of failure and lack of conformity to moral correctness in old age could qualify as a form of internalised ageism. The participants echoed the age-grade social discrimination that follows deviations from prescribed periods of engaging and disengaging from penetrative heterosexual relations. The night time (*ojo ale)*, as stated earlier, bestows on the elderly moral and cultural

responsibilities. Thus, the night time has both chronological and symbolic relevance in the Yoruba belief system.

Symbolically, the night time represents a period of darkness, reflection, and assessment of daily activities. It could also pose a period of despair when there are few alternatives to undo the outcomes of some erroneous decisions. It could also mean a period of dependence and craving for support. All these possibilities and interpretations govern the moral context of individual rights and pleasure satisfaction. The participants narrated further the reality of perceived stigma associated with sexual infections in old age:

> Well, it is natural that hospital workers would consider it shameful for such an old man to disturb his life through such an avoidable act. Therefore, he is bound to encounter reproach and shame. [IDI with a Male aged 69 years, Christian].

Based on the cultural notion of the exemplary elder, the participants recounted different dimensions of perceived and personal stigma about sexual infections in old age. As the majority of the FGD participants were followers of Christianity and Islam, it was understandable how stigmatisation became personal for any elderly person that contracted a sexual infection. Most religions provide prescriptions for sexual practices that adherents are expected to imbibe and live with, both in their private and public lives. Despite these expectations, members sometimes deviate and suffer unexpected or expected consequences such as contracting an infection.

The consequences and shame associated with contracting sexual infections could, therefore, be worse for elderly people in such religious groups. Similarly, religious beliefs would influence possible interpretations of causality, the source of support, and adherence to

treatment options. Thus, contracting a sexual infection by an experienced and sexually active elderly man or woman would attract blame and ridicule:

> An elderly man that contracts gonorrhea will be ridiculed because he ought to use traditional preventive measures that are efficient and available. [FGD with men aged 70-79years, Odo Oba Community].

> People are bound to use different names to address elderly men and women with sexual infections. They would even ask them why they got themselves into it and to the point of contracting an infection. [FGD with women aged 80 years and above, Oniyere Community].

As a social construct, gender also emerged dominant in the various FGDs. As noted in the literature, indulgence in multiple sexual relations is normatively permissible for men and in polygynous marriages. The social positioning and approval that come to men come with certain responsibilities and moral duties. These include the readiness to engage in safer sexual relations and avoid contracting sexually transmitted infections. In this regard, men possessed more privileges than women, in terms of stigma that comes with contracting sexual infections and help-seeking, as pointed out below:

> To contract a sexual infection in old age is miserable for the women. People will ask questions even the doctors and nurses would look at you somehow. [IDI with a woman aged, 74 years]

> Women hardly come for treatments that relate to sexual infections compared to men. Though even the men prefer not to mention this as a challenge, but they do come occasionally more than the women. [IDI with a doctor aged 43 years].

In discussing the possible variations in stigma experiences, the participants at different levels appealed to socioeconomic differentials. The dominant view of socioeconomic differentials is that individuals of moderate or high socioeconomic status enjoy the goodwill of the society in

new sexual relations. This privileged position also gives such individuals the advantage of engaging in proactive help-seeking. Whether the help sought is to enhance sexual performance or treat a sexual infection also varies by gender and socioeconomic condition. The participants argued that some high-profile elders with sexually transmitted infections would not visit hospitals and would prefer to receive treatment at home:

> Because of wealth and social position in the community, the average rich man would prefer to have a private physician or use the private hospital when they have personal problems like a sexual infection. [FGD with men aged 70-79 years, Sango Community].

The above view supports the differentials that could be observed when individuals are faced with similar health conditions. The participants posited that affluent elderly people would avoid public and open help-seeking. They hypothesised further that in the eventuality of seeking help at government hospitals, private consultation rooms and prompt attention to their needs would take place. Such conscious efforts promote differentiated susceptibility to stigmatisation:

> The time and attention that a patient receives in most government hospitals also depend on your age and socioeconomic status. When you are neatly dressed in expensive attire, just expect special attention. [FGD with women aged 60-69 years].

> Wealthy and highly placed elderly people in Nigeria hardly use public hospitals. Those who use public hospitals are poor, and the experiences are similar. You are likely to suffer neglect and delays even when you visit for other health conditions, not to mention sexually transmitted infection. [IDI with an elderly male aged 73 years].

Acceptance of stigmatisation at a personal level would also increase internalised ageism. At the individual level, acceptance of stigmatisation causes shame and loss of self-esteem and supports from significant others. A feeling of deviating from the cultural expectations

concerning exemplary elderly behaviour promotes shame and unwillingness to seek care. The participants cited shame and guilt feelings and the personal conviction of stigma as a barrier to seeking help:

> Unhappiness and disappointment with self is a factor. Like old people, they will not be happy due to their age as old man/woman, they will be ashamed to tell people, and this will cause Baba Alamu and Iya Asake setbacks. [FGD with men aged 60-69 years, Bodija Community].

> They will be ashamed to go to the hospital because of their old age. This would make them to secretly seek treatment from herb sellers, patent medicine vendors and self-medication since they would not like many people to know that they have contracted sexual infections. [FGD with men aged 60-69 years, Bodija Community].

> You see if a young person contracts an infection, it is much easier to treat and return to normal than if it were to be an older person. [FGD with men aged 80 years and above, Inalende Community].

> In my opinion, shyness will be a constraint, as they will say in their minds how someone of my age can contract a sexual infection. Since engagement in sex is done in secret, seeking care openly by going to an open place like the hospital may be difficult. [FGD with men aged 80 years and above, Inalende Community].

The views of the participants showed that both internalised and perceived stigmas could promote barriers and communication challenges in the ways social categories and elderly people are treated in therapeutic relations. For elderly people with low or poor socioeconomic status, personal and perceived stigmatisation could cause possible neglect and unfair treatment even when help is sought at the hospitals. The implication is that stigmatisation associated with sexually transmitted infections in old age may affect timely response to an elderly person when visiting the hospital for care. Another possibility is shift of blame to the elderly, such as being seen as careless and doing something unexpected from an exemplary elder.

Contraction of Sexual Infections and Quality of Support

Informal support represents an important way of coping with health challenges in old age. In old age, informal support could come from significant others, which include children, relatives, neighbours, and social or religious group members. As social actors, elderly people acquire informal support in various ways and could lose the same quality of support through the meaning and interpretation of their actions. Within the framework of the exemplary elder, as presented by the participants, the conscious efforts not to lose both ascribed and acquired social support remain paramount. To ensure sustained patronage and an arsenal of informal support, an exemplary elder must position himself or herself for the relative performance of moral duties and responsibilities as defined in their cultural settings. Contracting sexually transmitted infection was perceived as a derivative violation of the moral duties and responsibilities of an exemplary elder. In the first place, active engagement in sexual activities is a direct violation of these duties and responsibilities. Thus, by contracting a sexual infection, it becomes an added responsibility for an elderly to protect the shame and possible loss of networks of support. However, when it becomes impossible to personally initiate or engage in responsive help-seeking, the needed support to do that might not be available, as indicated in the following excerpts.

> Good behaviour is useful and must be developed right from childhood to old age. If an elderly person has good conduct, he will receive quality support in old age even when he is faced with a health challenge. However, an elderly or older person with bad behaviour will not receive help from people around him or her, even if he/she falls inside the gutter people are likely to turn a blind eye. [FGD with men aged 80 years and above, Inalende].

> May God help us. Baba Alamu's and Iya Asake's sexual behaviours are far below societal expectations and would work against them especially when faced with sexually transmitted infections. [FGD with men aged 60-69 years, Bodija].

Focusing on the various sources of informal support for the elderly, participants narrated the possible implications of contracting sexual infections for the quality of support from children, relatives, friends, neighbours, and members of their religious groups. Children are likely to cast aspersion on their elderly parents once they are sure it involves sexual infection. The reactions may be worse when it affects only one parent, especially mothers. As stated earlier, an elderly mother that engages in extra-marital relations is more likely to attract negative reactions from her children. The male children, in particular, are more likely to react negatively to their mothers without looking at the underlying reasons for their involvement. The disposition would be different if a father is involved, as indicated in the excerpt below:

> His wives and children will help to take such an old man to the hospital for treatment. Both his friends and neighbour can also assist them. If it involves money, if they have the means they can help him with money. [FGD with women aged 80 years and above, Inalende].

Thus, the withdrawal or loss of informal support as a result of contracting a sexual infection varies by gender and socioeconomic conditions. An elderly person with a regular source of income in old age would rely less on others including children in footing their hospital or treatment expenses. Appealing to cultural beliefs and expectations, a few of the participants expressed the need for children to support their parents no matter the situation. The cultural belief and expectation is that a good socioeconomic condition in life is a call to duty to provide support for others, especially parents and close relatives. Through various measures and networks of relations, these expectations and reciprocities are valued and enshrined in various ways. The participants noted the perceived blessings and non-rationalisation of performing these social obligations to aged parents:

> Why would they not be treated, since they have relatives and children? Let them call on their children and their relatives. Those they have been good to also will come to their aid unless they did not take care of children or be good to the relatives. [FGD with women aged 80 years and above, Inalende]
>
> If the children are well to do, they may take care of them even if they did not take care of those children so that it will not become a curse. [FGD with women aged 80 years and above, Inalende].
>
> If such old men have well to do children, they will take such an old man to the hospital for medical treatment and such old men do not have helpers they can die easily. [FGD with men aged 70-79years, Odo Oba].

Similarly, relatives and neighbours are expected to provide support for those in need around them. The participants also expressed possible withdrawal of or dwindling in the quality of support from relatives and neighbours in the event of an infection. However, the nature and value of available quality of support to an individual depends on how others perceive and evaluate the character and quality of the person's behaviour. The quality of previous relationships, especially with friends and relatives, could boost or puncture the quality of available support. Poor previous social relations and negative perceptions would promote neglect and abandonment. People refer to the character of the elderly person before the time of need. Once the assessment falls below average, support may be withdrawn or dwindle as character or assessment affects the social perceptions and evaluation of others, based on the law of sowing and reaping. Thus, elderly people with bad character or social reputation are less likely to attract the sympathy of others. Relatives and neighbours are likely to interpret present predicament as well deserved and inevitable due to past evil deeds, as articulated below:

> This depends on the quality of his relationship with his relations; if his personal human relations are good, his relations will not want him to die, and they will take care of him. On the contrary, bad relations with relatives could lead to sudden death under this circumstance. [FGD with men aged 80 years and above, Inalende Community].
>
> If he has been good to the relatives and friendly to them, they will come to his aid but it takes somebody that wet the ground to walk on the wet ground. [FGD with women aged 70-79 years, Sango Community].
>
> Within his neighbours this depends on his interpersonal human relations, if he is good, they help him to get adequate treatment but if his human relations are poor they will not assist him. Even if there is a close neighbour with the knowledge of what will cure the person, he/she will be denied the treatment if he/she has bad behaviour/poor interpersonal relations. [FGD with women aged 60 years, Bodija Community].

The moral contexts of support provision lend credence to the principle of reciprocity in social exchange theory. Support for the elderly is seen as essential to healthy ageing. In return, the elderly is expected to position themselves within the social framework of the exemplary elder. By expanding their resources in both cash and kind, elderly people are further motivated to conform by refraining from or engaging in healthy sexual practices where there are opportunities. However, when such sexual engagement falls outside expected forms, it leads to ridicule, castigation, and stigmatisation.

Furthermore, within medical systems, stigmatisation and bias towards post-reproductive sexual health were perceived as possible constraints on quality care and services. Beyond gender, other socioeconomic factors also account for the social variability in the opportunities and risks of expression of post-reproductive sexual needs. As such, the participants felt that the biomedical system was not responsive enough to post-reproductive sexual health care services. The traditional medical system fared better as the participants expressed pleasant dispositions and positive assessment of available remedies. In reaction to the views expressed by the FGD participants, the health care providers within the biomedical system expressed

their awareness of sexual health concerns of elderly people. The constraints ranged from work-pressure, inadequate consultation room and time, workload and communication barriers in therapeutic relations.

GENERAL DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This thesis provides an interpretative construction of sexuality, ageing and help-seeking behaviour and practices within a Yoruba cultural context. The global increase in ageing population has inherent challenges and opportunities that have contributed in diverse ways to the need for research on ageing, sexuality and help-seeking behaviour. With the dearth of such research, particularly in Africa, this thesis is timely in responding to the call for research and policy attention to these issues (Aboderin, 2014). The use of a sequential exploratory mixed-methods approach, in this study, to explore ageing, sexuality and help-seeking behaviour makes this work first among the few existing academic enquiries on ageing and sexuality in Africa.

Issues such as what constitutes old age, sexuality (sexual pleasure, and notions of risky sexual practices), and how older people engage in help-seeking for sexual health promotion and problem-solving are interrogated in-depth with the aim of gaining a nuanced understanding of their complexity. The study also focused on the perceived constraints and availability of post-reproductive sexual health care services within traditional and biomedical systems. This was to contextualise the inherent contradictions and motivations for help-seeking (medical and non-medical) when confronted with a sexual health challenge in old age.

The thesis addressed four related research objectives by focusing on meso and micro dimensions of ageing, sexuality and help-seeking behaviour and practices:

1. It explored the socio-cultural understandings and embodied experiences of old age and sexual health in later life among older Yoruba men and women (60-80 years and above).

2. Empirical evidence was generated on the popular forms of understanding, meaning, and practices relating to sexual pleasure and risk behaviour among older Yoruba men and women.

3. It acknowledged the individuation of sexual desires and prowess in expressions and then captured the decision-making processes associated with help-seeking for sexual health challenges in old age.

4. It also focused on perceptions of health care providers (biomedical and traditional) on sexuality and the prevention, treatment, and promotion of sexual health in old age.

This chapter presents a discussion of the main findings, accompanied by conclusion and recommendations. A review of the findings was done with a focus on convergent and divergent positions in the existing literature. Using a thematic approach, the chapter focuses on the major findings of the thesis:

- Socio-cultural descriptors of the exemplary elder and the 'good old age';
- Cultural beliefs and dispositions towards sexuality in old age;
- Heteronormativity and individuation in sexual desires and prowess in old age;
- The normativity of penetrative vaginal sex and perceived usefulness of aphrodisiacs in old age;
- Perceived health implications of bodily changes and sexual activities in old age;
- Prevention and treatability of sexual infections;
- Perceived obstacles and facilitators of responsive help-seeking for sexually transmitted infections in old age; and
- Medical systems and perceived responsiveness to sexual health needs in old age;

The Exemplary Elder as Socio-Cultural Descriptors of the 'Good Old Age'

Growing old and the associated experiences are driven by context and prevailing beliefs, values and practices. There are debates around what informs how old and older people negotiate and interpret the ageing process and the influence such process might have on their lived experiences, bodily changes and sexuality (Fileborn, Thorpe, Hawkes, Minichiello, & Pitts, 2015; Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015). By focusing on embodied experiences, this thesis revealed varied interpretations elderly people assign to bodily changes, sexuality, societal expectations, and well-being in later life. The findings revealed how age-grade expectations create exemplaries for elderly men and women to measure their moral correctness to the 'good old age'. Their interpretations showed that old age could be miserable and worse off for anyone. For these reasons, conscious efforts are needed to measure up to cultural exemplars in a cumulative manner that could ensure the avoidance of miserable old age (*agba inira*). Against this backdrop, the participants described an exemplary elder from a three-dimensional position that prescribes moral correctness as a requisite to the 'good old age.'

From an age-grade lens, an exemplary elder would first be someone with a social consciousness of what is culturally required and expected within a given time. As a mortal being, an elder would face life challenges and make mistakes. The fluidity and dynamics of handling life challenges and the lessons learnt must reflect in the quality of their relations with others. No consensus on conformity was presumed, as individuals conform differently to the moral correctness of an elder. The social expectation was that the failure and inability to attain moral correctness are inherent in individuals and the network of relations also provides some critical lessons. If adequately applied, such lessons would reflect in the quality of interpersonal relations and handling of life events that come with ageing. It is crucial to have

harmonious interactions with significant others. In the Yoruba belief system, having successful children and grandchildren and involvement in socially acceptable behaviours are social markers of the 'good old age' (Togunu-Bickersteth, 1988).

As a continuum, these experiences and processes have a cummulative effect on health whether as a physical, mental, emotional or spiritual reality. The findings support the holistic view of health and its social dimensionality, especially in interpersonal relations. The participants noted that health challenges are inevitable in old age. However, certain health conditions, especially those that are inexplicable, whether from a biomedical or traditional medical framework, are rewards for living outside the exemplary framework. This mode of explanation has its contradictions, as some conditions among the Yoruba have their aetiological foundation on preternatural sources, which include evil machinations and envy (Jegede, 2002). This notwithstanding, the belief that old age also improves spiritual knowledge and possession of strange powers was considered as a strength to ward off such evil machinations of self and significant others. While this assertation also differs among individuals, the social expectation is that the exemplary elderly must engage in spiritual activities by seeking help from those who have the powers, making sacrifices and praying for their children's well-being and peace in the community.

Despite the variations in cultural beliefs and practices, these attitudes and values had been observed among native elderly people in Bristol Bay, Alaska. The study revealed how the cultural value of measuring up to the moral correctness of being an elderly brings psychosocial satisfaction and social capital in old age (Lewis, 2011). A somewhat common position in the literature is the cultural belief in the rewards associated with the provision of care and support for elderly people. Studies have shown how family members have continued

to provide such supports despite the growing burden of providing informal care for the elderly (del-Pino-Casado, Frías-Osuna, & Palomino-Moral, 2011; Gupta, 2009; Kipp, Tindyebwa, Rubaale, Karamagi, & Bajenja, 2007; Uwakwe et al., 2009). Among the Yoruba people, the sustainability of this belief despite the constraints might revolve around the presumed blessings, which might outweigh the cost (Adeniyi-Ogunyankin, 2012). The sanctity of this belief is enshrined in all the three main religions (Christianity, Islam and Traditional Religion) among the Yoruba people (Balogun, 2011; Togunu-Bickersteth, 1988).

Peaceful and befitting burial attracts high value among the Yoruba people. At the fourth dimension, living as an exemplary elder was woven to life after death. The postulation was that the good old age transcends physical health, availability of material and non-material support and quality interpersonal relations, as revealed in the study by Fry et al. (1997). While this thesis espoused the relevance of these resources, the argument here is that peaceful death and the well-being of one's children after death are important derivatives of having lived an exemplary life as an elder.

Overall, the presumption was that conformity to the moral correctness that is expected of the elderly would minimise the possibility of experiencing challenging ageing experiences, described as *agba inira*, which includes peaceful death and well-being of significant others. There are close similarities with the emphasis placed on health by the participants in the study of Fry et al. (1997). In this thesis, the participants portrayed health as a continuum; therefore, sustained efforts are require to enjoy good health in old age.Consistent with those found elsewhere (Christensen et al., 2009), health was associated with multiple factors, which included psychological, lifestyle, biological, structural and cultural factors. The literature

shows that, across the life course, these factors jointly account for the variations in the quality and health status of individuals from different social categories (Marengoni et al., 2011).

Within this framework, the research participants affirmed heterosexual relations for the purpose of procreation as morally correct. The exemplary elders, therefore, would express their sexuality desires within the age-grade framework that allows relative freedom and restriction for men and women. In old age, reversal of the frequency of sexual involvement signifies a thoughtful response to bodily changes. While variations in sexual desires and activities were mentioned, lack of moderation in sexual desires and engagement was linked to negative health consequences. This lack of restraint could increase vulnerability to sexual infections, sudden death from a folk sexual infection (*magun*), abuse, neglect, loss of support from significant others. There a few exceptions: some elderly males that engage in unprotected multiple sexual relations might escape some of these consequences. Such elderly would include males with the average socioeconomic background, quality social capital, and spiritual knowledge to avoid sudden death (*magun*).

Cultural Beliefs and Dispositions towards Sexuality in Old Age

Cultural beliefs and practices influence how social actors position their sexuality and that of others. In this study, the participants described how sexual desires and opportunities for expressions were skewed in favour of men. The findings of this study showed variations by gender on the emphasis placed on meeting up with moral duties and fulfilment of rights. Among women, for instance, much emphasis was placed on measuring up to the cultural values of motherhood. The findings pointed to the social benefits associated with fulfilling the notion of motherhood, especially in polygynous marriages. The participants expressed the view that mothers in polygynous relationships would commit their energies to their children's

well-being rather than to expressing their sexual desires. This corroborates the view that, despite the competition for husband's attention, women in polygynous relationships prefer to protect their children's interest in their personal gains including their emotional health (McMahon, 2012).

How the performance of such duties affects sexual health remains under-researched. Mothers would be constrained further in their sexual expressions as such actions might be misconstrued as a misplaced priority. Outside the home front, the sexual health needs of women were also subsumed under the perceptions that their needs are met by fulfilling men's sexual needs. For instance, there are very few sexual health remedies to enhance women's sexual performance and desire in both biomedicine and the traditional medical system. In the traditional medical system, what is available is what can boost their fertility or improve the sexual pleasure of their partners. Conversely, elderly men have options to boost their fertility and sexual performance until old age. This social arrangement compromises women's sexual health in many ways. It portrays their sexual desires and expressions as dependent on their male counterparts. It creates limitations of options and their sexual life expectancy. It also influences dispositions towards help-seeking, as the available services are widely tailored towards reproduction and servicing of men's sexual needs.

This thesis provides insights into how cultural beliefs around bodily changes, such as menstruation and menopause, are sustained and deployed in framing sexuality and health outcomes in old age. The participants appealed to physiological changes and the woman's body in particular as key indicators of when to engage in, abstain from, or disengage from sexual activities. The woman's body is categorised into two broad phases: reproductive and post-reproductive stages. The woman's body has the highest sexual value during the

reproductive period. The participants linked sex and sexual activities to pleasure and procreation. The binary outcomes associated with sexual activities might become elusive when caution is not exercised regarding who, when and how sexual desires are expressed. Menstruation and menopause attract both physical and spiritual significance. With regard to physical interpretations, menstruation and menopause are critical markers and warning signs that state when to engage, abstain or disengage from sexual activities. To ensure some level of compliance, some cultures, including the Yoruba culture, have attached spirituality to menstruation and menopause.

Scholars have traced the spiritual interpretations of menstruation to dominant religions in the world (Dunnavant & Roberts, 2013; Johnston-Robledo & Stubbs, 2013). Through different rites, rituals and taboos, menstruation has acquired a symbolic status of being unclean, profane, but powerful to cause loss of spiritual powers (Makinde, 2004). The implication is that the presence of a menstruating woman in sacred places would cause profanity (Guterman, Mehta, & Gibbs, 2008; Makinde, 2004). As a warning, menstruating women are motivated to stay off certain religious rites and secular activities like sexual intercourse (Guterman et al., 2008).

The participants described sex with menstruating women as uncalled for and a possible source of losing spiritual blessings, and contracting infections, and a potential source of setback in life. They also explained the implications of sexual activities for menstruating women. A folk disease known as *idakole* was provided as a warning to men who are defiling themselves through sex with menstruating women.

The views expressed by the participants are in line with those in the literature. From historical sources, menstruating women in the Yoruba belief system must be excluded from participating in sacrifices to Obatala –a deity known for cleanliness and whiteness (Familusi, 2012). Also, there is the belief that menstruation can destroy the potency of traditional medicine (Makinde, 2004). By describing menstruating women as unclean, the value of the woman's body was subjected further to sexual purity and pleasure. Invariably, it was easy for the male participants in particular to position the woman's body and their sexualities around the occurrence or non-occurrence of menstruation.

As maintained by some of the male participants, sex with menopausal women gives less pleasure and unwarranted loss of sperm. The same argument was presented in support of the need for women to disengage from sexual activities, even when personal health and desire are favourable to sexual activities. Sex with younger women would guarantee more pleasure and the possibility of having a child for men with such interest. The finding that bodily changes reduce the sexual value of women and impact on cultural conceptions of the ideal body and the appropriate timing for sexual activities supports similar studies among older Chinese people (Ling, Wong, & Ho, 2007; Yang & Yan, 2016) and Taiwanese women (Yang, Kenney, Chang, & Chang, 2016) . In this thesis, such perceptions provided valid positions for sexually active elderly men to seek new or reinforce existing intimate relations with younger women. As described by the participants, patriarchal social arrangements position men to react in an advantaged position. However, it creates compromising effects on women's sexual health and well-being in old age.

How social positioning influences these gendered privileges in old age is missing in the gerontological literature. How individuals make sense of bodily changes has significant implications for their sense of judgement and interpretations of their sexuality and that of others (Pearce, Thøgersen-Ntoumani, Duda, & McKenna, 2014; Westerhof et al., 2012). The possible implications of bodily changes on sexual desire and the contradiction that might follow for the elderly and their partners (McHugh & Interligi, 2015; Thorpe et al., 2015) have been documented in some developed countries; such focus is scarce in Africa.

The thesis provides a window into the normativity and the use of sexual refusal and abstinence for engaging in extramarital relations. As shown in the literature, repeated sexual refusal has both intended and unintended consequences. In a Ugandan study, Cash (2011) reported how repeated refusal of sexual requests by either a woman or man was used as an excuse to engage in extramarital affairs. There are no studies on how elderly people make sense of sexual refusals from their partners. The findings of the thesis showed that sexual refusal provided opportunities for sexually active men to solidify existing extramarital relations or enter into new ones.

In contrast, such refusal also offers a framework for women to contest the silence on fulfilling sexual obligations in heterosexual relations. A study among elderly Chinese men and women revealed the influence of cultural beliefs on how elderly women experience and understand their sexuality and responds to their husband's sexual needs (Yan et al., 2011). The Chinese women in the study considered a prompt response to husband's sexual needs a duty even when they lacked the desire. Similarly, an Iranian study of women's sexual behaviours also revealed similar dispositions to husband's sexual needs. Responsiveness to husband's sexual demands and needs qualified the Iranian women as wives and positioned them to receive

Allah's blessings. Both the Iranian and Chinese studies revealed how cultural expectations and religious practices affect sexual experiences and engagements in reproductive ages (Merghati-Khoei, Ghorashi, Yousefi, & Smith, 2014), and in post-reproductive age (Yan et al., 2011).

Despite the similarities in the direction at which cultural beliefs, values, and practices influence sexual desires and expressions, there are some variations. An earlier study among the !Kung women in Botswana showed a relative level of freedom for postmenopausal women to fulfil their sexual needs. With age, !Kung women are allowed to enter into new sexual relations, including extramarital relations once they enter menopause and before they turn 65 years (Lee., 1992).

In this thesis, a departure was observed as the ownership and value placed on the woman's body changes and shifts through the ageing process. As documented by Oyesakin (1982), the woman's body, especially the breasts, provide irresistible features that attract and sustain men's attention. However, these values depreciate in old age; commitment and intimacy are required to appreciate the body during such period. Recent qualitative studies have shown how individual agencies, relationship contexts and the quality of social capital shape sexual desires and expressions in old age (DeLamater & Koepsel, 2015; Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015).

Across the life course, sexual desires and expressions are fluid and dynamic for individuals. In this thesis, the participants referenced psychosocial factors that could affect the willingness and unwillingness of some elderly men and women to engage in, disengage from, suppress, or abstain from sexual activities. Concerning heterosexual marriages, the participants

mentioned the role of psychosocial variables on sexual indulgence, abstinence, or suppression for elderly women. The majority of the participants from a polygynous background described postmenopausal sex as stressful and unprofitable for women.

Menopause, therefore, provides the vehicle for such women to react to their husband's sexual needs. In the menopausal period, denial and refusal to yield to laborious sexual demands become feasible and contested. Within the study settings, a wife that refuses sexual advances from her husband stands the chance of social condemnation and counter reactions from their partners. Psychosocial relationship and contextual factors affect sexual desires, expressions and experiences in old age (McHugh & Interligi, 2015; Ussher, Perz, & Parton, 2015). This thesis accounts for the variations in the ways elderly people construct and interpret their sexuality and that of others, as reflected in the findings.

In the light of the findings, this thesis supports the view that elderly men and women react and respond differently to the influence of psychosocial factors on sexual desires and expression (DeLamater & Koepsel, 2015; DeLamater, 2012). In the gerontological literature, a few studies have examined how individual factors, such as previous sexual experiences, sexual beliefs and health condition and the availability of a partner, shape how elderly men and women respond to their sexual needs and challenges (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015; Gott & Hinchliff, 2003; McHugh & Interligi, 2015; Zeiss & Kasl-Godley, 2001). Habitus and social positioning of social actors affect their sexual orientation and experiences across the life course. Accounting for individual particularities can provide unique opportunities to understand the differentials that exist in the significance of sexuality in old age. The explanations around contexts and individual experiences and interpretations around menopause provide support for phenomenological investigations on

menstruation and menopause (Fahs, 2011). The sharing of personal sexual experiences by some of the participants in this study provides some of these missing links in the literature.

Heteronormativity and Individuation in Sexual Desires and Prowess in Old Age

The findings of the thesis reiterated the critical need for fluid and gendered individuation in sexual desires and prowess in old age. The findings affirmed the existence of varied sexual desires and expressions in old age. The participants drew on their lived experiences and normative explanations within the Yoruba cultural belief system to support the heterogeneity in sexual desires and activities in old age. Yoruba cultural beliefs and practices around sexuality recognize penetrative sex as normative and essential to pleasure and procreation. As such heterosexuality is promoted and encouraged in diverse ways. Heterosexual practices in marriages were the only sexual behaviours mentioned among the research participants. This might also be associated with the type of sexual relations that were depicted in the vignettes and the silence on the possible existence of diverse sexual orientations among the Yoruba people.

There are variations in sexual practices and risk taking in old age (Thorpe et al., 2015). These variations depend on individual experiences framed alongside biological, psychosocial, and structural factors. Specifically, gender differences along with psychosocial factors and availability of partners affect sexual experiences (Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015). The findings also revealed the existence of varied measures that elderly men and a few women could adopt in ensuring the realisation of sexual pleasure across the life course. The likelihood of adopting any of these measures also varies with expectations and experiences as individuals move through different phases of life. The findings of this

study, therefore, provide insights into the normative explanations around existing individuation on sexual desires and prowess in old age. These interpretations are located in prevailing hegemonic masculinity and the perceived pleasure from penetrative vaginal sex across the life course.

Moreover, the findings revealed the willingness of sexually active men towards achieving such sexual experience for partners even in old age. For elderly men who could not, there were possible psychological effects of failure to measure up. With age, physiological changes for both genders make mobility difficult and point to a potential need for a shift from penetrative sex to other forms of sexual expressions. The ease of attaining such a change in sexual orientation might be challenging, especially in a culture with stereotypes around sexual subjectivity. This thesis makes a modest contribution by focusing on experiences, relationship and cultural values and beliefs that support or discourage sexual desires and practices in old age.

The normativity of penetrative vaginal sex and perceived usefulness of aphrodisiacs in old age

The emphasis on penetrative sex as pleasurable and satisfactory for men across the life course within the Yoruba culture has been reflected in the findings. Within this context, sustainable sexual performance is desirable and possible. However, while some men were considered naturally endowed and could sexually satisfy a woman, the common view was that, with age, sexual performance could become challenging and, therefore, require some form of biomedical or traditional aphrodisiacs. Indeed, these ideas were expressed among some elderly Yoruba people (Agunbiade, 2013; Agunbiade & Titilayo, 2012). These findings support the growing availability and use of traditional remedies in the management of sexual infection and erectile dysfunction (Kamatenesi-Mugisha & Oryem-Origa, 2005).

The availability and use of traditional aphrodisiacs have a long history in the Yoruba culture. With resilience, patronage and improvements, traditional aphrodisiac herbs have survived competing interests, including harsh colonial legislations against traditional medicine (Aderinto, 2012). Thus, it was not a surprise to see the narratives of the participants on how herbal and traditional aphrodisiacs enhance male sexual performance.

Across different communities in Africa, longer and repeated rounds of penetrative sex has high value among men and women. As such, efforts are consciously made to fit into this frame of defining satisfying sexual intercourse. A common name for the various traditional aphrodisiacs among the Yoruba people is *ale*, which means a substance that provides strength. For sexual purposes, *ale* strengthens the veins around the male sexual organ for longer sexual intercourse. Despite the absence of empirical studies on it, a possible achievement of this substance has somehow sustained the interests of the consumers of aphrodisiacs. Consumption of traditional and foreign aphrodisiacs is popular among different social categories in Nigeria (Borokini, Clement, Dickson, & Edagbo, 2013). The situation is also similar in some communities within the sub-Saharan Africa (Abdillahi & Van Staden, 2012; Kigen, Ronoh, Kipkore, & Rotich, 2013; Tabong & Adongo, 2013).

An observant in any major town in Southwest Nigeria will see in display information on the availability of different herbal medicines and possible places of purchase. Within this category of aphrodisiacs are alcoholic beverages that also claim to function as aphrodisiacs. These drinks are readily available from street vendors, bars, beer parlours, wholesalers, and retailers of soft and alcoholic beverages. In recent times, the consumption of some of these beverages has attained a new height (Obot, 2015). For instance, guests at social functions,

such as burial, marriage and naming ceremonies, are offered different types of these drinks (Dumbili, 2013; Nelson, 2014). Common among these alcoholic beverages with aphrodisiac claims are Alomo Bitters (A Ghanaian product), Tesoju e, Osomo, Pakuromo, and Ogidiga (Evans, 2014).

There are few studies with focus on the perceived relevance and use of aphrodisiacs among elderly Yoruba people (Agunbiade, 2013; Agunbiade & Titilayo, 2012). The findings of this study depicted contextual rationale and positive dispositions towards the consumption of traditional types of aphrodisiacs among young and old people. In this direction, two dominant positions were advanced. The first view was associated with fertility and the need for procreation, especially for the elderly with fertility problems. The second position rested on the need to measure up with the hegemonic masculinity of performance enhancement and avoidance of sexual infections. Expectedly, there was much emphasis on physiological changes and physical strength as requisite conditions for pleasurable sex. This view cannot be separated from the hegemonic masculinity that associates heterosexual penetrative and longer sexual intercourse as pleasurable and satisfying for women.

Perceived Health Implications of Bodily Changes and Sexual Activities in Old Age

Bodily changes are ongoing indicators that the body as a psychosocial and physical space is deteriorating. This was one of the cross-cutting views that emerged from the findings.The research participants argued that the process and reactions to bodily changes could be dissimilar within and across gender. This is in tandem with other studies claiming that individuals react differently to bodily changes owing to psychosocial factors and cultural

beliefs associated with the body (DeLamater & Koepsel, 2015; Fileborn, Thorpe, Hawkes, Minichiello, Pitts, et al., 2015).

From a normative stance, the findings revealed more negative health implications for elderly women who continue to engage in sexual activities than for men. The availability and consumption of aphrodisiacs provide strength and sexual pleasure for men. However, the case is different for elderly women with sexual desires. Such elderly women stand the risks of attracting labels such as the elderly without sexual discipline (*oni sekuse*). Such women are believed to have had their vulva eaten by a dog or had a rough cut of their umbilical cord as infants. Women in this category would contract a sexual infection, have vaginas shattered and dripping with fluids. They would have bulged stomach, look haggard and older than their age mates. The chances of also suffering from a folk pregnancy, described as *oyun iju,* are more likely among elderly women who engage in sex.

With a consciousness of possible health implications, it was not surprising that the participants suggested abstinence, sexual suppression, and occasional sex for elderly married women. The misconceptions around menopause might have influenced the perceived implications of sexual activities on the well-being and sexual health of women in old age. Similarly, such views also frame the woman's body as useless and unpleasurable for penetrative vaginal sex. All these have implications for elderly women's sexual health and well-being. The possibility of also suffering some health setbacks was also considered among elderly men. Elderly men that engage in frequent and unprotected sex could also contract sexually transmitted infections and a liable to die from *magun*. Too frequent sexual activities could also affect their well-being in old age.

Prevention and Treatability of Sexual Infections

Unprotected sexual relations, multiple sexual partners and the non-use of condoms were described as potential conditions for contracting sexual infections. The common sexual infections mentioned included gonorrhoea, syphilis and *magun*. All these conditions affect both young and old. In contrast to *oyun iju*, these conditions are treatable using both traditional and biomedical remedies. However, *magun* was considered untreatable; it could only be prevented. *Magun* could be avoided or temporarily neutralised by men with the appropriate knowledge (Ogunsakin-Fabarebo, 1998). The research participants emphasized the principle of prevention over treatability of sexual infections.

Drawing from the view that fallibility and frailty are inherent in the human nature, the research participants embraced the inevitability of contracting sexual infections. In particular, young and old men that are sexually active and practice unprotected sex with multiple partners were considered susceptible to sexual infections. This view might be associated with the prevalence of sexual unfaithfulness and extramarital relations. Even in the Ifa oral tradition, an extramarital relation is depicted as a source of contracting *atosi* (gonorrhoea).

Ifa, a form of Traditional Religion preaches against marital infidelity. Other dominant religions among the Yoruba people, Christianity and Islam, also preach against extramarital affairs, but not in association with gonorrhoea. Other practices, such polygyny and ineffective use of condom, were also considered as an avenue to contracting sexual infections. Some of the male participants justified extramarital relations and unprotected sex with multiple partners. These findings corroborate the argument that gaps between knowledge and actual practices could increase susceptibility to infections (Glanz, Rimer, & Viswanath, 2008). A recent study on HIV prevalence and sexual behaviour among older people in rural Malawi

revealed a mismatch between awareness of sexual infections and associated risk factors. The results showed that the average number of sexual partners was more than one within the last 12 months among elderly men aged 65 years and above.

With the possibility of contracting sexual infections, the research participants invoked a normative saying that whoever asks for help would receive it when sought from the right source as indispensable recovery. While norms are extolling the benefits of responsive help-seeking, there are contradictions in same norms, as some stigmatise and label elderly people with sexual infections as sexually uncontrollable and shameless individuals. Such paradoxes would continue to limit help-seeking around sexual infections.

From the findings, help-seeking for sexual health challenges is situated in normative beliefs and values and dominant aetiological explanations. Studies have shown that cultural beliefs are inseparable from what qualifies as aetiology of sexual health challenges and help-seeking behaviours. In Yoruba cosmology, aetiological explanations around disease and illness revolve around three interconnected dimensions. There are explanations around natural, preternatural and supernatural causations (Jegede, 2002). Under a given circumstance, what determines the form of explanation that would be invoked depends on a web of factors. Such factors include familiarity with the nature and symptoms of the disease or illness, and circumstantial factors traceable to the condition (Akin-Otiko, 2013; Jegede, 2002). Natural aetiological explanations around diseases and illness conditions promote individual and societal responsiveness towards the identification and removal of predisposing factors that could increase the vulnerability of individual members and social categories. The findings of this study showed that aetiological explanations associated with sexual health challenges are

categorizable into natural, preternatural and supernatural causations. These explanations are located in normative views and interactions with medical systems.

Medical systems have an influence on health behaviours and therapeutic outcomes. In social settings with plural medical systems, such interactions could create tensions and contradictions as clients move between what qualifies as acceptable aetiological explanation and availability of therapeutic support. An instance may be found in the perception of *magun* and the perceptions around its untreatability using either biomedicine or traditional medicine. The findings revealed clarity in thought, as the participants linked HIV to infection from micro-organism, as against the magical link with *magun*. Despite the media campaign around the severity of HIV, the participants described *magun* as closer and resulting in instant death, unlike HIV. *Magun* could only be prevented by sexual abstinence and the use of right traditional antidote. Unlike HIV, *magun* cannot be avoided with the use of condoms.

Although HIV was accorded a similar explanation, it was considered untreatable with traditional medicine or biomedicine. This view may be associated with influence from public health campaigns around causation and prevention of sexually transmitted infections. Some other sexual health challenges, like medically inexplicable infertility and occasional erection problem (a magically induced erection problem that affects men with multiple sexual partners) fall within the realm of preternatural and supernatural explanations. These latter conditions were considered preventable and treatable only through spirituality and the use of traditional medicine. In sum, these findings revealed a level of awareness of sexually transmitted infections as preventable and treatable. However, the prevailing aetiological explanations, whether they are consistent with the verifiable empirical evidence or not, have

implications for help-seeking behaviour. They would also influence where help is sought, as well as when and how it would relate to the therapies provided.

Perceived Obstacles and Facilitators of Responsive Help-Seeking for Sexually Transmitted Infections in Old Age

Contraction of sexual infections affects survival and performance of normative roles. The findings revealed that recovery from sexual infections was one route to avoidance of *agba inira*, earlier described as miserable or challenging ageing experiences. Normatively, an exemplary elderly was described as one who would engage in responsive help-seeking when confronted with a challenge to improve sexual performance or overcome a sexual infection. However, the decision to seek help was pictured as a reality that involves a web of factors. Within these factors, only the normative expectation and the possibility of recovery were identified as facilitators. Other factors were categorised as constraints to responsive help-seeking. In reality, the dichotomy between facilitators and limitations is somewhat misleading. An understanding of how elderly people frame these factors is relevant to help-seeking behaviour and healthy ageing within context.

Normative expectations and perceived possibility of recovering from an illness emerged as part of the facilitators to help-seeking. In this thesis, the qualitative findings indicated that untreated sexual infections could also create offensive smells around the carriers. Such smell would detract their network of relations and attract shame and embarrassment. Stereotypes, discrimination and abuse are enshrined in a network of relations that are sustained by normative values and practices (Link & Phelan, 2013). How individuals conceive and internalise stigma and stereotypes could determine the possible effect on their help-seeking behaviour when faced with a sexual infection. Contracting a sexual infection might not produce sufficient grounds for feelings of shame and stigma.

In a recent qualitative study on stigma and help-seeking for urine incontinence, individual feelings of stigmatisation were found to have a more significant influence than the condition itself (Elstad et al., 2010). Similarly, the findings of this study showed how the meanings ascribed to the notion of the exemplary elderly could create feelings of stigma and shame in old age. This supports the conclusion that internalised stigma has implications for how elderly people see themselves and seek treatment for a socially stigmatising condition, like urinary incontinence (Wang et al., 2015). With stigmatisation, it could become worse for vulnerable and marginalised social categories, like the aged. It could also weaken their resilience and hope for living. The psychological effects of shame and embarrassment could also aggravate loneliness and neglect in old age. Findings from a recent study on suicidal behaviour in old age among elderly Yoruba people indicated how stigmatisation and feelings of loneliness could increase suicidal intentions (Ojagbemi et al., 2013).

The ways the elderly people in this study engaged in conscious efforts to avoid attracting different derogatory labels or names featured prominently in this study. Such efforts were justified as contracting sexual infections could also lead to the withdrawal of support from significant others. Falling short of the notion of exemplary elder has some dysfunctional effects on the network of support and how elderly people make sense of sexual infections and seek treatments (Lichtenstein, 2008). According to the findings, an elderly person with a sexually transmitted infection would attract negative labels as sexually uncontrolled. Thus, the consciousness of falling short of moral expectations could continue to hunt such individuals and may sometimes hinder help-seeking and therapeutic outcomes.

Illness-related factors and perceived aetiology also emerged as perceived constraints to help-seeking. This finding is consistent with those in the literature where sexual health difficulties that are beyond natural explanation are considered untreatable (Moyo, 2013; Pearson & Makadzange, 2008). Such sexual health concerns are rooted in normative beliefs and practices that are supported by therapeutic measures in African traditional medical systems (Agunbiade & Titilayo, 2012; Akin-Otiko, 2013; Moyo, 2013; Pearson & Makadzange, 2008). Agents of causation could include witches, wizards, evil machinations and consequences of sin (Dime, 1995; Pearson & Makadzange, 2008).

Previous experiences with help sought for a sexual health condition and the financial implications also emerged as important factors. Satisfactory outcomes from previous help sought could be personal or from a significant other. At some point, the participants in this research postulated that some sexual health conditions could be effectively treated in one medical system than the other. Such assertions are associated with cultural beliefs that affect both clients and healers inclusive (Kleinman, 1980). The findings of the study point towards a pattern of plural medical help-seeking and a possible switch between medical systems depending on perceived recovery in line with ideas expressed by others that cultural beliefs and practices are critical in making decisions and are a pathway to sexual health problems and help-seeking behaviours (Hinchliff & Gott, 2011; Pearson & Makadzange, 2008).

In addition, finances were found to be one of the critical constraints to help-seeking. For socio-cultural reasons and common in social settings with the absence of formal support for the elderly, family members often bear the brunt of supporting their aged parents and relatives (Aboderin, 2011a; Adeniyi-Ogunyankin, 2012). Such responsibilities include payment for accessing quality health care services that might be out of reach, especially in a

low-resource setting, like the place where this study was conducted. The findings revealed postulations of possible withdrawal of support for elderly people with sexual infections.

As elucidated in the literature, ill- health in old age could be worse than imagined when there are limited or inadequate support and poor access to quality health care services (Rose, 2013). With possible withdrawal of support owing to contracting of sexual infection, concealment of status and self-medication may become more preferred. Such decision would thrive especially with inadequate personal income in old age and the widespread of patent medicine vendors in many Nigerian communities (Brieger, Osamor, Salami, Oladepo, & Otusanya, 2004). Findings from an earlier study showed dwindling of personal income and inadequate or absence of formal support in the study setting (Adeniyi-Ogunyankin, 2012).

In Nigeria, affordability of modern health care services is a challenge, as clients/patients pay for these. There is no existing form of formal support for the elderly, including social security policies, to meet their health needs. Limited options are available to older people regarding access to quality health care services in Nigeria (Togonu-Bickersteth & Akinyemi, 2014). The psychosocial effects of this neglect are enormous on the elderly, their significant others and society.

The situation is growing worse for the aged in Africa; they have to depend on remittances and inadequate support from their significant others for their daily needs and health care finance (Aboderin, 2011a). With the need to provide for the everyday needs of the elderly, contracting a sexual infection and the need to pay for health care services could be challenging. The experience might be unpleasant for older people, those who are poor and without a regular source of income would find the situation more difficult.

The National Health Insurance Scheme, an initiative of the Federal Government of Nigeria, only covers government workers and four children or immediate members of their family (Odeyemi & Nixon, 2013). This leaves out a high proportion of the elderly, especially those in the rural areas and those in the informal sector of the economy (Kana, 2014). Availability of social insurance for all categories of old and older people could cushion the financial burden of paying on one's own for health care services. The attitude of the government has been worrisome, as it shifts the financial cost of accessing modern health care services on family members and children, in particular (Kana, 2014). This undesirable situation persists despite recurring evidence on the ineffectiveness and perceived inadequacies from an informal network of support for the elderly.

The unavailability of culturally sensitive sexual health care services at the modern hospital also featured as a possible constraint. With personal internalisation of shame, it would be difficult for elderly people with sexually transmitted infections to open up and seek help from modern hospitals. The participants interpreted the hospital as an open space that lacks the needed confidentiality that goes with sexual health. The perceived absence of privacy was also corroborated by the narratives of the health care providers that were interviewed at the Geriatrics Unit at the University College Hospital, Ibadan. As an alternative, self-medication and patronage of traditional health care providers were viewed as possible sources of support. This finding exposes a problematic medical system as well as health policy gaps.

Medical Systems and Perceived Responsiveness to Sexual Health Needs in Old Age

The findings portrayed consensus views on the need for sexual health services in old age. Health care providers from the two medical systems acknowledged the existence and the

desire to access post-reproductive sexual health care services among the elderly. Such services were, however, perceived along gender divide, as more elderly males than females expressed and sought help from both systems. Both qualitative and quantitative findings revealed convergent views among the elderly themselves. The misconceptions about menopause and sexual needs of women remain largely unaddressed, especially within the traditional medical system. The similitude in normative beliefs and practices with traditional medicine seems to strengthen the values placed on the woman's body and the less attention given to women's sexual needs in old age. Biomedicine attracted some plus, with a few of the female participants acknowledging the efforts of physicians and nurses in creating awareness on how to overcome menopausal challenges.

The findings also showed varied assessment and absence of sexual health care services for elderly people. The elderly men viewed traditional medicine as having more therapeutic measures that align with their sexual health needs in old age. For the women, traditional medicine has failed to account for post-reproductive sexual health needs of women, except to support and help men to satisfy their sexual needs. Only remedies that could improve women's conceptions, and fertility is available. Therapies that could help reduce vaginal dryness, and pains during sexual intercourse are hardly accessible in traditional medicine. In contrast, the biomedical health care providers mentioned such therapies. However, access and acceptability of these services remain problematic among elderly women. Normative beliefs and the social expectations that women should quit sexual activities once they attain menopause could be contributing to this development.

Furthermore, the unmet need for sexual health care services may have contributed to the likelihood of low patronage of services that could aid sexual desires in old age. However, the internalisation of stigma and the perceptions that, in old age, other activities and issues should take priority over sexual health needs could also be compounding the situation. The results from a recent cross-sectional survey in Hong Kong showed that health care services for children and technology were ranked higher than the ones for the aged (Mak, Woo, Bowling, Wong, & Chau, 2011). With a sexual health need in old age, the chances are high that other health needs might take priority in the scale of preference. Such may be more profound for elderly people with low socioeconomic background and with other health conditions present.

The findings tilted towards issues around quality of care, but with emphasis on therapeutic relations. Hospitals as bureaucratic organisations create procedures to access and deliver quality care. Unfortunately, these procedures could become bottlenecks and delay rather than facilitating access to the desired care. The time that a patient spends before accessing care was one of the discouraging factors that emerged from the findings. Concerning the University College Hospital, the research participants spoke of time wasting at the point of entry and classification of patients at the hospital. Through this procedure, patients seeking care at the hospital are subjectively assessed and directed to the relevant unit for appropriate care. In the eyes of the research participants, such procedures only elongate the duration of accessing care and the start of treatment.

The health care providers shifted their focus to the traffic of patients that seek care at the hospital and the need for proper classification to ensure effective use of available resources. Without denying the possibility of patients going through delays before consultations, the need to attend to several patients within a short period was given priority in the qualitative

findings with the physicians and nurses. Such adjustment has effects on quality of care. The temptation remains high for health care providers to reduce the average time spent on a patient and attend to more patients within a given period. The desire to timely attend to patients could compromise the quality of time required to assist a patient and inquire more information about his/her health status. Equally, more clients/patients would likely seek help elsewhere, as physicians try to shorten the time spent with their patients. Any disconnect between patients'/clients' needs and services being provided would redirect help-seeking to other alternatives. Whether the process of arriving at this decision was objectively or subjectively determined, the satisfaction from other sources could reinforce repeated patronage, further search or return to the cycle of sources.

Confidentiality and privacy during consultations appeared as critical in the qualitative findings. Both the health care providers and some of the elderly men, in particular, complained about the lack of confidentiality and privacy during consultations. The situation may not be associated with the spatial arrangement of the hospital and the lack of private rooms for consultation. The findings showed that elderly people are often accompanied to the hospital by a significant other. This is in congruence with the normative practice of supporting an elderly person, especially when there is a health challenge. However, during the consultation, such significant other would rather stay with the patient and thereby complicate the therapeutic interaction. The intention to stay might be a presumption that communication would be more effective. Such presence compromises confidentiality, as some of the physicians reported uneasiness of their clients in speaking about their sexual health needs during such consultations. As a way out, some of their elderly clients reverted to the use of unclear terms and switched their complaints to less stigmatising health conditions.

Delays in responding to privacy and confidentiality during such therapeutic encounters have negative effects on rapport-building and truth-sharing of information that could aid proper diagnosis. Ability to create privacy during consultations could have helped the physicians in probing beyond the common conditions their clients would report if a significant other were present. By creating confidential interaction, effective communication and sharing of helpful information could be guaranteed, as against the experiences shared by the physicians and some of the research participants.

The disparity between expected and demonstrated dispositions during therapeutic encounters must be addressed at the demand and supply end of post-reproductive sexual health care services. On the demand side, attitudinal constraints include poor medical adherence, failure to meet up clinical appointments, impatience during the consultation and clinical investigation periods. Working at a geriatric unit at a teaching hospital would require some level of training and specialisation. Such background and environment would give nurses and physicians at the hospital better competence.

Theoretical Implications of the Findings

The findings of this study underline the analytical and contextual usefulness of approaching the intersections of ageing, sexuality, and gender from an interpretative constructivist perspective. This was achieved with a synthesis of Bourdieu's concepts of habitus, fields, and capital with the social positioning theory and age-grade approach to sexuality. The synthesis provided an opportunity to observe the constant interactions amongst macro, meso and micro variables in the social production of unequal sexual health outcomes in old age.

From a macro position, Talcott Parsons' pattern variable analysis depicts cultural descriptors and exemplars as functional frameworks. They define role performance and expectations that are requisite to the survival of sub-systems and the larger social system (Cuff, Sharrock, Dennis, & Francis, 2006, p. 90). Through role enactment and appropriation of expected duties, social actors engage in instrumental or emotional actions to attain satisfaction and fulfilment. These expectations are gendered and inherent with some contradictions, which sometimes create constraints for social actors (West & Zimmerman, 1987).

Within systems and sub-systems, social actors operate in different social fields to maintain a level of equilibrium and functionality. Central to social actors' ability to maintain a level of functionality of systems and sub-systems is what Bourdieu labelled as habitus. Bourdieu postulated that each social actor possesses a degree of individuality of habitus as they engage other social actors within social fields (Bourdieu, 1992). Through this process, individuals acquire capitals of different forms, recapitalise and deploy their capitals within fields in a competitive manner with other social actors. The findings of this study revealed that, within post-reproductive sexual fields, the individualities in habituses emerge further as elderly men and women relate in differentiated and gendered ways to bodily changes and sexual needs (Katz & Marshall, 2003). The observed changes and reactions to sexual needs are, however, positioned within storylines that elderly people construct to reflect moral correctness within cultural settings. Such constructions are further enacted and popularised through age-grade relationships, as elderly people are socially defined as exemplars across different spheres of life. Within this framework, individuals and social categories are socialised into certain social expectations that guide the performance of rights and duties within a given social setting. Through this process of social exchange, exemplars are formed, modified, and enshrined into a diverse network of relations.

Among the Yoruba, what qualifies a social actor as an elderly person include chronological age, personal experiences, perceived capabilities in handling life events and interpersonal relations (Togunu-Bickersteth, 1988). Thus, in everyday interactions old and older people appraise themselves and others within existing exemplars. The findings of this study revealed how class segregation, interests, and socioeconomic status influence willingness to meet up with exemplary living and sanctions that trail deviations. Based on age-grade duties and rights, all forms of social relations, including sexual relations are defined and gratified in a morally defined manner that produces uneven outcomes for elderly men and women.

Hence, this thesis argues that, while social actors might express support for existing cultural descriptors, their lived experiences could contradict what they profess to. Such inherent contradictions could be observed in sexual relations and engagement in practices that sometimes compromise sexual health. Similarly, while society preaches the need to seek professional help and build healthy populations, such support is also not provided equally. As such, elderly people that seek help for sexually transmitted infections might not access the needed help. Ageist attitudes and health inequalities contribute in diverse ways to widening the challenge of providing quality post-reproductive health care services for older people (Hillman, 2012; Hinchliff & Gott, 2011; Hinchliff et al., 2005).

The thesis corroborates the nature of medical systems as open to and also creating socio-cultural understanding that expands inherent inequalities in the intersections between ageing, sexuality and gender within a given context. As sub-systems, the responsiveness of medical systems to health needs, including the provision of post-reproductive sexual health needs, depends on developments within society (Hinchliff & Gott, 2011; Hinchliff et al., 2005). It is against this background that social actors understand and experience their sexuality as well as

engage in actions that could resolve a sexual problem or promote sexual health. This consciousness affects the quality and quantity of sexual capitals.

At the individual level, sexual capital includes available opportunities for sexual networking, engagement, prevention and resolution of sexual challenges (Michael, 2004). Therefore, sexual capital varies by gender, personal experiences, marital status and type of marriage, religion and other socioeconomic factors (Levi Martin & George, 2006).By aiming at moral correctness, there are consequences for individual rights, esteem and psychological well-being in old age. This thesis adds that the methods and resilience that the elderly might adopt in measuring up to exemplary living impacts on their sexual health.

Furthermore, the outright neglect of sexual needs in old age could also be described as deprivation in a sense. The potentiality of material deprivation in negatively shaping how social categories make sense of the sexual health of the elderly has been slightly studied among elderly people (Freeman, 2012; Van Der Geest, 2001). The findings of this study expand on such explanation as accounted for in the differentiated and gendered interpretations of risky sexual practices. Such practices are sometimes normatively justified; as social actors situate their actions within contexts. Without relegating the health implications of risky sexual practices, this thesis supports calls for a focus on perceived pleasures as rationale for engaging in risky sexual practices in old age.

Until recently, engagement in risky sexual practices in old age was hardly conceived as a reality that deserves both research and policy attentions in Africa (Wright, Zalwango, Seeley, Mugisha, & Scholten, 2012), thereby creating further inequalities and challenging ageing experiences for sexually active elderly on the continent. Individuals as social actors act within

certain social frameworks which they are part of, but which have consequences for their agencies and health outcomes. All these create unequal health outcomes across the life course. For instance, the findings stressed the absence of post-reproductive sexual health care services for women and the associated challenges to seek responsive help to improve their sexual health. In addition, they illustrated how unequal access also promotes misconceptions and ageist attitudes even among the elderly people. Unfortunately, the normative value of penetrative sex limits the possibility of other forms of sexual expression in old age. It also promotes justifications for extramarital relations, given the findings of this study that position elderly men as possible sexual pleasure seekers outside their marriage. The thesis showed that an interpretative constructivist stance could provide an opportunity to understand what constitute pleasure or risks to individuals.

In line with existing explanations around masculinity and femininity (González, 2007; Spector-Mersel, 2006), the findings pointed to conscious engagement and strive to measure up with moral correctness of exemplary elders. Elderly men and women strive to conform to prevailing hegemonic notions or masculinity and femininity (González, 2007). For men, the view that sexual pleasures are derived from penetrative and lasting erection may have prompted the use of aphrodisiacs, intergenerational dating, extramarital relations, and child sexual abuse, in some instances. Among the women, the patriarchal preaching around submissiveness and fulfilment of a husband's sexual need affects disposition to sexual expression. Among the women, polygyny also creates some form of negative influence on sexual desires. This thesis provides additional insight in this regard, as it addresses the influence of type of marriage and perceived quality of marital relations as being essential to sexual desires and expression in old age. The views around menopausal experiences also provide opportunities for diverse experiences for both males and females. This again

confirms how social positioning and contextual factors define sexual subjectivity of both males and females across the life course.

A look at the particularities of menopause as against the somewhat static and biomedical unified interpretation helps to achieve fluid, dynamic, and context-specific understanding. It also explains the dynamics and fluidity of sexual desires across the life course. The findings of this thesis support calls for a contextual understanding of sexual stereotypes and prevailing practices associated with sexual subjectivities in old age (Fileborn, Thorpe, Hawkes, Minichiello, & Pitts, 2015).

The skewness of the existing efforts on prevention of sexually transmitted infections in the social marketing of health initiatives and policy formulation has influenced the framing of sexual pleasures and prevention of sexually transmitted infections among the elderly. In a way, the findings point to perceived neglect of sexual health needs in old age and a reinforcement of ageist health policy. For instance, a male participant lamented the neglect of the elderly in Nigeria by pointing to the absence of social security and the unwillingness to identify and protect the vulnerability of older people. Such actions could worsen the hope for living and a possible stimulation of interest in risky sexual practices. Previous studies have shown how low self-esteem and disappointment with circumstances could aid risky sexual practices.

The uneven health outcomes across the life course further reveal the dynamics and context-specific nature of constraints to and facilitators of responsive help-seeking. The findings also point to the glaring absence of culturally sensitive care and support recent calls for a shift in the paradigm of care provision. The particularity and cultural sensitivity of health need in old

age call for change from a rigid biomedical model to a social model of care. Such shifts promote wider understanding, acceptable health care services, and a possible reduction in health equality and health outcomes across the life course.

Strengths and Limitations of this research

The adoption of a sequential exploratory mixed-methods design in this research constitutes a strength. The use of this approach in exploring the intersections between ageing, sexuality and gender is unique, as a monolithic methodological approach dominates the literature (Agunbiade, 2013; Agunbiade & Titilayo, 2012; Fenge & Jones, 2011; Freeman, 2012; Gott & Hinchliff, 2003).

In Africa, research efforts on ageing and sexuality have been on the margin, thereby necessitating exploratory research designs. By approaching the research questions from a sequential exploratory mixed-methods approach, this thesis takes a lead in providing contextual and culturally relevant insights into the realities of ageing, sexuality and help-seeking among the Yoruba people, southwest, Nigeria. Specifically, the development and validation of qualitative vignettes in this thesis is a noteworthy effort. The development of context-specific vignettes and their use in the qualitative stage of data generation helped in overcoming the challenge of initiating a focused conversation on sexuality with elderly people. Prior studies have shown the richness and suitability of the qualitative method in investigating sexuality in old age (Freeman, 2012; Gott & Hinchliff, 2003). Through a qualitative content validity of the vignette, this thesis was able to also demonstrate the richness and possibility of developing vignettes that are close to reality. The findings also point to the strength in the use of context-relevant and realistic vignettes to stimulate focused conversations on sexuality and ageing within social relations and personal experiences.

Nonetheless, there are some limitations with this research. First, the sampling design and recruitment procedure in the qualitative stage of the research ensured the recruitment of elderly Yoruba people from the inner core areas of the study sites. There are chances that these participants are likely to differ from other elderly Yoruba people in urban Ibadan with regard to their worldviews, ageing experiences, sexuality, and help-seeking behaviour. The categorisation of the research participants into three broad age groups (60-69, 70-79 and 80 years and above) had some cultural values but added little salience for a cultural analysis and understanding of the findings when compared to gender as a variable. Similarly, the categorisation of the research participants proved useful and feasible owing to the use of a purposive sampling approach.

It was, however, difficult in the survey to categorise and recruit a larger proportion of respondents within the three age categories. Furthermore, the study was limited by its focus on 6 communities and inner core areas within urban Ibadan. The thesis situated ageing, sexuality, and help-seeking within a cultural framework. This gave the opportunity to gain a context-specific understanding of the intersection of ageing, sexuality, and help-seeking in relation with wider social events. The use of qualitative vignettes in the focus group discussions ensured the generation of data that captured linkages with wider socio-cultural developments. As such, there were empirical findings on socio-cultural understanding on how age, gender, and sexuality intersect to facilitate a matrix of inequalities and opportunities within the Yoruba cultural context. The thesis shifted from an artificial depiction of ageing and sexuality within a context, a dominant shortcoming identified with earlier gerontological studies in Africa (Freeman, 2012; Makoni, 2008)

Despite the use of qualitative vignettes in the FGDs and additional findings from semi-structured interviews, more insights could have emerged if a phenomenological approach was added. In the literature, interpretative phenomenological studies on ageing and sexuality are lacking. Such aid understanding of sexual subjectivity and how individuals negotiate and seek help for sexual health challenges within a given context. The longitudinal qualitative approach could also contribute to understanding the time variations and particularity of ageing and sexuality-related experiences (Wright et al., 2012). However, the specific focus of this thesis' focus is on socio-cultural constructions and understanding that favoured an interpretative constructivist approach. To cater for the possible richness that comes with a phenomenological analysis, the thesis also employed the use of face-to-face interviews in order to understand the experiences of individuals, the interconnectivity between their individual agencies and the influence of normative framework on their sexualities and help-seeking. The use of both qualitative and quantitative methodologies also helped to add rigour into the subject of interest and the generation of fluid and context specific findings from different sources and perspectives.

The use of a cluster sampling approach in the quantitative phase also introduced some limitations to the findings. Through this approach, the survey respondents were also recruited from the six communities covered in the qualitative phase. The recruitment of the respondents with similar social conditions strengthened the analysis. Such insights might not be feasible if a different research design is adopted. With the focus on understanding the relationship among ageing, gender, sexuality, and structural factors, like religion and ethnicity, it is helpful to undertake a sequential exploratory mixed-methods design.

As a departure from the dominant focus on one gender in African gerontological studies, this thesis explored how elderly male and female Yoruba people (60 years +) articulate and give meanings to sexuality in old age and seek help. Specific efforts were on exploring pleasure, sexual health promotion, and the search for solutions to sexual health challenges in old age. Furthermore, the research approach also provided an opportunity to focus on the views of elderly people and health care providers within the biomedical and traditional medical systems. This produced rich insights into how the 'body as a site for moral actions' influence sexuality, help-seeking and the neglect of post-reproductive sexual health care services.

Subjecting the qualitative findings to a larger sample of elderly Yoruba people also added strength to the findings. This provided an opportunity to examine the wider acceptance or dismissal of some views shared at the group and individual levels. However, the generation of contextualized intersection between ageing, sexuality and gender within the Yoruba cultural context somewhat restricted the findings to this sample.

Conclusion

Ageing, sexuality, and gender are intersected in several ways with implications for how elderly people make sense of bodily changes and seek help when faced with sexual health challenges. This thesis provided contextualised insights into cultural interpretations, values, beliefs, and embodied practices associated with sexuality and help-seeking among urban-dwelling elderly Yoruba people in the city of Ibadan, southwest Nigeria. In addition, it also investigated the conceptions of sexuality held by biomedical and traditional health care providers, and how they deal with sexual health issues in old age. The perspectives provided by the health care providers and the experiences of the elderly people gave insights on the sexual practices, pleasure-seeking, vulnerability to sexual infections, as well as prevention

and promotion of sexual health. It also helped in assessing the availability of sexual health care services for elderly people. Similarly, their views related to the perceived constraints and motivations for seeking medical help for sexual health challenges in old age. As such, it was possible to contextualise the intersections amongst socio-cultural beliefs and practices, ageing, gender, sexuality and help-seeking. These networks of relations influence how elderly men and women frame sexual health needs and the responses from the two medical systems. Through this, the thesis has contributed to a contextual understanding of unmet needs in post-reproductive sexual health care services within the study context.

The use of the age-grade perspective alongside Bourdieu's concepts of habitus, fields and capital and the social positioning theory helped in understanding the variations in ageing, sexuality and help-seeking among elderly Yoruba men and women.

Socio-cultural understanding of old age and sexuality was prominent in the views and experiences of the research participants. For instance, the notion of an exemplary elderly repeatedly occurred, as the research participants presented a binary conception of old age as good or miserable (*agba inira*). Certain subjective indicators were used to appraisal whether an individual has a good or despairing experiences in old age. These included happenings or events around the individual, whether positive or negative. The presence or absence of health challenges and medically inexplicable ones, in particular, the well-being of family members and children, in particular, and whether an individual dies peacefully or sorrowfully. Cumulatively, all these factors affect ageing experiences and the likelihood of old age being despairing or hopeful.

To enjoy the good old age, individuals and social categories must aim at living an exemplary life as an elder. Such lifestyle would require moderation and avoidance of behaviours and practices that could attract stigma and shame. Uncontrollable sexual appetite, greed, evil machinations and dubious dealings, whether for financial and non-financial benefits would attract stigma and negative labels. Stigmatisation and labelling were described as social forms of regulating and ensuring that individuals comport themselves in line with the moral correctness required of the exemplary elder. The thesis added that measuring up to moral correctness by exemplary lifestyle has consequences for individual rights, esteem, and psychological well-being in old age.

However, the notion of the exemplary elderly is inherent with some contradictions and tensions. Such paradoxes could be seen in the approval and disapproval of sexual activities for elderly men and women. Elderly men could express their sexual desires; women who do so are labelled as sexually uncontrollable and stigmatised. The ageist dispositions towards sexual activities exist among health care providers and older people (Dogan, Demir, Eker, & Karim, 2008; Gott & Hinchliff, 2003; Gott et al., 2004; Henderson et al., 2004). The view that old age comes with ill-health reaffirms ageist attitudes among the participants in this research.

Sex was normatively considered for procreation and pleasure. However, with old age, diminished returns set in on the possibly derivable pleasure from penetrative sex. From the participants' frame of reference, sexual activities in old age have their benefits, but could worsen the frail health that comes with old age. Access and affordable support from biomedicine and the African traditional medical system could lessen health challenges in old age. With reference to perceived effects of anti-ageing medicine, the thesis revealed how the

use of *so- agba d'ewe* (traditional anti-ageing medicine) is rooted in the normative belief that both women and men should keep a physical appearance that is attractive and appear healthy as they grow old.

Men are provided with biomedical and traditional aphrodisiacs to enhance sexual performance and pleasure. In contrast, suppression of sexual desires and abstinence indicate the moral correctness of the exemplary woman. Concerning the Sustainable Development Goal 3, on health for all (UN, 2015), the thesis argued that elderly women are likely to have their sexual rights compromised in a manner that differs remarkably from their male counterparts. Such possibility is inherent in the socio-cultural understanding that portray post-menopausal sexual activities as harmful to the woman's body; and the postulation that sexual activities would lead to a folk pregnancy (o*yun Iju*). In contrast, men could express their sexual desires, engage in concurrent sex with multiple partners, and use aphrodisiacs to enhance performance and pleasure. Although there are unverified claims of alcoholic herbal aphrodisiacs, chances are more that elderly men may become addicted to these products. These practices have implications for men's sexual health and well-being of elderly men.

The desire for pleasurable sex also manifested in the aversion for condom use and preference for the use of traditional remedies to guide against infections. Sexual infections with aetiological explanations around preternatural and supernatural factors influenced the view that traditional remedies would effectively handle some sexual infections than biomedicine. A folk sexual infection, *magun*, was adopted in advancing this view among the research participants. While verifiable evidence did not support the reality of such infection, reports on such deaths have featured in the media (Akinode, 2012; Olusakin, 2015; Onyelemelam,

2014). The publicity that comes with such reports could sometimes reinforce medicalisation and folk construction of sexual infections and help-seeking behaviour.

The thesis supports the argument that heterogeneity in sexual history, experiences and practices exist among social categories across the life course. By focusing on embodied sexual experiences and practices in old age, the heterogenous nature and interaction among ageing, gender and sexuality becomes more visible(DeLamater & Koepsel, 2015; Lee, Nazroo, O'Connor, Blake, & Pendleton, 2016; Ussher et al., 2015). This thesis contends that relationship qualities, which include intimacy, perceived faithfulness and health, shape how elderly women make sense of their sexuality. In contrast, elderly men lay emphasis on bodily changes and perceived derivable satisfaction from penetrative sex as more appealing. In this regard, women and men react differently to the physiological changes that come with menopause.

The thesis claims that responsive help-seeking is rooted in the exemplary expectations and socio-cultural understandings However, stigma, shame, financial constraints, and a poor network of support affect responsive medical help-seeking. With stigmatisation, contracting sexual infection could weaken an individual's resilience, survival, and well-being in old age. This thesis support the existing position, that poor network of support and dwindling resources in old age increases the internalisation of stigma and shame and survival challenges in old age (Rose, 2013).

The research participants postulated the possible withdrawal of supports from significant others. Contracting sexual infections could stimulate withdrawal of support, especially if the elderly in question is a woman and with adult children and grandchildren. The survival challenges that would confront such elderly person might be worse where more physical

strength is required to meet up with everyday activities (Lloyd-Sherlock, 2000). While the withdrawal of support might increase self-reliance, it would lead to inability and neglect of other things, such as going to the hospital for medical appointments and procurement of essential drugs when necessary.

Individual strategies are often deployed in coping with health challenges (Lloyd et al., 2014; Mudege & Ezeh, 2009). Such strategies could influence concealment of sexual health infection and recourse to self-medication. Self-medication might be an indication of increasing acceptability of personal responsibilities and taking ownership of one's health, especially in the absence of social securities and inclusive health insurance plans for the aged in Nigeria (Togonu-Bickersteth & Akinyemi, 2014).

Responsiveness to post-reproductive sexual needs seem poor in both traditional and biomedical systems. Critical in this direction is the indifference of modern health care providers towards sexual health needs in old age. Such indifference could be seen in the concerns of the research participants on confidentiality and lack of privacy during therapeutic interactions. The inability to create and maintain privacy with elderly clients could affect rapport and hinder effective communication and therapeutic outcomes. The absence of health insurance scheme for elderly people and poor financing of modern health care services are compounding access to quality care and responsive medical help seeking. The traditional medical system may not fare better, but has remedies that support sexual exploits of elderly men and performance enhancement. However, traditional herbal remedies are hardly verified through empirical evidence. The aphrodisiac claims by existing alcoholic beverages require urgent attention, as unregulated access, and wide consumption could compound health challenges in old age.

Recommendations and Policy Implications of the Findings

Empirical findings from this thesis have shown concerns for a 'good old age' and avoidance of despairing experiences in old age. Similarly, some findings revealed misconceptions on the intersections of ageing, sexuality, and gender. This understanding is rooted in socio-cultural beliefs and practices, which affect how elderly people make sense of their sexuality, as well as seek help and the corresponding responsiveness from the medical systems. These findings point to the existence of unmet post-reproductive sexual health need with significant policy implications. Public enlightenment around sexual rights across the life course are needed urgent needed to bridge the gaps in knowledge and erode the misconceptions around the diversities in sexuality in old age. The public campaigns must target the particularity in sexual history, experiences and practices. A possible constraint around such campaigns is the misconception of the initiative for sexual promiscuity. Nonetheless, the absence of sexual education at the societal level creates series of setback for the country. Such setbacks include a growing incidence and prevalence of sexual infections and delay in help-seeking. As shown by the findings from this thesis, stigma and loss of support for elderly people that contract sexual infections will increase. Given these possibilities, there is need for public enlightenment and a review of existing sexual healthcare services in Nigeria. By reviewing existing medical education curriculum, specialists in biomedical healthcare professionals will have more information on geriatric needs and their sexuality. It will also improve the therapeutic relations between them and their clients. These initiatives can position professional healthcare providers for responsive diagnosis, prevention and management of post-reproductive sexual health needs and a possible realisation of healthy ageing population in Nigeria.

The findings highlight survival challenges in appraising old age as 'good old age' or miserable. The participants expressed concerns about fundamental health challenges in old age, children's well-being, and success in life. These views could have been informed by the growing cases of elder abuse and neglect as well as the absence of formal support for the elderly in Nigeria (Cadmus & Owoaje, 2012). The participants expressed the need to avoid expressing behaviours that are socially unapproved for the fear of losing supports from their significant others. Family members remain the primary source of support for the elderly in Nigeria and most countries in the sub-Saharan Africa (Adeniyi-Ogunyankin, 2012; Ogwumike & Aboderin, 2005). Such support includes paying their bills for health care services, provision of food, clothing, shelter and emotional support (Aboderin, 2011a). With growing socioeconomic challenges, the burden of care has increased on family members, and more elderly people have to work and also help their relatives (Adeniyi-Ogunyankin, 2012). Nigeria adopted a National Policy on the Care and Well-Being of the Elderly in Nigeria in 2003 (Togonu-Bickersteth & Akinyemi, 2014). Twelve years down the line, the policy is still awaiting ratification and passage into law.

Urgent efforts are, therefore, required for ratification and implementation of this policy at the three levels of government in Nigeria. Conditional cash transfer programmes could be introduced to support elderly people that are trading and those willing to engage in less stressful economic activities. Such programmes should also include health vouchers that would offset the medical bills for common health challenges in old age. In developing countries, there are success stories on the effectiveness of conditional cash transfers for economic empowerment (Barrientos, 2013). Lessons can be taken from these initiatives to address the need for financial independence in old age. Recent evidence from Mexico has shown a positive impact of conditional cash transfer programmes on the mortality of the

elderly (Barham & Rowberry, 2013). Similarly, the non-governmental organisations and community-based organisations in Nigeria can empower the elderly people in activities that could generate income.

The research participants described the existence of a social framework that defines moral correctness and perceived consequences for non-conformists in old age. They affirmed the existence and expression of varied gendered sexual desires and practices in old age. With menopause, elderly women should abstain from and suppress their sexual desires, or disengage from sexual activities. Such decisions would help them to avoid stigma, contracting sexual infections and *oyun iju*. For elderly men, abstinence, suppression, and disengagement are difficult to practice. As such, sexual refusal from their wives could be justified, but this opens up opportunities for extramarital relations. While penetrative vaginal sex brings pleasure, it requires physical strength. For most elderly men, physical strength for sexual performance reduces. The participants conceived aphrodisiacs intake as a boost to sexual performance.

Therefore, it is important for post-reproductive sex education to be incorporated into existing sexual and reproductive health initiatives in Nigeria. Before the incorporation, the following steps could be taken:

- extensive mass sensitization on correcting misconceptions associated with ageing, gender, and sexuality;
- sensitization on the heterogeneity in sexual desires within and across gender;
- public campaign and provision of counselling on strategies to cope with bodily changes in old age;

- capacity building of biomedical and traditional health care providers on existing sexual health needs in old age and the need for a prompt and comprehensive response; and
- establishment of post-reproductive sexual health clinics alongside the existing reproductive health units at the three levels of care in Nigeria.

The growing spread and use of alcoholic beverages with aphrodisiac claims were reported among the research participants. Although availability and use of herbal alcoholic beverages have been found among different social categories, this study stresses the need for inclusive and active pharmaco-vigilance. At present, the Nigerian market is infiltrated with alcoholic beverages claiming to address the growing burden of sexual dysfunction across the life course (Aderinto, 2012; Bella & Shamloul, 2014; Erhenhi & Obadoni, 2015). Thus, there is an urgent need for alcohol policy and effective regulation in Nigeria. This could safethe public from indiscriminate consumption and consequences of alcoholic beverages.

The research participants claimed that unprotected sex with multiple partners could lead to sexual infections and premature death, such as *magun*-related death. With the availability of the male condom, some sexual infections could be prevented. *Magun*, a magical death that occurs through sexual intercourse, is unpreventable using a condom. The qualitative and quantitative findings postulated that the use of a condom reduces sexual pleasure. This view might be associated with the skewed attention given to young and middle-aged adults in the social marketing of condoms and prevention of sexually transmitted infections.

Some of the male participants suggested the use of charms, incisions to avoid sexual intercourse with an infection-carrying woman. There are consequences along this line. The

possibility of breaking the taboos that are associated with such charms was acknowledged. Public campaigns that promote the strengths of the two medical systems would be effective. Such efforts could increase the chances of accessing available services for some sexual infections. Similarly, social marketing of condoms and prevention of sexual infections must be more participatory to include elderly people.

This study found that there are related medical constraints around the provision of timely and quality care for elderly clients. These include the perceptions and dispositions of health care providers; the lack of confidentiality and privacy during therapeutic relations; and the high ratio of physician to a client at the geriatric clinic. Hence, healthcare providers need to devote additional time to asking questions around and individual's sexual health needs during the consultation. This would also require training and retraining of health care providers on culturally sensitive probes and communication approach that would encourage openness and rapport. At each consultation, strict compliance to privacy and confidentiality must be maintained. This would eliminate the presumption that a patient would present a free report on his/her health condition during consultation. With a shift to a social model of care, health care provision would be more culturally sensitive to sexual needs in old age.

Frontiers for Future Research

- There is a need for epidemiological studies on prevalence and incidence of sexual infections among elderly people. The situation is gradually becoming precarious in Nigeria where the burden of sexual infections is growing among young and old in heterosexual relations. Despite all these evidence, there is dearth of studies and polices that are targeting sexual practices and infections in old age. Epidemiological studies will provide a

situational analysis of the types and variations of sexual infections in old age. It would also help in building a database on the epidemiological transition of sexual infections and efficient diagnosis among elderly people.

- With the existence and emphasis on penetrative vaginal sex, there is a need for phenomenological studies around lived experiences of sexual pleasures and sexual practices. Through an understanding of existing practices that are tailored to aid sexual pleasures, appropriate public enlightenment around the dangers can be deployed. It will also provide insights into the fluidity of sexual pleasures and possible consequences on ageing as a process. Part of the findings revealed how peer pressure and normative beliefs around sexuality could predispose some elderly people into sexual practices that are unhealthy. Similar studies can also focus on lived experiences around sexual infections and constraints to responsive help-seeking. At this point, it will be feasible to assess a trajectory of pathways to help-seeking in the course of sexual infections in old age. It will also provide insights for policies that can address the existing constraints around help-seeking for sexual health needs in old age.

- Longitudinal studies on sexual histories and sexual health progression are currently absent in the gerontological literature. An understanding of the particularity and variability in sexual histories and health progression will improve the constraints around therapeutic communication during help-seeking. Such studies will provide information on and around individuals and social categories in relation to their sexuality and sexual health across the life course. It will again help in fashioning policies that can improve sexual health and minimise the possible loss of sexual

health as an important indicator of well-being in old age. Contextual variables such the dominant values and beliefs around sexuality affect sexual practices and disposition to sexual risks. Studies that account for sexual histories and sexual health progression will reveal the nature, patterns, meanings and possible influence of contextual and individual factors on sexual health in old age.

- There is a need for mixed-methods studies on age cohort differences and justifications for 'sexuopharmaceuticals' and the perceived health implications. There is a high presence, acceptance and consumption of aphrodisiacs in Nigeria. Sexupharmaceuticals have taken leverage of the normativity of sexual enhancement. Nonetheless, there are no checks from the consumer protection agency on the growing spread of health products with aphrodisiac claims. In the context of weak regulations and surveillance on the sale of these products, it will be timely to examine the rationale and justifications around the use of these products among age cohorts. Hence, there is a need for multidisciplinary investigations on existing alcoholic beverages with aphrodisiac claims in Nigeria. Such studies should also focus on the possible side effects of these products on sexual health across the life course.

- Mixed-methods studies are required to understand and contextualise barriers to effective therapeutic relations and development of culturally sensitive post-reproductive sexual health care services. The availability of studies in this direction will improve current understanding and scale-up the need for post-reproductive sexual healthcare services. It will provide contextual evidence that is needed to address the policy and research gaps on sexual and reproductive health rights of older men and women (Aboderin, 2014).

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APPENDICES

Appendix A: Focus Group Discussion Guide and Vignettes for the three Categories of Elderly People (English Language Version)

Ice Breaker*: Please describe to me what it means to be an older man or woman* of your age in *this community?*

Theme 1: Cultural understandings of being an older man or woman in Yoruba society

Questions:

1. What do you think are the aspirations of old people in this community?
   For each aspiration mentioned probe for reasons and gender differences

2. Could you please tell me the things that are most important in life as people grow old?
   For each thing mentioned probe for reasons and gender differences

3. What activities do you think old people would want to avoid, as they grow older?
   For each activity mentioned probe for reasons and for gender differences

4. What are the local terminologies used in describing an older person that is acting/talking/behaving in way(s) that are culturally unacceptable?
   Probe for variations and similarities in context by gender

5. How will you describe the ways old people are treated in this community?
   Probe for challenges related to interpersonal and intergenerational relations

Situational Vignette A: Baba Alamu

Baba Alamu is between 60-70 years old. He has 3 wives, a concubine (mistress), and 12 children.

Theme 2: Cultural values and sexual behaviours in old age
Questions from vignette A:

1. What do you think are Baba Alamu's basic responsibilities to his wives and the concubine?
   Probe for explanations and basis for each responsibility mentioned.

2. How will you describe Baba Alamu's sexual behaviour?
   Probe for explanations and basis for describing Baba Alamu's sexual behaviour in acceptable or non-acceptable manner.
   Probe for the kind of reactions Baba Alamu's sexual behaviour may attract from the wives, children, relatives, friends, and Neighbours.

3. What factors do you think would help Baba Alamu in meeting his sexual responsibilities to his wives and concubine?
   Probe for explanations around healthcare practices, personal beliefs, and socio-economic status.

Situational Vignette B: Iya Asake

Iya Asake is between 60-70 years old. She has a concubine, six children and lives with her husband.

Questions from vignette B:

1. What do you think are Iya Asake's basic responsibilities to her husband and the concubine?
   Probe for explanations and basis for each responsibility mentioned.

2. How will you describe Iya Asake's sexual behaviour?
   Probe for explanations and basis for describing Iya Asake's sexual behaviour in acceptable or non-acceptable manner.
   Probe for the kind of reactions Iya Asake's sexual behaviour may attract from her husband, children, relatives, friends, and Neighbours.

3. How common is extra marital relations among old men/women?
   Probe for factors that may be responsible for this practice among men and women?

Theme 3: Sexual pleasures, risk and health practices
Continuation: Vignette A

Recently, Baba Alamu married a fourth wife that is much younger than the other wives are.

Questions from vignette A:

1. What kind of measures do you think Baba Alamu will adopt to be able to satisfy his new wife sexually?
   Probe for reasons for the kind(s) of description(s) given
2. What are the common measures of maintaining or improving sexual performance among men?
   Probe for the use of herbal mixtures (e.g. Pakurumo, Alomo, Osomo) Probe for differences and similarities in measures along traditional and modern medicines used by age (young and old) and by socio-economic status

3. Apart from marrying another woman or having a concubine, what other practices do men of Baba Alamu's age engage in to satisfy their sexual needs or companionship?

Continuation of Vignette B

Iya Asake engages in sexual relations with her husband and the concubine.

Questions from vignette B:

1. What kind of measures do you think Iya Asake will adopt to be able to satisfy her husband and the concubine sexually?
   Probe for reasons for the kind(s) of description(s) given
2. What are the common measures of maintaining or improving sexual performance among women?
   Probe for differences in measures used by age- young and old and variations by socio-economic status
3. How will you assess the risks/chances of contracting sexually transmitted infections among old men and women?
   Probe for gender differences in the assessments of risks of contracting STIs

Continuation of Vignettes A and B
Vignette A

Six months after marrying the fourth wife, Baba Alamu contracted a sexually transmitted infection.

Vignette B

Six months after, Iya Asake got a new concubine and she contracted a sexually transmitted infection.

Questions from Vignettes A and B

1. What kind of sexually transmitted infection(s) do you think are common with old people like Baba Alamu's and Iya Asake in this community?
   Probe for factors and practices that could influence the contraction and spread of the infections(s) among men/women in the community.

2. Are there some traditional remedies or ways of preventing sexually transmitted infections?
   Probe for the wide usage or non-usage among young and old, men and women, factors responsible for whatever answer that is given
   Probe for the effectiveness and efficacy of such measures

3. Do you think condoms use can prevent sexually transmitted infections among old men and women?

   Probe for explanations
4. What factors do you think are discouraging old men and women that are sexually active from the use of condoms?
   Probe for explanations and gender variations

Theme 4: Help-Seeking behaviour and sexual health

Questions from vignettes A & B:

1. Why did Baba Alamu and Iya Asake find it difficult to prevent themselves from contracting the infection(s)?
   Probe for socio-cultural, economic, religion and personal reasons

2. Could you please tell me some of the local remedies or treatments for sexually transmitted infection(s) such as the one(s) contracted by Baba Alamu and Iya Asake?

3. What steps do you think Baba Alamu/ Iya Asake can take to get solution(s) to the sexually transmitted infection(s)?
   Probe for solutions based on the type of infection(s) suggested
   Probe for medical and non-medical related measures

4. What factors do you think could discourage Baba Alamu/Iya Asake from seeking help for their conditions at the hospital?
   Probe for explanations and gender variations

Theme 5: Sexual health in old age: existing practices, network of support, availability and quality of post-reproductive care services

Questions from vignettes A & B:

1. What challenges do you think Baba Alamu/Iya Asake will face in an effort to get a solution to the sexually transmitted infection?
   Probe for reactions/challenges from members of his household, relatives, religious leaders and community members

2. How will you describe the quality of support given to old people when they have a health challenge?
   Probe for differences based on health conditions such as sexually transmitted infections in comparison to arthritis, malaria among other conditions
   Probe for differences based on whether it is a modern health provider or traditional medical practitioner

3. At what age do you think a man/woman should stop sexual relations?
   Probe for explanations and examples in relation to each of the activity mentioned

4. How does engagement in sexual activities affect health in old age?

5. In Yoruba proverbs or wise sayings, how would you describe Baba Alamu's and Iya Asake's sexual exploits?

6. In what ways do you think sexual activities in old age could affect other areas of life?

Closure of Group

- Bring together patterns, consensus and any conflicts that emerged during the group discussion
- Note notable quotes (highlight them if possible);
- Present a short summary of discussion back to the group and note affirmation and/or rejection of earlier opinions.

Appendix B: Focus Group Discussion Guide and Vignettes for the three Categories of Elderly People (Yorùbá Version of the Focus Group Guide)

Àkíyèsí Ìjíròrò fún Ìtọ́ni lórí Ẹlẹ́gbẹ́jẹgbẹ́ àti Ojúlówó Abala Ìhùwàsí àwọn Àgbàlagbà Mẹ́tẹ̀ẹ̀ta

Ìpínsísọ̀rí: Jọ̀wọ́ ṣe àpèjúwe fún mi ohun tí ó túmọ̀ sí láti jẹ́ àgbàlagbà lọ́kùnrin tàbí lóbìnrin bí i ti ọjọ́ orí yín ní ìlú yìí?

Ọ̀rọ̀ Ìpìlẹ̀ 1: Òye àṣà lórí jíjẹ́ àgbàlagbà lọ́kùnrin tàbí lóbìnrin ní àwùjọ Yorùbá.

Àwọn ìbéèrè:

1. Kín ni ẹ lérò pé ó jẹ́ ìfọkàn-dànìíyàn àwọn àgbàlagbà lọ́kùnrin tàbí lóbìnrin ní ìlú yìí?
   Fún ìfọkàn-dànìíyàn kọ̀ọ̀kan tí a dárúkọ, bèèrè fún àwọn ìdí fún takọ tabo?
2. Ǹjẹ́ ẹ lè jọ̀wọ́ sọ fún mi àwọn nǹkan tó ṣe pàtàkì láyé nígbà tí àwọn ènìyàn bá ń di àgbàlagbà?
   Fún àwọn nǹkan kọ̀ọ̀kan tí a dárúkọ bèèrè fún ìyàtọ̀ tó wà láàrin takọ tabo.

3. Kín ni àwọn nǹkan tí ẹ lérò pé àwọn àgbàlagbà yóó fẹ́ yàgò fún, bí wọ́n bá ti ń dàgbà lọ́jọ́ ori?
   Fún àwọn nǹkan kọ̀ọ̀kan tàbí nǹkan tí a dárúkọ, bèèrè fún àwọn ìdí fún ìyàtọ̀ tó wà láàrin takọ tabo
4. Kín ni àwọn ìpèdè ìbílẹ̀ tí a máa ń lò láti ṣe àpèjúwe àgbàlagbà tí ó ń ṣe/sọ̀rọ̀/hùwà ní àwọn ọ̀nà tí kò jẹ́ ìtẹ́wógbà nínú àṣà?
   Bèèrè fún àwọn ìyàtọ̀ àti ìjọra ní ìbámu pẹ̀lú takọ tabo
5. Báwo ni a ṣe le ṣàpèjúwe lórí bí wọ́n ti máa ń hùwà sí àwọn àgbàlagbà ní ìlú yìí?
   Bèèrè fún àwọn ìpèníjà tó jẹ mọ́ ìbáṣepọ̀ láwùjọ àti láàrin àwọn ojúgbà àti àwọn tí ó kéré sí wọn lọ́jọ́ orí

Abala Ìhùwàsí: Bàbá Àlàmú

Bàbá Àlàmú jẹ́ ọmọ ọgọ́ta sí àádọ́rin ọdún. Ó ní ìyàwó méta, àlè kan (omidan), àti ọmọ méjìlá.

Ọ̀rọ̀ Ìpìlẹ̀ 2: Àwọn àmúyẹ àṣà àti ìhùwàsí nípa ìbálòpọ̀ ní ọjọ́ ogbó.

Àwọn ìbéèrè láti ara Abala Ìhùwàsí A:

1. Kín ni ẹ rò pé ó jẹ́ àwọn ojúṣe Bàbá Àlàmú sí àwọn ìyàwó àti àlè rẹ̀?
   Bèèrè fún àwọn àlàyé àti ìdí fún ojúṣe kọ̀ọ̀kan tí a dárúkọ.
2. Báwo ni o ṣe lè ṣe àpèjúwe ìhùwàsí bàbá Àlàmú nípa ìbálòpọ̀?
   Bèèrè fún àwọn àlàyé àti ìdí fún ṣíṣe àpèjúwe ìhùwàsí nípa ìbálòpọ̀ bàbá Àlàmú ní ọ̀nà tó jẹ́ ìtẹ́wọ́gbà àti ọ̀nà tí kò jẹ́ ìtẹ́wọ́gbà.
   Bèèrè fún irú ìṣesí àti ìhùwàsí tí ó le súyọ láti ọ̀dọ̀ àwọn ìyàwó, ọmọ, ẹbí, ọ̀rẹ́ àti aládùúgbò nítorí ìwà ìbálòpọ̀ bàbá Àlàmú.

3. Kín ni àwọn ìdí tí o lérò pé ó ran bàbá Àlàmú lọ́wọ́ nínú ṣíṣe ojúṣe rẹ̀ nípa ìbálòpọ̀ sí àwọn ìyàwó àti àlè rẹ̀?
   Bèèrè fún àlàyé lórí irú ìgbésẹ̀ fún ìtọ́jú ara, ìgbàgbọ́-ẹni, ipò àti ètò-ìsúnná rẹ̀ ní àwùjọ.

Àwọn Ìṣẹ̀lẹ̀ Abala Ìhùwàsí: Ìyá Àsakẹ́

Ìyá Àsakẹ́ jẹ́ ọmọ ọgọ́ta sí àádọ́rin ọdún, ó ní àlè kan, ọmọ méfà ó sì ń gbé pẹ̀lú ọkọ rẹ̀ lọ́wọ́lọ́wọ́.

Àwọn ìbéèrè láti ara Abala Ìhùwàsí B:

1. Kín ni o lérò pé ó jẹ́ àwọn ojúṣe ìyá Àsakẹ́ sí ọkọ rẹ̀ àti àlè rẹ̀?
   Bèèrè fún àlàyé àti ìdí fún ojúṣe kọ̀ọ̀kan tí ó dárúkọ

2. Báwo ni o ṣe lè ṣe àpèjúwe ìhùwàsí ìyá Àṣàkẹ́ nípa ìbálòpọ̀?
   Bèèrè fún àwọn àlàyé àti ìdí fún ṣíṣe àpèjúwe ìhùwàsí ìyá Àṣàkẹ́ nípa ìbálòpọ̀ ní ọ̀nà tó jẹ́ ìtẹ́wọ́gbà àti ọ̀nà tí kò jẹ́ ìtẹ́wọ́gbà.
   Bèèrè fún irú ìṣesí àti ìhùwàsí tí ó le súyọ láti ọ̀dọ̀ àwọn ìyàwó, ọmọ, ẹbí, ọ̀rẹ́ àti aládùúgbò nitori ìwà ìbálòpọ̀ ìyá Àṣàkẹ́.

3. Báwo ni ìbálòpọ̀ tó jẹ mọ́ àlè yíyàn ṣe wọ́pọ̀ sí láàrin àwọn àgbàlagbà lọ́kùnrin/lóbìnrin?
   Bèèrè fún àwọn ohun tó le fa irú ìṣesí yìí láàrin ọkùnrin àti obìnrin.

Ọ̀rọ̀ Ìpìlẹ̀ 3: Àwọn adùn ìbálòpọ̀, ewu àti àmúṣe ètò ìlera ní ọjọ́ ogbó.

Ìtẹ̀síwájú lórí Apá kan Ihuwasi A

Ní àìpẹ́ yìí, bàbá Àlàmú fẹ́ ìyàwó kẹ̣rin tó kéré lọ́jọ́ orí ju àwọn ìyàwó yòókù lọ.

Àwọn ìbéèrè láti Apá kan Ìhùwàsí A:

1. Kín ni ohun tí ẹ lérò pé bàbá Àlàmú yóò lò láti tẹ́ ìyàwó rẹ̀ tuntun lọ́rùn nípa ìbálòpọ̀?
   Bèèrè fún àwọn ìdí lórí àpèjúwe tí a tọ́ka sí

2. Kín ni àwọn ọ̀nà, ìgbésẹ̀ tàbí iṣẹ́ tí àwọn ọkùnrin máa ń gbà láti lè ṣe déédé nípa ìbálòpọ̀?
   Bèèrè fún lílo àwọn oríṣìíríṣìí àgbo (Pakurumọ, Alọmọ, Ọ̀ṣọmọ, ọ̀pá-ẹ̀yìn, ale àti bẹ́ẹ̀ bẹ́ẹ̀ lọ)
   Bèèrè fún ìyàtọ̀ àti ìjọra nípa lílo òògùn ìbílẹ̀ tàbí ti Òyìnbó láàrin ọ̀dọ́ àti àgbàlagbà àti láàrin àwọn oríṣìíríṣìí ipò àti ètò-ìsúnà ní àwùjọ.

3. Yàtọ̀ sí fífẹ́ ìyàwó mìíràn tàbí yíyan àlè, kì ni àwọn ìṣesí mìíràn tí àwọn ọkùnrin tó jẹ́ ẹgbẹ́ pẹ̀lú bàbá Àlàmú máa ń ṣe láti tẹ́ ara wọn lọ́rùn nípa ìbálòpọ̀ tàbí níní ojúgbà

Ìtẹ̀síwájú Abala Ìhùwàsí B

Ìyá Àṣàkẹ́ ní ìbálòpọ̀ pẹ̀lú ọkọ àti àlè rẹ̀

Ìbéèrè láti ara abala ìhùwàsí B

1. Kín ni àwọn ohun tí ìyá Àṣàkẹ́ lè ṣe láti tẹ́ ọkọ àti àlè rẹ̀ lọ́rùn nípa ìbálọ̀pọ̀?
   Bèèrè fún àwọn ìdí lóri oríṣìíríṣìí àlàyé tí a ṣe.

2. Kín ni àwọn ọ̀nà, ìgbésẹ̀ tàbí iṣẹ́ tí àwọn obìnrin máa n gbà láti ṣe kí wọn ó lè ṣe déédé nípa ti ìbálòpọ̀?
   Bèèrè fún lílo àwọn oríṣìíríṣìí àgbo
   Bèèrè fún ìyàtọ̀ àti ìjọra nípa lílo òògùn ìbílẹ̀ tàbí ti Òyìnbó láàrin ọ̀dọ́ àti àgbàlagbà àti láàrin àwọn oríṣìíríṣìí ipò àti ètò-ìsúnà ní àwùjọ.
   .

3. Báwo ni àgbéyẹ̀wò yín nípa àwọn ewu/ṣíṣeése láti kó àwọn àrùn ìbálòpọ̀ láàrin àwọn àgbàlagbà lọ́kùnrin àti lóbìnrin?

Bèèrè fún àwọn ìyàtọ̀ nínú àgbéyẹ̀wò àwọn ewu tó rọ̀ mọ́ kíkó àrùn ìbálòpọ̀

Ìtẹ̀síwájú lórí Apá kan Ìhùwàsí A ati B
Apá kan Ìhùwàsí A
Lẹ́yìn oṣù méfà tí bàbá Àlàmú fẹ́ ìyàwó kẹ́rin, ó kó àrùn ìbálòpọ̀.

Apá kan Ìhùwàsí B
Lẹ́yìn oṣù méfà tí ìyá Àṣàkẹ́ ní àlè tuntun, ó kó àrùn ìbálòpọ̀.

Àwọn Ìbéèrè láti ara Apá kan Ìhùwàsí A ati B

1. Irú àrùn ìbálòpọ̀ wo ni ẹ lérò pé ó wọ́pọ̀ láàrin àwọn àgbàlagbà bí bàbá Àlàmú àti ìyá Àṣàkẹ́ ní ìlú yìí?

   Bèèrè fún ìdí àti ìṣesí tó le ṣokùnfà kíkó àti títànkálẹ̀ àwọn àrùn ìbálòpọ̀ láàrin àwọn ọkùnrin àti obìnrin ìlú yìí

2. Ǹjẹ́ àwọn òògùn ìbílẹ̀ tàbí àgbo-àdáyé-bá wà láti dènà kíkó àrùn ìbálòpọ̀?

   Bèèrè fún àmúlò tó gbòòrò tàbí àìlò rárá láàrin àwọn ọ̀dọ́ àti àgbàlagbà, àwọn ọkùnrin àti obìnrin, ìdí abájọ tó ń ṣokùnfà ìdáhùn wọn
   Bèèrè fún bí òdiwọ̀n náà ti ṣe lágbára sí àti bí ó ṣe múnádóko sí.
3. Ǹjẹ́ ẹ lérò pé lílo rọ́bà-ìdáàbòbò lè dènà kíkó àrùn ìbálòpọ̀ láàrin àwọn àgbàlagbà lọ́kùnrin àti lóbìnrin?

   Bèèrè fún àwọn àlàyé
4. Kín ni àwọn ìdí tí ẹ lérò pé ó ń dáyafo awon okunrin ati obìnrin to lakikanju nipa ìbálòpò láti ma máa lo roba ìdáàbòbo?

   Bèèrè fun awon àlàyé ati ìyàtò láàrin awon okunrin ati obìnrin

Oro Ipile 4: Ihuwasi Wiwa Ilera ati Ilera Ìbálòpò
Awon Ìbéèrè láti ara Ihuwasi A ati B

1. Kin ni ìdi re ti o fi soro fun baba Alamu ati iya Asake láti daabo bo ara won láti ma ko awon àrùn ìbálòpò?

   Bèèrè fun awon ìdí to je mo asa-ibagbepo, eto oro-aje, esin ati ti oro ara eni.
2. Nje e le so fun mi, die lara awon ogun ibile tàbí awon ona ìtójú awon àrùn ìbálòpò gege bi eyi ti baba Alamu ati iya Asake ko?

3. Awon ìgbésè wo ni e lérò pe baba Alamu/iya Asake le gba láti wa ona abayo si awon àrùn ìbálòpò ti won ko?

   Bèèrè fun awon ona abayo ni ìbámu pelu awon àrùn ti won dabaa/dárúko
   Beere fun awon ilana isegun ati eyi ti ko je mo isegun

4. Kin ni awon idi ti e lero pe o le mu irewesi ba baba Alamu/iya Asake lati wa iranlowo lori oro won lo si ile-iwosan?

   Beere fun alaye ati iyato laarin ti okunrin ati obinrin

Ọ̀rọ̀ Ìpìlẹ̀ 5: Ìlera ìbálòpọ̀ ní ọjọ́ ogbó:àmúṣe/ìṣesí tó wà, ìrànlọ́wọ́ afarapẹ́ra, wíwá àti pípéye ìtọ́jú lẹ́yìn àsìkò ìbímọ.

Àwọn Ìbéèrè láti ara ìhùwàsí A ati B:

1. Kín ni àwọn ìpèníjà tí ẹ lérò pé bàbá Àlàmú/ìyá Àṣàkẹ́ yóò dojúkọ nínú akitiyan láti wá ọ̀nà àbáyọ sí àwọn àrùn ìbálòpọ̀ tí wọ́n kó?
   Bèèrè fún àwọn ìdí tàbí ìpèníjà tí o lè dojúkọ láti ọ̀dọ̀ àwọn ará ilé, ojúlùmọ̀, àwọn olórí ẹ̀lẹ́sìn àti àwọn ará agbègbè rẹ
2. Báwo ni ẹ ṣe lè ṣe àpèjúwe ojúlówó ìrànlọ́wọ́ tí wọ́n máa ń fún àwọn àgbàlagbà nígbà tí wọ́n bá ní ìṣòro ìlera?
   Bèèrè fún àwọn ìyàtọ̀ ní ìbámu pẹ̀lú ipò ìlera bí àrùn ìbálòpọ̀ ní àfiwé pẹ̀lú arọmọléegun, ibà àti àwọn ipò mìíràn
   Bèèrè fún àwọn ìyàtọ̀ ní ìbámu pẹ̀lú bóyá ètò ìlera ìgbàlódé tàbí ti ìlànà oníṣègùn ìbílẹ̀
3. Ọdún wo ni ẹ lérò pé ó yẹ kí ọkùnrin/obìnrin dáwọ́ ìbálòpọ̀ dúró?
   Bèèrè fún àwọn àlàyé ní ìbámu pẹ̀lú ìṣesí ọ̀kọ̀ọ̀kan tí a dárúkọ
4. Báwo ni níní ìbálòpọ̀ ṣe máa ń pa ìlera lára lọ́jọ́ ogbó?
5. Nínú àwọn òwe tàbí ọ̀rọ̀ ọlọgbọ́n Yorùbá, báwo ni ẹ ṣe le ṣe àpèjúwe ìhùwàsí bàbá Àlàmú àti ìyá Àṣàkẹ́ nípa ìbálòpọ̀ àìlódiwọ̀n?

6. Ọ̀nà wo ni ẹ lérò pé ìbálòpọ̀ ṣe lè pa abala ìgbé-ayé mìíran lára lọ́jọ́ ogbó?

Ìkádìí Àkójọpọ̀ Ìjíròrò

- Ṣíṣe àkójọpọ̀ àwòṣe, ìfohùnsọ́kàn èrò, àti ìkọlura yòówù tó bá jẹ yọ lásìkò ìjíròrò àgbáríjọ.
- Ṣe àkíyèsí àwọn ìtọ́kasí oníyelórí (ṣe àfihàn ìfojúsí wọn bó bá ṣe é ṣe).
- Ṣe ìsọníṣókí ìjíròrò padà fún àkójọpò, kí o sì kíyèsí ìfimúlẹ̀ àti/tàbí ìkọ̀sílẹ̀ àwọn èrò àkọ́kọ́.

Appendix C: In-depth Interview Guide for the three Categories of Elderly People (English Language Version)

Ice Breaker*: Please describe to me what it means to be an older man or woman* of your age in *this community?*

Theme 1: embodied experiences of old age and sexual health in later life

Questions:

1. Could you please share with me your opinion on activities that are important in life, as people grow old?
   For each activity mentioned and probe for reasons and possible changes over the years
2. What activities do you think old people would want to avoid, as they grow older?
   For each activity mentioned probe for reasons and for gender differences

3. Could you please share with me your opinion about sexuality (*this includes sexual desires, expressions, practices/activities*) in old age.

4. In your opinion, what factors do you think could influence sexual health *(ability or inability to express sexual desires, engage in sexual practices and the presence or absence of infections)* in old age?
   Probe for gender differences in relation to the factors

5. Could you please share with me any experience of how an individual's sexual health may change over the years?
   Probe for explanations in relation to the changes and factors responsible on gender basis

Theme 2: Cultural values and sexual behaviours in old age

Questions:

1. What do you think are the basic responsibilities of a husband to his wives?

   Probe also for the basic responsibilities of a wife to her husband
   Probe for explanations and basis for each responsibility mentioned
   Probe for variations in these responsibilities as individuals grow old

2. Could you please share with me the similarities/differences between old men and women's sexual behaviours?
   Probe for how one's socio-economic status may influence sexual behaviours
   Probe for explanations on acceptable or non-acceptable sexual behaviours.
   Probe for the kind of reactions a man or woman's sexual behaviour may attract from spouse (husband/wife) children, relatives, friends, and Neighbours.

3. What factors do you think may be responsible for the practice of extra marital relations among old men/women?
   Probe for differences in factors between men and women

4. In your opinion, what factors do you think may be responsible for intergenerational sexual relations (between old and young people) in this community?
   Probe for differences in factors between men and women

5. What factors do you think could help an old man in meeting his sexual responsibilities to his wives and concubine?
   Probe for explanations around healthcare practices, personal beliefs, and socio-economic status

6. What factors do you think could help an old woman in meeting her sexual responsibilities to her husband or concubine?
   Probe for explanations around healthcare practices, personal beliefs, and socio-economic status

Theme 3: Sexual pleasures, risk and health practices

1. What are the common measures of maintaining or improving sexual performance among men?
   Probe for the use of herbal mixtures (e.g. Pakurumo, Alomo, Osomo)
   Probe for differences and similarities in measures along traditional and modern medicines used by age (young and old) and by socio-economic status
2. What are the common measures of maintaining or improving sexual performance among women?
   Probe for differences in measures used by age- young and old and variations by socio-economic status
3. Could you please share with me some traditional medicines that help to improve sexual pleasures/sweetness?

4. How will you describe the use of these measures among old men and women in this community?
   Probe for differentials among younger and older people

5. How will you assess the risks/chances of contracting sexually transmitted infections among old men and women?
   Probe for gender differences in the assessments of risks of contracting STIs

6. What kind of sexually transmitted infection(s) do you think are common with old people in this community?
   Probe for factors and practices that could influence the contraction and spread of the infections(s) among men/women in the community

7. Please tell some of the traditional ways or remedies of preventing sexually transmitted infections

   Probe for the wide usage or non-usage among young and old, men and women, factors responsible for whatever answer that is given
   Probe for the effectiveness and efficacy of such measures

8. Do you think condoms use can prevent sexually transmitted infections among old men and women?

   Probe for explanations

9. What factors do you think are discouraging old men and women that are sexually active from the use of condoms?

   Probe for explanations and gender variations

Theme 4: Prevention, treatment, and promotion of sexual health in old age

Questions:

1. Could you please tell me some of the local remedies or treatments for sexually transmitted infection(s)?

2. What steps do you think old men and women that contract sexually transmitted infection(s) would take to get solutions to such problems?

   Probe for solutions based on the type of infection(s) suggested
   Probe for medical and non-medical related measures

3. What factors do you think could discourage old men and women from seeking help for sexually transmitted infections?

   Probe for possible variations based on sources of help (hospital, traditional healers) and gender variations

Theme 5: Network of support, availability and quality of post-reproductive care services

1. How will you describe old men/women that contract sexually transmitted infection(s)?

2. How will you describe the quality of support given to old people when they have a health challenge?

   Probe for differences based on health conditions such as sexually transmitted infections in comparison to arthritis, malaria among other conditions
   Probe for differences based on whether it is a modern health provider or traditional medical practitioner

3. What challenges do you think old men/women will face in an effort to get a solution to sexually transmitted infections at the hospital?

Probe for challenges based on attitudes of health workers, cost of services, from members of his household, relatives, religious leaders and community members

4. Please at what age do you think a man/woman should stop sexual relations?
   Probe for explanations in relation to differences in the ages mentioned
5. How does engagement in sexual activities affect a man/woman's health in old age?

6. In what ways do you think sexual activities in old age could affect other areas of one's life?

7. Could you please share with me some Yoruba proverbs or wise sayings describing the importance of sex in a man/woman's life?

Closure of the interview

- Bring together patterns and examples that emerged during the interview
- Note notable quotes, proverbs or wise sayings and seek for clarifications in meanings and interpretations
- Present a short summary of discussion back to the interviewee and note affirmation and/or rejection of earlier opinions.

Appendix D: In-depth Interview Guide for the three Categories of Elderly People (Yoruba Language Version)

Ọ̀rọ̀ Ìpìlẹ̀*: Ẹ jọ̀wọ́, ẹ ṣe àpèjúwe ìtumọ̀ kí ènìyàn ó jẹ́ àgbàlagbà lọ́kùnrin tàbí lóbìnrin tí ó jẹ́ irọ̀ yín ní àdúgbò yìí fún mi.*

Kókó ọ̀rọ̀ 1: Orísìírísìí ìrírí ní ọjọ́ ogbó, àti nípa ìlera ìbálòpọ̀ ní ọjọ́ iwájú

Àwọn Ìbéèrè:

6. Ǹjẹ́ ẹ lè sọ fún mi ní èrò ti yín, àwọn nǹkan tí ó ṣe pàtàkì ní ayé àwọn ènìyàn bí wọ́n ṣe ń dàgbà?

   Fún ìkọ̀ọ̀kan àwọn nǹkan tí a dárúkọ, bèèrè ìdí fún ìkọ̀ọ̀kan àti àwọn àyípadà tí ó ṣeéṣe kí ó wáyé.
7. Kín ni àwọn nǹkan tí ẹ lérò pé àwọn àgbàlagbà lè máa sá fún bí wọ́n ṣe ń dàgbà síwájú sí i.

   Fún ìkọ̀ọ́kan àwọn nǹkan tí a dárúkọ lókè, bèèrè fún ìdí tí ó fi rí bẹ́ẹ̀, àti ìyàtọ̀ tí ó wà láàrin ti ọkùnrin àti ti obìnrin.
8. Ǹjẹ́ ẹ lè jọ̀wọ́, kí ẹ sọ ohun tí ẹ lérò pé ìbálòpọ̀ jẹ́ (èyí pẹ̀lú ìpòǹgbẹ fún ìbálòpọ̀, ìṣesí fún ìbálòpo, níní ìbálòpọ̀) ní ọjọ́ ogbó
9. Ní èrò ti yín, kín ni àwọn nǹkan tí ó lè fúnni ní ìlera ìbálòpọ̀ (Ṣíṣe àfihàn àti àìlèṣe àfihàn ìpòǹgbẹ ẹni fún ìbálòpọ̀, níní ìbálòpọ̀, pẹ̀lú àrùn tàbí àìní àrùn ìbálòpọ̀) ní ọjọ́ ogbó?

   Bèèrè fún ìyàtọ̀ tó wà láàrin ti ọkùnrin àti ti obìnrin lóri ohun tí à ń sọ̀rọ̀ bá

10. Ǹjẹ́ ẹ lè sọ ìrírí yín kankan fún mi nípa bí ìlera ẹni fún ìbálòpọ̀ ṣe lè yípadà bí ènìyàn bá ṣe ń dàgbà sí i?

    Bèèrè fún àlàyé ní ìbámu pẹ̀lú àwọn àyípadà àti àwọn nǹkan tó ń fa ìyàtọ̀ láàrin ti ọkùnrin àti ti obìnrin

Kókó-ọ̀rọ̀ kejì 2: Àwọn nnàkan Pàtàkì Ajẹmáṣà àti ìhùwàsí ajẹmọ́-ìbálòpọ̀ ní ọjọ́ ogbó
Àwọn Ìbéèrè:

4. Kín ni àwọn ohun tí ẹ rò pé ó jẹ́ ojúṣe ọkọ sí àwọn ìyàwó rẹ̀?

   Tún bèèrè fún àwọn ohun tí ó jẹ́ ojúṣe ìyàwó sí ọkọ rẹ
   Bèèrè fún àlàyé àti àwọn ohun tí ó pè fún àwọn ojúṣe tí a dárúkọ náà
   Bèèrè fún àwọn ìyàtọ̀ tó ń dé bá àwọn ojúṣe wọ̀nyí bí ẹnìkọ̀ọ̀kan ṣe ń di ogbó

5. Ǹjẹ́ ẹ lè jọ̀wọ́ ṣe àlàyé àwọn ìyàtọ/ìjọra tó wà láàrin ìṣesí/ìhùwàsí ajẹmọ́-ìbálòpọ̀ láàrin àwọn ọkùnrin àti obìnrin tí wọ́n ti ń di ogbó?

   Bèèrè fún bí èto ìsúná ẹni ní àwùjọ ṣe lè ní ipa lórí ìhùwàsí ajẹmọ́-ìbálòpọ̀
   Bèère fún àwọn ìhùwàsí ajẹmọ́-ìbálòpọ̀ tí ó ṣe ìtẹ́wọ́gbà àti èyí tí kò ṣe ìtẹ́wọ́gbà
   Bèèrè fún irú ìṣesí tí ìhùwàsí ajẹmọ́-ìbálòpọ̀ lè pè fún láti ọ̀dọ̀ ọkọ sí ìyàwó/ìyàwó sí ọkọ, ọmọ, mọ̀lẹ́bí, ọ̀rẹ́ àti ojúlùmọ̀

6. Kín ni àwọn nǹkan tí o lérò pé ó lè fa àlè yíyàn láàrin àwọn ogbó lọ́kùnrin àti lóbìnrin?

   Bèèrè fún àwọn ìyàtọ̀ tí ó wà láàrin ti ọkùnrin àti ti obìnrin

7. Ní èrò tìrẹ, kín ni o rò pé ó lè máa fa ìbálòpọ̀ onírandéra (láàrin àgbàlagbà àti ọmọdé) ní àdúgbò yìí?

   Bèèrè fún àwọn ìyàtọ̀ tí ó wà láàrin ti ọkùnrin àti obìnrin

8. Kín ni àwọn nǹkan tí ẹ lérò pé ó lè ran ogbó lọ́kùnrin lọ́wọ́ láti lè máa ṣe déédé nínú ojúṣe ìbálòpọ̀ lọ́dọ̀ àwọn ìyàwó àti àwọn àlè rẹ̀?

   Bèère fún àlàyé tí ó jẹ mọ́ lílò ó fún ìtọ́jú ara, ìgbàgbọ́ ẹni, àti ipò ètò ìsúnná ní àwùjọ

9. Kín ni àwọn nǹkan tí ẹ lérò pé ó lè ran obìnrin lọ́wọ́ láti lè ṣe déédé nínú ojúṣe ajẹmọ́-ìbálòpọ̀ sí ọkọ tàbí àlè rẹ̀?

   Bèèrè fún àlàyé tí ó jẹ mọ́ lílò ó fún ìtọ́jú ara, ìgbàgbọ́ ẹni, àti ipò ètò ìsúnná ní àwùjọ

Kókó-ọ̀rọ̀ 3: Ìgbádùn ajẹmọ́-ìbálòpọ̀, ewu àti ìlànà ìtọ́jú ara

4. Àwọn ọ̀nà wo ni ó wọ́pọ̀ tí àwọn ọkùnrin ń gbà mójútó tàbí tí wọ́n ń gbà mú àyípadà rere bá ìgbé-ayé ìbálòpọ̀ wọn?

   Bèèrè fún ìlò òògùn ajẹmọ́ tewétegbò (fún àpẹẹrẹ, Pakurumọ, Alọmọ, Ọ̀ṣọmọ)

   Bèèrè fún àwọn ìyàtọ̀ àti àwọn ìjọra tí ó wà láàrin àwọn ìlànà lílo òògùn ìbílẹ̀ àti òògùn Òyìnbó (lọ́mọdé àti lágbà) àti nípa ipò ètò ìsúnná onírúurú ní àwùjọ

5. Àwọn ọ̀nà wo ni ó wọ́pọ̀ tí àwọn obìnrin ń gbà mójútó tàbí tí wọ́n ń gbà mú àyípadà rere bá ìgbé-ayé ìbálòpọ̀ wọn?

   Bèèrè fún àwọn ìyàtọ̀ àti àwọn ìjọra tí ó wà láàrin àwọn ìlànà lílo òògùn ìbílẹ̀ àti òògùn Òyìnbó (lọ́mọdé àti lágbà) àti nípa ipò ètò ìsúnná onírúurú ní àwùjọ

6. Ǹjẹ́ ẹ lè jọ̀wọ́ so àwọn òògùn ìbílẹ̀ tí ó ń ranni lọ́wọ́ láti mú kí Ìgbádùn/adùn ìbálòpọ̀ dára sí i?

10. Báwo ni ẹ ṣe lè àpèjúwe bí àwọn ogbó lọ́kùnrin àti lóbìnrin ṣe ń lo àwọn nǹkan wọ̀nyí sí ní àdúgbò yìí?

    Bèèrè fún àwọn ìyàtọ̀ tí ó wà nínú ìlò rẹ̀ láàrin àwọn àgbàlagbà àti àwọn ọ̀dọ́

11. Báwo ni a ṣe ń mọ bí ènìyàn ṣe lè lùgbàdì ewu/àwọn ọ̀na wo ni ènìyàn lè gbà kó àrùn ìbálòpọ̀ láàrin àwọn ogbó lọ́kùnrin àti lóbìnrin?

    Bèèrè fún àwọn ìyàtọ̀ tí ó wà láàrin bí ọkùnrin àti obìnrin ṣe lè kó àrùn ìbálòpọ̀

12. Irú àrùn ìbálòpọ̀ wo ni ẹ lérò pé ó wọ́pọ̀ jù lọ láàrin àwọn àgbàlagbà ní àdúgbò yìí?

    Bèèrè fún àwọn nǹkan tàbí ìṣe tí ó lè ṣokùnfa kíkó àti títànkálẹ̀ àrùn náà láàrin àwọn ọkùnrin àti obìnrin ní àdúgbò yìí

13. Jọ̀wọ́ dárúkọ àwọn ìlànà ìbílẹ̀ tí a lè gbà dènà kíkó àrùn ajẹmọ́-ìbálòpọ̀

    Bèèrè fún ìlò yanturu tàbí àìlò láàrin àwọn àgbàlagbà àti àwọn ọ̀dọ́, ọkùnrin àti obìnrin, ìdí fún ìdáhùn tí wọ́n bá fún wa

    Bèèrè fún bí irú ìlànà bẹ́ẹ̀ ṣe ń ṣíṣẹ́ tó

14. Ǹjẹ́ ẹ lérò pé rọ́bà-ìdáàbòbò lè dènà àrùn ajẹmọ́-ìbálòpọ̀ láàrin ogbó lọ́kùnrin àti lóbìnrin?

Bèèrè fún àlàyé

15. Kín ni ẹ rò pé ó ń mú kí àwọn ogbó lọ́kùnrin àti lóbìnrin tó ń ní ìbálòpọ̀ má fẹ́ láti lo rọ́bà-ìdáàbòbò?

Bèèrè fún àlàyé àti ìyàtọ̀ tó wà láàrin ti ọkùnrin àti ti obìnrin

Kókó-ọ̀rọ̀ 4: Ìdènà àrùn, Ìtọ́jú, àti mímú àyípadà rere bá ìlera ajẹmọ́-ìbálòpọ̀ ní ọjọ́ ogbó

Àwọn Ìbéèrè:

4. Ẹ jọ̀wọ́, ǹjẹ́ ẹ lè dárúkọ lára àwọn òògùn ìbílẹ̀ tí a lè lò fún ìtọ́jú àrùn ajẹmọ́-ìbálòpọ̀?

5. Ìgbésẹ̀ wo ni ẹ rò pé àwọn ogbó lọ́kùnrin àti lóbìnrin tó ti lùgbàdì àrùn ajẹmọ́-ìbálòpọ̀ lè gbé láti wá ọ̀nà àbáyọ sí ìṣòro náà?

Bèèrè fún ọ̀nà àbáyọ fún irúfẹ́ àrùn tí wọ́n bá dárúkọ

Bèèrè fún àwọn ìlànà ajẹmọ́-ètò ìlera Òyìnbó àti èyí tí kò jẹ mọ́ ètò ìlera Òyìnbó

6. Kín ni àwọn nǹkan tí ẹ lérò pé ó lè mú kí àwọn ogbó lọ́kùnrin àti lóbìnrin kó láti wa ìtọ́jú fún àrùn ajẹmọ́-ìbálòpọ̀?

Bèèrè fún àwọn ìyàtọ̀ tí ó lè wà ní ìbámu pẹ̀lú ibi tí wọ́n bá ti ń gba ìtọ́jú (ilé-ìwòsàn, oníwòsàn ìbílẹ̀) àti ìyàtọ̀ láàrin ti ọkùnrin àti ti obìnrin

Kókó-ọ̀rọ̀ 5: Àtìlẹ́yìn, wíwà ní àrọ́wọ́tọ́ àti dídára ìtọ́jú lẹ́yìn ìdáwọ́ ọmọ bíbí dúró

8. Báwo ni ẹ ṣe lè ṣe àpèjúwe àwọn ogbò lọ́kùnrin/lóbìnrin tí wọ́n ti lùgbàdì àrùn ìbálòpọ̀?

9. Báwo ni ẹ ṣe lè ṣe àpèjúwe bí ìtọ́jú àti àtìlẹ́yìn tí à ń fún àwọn àgbàlagbà nígbà tí wọ́n bá ní ìpèníjà nípa ìlera?

Bèèrè fún àwọn ìyàtọ̀ ní ìbámu pẹ̀lú ipó ìlera bí ti ẹni tí ó ti kó àrùn ìbálòpọ̀ ní àfiwé pẹ̀lú àwọn àìsàn ara wíwú, ibà àti àwọn àìsàn mìíràn.

Bèèrè fún àwọn ìyàtọ̀ bóyá oníṣẹ́ ìlera ìgbàlódé tàbí ti ìbílẹ̀ ló ń pèsè ìtọ́jú

10. Irú àwọn ìpèníjà wo ni ẹ rò pé àwọn ogbó lọ́kùnrin/lóbìnrin yóò kojú ní ilé-ìwòsàn lọ́nà àtiwá ọ̀nà àbáyọ sí àwọn àrùn ìbálòpọ̀ tí wọ́n ti lùgbàdì?

Bèèrè fún àwọn ìpèníjà tí ó ń ti ibi ìṣesí àwọn oníṣẹ́ ìlera, owó ìtọ́jú, àwọn alábàágbépọ̀, mọ̀lẹ́bí, àwọn olórí ẹlẹ́sìn àti àwọn ará àdúgbò wa.

11. Ẹ jọ̀wọ́, ọjọ́-orí wo ni ẹ lérò pé ó yẹ kí ọkùnrin/obìnrin ó dẹ́kun níní ìbálòpọ̀?

Bèèrè fún àlàyé ní ìbámu pèlú ìyàtọ̀ tí ó wà nínú àwọn ọjọ́-orí tí wọ́n dárúkọ

12. Báwo ni ìbálòpọ̀ ṣe ń ní ipa lórí ìlera ọkùnrin àti obìnrin ní ọjọ́ ogbó?

13. Àwọn ọ̀nà wo ni ẹ rò pé níní ìbálòpọ̀ ṣe lè kó ipa lórí àwọn abala ìgbé-ayé ènìyàn yòókù?

14. Ẹ jọ̀wọ́, ǹjẹ́ ẹ lè pa àwọn òwe Yorùbá tàbí kí ẹ sọ àwọn ọ̀rọ̀-ọlọgbọ́n tí ó ń ṣe àpèjúwe pàtàkì ìbálòpọ̀ nínú ayé ọkùnrin àti obìnrin?

Ìkádìí ìfọ̀rọ̀wánilẹ́nuwò

- Ṣe àkójọpọ̀ ọ̀wọ̀n ìlànà àti àpẹẹrẹ tí ó jẹ́ jáde ní àsìkò ìfọ̀rọ̀wánilẹ́nuwò
- Ṣe àkíyèsí àwọn ọ̀rọ̀ pàtàkì, òwe tàbí ọ̀rọ̀ ọlọgbọ́n kí o sì ṣe ìpínsísọ̀rí wọn lábẹ́ ìtumọ̀ àti ìtúpalẹ̀.
- Ṣe ìsọníṣókí ìfọ̀rọ̀wánilẹ́nuwò náà fún abẹ́nà-ìmọ̀ kí o sì ṣe àkíyèsí bóyá ó fi ara mọ́ ọn tàbí kò fi ara mọ́ ohun tí o ti sọ tẹ́lẹ̀.

Appendix E: In-depth Interview Guide for Modern Healthcare Providers (English Language Version)

Theme 1: Cultural values and sexual health in old age

Questions:

6. Could you please share with me your opinion on activities that are important in life, as people grow old?
   For each activity mentioned and probe for reasons and possible changes over the years

7. What activities do you think old people would want to avoid, as they grow older?
   For each activity mentioned probe for reasons and for gender differences

8. Could you please share with me your opinion about sexuality (*this includes sexual desires, expressions, practices/activities*) in old age?

9. In your opinion, how important is sexuality to old and older people?
   Probe for gender differences in relation to perceived importance

10. In your opinion, what factors do you think could account for changes in old and older people's sexual health *(ability or inability to express sexual desires, engage in sexual practices and existing sexual enhancement practices)*?
    Probe for gender differences in relation to the factors

11. What factors do you think may be responsible for the practice of extra marital relations among old men/women?
    Probe for differences in factors between men and women

12. In your opinion, what factors do you think may be responsible for intergenerational sexual relations (between old and young people) in this community?
    Probe for differences in factors between men and women

Theme 2: Sexual pleasures, risk and health practices

15. What are the common measures of maintaining or improving sexual performance?
    Probe for the use of sexual performance enhancement drugs mixtures
    Probe for differences and similarities in measures along traditional and modern medicines used by age (young and old) and by socio-economic status

16. What are the common dangers in using sexual performance enhancement drugs in old age?
    Probe for differences in measures used by age- young and old and variations by socio-economic status

17. What kind of sexually transmitted infection(s) do you think are common with old people in this community?

    Probe for factors and practices that could influence the contraction and spread of the infections(s) among men/women in the community

18. What methods do you think old men and women can use to prevent the contraction of sexually transmitted infections?

    Probe for explanations

19. What factors do you think may be discouraging old men and women that are sexually active from the use of condoms?

    Probe for explanations and gender variations

Theme 3: Prevention, treatment, and promotion of sexual health in old age

Questions:

1. What steps do you think old men and women that contract sexually transmitted infection(s) would take to get solutions to such problems?

   Probe for solutions based on the type of infection(s) suggested
   Probe for medical and non-medical related measures

2. What factors do you think could discourage old men and women from seeking help for sexually transmitted infections?

   Probe for possible variations based on sources of help (hospital, traditional healers) and gender variations

Theme 4: Network of support, availability and quality of post-reproductive care services

1. What kind of health problems do old men and women come here for?

   Probe for the differences in health concerns between old men and women
   Probe for the current challenges in meeting the expectations of these men and women

2. What are the available treatment or care services for old men or women that contract sexually transmitted infections?

3. What challenges do you think old men/women will face in an effort to get a solution to sexually transmitted infections at the hospital?

   Probe for challenges based on attitudes of health workers, cost of services, from members of his household, relatives, religious leaders and community members

4. *Could you please share some of your experiences or interactions with old and older people in relation with their sexuality (this includes sexual desires, expressions, practices/activities) with me?*

5. At what age do you think a man/woman should stop sexual relations?
   Probe for explanations in relation to differences in the ages mentioned

6. How does engagement in sexual activities affect a man/woman's health in old age?

7. In what ways do you think sexual activities in old age could affect other areas of life?

8. What is your assessment of Geriatrics Care in Nigeria?
   Probe for availability, accessibility and acceptability of existing services among the elderly?

Closure of the interview

- Bring together patterns and examples that emerged during the interview
- Note notable quotes, proverbs or wise sayings and seek for clarifications in meanings and interpretations
- Present a short summary of discussion back to the interviewee and note affirmation and/or rejection of earlier opinions.

Appendix F: In-Depth Interview Guide for Modern Healthcare Providers (Yoruba Language Version)

Kókó-ọ̀rọ̀ 1: Àwọn nǹkan pàtàkì ajẹmáṣà àti ìlera ajẹmọ́-ìbálòpọ̀ ní ọjọ́ ogbó

Àwọn Ìbéèrè:

13. Ẹ jọ̀wọ́, ǹjẹ́ ẹ lè sọ èrò yín nípa àwọn nǹkan tí o ṣe pàtàkì nínú ayé ènìyàn bí wọ́n ṣe ń di àgbàlagbà fún mi?
    Fún nǹkan kọ̀ọ̀kan tí a dárúkọ, bèèrè fún ìdí tí wọ́n fi ṣe pàtàkì àti àwọn àyípadà tí ó lè dé bá wọn bí àgbà bá ṣe ń dé.

14. Irú àwọn nǹkan wo ni ẹ lérò pé àwọn àgbàlagbà yóò fẹ́ láti yàgò fún bí wọ́n bá ṣe ń dàgbà sí i?
    Fún nǹkan kọ̀ọ̀kan tí a dárúkọ, bèèrè ìdí tí ó fi rí bẹ́ẹ̀ àti ìyàtọ̀ tí ó wà láàrin ti ọkùnrin àti ti obìnrin

15. Ǹjẹ́ ẹ lè ṣọ èrò ti yín nípa ìbálòpọ̀ ní ọjọ́ ogbó fún mi? (nínú èyí ni a ti rí ìpòǹgbẹ fún ìbálòpọ̀, àfihàn ìpòǹgbẹ fún ìbálòpọ̀ àti níní ìbálòpọ̀/àwọn ìṣe tí ó rò mọ́ ìbálòpọ̀)

16. Nínú èrò ti yín, báwo ni ẹ ṣe rò pé ìbálòpọ̀ ṣe ṣe pàtàkì sí fún àwọn àgbàlagbà àti àwọn arúgbó?
    Bèèrè fún àwọn ìyàtọ̀ tí ó wà láàrin ti ọkùnrin àti ti obìnrin ní ìbámu pẹ̀lú bí ẹ ṣe wòye pé ó ṣe pàtàkì sí.

17. Ní èrò ti yín, kín ni àwọn nǹkan tí ó lè fa àyípadà nínú ìlera ajẹmọ́-ìbálòpọ̀ àwọn àgbàlagbà àti arúgbó *(níní agbára tàbí àìní agbára láti ṣe àfihàn ìpòǹgbẹ ìbálòpọ̀, níní ìbálòpọ̀ àti ṣíṣe àwọn nǹkan tí ó lè mú kí Ìgbádùn ìbálòpọ̀ dára sí i)*?
    Bèèrè fún àwọn ìyàtọ̀ tí ó wà fún ti ọkùnrin àti ti obìnrin ní ìbámu pẹ̀lú àwọn nǹkan tí a dárúkọ

18. Kín ni àwọn nǹkan tí ẹ lérò pé ó ń ṣokùnfa yíyan àlè láàrin àwọn àgbàlagbà lọ́kùnrin/lóbìnrin?
    Bèèrè fún àwọn ìyàtọ̀ tó wà láàrin àwọn nǹkan náà láàrin ọkùnrin àti obìnrin

19. Ní èrò ti yín, kín ni àwọn nǹkan tí ẹ rò pé ó lè ṣokùnfa ìbálòpọ̀ onírandéran (láàrin àwọn àgbàlagbà àti àwọn ọ̀dọ́) ní àdúgbò yìí?
    Bèèrè fún àwọn ìyàtọ̀ tó wà láàrin ti àwọn ọkùnrin àti ti àwọn obìnrin

Kókó-ọ̀rọ̀ 2: Ìgbádùn ajẹmọ́-ìbálòpọ̀, ewu àti ìlànà ìtọ́jú ara

20. Àwọn ọ̀nà wo ni ó wọ́pọ̀ tí àwọn ọkùnrin ń gbà mójútó tàbí tí wọ́n ń gbà mú àyípadà rere bá ìgbé-ayé ìbálòpọ̀ wọn?
    Bèèrè fún ìlò òògùn ajẹmọ́ tewétegbò (fún àpẹẹrẹ, Pakurumọ, Alọmọ, Ọ̀ṣọmọ)
    Bèèrè fún àwọn ìyàtọ̀ àti àwọn ìjọra tí ó wà láàrin àwọn ìlànà lílo òògùn ìbílẹ̀ àti òògùn Òyìnbó (lọ́mọdé àti lágbà) àti nípa ipò ètò ìsúnáonikálùkù ní àwùjọ

21. Kín ni àwọn ewu tó rọ mó lílo òògùn amára-jípépé fún ìbálòpọ̀ ní ọjọ́ ogbó?
    Bèèrè fún orísìírísìí ọ̀nà tí àwọn àgbàlagbà àti ọ̀dọ́ ń gbà lò ó ni ìbámu pẹ̀lú ètò ìsúnná wọn ní àwùjo
22. Irú àrùn ìbálòpọ̀ wo ni ẹ lérò pé ó wọ́pọ̀ jù lọ láàrin àwọn àgbàlagbà ní àdúgbò yìí?
    Bèèrè fún àwọn nǹkan tàbí ìṣe tí ó lè ṣokùnfa kíkó àti títànkálẹ̀ àrùn náà láàrin àwọn ọkùnrin àti obìnrin ní àdúgbò yìi?
23. Àwọn ọ̀nà wo ni ẹ rò pé àwọn ogbó lọ́kùnrin àti lóbìnrin lè gbà dènà kíkó àrùn ajẹmọ́-ìbálòpọ̀?
    Bèèrè fún àlàyé

24. Kín ni ẹ rò pé ó ń mú kí àwọn ogbó lọ́kùnrin àti lóbìnrin tó ń ní ìbálòpọ̀ má fẹ́ láti lo rọ́bà-ìdáàbòbò?
    Bèèrè fún àlàyé àti ìyàtọ̀ tó wà láàrin ti ọkùnrin àti ti obìnrin

Koko-oro 3: Ìdènà àrùn, Ìtọ́jú, àti mímú àyípadà rere bá ìlera ajẹmọ́-ìbálòpọ̀ ní ọjọ́ ogbó

Àwọn Ìbéèrè:

1. Ìgbésẹ̀ wo ni ẹ rò pé àwọn ogbó lọ́kùnrin àti lóbìnrin tó ti lùgbàdì àrùn ajẹmọ́-ìbálòpọ̀ lè gbé láti wá ọ̀nà àbáyọ sí ìṣòro náà?
   Bèèrè fún ọ̀nà àbáyọ fún irúfẹ́ àrùn tí wọ́n bá dárúkọ
   Bèèrè fún àwọn ìlànà ajẹmọ́-ètò ìlera Òyìnbó àti èyí tí kò jẹ mọ́ ètò ìlera Òyìnbó

2. Kín ni àwọn nǹkan tí ẹ lérò pé ó lè mú kí àwọn ogbó lọ́kùnrin àti lóbìnrin kó láti wa ìtọ́jú fún àrùn ajẹmọ́-ìbálòpọ̀?
   Bèèrè fún àwọn ìyàtọ̀ tí ó lè wà ní ìbámu pẹ̀lú ibi tí wọ́n bá ti ń gba ìtọ́jú (ilé-ìwòsàn, oníwòsàn ìbílẹ̀) àti ìyàtọ̀ láàrin ti ọkùnrin àti ti obìnrin

Kókó-ọ̀rọ̀ 5: Àtìlẹ́yìn, wíwà ní àrọ́wọ́tọ́ àti dídára ìtọ́jú lẹ́yìn ìdáwọ́ ọmọ bíbí dúró

1. Irú àwọn ìṣòro ajẹmọ́-ìlera wo ni àwọn àgbàlagbà lọ́kùnrin àti lóbìnrin máa ń wá gbà níbí yìí?
   Bèèrè fún ìyàtọ̀ tó wà láàrin àwọn ìpèníjà ajẹmólera tó ń bá àwọn àgbàlagbà lọ́kùnrin àti lóbìnrin fínra
   Bèèrè fún ìpèníjà tí ó ń kojú ìrètí àwọn ọkùnrin àti obìnrin wọ̀nyí

2. Irú ìtọ́jú wo ni ó wà ní ṣẹpẹ́ fún àwọn ogbó lọ́kùnrin àti lóbìnrin tó ti lùgbàdì àrùn ìbálòpọ̀?

3. Irú àwọn ìpèníjà wo ni ẹ rò pé àwọn ogbó lọ́kùnrin/lóbìnrin yóò kojú ní ilé-ìwòsàn lọ́nà àtiwá ọ̀nà àbáyọ sí àwọn àrùn ìbálòpọ̀ tí wọ́n ti lùgbàdì?

   Bèèrè fún àwọn ìpèníjà tí ó ń ti ibi ìṣesí àwọn oníṣẹ́ ìlera, owó ìtójú, àwọn alábàágbépọ̀, mọ̀lẹ́bí, àwọn olórí ẹlẹ́sìn àti àwọn ará àdúgbò wa.

4. *Ẹ jọ̀wọ́, ǹjẹ́ ẹ lè sọ ìrírí yín nínú ìbánisọ̀rọ̀ yín pẹ̀lú àwọn àgbàlagbà àti àwọn arúgbó nínú ìgbé-ayé ìbálòpọ̀ wọn (èyí pẹ̀lú ìpòǹgbẹ fún ìbálòpọ̀, àfihàn ìpòǹgbẹ, níní ìbálòpọ̀ àti ṣíṣe àwọn nǹkan tí ó rọ mọ́ níní ìbálòpọ̀) fún mi?*

5. Ẹ jọ̀wọ́, ọjọ́-orí wo ni ẹ lérò pé ó yẹ kí ọkùnrin/obìnrin ó dẹ́kun níní ìbálòpọ̀?
   Bèèrè fún àlàyé ní ìbámu pèlú ìyàtọ̀ tí ó wà nínú àwọn ọjọ́-orí tí wọ́n dárúkọ
6. Báwo ni ìbálòpọ̀ ṣe ń ní ipa lórí ìlera ọkùnrin àti obìnrin ní ọjọ́ ogbó?

7. Àwọn ọ̀nà wo ni ẹ rò pé níní ìbálòpọ̀ ṣe lè kó ipa lórí àwọn abala ìgbé-ayé èníyàn yòókù?

8. Kín ni èrò yín nípa irú ìtọ́jú tí ó wà fún àwọn arúgbó ní orílẹ̀-èdè nàìjíríà?
   Bèèrè fún wíwà, rírí àti títẹ́wọ́gba ìtọ́jú tí ó wà fún àwọn àgbàlagbà

Ìkádìí ìfọ̀rọ̀wánilẹ́nuwò

- Ṣe àkójọpọ̀ ọ̀wọ́n ìlànà àti àpẹẹrẹ tí ó jẹ́ jáde ní àsìkò ìfọ̀rọ̀wánilẹ́nuwò
- Ṣe àkíyèsí àwọn ọ̀rọ̀ pàtàkì, òwe tàbí ọ̀rọ̀ ọlọgbọ́n kí o sì ṣe ìpínsísọ̀rí wọn lábẹ́ ìtumọ̀ àti ìtúpalẹ̀.
- Ṣe ìsọníṣókí ìfọ̀rọ̀wánilẹ́nuwò náà fún abẹ́nà-ìmọ̀ kí o sì ṣe àkíyèsí bóyá ó fi ara mọ́ ọn tàbí kò fi ara mọ́ ohun tí o ti sọ tẹ́lẹ̀.

Appendix G: In-Depth Interview Guide for Traditional Healthcare Providers (English Language Version)

Ice Breaker*: Please describe to me what it means to be a traditional healthcare provider?*

Theme 1: Cultural values and sexual health in old age

Questions:

1. Could you please share with me your opinion on activities that are important in life, as people grow old?
   For each activity mentioned and probe for reasons and possible changes over the years
2. What activities do you think old people would want to avoid, as they grow older?
   For each activity mentioned probe for reasons and for gender differences

3. Could you please share with me your opinion about sexuality (*this includes sexual desires, expressions, practices/activities*) in old age?
4. In your opinion, how important is sexuality to old and older people?
   Probe for gender differences in relation to perceived importance

5. In your opinion, what factors do you think could account for changes in old and older people's sexual health *(ability or inability to express sexual desires, engage in sexual practices and existing sexual enhancement practices)*?
   Probe for gender differences in relation to the factors
6. What factors do you think may be responsible for the practice of extra marital relations among old men/women?
   Probe for differences in factors between men and women
7. In your opinion, what factors do you think may be responsible for intergenerational sexual relations (between old and young people) in this community?
   Probe for differences in factors between men and women

Theme 2: Sexual pleasures, risk and health practices

9. What are the common measures of maintaining or improving sexual performance?
   Probe for the use of sexual performance enhancement drugs mixtures
   Probe for differences and similarities in measures along traditional and modern medicines used by age (young and old) and by socio-economic status

10. What are the common dangers in using sexual performance enhancement drugs in old age?
    Probe for differences in measures used by age- young and old and variations by socio-economic status

11. Could you please share with me some medicines that can help to improve sexual pleasures/sweetness?

12. How will you describe the use of these measures among old men and women in this community?
    Probe for differentials among younger and older people

13. What kind of sexually transmitted infection(s) do you think are common with old people in this community?

    Probe for factors and practices that could influence the contraction and spread of the infections(s) among men/women in the community

14. Please tell some of the traditional remedies or ways of preventing sexually transmitted infections

    Probe for the wide usage or non-usage among young and old, men and women, factors responsible for whatever answer that is given
    Probe for the effectiveness and efficacy of such measures

15. What methods do you think old men and women can use to prevent the contraction of sexually transmitted infections?

    Probe for explanations

16. What factors do you think may be discouraging old men and women that are sexually active from the use of condoms?

    Probe for explanations and gender variations

Theme 3: Prevention, treatment, and promotion of sexual health in old age

Questions:

17. Could you please tell me some of the local remedies or treatments you have for sexually transmitted infection(s)?
18. What steps do you think old men and women that contract sexually transmitted infection(s) would take to get solutions to such problems?

    Probe for solutions based on the type of infection(s) suggested
    Probe for medical and non-medical related measures

19. What factors do you think could discourage old men and women from seeking help for sexually transmitted infections?

    Probe for possible variations based on sources of help (hospital, traditional healers) and gender variations

20. *Could you please share some of your experiences or interactions with old and older people in relation with their sexuality (this includes sexual desires, expressions, practices/activities) with me?*

Theme 4: Network of support, availability and quality of post-reproductive care services

21. What kind of health problems do old men and women come here for?

    Probe for the differences in health concerns between old men and women
    Probe for the current challenges in meeting the expectations of these men and women

22. What are the available treatment or care services for old men or women that contract sexually transmitted infections?

23. What challenges do you think old men/women will face in an effort to get a solution to sexually transmitted infections at the hospital?

    Probe for challenges based on attitudes of health workers, cost of services, from members of his household, relatives, religious leaders and community members

24. At what age do you think a man/woman should stop sexual relations?
    Probe for explanations in relation to differences in the ages mentioned
25. How does engagement in sexual activities affect a man/woman's health in old age?

26. In what ways do you think sexual activities in old age could affect other areas of life?

27. Could you please share with me some Yoruba proverbs or wise sayings describing the importance of sex in a man/woman's life?

Closure of the interview

- Bring together patterns and examples that emerged during the interview
- Note notable quotes, proverbs or wise sayings and seek for clarifications in meanings and interpretations
- Present a short summary of discussion back to the interviewee and note affirmation and/or rejection of earlier opinions.

Appendix H: In-depth Interview Guide for Traditional Healthcare Providers (Yoruba Language Version)

Ọ̀rọ̀-ìpìlẹ̀*: Ẹ jọ̀wọ́ ẹ ṣàlàyé ohun tí ó túmọ̀ sí láti jẹ́ elétò ìlera ní ìlànà ìbílẹ̀ fún mi.*

Kókó-ọ̀rọ̀ 1: Àwọn nnàkan Pàtàkì Ajẹmáṣà àti ìhùwàsí ajẹmọ́-ìbálòpọ̀ ní ọjọ́ ogbó

Àwọn Ìbéèrè:

1. Ẹ jọ̀wọ́, ǹjẹ́ ẹ lè sọ èrò yín nípa àwọn nǹkan tí o ṣe pàtàkì nínú ayé ènìyàn bí wọ́n ṣe ń di àgbàlagbà fún mi?
   Fún nǹkan kọ̀ọ̀kan tí a dárúkọ, bèèrè fún ìdí tí wọ́n fi ṣe pàtàkì àti àwọn àyípadà tí ó lè dé bá wọn bí àgbà bá ṣe ń dé.

2. Irú àwọn nǹkan wo ni ẹ lérò pé àwọn àgbàlagbà yóò fẹ́ láti yàgò fún bí wọ́n bá ṣe ń dàgbà sí i?
   Fún nǹkan kọ̀ọ̀kan tí a dárúkọ, bèèrè ìdí tí ó fi rí bẹ́ẹ̀ àti ìyàtọ̀ tí ó wà láàrin ti ọkùnrin àti ti obìnrin

3. Ǹjẹ́ ẹ lè ṣọ èrò ti yín nípa ìbálòpọ̀ ní ọjọ́ ogbó fún mi ? (nínú èyí ni a ti rí ìpòǹgbẹ fún ìbálòpọ̀, àfihàn ìpòǹgbẹ fún ìbálòpọ̀ àti níní ìbálòpọ̀/àwọn ìṣe tí ó rò mọ́ ìbálòpọ̀)

4. Nínú èrò ti yín, báwo ni ẹ ṣe rò pé ìbálòpọ̀ ṣe ṣe pàtàkì sí fún àwọn àgbàlagbà àti àwọn arúgbó?
   Bèèrè fún àwọn ìyàtọ̀ tí ó wà láàrin ti ọkùnrin àti ti obìnrin ní ìbámu pẹ̀lú bí ẹ ṣe wòye pé ó ṣe pàtàkì sí.

5. Ní èrò ti yín, kín ni àwọn nǹkan tí ó lè fa àyípadà nínú ìlera ajẹmọ́-ìbálòpọ̀ àwọn àgbàlagbà àti arúgbó *(níní agbára tàbí àìní agbára láti ṣe àfihàn ìpòǹgbẹ ìbálòpọ̀, níní ìbálòpọ̀ àti ṣíṣe àwọn nǹkan tí ó lè mú kí Ìgbádùn ìbálòpọ̀ dára sí i)*?
   Bèèrè fún àwọn ìyàtọ̀ tí ó wà fún ti ọkùnrin àti ti obìnrin ní ìbámu pẹ̀lú àwọn nǹkan tí a dárúkọ

6. Kín ni àwọn nǹkan tí ẹ lérò pé ó ń ṣokùnfa yíyan àlè láàrin àwọn àgbàlagbà lọ́kùnrin/lóbìnrin?
   Bèèrè fún àwọn ìyàtọ̀ tó wà láàrin àwọn nǹkan náà láàrin ọkùnrin àti obìnrin

7. Ní èrò ti yín, kín ni àwọn nǹkan tí ẹ rò pé ó lè ṣokùnfa ìbálòpọ̀ onírandéran (láàrin àwọn àgbàlagbà àti àwọn ọ̀dọ́) ní àdúgbò yìí?
   Bèèrè fún àwọn ìyàtọ̀ tó wà láàrin ti àwọn ọkùnrin àti ti àwọn obìnrin

Kókó-ọ̀rọ̀ 2: Ìgbádùn ajẹmọ́-ìbálòpọ̀, ewu àti ìlànà ìtọ́jú ara

8. Àwọn ọ̀nà wo ni ó wọ́pọ̀ tí àwọn ọkùnrin ń gbà mójútó tàbí tí wọ́n ń gbà mú àyípadà rere bá ìgbé-ayé ìbálòpọ̀ wọn?
   Bèèrè fún ìlò òògùn ajẹmọ́ tewétegbò (fún àpẹẹrẹ, Pakurumọ, Alọmọ, Ọ̀ṣọmọ)

Bèèrè fún àwọn ìyàtọ̀ àti àwọn ìjọra tí ó wà láàrin àwọn ìlànà lílo òògùn ìbílẹ̀ àti òògùn Òyìnbó (lọ́mọdé àti lágbà) àti nípa ipò ètò ìsúná oníkálùkù ní àwùjọ

9. Kin ni awon ewu ti o wopo ti o ro mo lilo oogun amára-jípépe fun ìbálòpò ni ojo ogbo?
   Bèèrè fun ìyàtò ti o wa láàrin iru eyi ti awon àgbàlagbà ati awon odo n lo ni ìbámu pelu eto ìsúna won ni àwùjo

9. Ǹjẹ́ ẹ lè jọ̀wọ́ sọ àwọn òògùn ìbílẹ̀ tí ó ń ranni lọ́wọ́ láti mú kí Ìgbádùn/adùn ìbálòpọ̀ dára sí i?

10. Báwo ni ẹ ṣe lè ṣe àpèjúwe bí àwọn ogbó lọ́kùnrin àti lóbìnrin ṣe ń lo àwọn nǹkan wọ̀nyí sí ní àdúgbò yìí?
    Bèèrè fún àwọn ìyàtọ̀ tí ó wà nínú ìlò rẹ̀ láàrin àwọn àgbàlagbà àti àwọn ọ̀dọ́

11. Irú àrùn ìbálòpọ̀ wo ni ẹ lérò pé ó wọ́pọ̀ jù lọ láàrin àwọn àgbàlagbà ní àdúgbò yìí?
    Bèèrè fún àwọn nǹkan tàbí ìṣe tí ó lè ṣokùnfa kíkó àti títànkálẹ̀ àrùn náà láàrin àwọn ọkùnrin àti obìnrin ní àdúgbò yìí

12. Jọ̀wọ́ dárúkọ àwọn ìlànà ìbílẹ̀ tí a lè gbà dènà kíkó àrùn ajẹmọ́-ìbálòpọ̀
    Bèèrè fún ìlò yanturu tàbí àìlò láàrin àwọn àgbàlagbà àti àwọn ọ̀dọ́, ọkùnrin àti obìnrin, ìdí fún ìdáhùn tí wọ́n bá fún wa
    Bèèrè fún bí irú ìlànà bẹ́ẹ̀ ṣe ń ṣiṣẹ́ tó

13. Àwọn ọ̀nà wo ni ẹ rò pé àwọn ogbó lọ́kùnrin àti lóbìnrin ń gbà dènà kíkó àrùn ìbálòpọ̀?
    Bèèrè fún àlàyé

14. Kín ni ẹ rò pé ó ń mú kí àwọn ogbó lọ́kùnrin àti lóbìnrin tó ń ní ìbálòpọ̀ má fẹ́ láti lo rọ́bà-ìdáàbòbò?
    Bèèrè fún àlàyé àti ìyàtọ̀ tó wà láàrin ti ọkùnrin àti ti obìnrin

Kókó-ọ̀rọ̀ 3: Ìdènà àrùn, Ìtọ́jú, àti mímú àyípadà rere bá ìlera ajẹmọ́-ìbálòpọ̀ ní ọjọ́ ogbó

Àwọn Ìbéèrè:

15. Ẹ jọ̀wọ́, ǹjẹ́ ẹ lè dárúkọ lára àwọn òògùn ìbílè tí a lè lò fún ìtọ́jú àrùn-ajẹmọ́ ìbálòpò?

16. Ìgbésẹ̀ wo ni ẹ rò pé àwọn ogbó lọ́kùnrin àti lóbìnrin tó ti lùgbàdì àrùn ajẹmọ́-ìbálòpọ̀ lè gbé láti wá ọ̀nà àbáyọ sí ìṣòro náà?
    Bèèrè fún ọ̀nà àbáyọ fún irúfẹ́ àrùn tí wọ́n bá dárúkọ
    Bèèrè fún àwọn ìlànà ajẹmọ́-ètò ìlera Òyìnbó àti èyí tí kò jẹ mọ́ ètò ìlera Òyìnbó

17. Kín ni àwọn nǹkan tí ẹ lérò pé ó lè mú kí àwọn ogbó lọ́kùnrin àti lóbìnrin kó láti wa ìtọ́jú fún àrùn ajẹmọ́-ìbálòpọ̀?
    Bèèrè fún àwọn ìyàtọ̀ tí ó lè wà ní ìbámu pẹ̀lú ibi tí wọ́n bá ti ń gba ìtọ́jú (ilé-ìwòsàn, oníwòsàn ìbílẹ̀) àti ìyàtọ̀ láàrin ti ọkùnrin àti ti obìnrin

18. *Ẹ jọ̀wọ́, ǹjẹ́ ẹ lè sọ ìrírí yín nínú ìbánisọ̀rọ̀ yín pẹ̀lú àwọn àgbàlagbà àti àwọn arúgbó nínú ìgbé-ayé ìbálòpọ̀ wọn (èyí pẹ̀lú ìpòǹgbẹ fún ìbálòpọ̀, àfihàn ìpòǹgbẹ, níní ìbálòpọ̀ àti ṣíṣe àwọn nǹkan tí ó rọ̀ mọ́ níní ìbálòpọ̀) fún mi?*

Kókó-ọ̀rọ̀ 4: Àtìlẹ́yìn, wíwà ní àrọ́wọ́tọ́ àti dídára ìtọ́jú lẹ́yìn ìdáwọ́ ọmọ bíbí dúró

19. Irú àwọn ìṣòro ajẹmọ́-ìlera wo ni àwọn àgbàlagbà lọ́kùnrin àti lóbìnrin máa ń wá gbà níbí yìí?
    Bèèrè fún ìyàtọ̀ tó wà láàrin àwọn ìpènijà ajẹmólera tó ń bá àwọn àgbàlagbà lọ́kùnrin àti lóbìnrin fínra
    Bèèrè fún ìpènijà tí ó ń kojú ìrètí àwọn ọkùnrin àti obìnrin wọ̀nyí
20. Irú ìtọ́jú wo ni ó wà ní ṣẹpẹ́ fún àwọn ogbó lọ́kùnrin àti lóbìnrin tó ti lùgbàdì àrùn ìbálòpọ̀?
21. Báwo ni ẹ ṣe lè ṣe àpèjúwe àwọn ogbò lọ́kùnrin/lóbìnrin tí wọ́n ti lùgbàdì àrùn ìbálòpọ̀?
22. Báwo ni ẹ ṣe lè ṣe àpèjúwe bí ìtọ́jú àti àtìlẹ́yìn tí à ń fún àwọn àgbàlagbà nígbà tí wọ́n bá ní ìpènijà nípa ìlera?

    Bèèrè fún àwọn ìyàtọ̀ ní ìbámu pẹ̀lú ipó ìlera bí ti ẹni tí ó ti kó àrùn ìbálòpọ̀ ní àfiwé pẹ̀lú àwọn àìsàn ara wíwú, ibà àti àwọn àìsàn mìíràn.
    Bèèrè fún àwọn ìyàtọ̀ bóyá onísẹ́ ìlera ìgbàlódé tàbí ti ìbílẹ̀ ló ń pèsè ìtọ́jú
23. Irú àwọn ìpènijà wo ni ẹ rò pé àwọn ogbó lọ́kùnrin/lóbìnrin yóò kojú ní ilé-ìwòsàn lọ́nà àtiwá ọ̀nà àbáyọ sí àwọn àrùn ìbálòpọ̀ tí wọ́n ti lùgbàdì?

    Bèèrè fún àwọn ìpènijà tí ó ń ti ibi ìṣesí àwọn onísẹ́ ìlera, owó ìtójú, àwọn alábàágbépọ̀, mọ̀lẹ́bí, àwọn olórí ẹlẹ́sìn àti àwọn ará àdúgbò wa.

24. Ẹ jọ̀wọ́, ọjọ́-orí wo ni ẹ lérò pé ó yẹ kí ọkùnrin/obìnrin ó dẹ́kun níní ìbálòpọ̀?
    Bèèrè fún àlàyé ní ìbámu pèlú ìyàtọ̀ tí ó wà nínú àwọn ọjọ́-orí tí wọ́n dárúkọ
25. Báwo ni ìbálòpọ̀ ṣe ń ní ipa lórí ìlera ọkùnrin àti obìnrin ní ọjọ́ ogbó?

26. Àwọn ọ̀nà wo ni ẹ rò pé níní ìbálòpọ̀ ṣe lè kó ipa lórí àwọn abala ìgbé-ayé èníyàn yòókù?

25. Ẹ jọ̀wọ́, ǹjẹ́ ẹ lè pa àwọn òwe Yorùbá tàbí kí ẹ sọ àwọn ọ̀rọ̀-ọlọgbọ́n tí ó ń ṣe àpèjúwe pàtàkì ìbálòpọ̀ nínú ayé ọkùnrin àti obìnrin?

Ìkádìí ìfọ̀rọ̀wánilẹ́nuwò

- Ṣe àkójọpọ̀ àwọn ìlànà àti àpẹẹrẹ tí ó jẹ jáde ní àsìkò ìfọ̀rọ̀wánilẹ́nuwò
- Ṣe àkíyèsí àwọn ọ̀rọ̀ pàtàkì, òwe tàbí ọ̀rọ̀ ọlọgbọ́n kí o sì ṣe ìpínsísọ̀rí wọn lábẹ́ ìtumọ̀ àti ìtúpalẹ̀.
- Ṣe ìsọníṣókí ìfọ̀rọ̀wánilẹ́nuwò náà fún abẹ́nà-ìmọ̀ kí o sì ṣe àkíyèsí bóyá ó fi ara mọ́ ọn tàbí kò fi ara mọ́ ohun tí o ti sọ tẹ́lẹ̀.

Appendix I: Questionnaire for the Survey Respondents (English Language Version)

Socio-Cultural Constructions of Sexuality and Help-Seeking Behaviour among Elderly Yoruba People in Urban Ibadan, Southwest Nigeria

My name is Ojo Melvin Agunbiade. I am a Doctoral student at University of the Witwatersrand, South Africa.

I am conducting a research that aims to investigate the interpretations, values, beliefs, and practices associated with sexuality and sexual health in old age. It will also focus on the various approaches and patterns of seeking medical and non-medical help on issues bordering on sexuality and sexual health in old age among Yoruba people. In addition, I will also examine the perceptions healthcare providers (biomedicine and traditional) have of sexuality and the prevention, treatment, and promotion of sexual health in old age.

Socio-Demographics of Respondents

1. Gender……
2. Age at last birthday…….
3. Marital status…….
4. Age of partner if married…….
5. Number of years in marriage……
6. Educational level…….
7. Religious affiliation…….
8. Occupation…….
9. Current source of income

   i. Children ()
   ii. Family members ()
   iii. Present occupation ()
   iv. Pensions ()
   v. Personal investment ()
   vi. Others, please kindly specify…….

Please kindly provide your genuine opinions and feelings in response to each item in this questionnaire.

For each item, indicate whether you (1) disagree, (2) somewhat disagree, (3) neutral, (4) somewhat agree, (5) agree

Section B: Sexual desires and expressions in old age

		Disagree				**Agree**
		1	2	3	4	5
1	I am in good health condition					
2	I see sexual health problems as a normal part of the ageing process					
3	Many people of my age prefer to supress their sexual desires and feelings					
4	Many old men/women have interest in sexual activity					
5	Many old men/women of my age engage in sexual intercourse at least once in a month					
6	I believe old and elderly women should engage in sexual activities if their health allows it					
7	There are social opportunities for elderly men to satisfy their sexual desires					
8	There are social opportunities for elderly women to satisfy their sexual desires					
9	I believe old and elderly men should engage in sexual activities if their health allows it					
10	I engage in sexual intercourse at least once in a month					
11	Many old men engage in extra marital relations					
12	Many old women engage in extra marital relations					
13	No woman can vouch that her husband has never slept with another woman since they have been married					
14	No man can vouch that his wife has never slept with another man since they have been married					
15	Old and elderly men who engage in sexual activities are likely to be in ‘good health’					
16	Old and elderly women who engage in sexual activities are likely to be in ‘good health’					
17	I have no interest in sexual activities because of a health problem					
18	I have no interest in sexual activities because of my age					
19	People will call me different names if I engage in sexual intercourse					
20	I have no interest in sexual activities because there is no partner/person available					

Section C: Help seeking for sexual problems in old age

		Disagree				Agree
		1	2	3	4	5
21	Many elderly people of my age have at least a sexual health challenge that needs medical attention					
22	Elderly people of my age are likely to get the needed help to a sexual health problem from a medical doctor in a modern hospital					
23	Elderly people of my age are likely to get the needed help to a sexual health problem at from a traditional healthcare practitioner					
24	Many elderly people of my age will prefer to share their sexual health problem with a traditionalist					
25	Many elderly people of my age will prefer to share their sexual health problem with a modern medical doctor					
26	Some sexual health problems are caused by spiritual powers					
27	Some sexually transmitted infections cannot be treated via modern medicine					
28	Some sexually transmitted infections cannot be treated by traditional medicine					
29	Shame will not allow me to seek help at the hospital when I have a sexually transmitted infection					
30	Doctors can be indifferent to treating older people with sexually transmitted infection or any sexual health challenge					
31	Going to the hospital to treat a sexually transmitted infection is a waste of time					
32	It is more effective to use traditional medical remedies(herbs/concoctions) to treat/cure sexual problems					
33	It is more effective to use modern medical remedies(drugs) to treat/cure sexual problems					

Section D: Support for sexual pleasures and problems in old age

		Disagree				Agree
		1	2	3	4	5
34	I often inform my children/relatives about my health condition					
35	There are certain health problems I cannot share with my children/relatives					
36	I depend often on my children/relatives to take care of my health					
37	I prefer to take care of my health myself if I had the money					
38	Due to lack of money, many old men/women are afraid to inform their children/relatives about the true condition of their health					

39	My children are likely to abandon me if I contract a sexually transmitted infection					
40	My religious group members are likely to abandon me if I contract a sexually transmitted infection					
41	Members of my family are likely to abandon me if I contract a sexually transmitted infection					
42	Condom use can prevent sexually transmitted infections					
43	I can use condoms to prevent sexually transmitted infections					
44	The use of condoms can reduce sexual pleasures					
45	Younger people will find condoms more useful than elderly people					
47	There are traditional remedies to make sex pleasurable for old men					
48	There are traditional remedies to make sex pleasurable for old women					
49	Men of my age should stop having sex					
50	Women of my age should stop having sex					

51. At what age do you think men should stop having sex? Please, kindly specify……

52. At what age do you think women should stop having sex? Please, kindly specify.....

Appendix J: Questionnaire for the Survey Respondents (Yoruba Language Version)

Ojú tí a fi wo Ìbálòpọ̀ àti Ìwà bí a ṣe ń Gba Ìtọ́jú láàrin àwon Àgbàlagbà Yorùbá ní Agbègbè Ìbàdàn, Apá Gúúsù-mọ́-ìwọ̀-oòrùn Orílẹ̀-èdè Nàìjíríà

Orúkọ mi ni Ojo Melvin Agunbiade. Mo jẹ́ akẹ́kọ̀ọ́ tí ó fẹ́ gba oyè Ọ̀mọ̀wé ní University of the Witwatersrand, South Africa.

Mò ń ṣe iṣẹ́ ìwádìí tí àfojúsùn rẹ̀ dá lórí ojú tí a fi wo ìbálòpọ̀ àti ìlera ajẹmọ́-ìbálòpọ̀, àwọn ohun tó rọ̀ mọ́ wọn, ìgbàgbọ́ wa nípa wọn àti àwọn ìṣesí tí ó rọ̀ mọ́ ìbálòpọ̀ àti ìlera ìbálòpọ̀ ní ọjọ́ ogbó. Yóó tún ṣe àyẹ̀wò oríṣiíríìsìí ọ̀nà tí à ń gbà wá ìrànlọ́wọ́ nípa ètò ìlera àti èyí tí kò ní ṣe pẹ̀lú ètò ìlera lórí àwọn nǹkan tó ń yọ wá lẹ́nu lórí ìbálòpọ̀ àti ìlera ìbálòpò ní ọjọ́ ogbó láàrin àwa Yorùbá. Ní àfikún, a ó tún ṣe àgbéyẹ̀wò ojú tí àwọn elétò ìlera (ti ìgbàlódé àti ti ìbílẹ̀) fi wo ìbálòpọ̀, yíyàgò fún ìbálòpọ̀, ìtọ́jú, àti mímú àyípadà tó dára bá ìlera ìbálòpọ̀ ní ọjọ́ ogbó.

Àlàyé nípa Abẹ́nà-ìmọ̀

10. Akọ-n-bábo……

11. Ọjọ́-orí mi nígbà tí mo ṣe ọjọ́ ìbí tó kọjá…….

12. Ipò Mọ̀lẹ́bí…….

13. Ọjọ́-orí ọkọ/ìyàwó bí ẹ bá ti ṣe ìgbéyàwó…….

14. Iye ọdún tí ẹ ti lò nínú ìgbéyàwó……

15. Ìpele Ẹ̀kọ́…….

16. Ẹ̀sìn…….

17. Iṣẹ́…….

18. Ọ̀nà tí owó ń gbà wọlé fún ọ báyìí:

    i. Àwọn ọmọ ( )
    ii. Mọ̀lẹ́bí ( )
    iii. Iṣe tí mò ń ṣe lọ́wọ́ ( )
    iv. Owó ìfẹ̀yìntì lẹ́nu iṣẹ́ ( )
    v. Okòwò àdàni ( )
    vi. Òmíràn. Jọ̀wọ́ tọ́ka sí i…….

Jọ̀wọ́ fún wa ní ìdáhùn tí ó jẹ́ òdodo nípa èrò tì ẹ lórí àwọn ìbéèrè tó wà nínú ìwé ìwádìí yìí. Fún ìbéèrè kọ̀ọ̀kan, ṣe àfihàn bóyá (1)o kò gbà, (2) o kò gbà pátápátá, (3) o wà ní ààrin (4) o gbà níwọ̀nba (5) o gbà dáadáa

Abala B: Ìpòǹgbẹ fún ìbálòpọ̀ àti àfihàn rẹ̀ ní ọjọ́ ogbó

		Mo gbà				**N kò gbà**
		1	2	3	4	5
1	Ìlera mi dára					
2	Mo rí àìlera ìbálòpọ̀ gẹ́gẹ́ bí ara àwọn nǹkan tó rọ̀ mọ́ ojó ogbó.					
3	Púpọ̀ lára àwọn tí a jọ jẹ́ ẹgbẹ́ ló máa ń fẹ́ láti pa ìfẹ́ àti òǹgbẹ wọn fún ìbálòpọ̀ mọ́lẹ̀					
4	Ọ̀pọ̀lọpọ̀ àwọn àgbàlagbà lọ́kùnrin/lóbìnrin ló ní ìfẹ́ sí ìbálòpọ̀					
5	Ọ̀pọ̀lọpọ̀ àwọn àgbàlagbà lọ́kùnrin/lóbìnrin ló ń ní ìbálòpọ̀ ní ẹ̀ẹ̀kan lóṣù, ó kéré jù.					
6	Mo gbà pé ó yẹ kí àwọn àgbàlagbà obìnrin máa ní ìbálòpọ̀ bí ìlera wọn bá fi ààyè gbà á					
7	Àǹfààní pọ̀ fún àwọn àgbàlagbà ọkùnrin ní àwùjọ láti rẹ̀ òǹgbẹ wọn fún ìbálòpọ̀					
8	Àǹfààní pọ̀ fún àwọn àgbàlagbà obìnrin ní àwùjọ láti rẹ̀ òǹgbẹ wọn fún ìbálòpọ̀					
9	Mo gbà pé ó yẹ kí àwọn arúgbó àti àgbàlagbà lọ́kùnrin ó máa ní ìbálòpọ̀ bí ìlera wọn bá fi àyè gbà á					
10	Mo máa ń ní ìbálòpọ̀, ó kéré jù, ní ẹ̀ẹ̀kan lóṣù					
11	Ọ̀pọ̀lọpọ̀ àwọn àgbàlagbà lọ́kùnrin ló ń yan àlè					
12	Ọ̀pọ̀lọpọ̀ àwọn àgbàlagbà lobìnrin ló ń yan àlè					
13	Kò sí obìrin tí ó lè fi ọwọ́ sọ̀yà pé ọkọ òun kò tíì ní ìbálòpọ̀ pẹ̀lú obìnrin mìíràn láti ìgbà tí wọ́n ti ṣe ìgbéyàwó					
14	Kò sí ọkùnrin tí ó lè fi ọwọ́ sọ̀yà pé ìyàwó òun kò tíì ní ìbálòpọ̀ pẹ̀lú ọkùnrin mìíràn láti ìgbà tí wọ́n ti ṣe ìgbéyàwó					
15	Ó ṣeéṣe kí àwọn àgbàlagbà àti arúgbó tó bá ń ní ìbálòpọ̀ ní ‘ìlera pípé’					
16	Ó ṣeéṣe kí àwọn ọ̀dọ́ àti arúgbó tó ń ní ìbálòpò wà ní ipò ìlera pípé					
17	N kọ̀ ní ìfẹ́ sí ìbálòpọ̀ nítorí àìlera mi					
18	N kò ní ìfẹ́ sí ìbálòpọ̀ nítorí ọjọ́-orí mi					
19	Oríṣìíríṣìí orúkọ ni àwọn eniyan yoo pe mi bi mo ba n ni ibalopo					
20	N kò ní ìfẹ́ sí ìbálòpọ̀ nítorí kò sí ẹni/àwọn tí mo lè bá ní àjọṣepọ̀.					

Abala D: Wíwá ìrànlọ́wọ́ lórí ìṣòro ajẹmọ́-ìbálòpọ̀ ní ọjọ́ ogbó

		N kò gbà				Mo gbà
		1	2	3	4	5
21	Ọpọ̀lọpọ̀ àwọn àgbàlagbà tí a jọ jẹ́ ẹgbẹ́ ni wọ́n ní ìṣòro nípa ìlera tó sì nílò àmójútó					
22	Ó ṣeéṣe kí àwọn àgbàlagbà tí a jọ jẹ́ ẹgbẹ́ tí wọ́n ní ìṣòro ìlera nípa ìbálòpọ̀ ó rí ìtọ́jú gbà lọ́dọ̀ àwọn dókítà ní ilé-ìwòsàn ìgbàlódé					
23	Ó ṣeéṣe kí àwọn àgbàlagbà tí a jọ jẹ́ ẹgbẹ́ tí wọ́n ní ìṣòro ìlera nípa ìbálòpọ̀ ó rí ìtọ́jú gbà lọ́dọ̀ àwọn elétò ìlera ní ìlànà ìbílẹ̀					
24	Ọpọ̀lọpọ̀ àwọn àgbàlagbà tí a jọ jẹ́ irọ̀ ló máa ní ìfẹ́ sí fífi àìlera nípa ìbálòpọ̀ wọn tó àwọn olùtọ́jú ní ìlànà ìbílẹ̀ létí					
25	Púpọ̀ lára àwọn àgbàlagba tí a jọ jẹ́ irò ló fẹ́ láti sọ ìṣòro tí wọ́n ń kojú nípa ìlera ìbálòpọ̀ fún dókítà ìgbàlódé					
26	Àwọn ẹ̀mí àìrí ló ń fa àwọn àrùn ìbálòpọ̀ kan					
27	Àwọn àrùn láti ara ìbálòpọ̀ kan wà tí a kò lè fi òògùn Òyìnbó tọ́jú					
28	Àwọn àrùn láti ara ìbálòpọ̀ kan wà tí a kò lè fi òògùn ìbílẹ̀ tọ́jú					
29	Ìtìjú kò ní jẹ́ kí n wá ìtọ́jú lọ sí ilé-ìwòsàn bí mo bá ní àrùn láti ara ìbálòpọ̀.					
30	Àwọn dókítà lè má fẹ́ tọ́jú àwọn àgbàlagbà tó ní àrùn tàbí ìpèníjà nípa ìlera ìbálòpọ̀					
31	Ìfàkókòṣòfò ni lílọ sí ilé-ìwòsàn fún ìtọ́jú àrùn ìbálòpọ̀					
32	Ó máa ń dára jù láti lo òògùn ìbílẹ̀ (àgbo/àsèjẹ) fún ìtọ́jú ìṣòro ìbálòpọ̀					
33	Ó máa ń dára jù láti lo òògùn Òyìnbó fún ìtọ́jú ìṣòro ìbálòpọ̀					

ABALA E: Àtìlẹ́yìn fùn ìgbádùn ìbálòpọ̀ àti àwọn ìṣòro ajẹmọ́ ìbálòpọ̀ ní ọjọ́ ogbó

		N kò gbà				Mo gbà
		1	2	3	4	5
34	Mo ṣáábà máa ń sọ ipò ìlera mi fún àwọn ọmọ/mọ̀lẹ́bí mi					
35	Àwọn àìlera kan wà tí n kò le bá àwọn ọmọ/mọ̀lẹ́bí mi sọ					
36	Àwọn ọmọ/mọ̀lẹ́bí mi ni mo gbẹ́kẹ̀lé fún ìtọ́jú ara mi.					
37	Mo fẹ́ láti máa ṣe ìtọ́jú ara mi fúnra mi bí mo bá ní owó rẹ̀					
38	Nítorí àìsí owó, ọpọ̀lọpọ̀ àwọn àgbàlagbà lọ́kùnrin/lóbìnrin ni ẹ̀rù ń bà láti sọ òdodo nípa ipò ìlera wọn fún àwọn ọmọ/mọ̀lẹ́bí wọn					
39	Ó ṣeéṣe kí àwọn ọmọ mi fi mí sílẹ̀ bí mo bá kó àrùn ìbálòpọ̀					
40	Ó ṣeéṣe kí àwọn tí a jọ ń jọ́sìn pa mí tì bí mo bá kó àrùn ìbálòpọ̀					
41	Ó ṣeéṣe kí àwọn mọ̀lẹ́bí mi pa mí tì bí mo bá kó àrùn					

	ìbálòpọ̀					
42	Ìlò rọ̀bà ìdáàbòbò lè dènà kíkó àrùn ìbálòpọ̀					
43	Mo lè lo rọ́bà ìdáàbòbò láti dènà àrùn ìbálòpọ̀					
44	Ìlò rọ́bà ìdáàbòbò lè dín ìgbádùn ìbálópọ̀ kù					
45	Àwọn ọ̀dọ́ yóò mọ ìwúlò rọ́bà ìdáàbòbò ju àwọn àgbàlagbà lọ					
47	Àwọn àtúnsẹ ní ìlànà ìbílẹ̀ wà tí àwọn ọkùnrin lè ṣe láti gbádùn ìbálòpọ̀					
48	Àwọn àtúnsẹ ní ìlànà ìbílẹ̀ wà tí àwọn obìnrin lè ṣe láti gbádùn ìbálòpọ̀					
49	Kí àwọn ọkùnrin tí a jọ jẹ́ ọjọ́-orí kan náà ó dẹ́kun níní ìbálòpọ̀					
50	Kí àwọn obìnrin tí a jọ jẹ́ ọjọ́-orí kan náà ó dẹ́kun níní ìbálòpọ̀					

51. Ọjọ́ orí wo ni ẹ lérò pé ó yẹ kí àwọn obìnrin dẹ́kun níní ìbálòpọ̀? Ẹ jọ̀wọ́, ẹ tọ́ka sí i.....

52. Ọjọ́ orí wo ni ẹ lérò pé ó yẹ kí àwọn ọkùnrin dẹ́kun níní ìbálòpọ̀? Ẹ jọ̀wọ́, ẹ tọ́ka sí i.....

Appendix K: Participants' Information Sheet (English Language Version)

Good Morning/Afternoon ma/sir,

My name is Ojo Melvin Agunbiade. I am a Doctoral student at University of the Witwatersrand, South Africa. I am conducting a research on sexuality and help-seeking in old age among Yoruba people for my doctoral thesis. Please I invite you to kindle share your views and experiences as an elderly Yoruba person in this community.

The general objectives of the research are to investigate the interpretations, values, beliefs, and practices associated with sexuality and sexual health in old age. In addition, I will also examine the perceptions healthcare providers (biomedicine and traditional) have of sexuality and the prevention, treatment, and promotion of sexual health in old age.

The study has no direct benefit(s) to you as an individual, but your views and experiences will help in understanding sexuality, sexual health and help-seeking in old age within the Yoruba context. The information will help the government, healthcare providers, marriage counsellors and other stakeholders in understanding sexuality and sexual health need in old age. It will also help in making the primary healthcare in Nigeria more culturally sensitive and responsive to sexual health promotion in old age.

Participation in the discussion is voluntary and you are free to withdraw your participation at any time during the session without any recourse. The discussion is estimated to last about an hour and you are free to withdraw at any time. If any of the issues discussed have upset or made you uncomfortable and you feel that you would like to receive counselling, you are free to contact:

1. Dr. Adeboye Ayinde, Department of Psychology, Obafemi Awolowo University, Ile-Ife, Nigeria Mobile Phone number: +2348028294888. Dr Ayinde is a trained Psychologist. He will provide free counselling on how to handle sexual health and ageing challenges. Free airtime voucher worth N300 (equivalent to $2 US Dollars) will be provided by the researcher to cover the cost of making the phone call.

2. Dr. Ibidolapo Taiwo Ijarotimi, Department of Community Health, University College Hospital Ibadan, Nigeria. Mobile Phone number: +2348052837292. Dr Ijarotimi is a trained Physician. She will provide free medical information on management and treatment of sexual health and ageing challenges. Free airtime voucher worth N300 (equivalent to $2 US Dollars) will be provided by the researcher to cover the cost of making the phone call.

Investigator:
Ojo Melvin Agunbiade, Doctoral Candidate, Department of Sociology, University of the Witwatersrand, South Africa. Mobile Phone numbers: +2348059221715, +27782694649

Research Supervisor:
Prof. Leah Gilbert, Department of Sociology, University of the Witwatersrand, South Africa

Appendix L: Participants' Information Sheet (Yoruba Language Version)

Ẹ káàárọ̀/Ẹ káàsán mà/sà,

Orúkọ mi ni Ojo Melvin Agunbiade. Mo jẹ́ akẹ́kọ̀ọ́ fún oyè ọ̀mọ̀wé ní University of Witwatersrand, South Africa. Mò ń ṣe iṣẹ́ ìwádìí lórí ìbálòpọ̀ àti bí a ṣe ń wá ìrànlọ́wọ́ ní ọjọ́ ogbó láàrin àwọn Yorùbá fún àpilẹkọ mi fún oyè ọ̀mọ̀wé. Ẹ jọ̀wọ́, mo fẹ́ kí ẹ pín ìrírí yín pẹ̀lú wa gẹ́gẹ́ bí àgbàlagbà tí ó jẹ́ ọmọ Yorùbá ní àdúgbò yìí.

Kókó àfojúsùn iṣẹ́ yìí ni láti ṣe ìwádìí lórí ojú tí a fi wo ìbálòpọ̀ àti ìlera ajẹmọ́-ìbálòpọ̀ ní ọjọ́ ogbó; ìgbàgbọ́ wa nípa rẹ̀, pàtàkì àti ìṣe tí ó rọ̀ mọ́ níní ìbálòpọ̀ ní ọjọ́ ogbó. Ní àfikún, a ó ṣe àgbéyẹ̀wò ojú tí àwọn elétò ìlera (ní ilànà Òyìnbó àti ti ìbílẹ̀ fi wo ìbálòpọ̀ àti ọ̀nà tí à ń gbà dènà àrùn, ọ̀nà tí à ń gbà gba ìtọ́jú àti ọ̀nà tí à ń gbà ní ìlera fún ìbálòpọ̀ ní ọjọ́ ogbó.

Iṣẹ́ yìí kò ní àǹfààní kan tí ẹ lè jẹ gẹ́gẹ́ bí ẹnìkan báyìí, ṣùgbọ́n ìmọ̀ tí ẹ bá pín pẹ̀lú wa yóò mú kí á ní òye nípa ìbálòpọ̀ ní ọjọ́ ogbó ní àwùjọ àwọn Yorùbá. Àlàyé náà yóò ran ìjọba, àwọn elétò ìlera, àwọn olùtọ́nisọ́nà fún ìgbeyàwó àti àwọn mìíràn tí ọ̀rọ̀ kàn láti ní òye ohun tí ìbálòpọ̀ jẹ́ àti ohun tí ó pè fún ní ọjọ́ ogbó. Yóò tún mú kí àwọn àjọ elétò ìlera ní orílẹ̀-èdè Nàìjíríà ní òye àṣà tí ó rọ̀ mọ́ ìbálòpọ̀ àti ọ̀nà tí wọ́n lè gbà mú kí níní ìlera ìbálòpọ̀ ní ọjọ́ ogbó dára sí i.

Wọ́fún ni ìkópa nínú iṣẹ́ ìwádìí yìí, o sì lè kúrò ní àsìkò tí ó bá wù ọ́ nígbà tí iṣẹ́ ìwádìí náà bá ń lọ lọ́wọ́ láìsí wàhálà kankan. Ìfọ̀rọ̀jìrọ̀ náà yóò gbà tó wákàtí kan, o sì lè kúrò ní àsìkò tí ó bá wù ọ́. Bí o bá wòye pé àwọn nǹkan tí à ń sọ ti ń mú inú bí ọ, tí o sì lérò pé o nílò ìtọ́sọ́nà, o lè kàn sí àwọn àdírẹ́sì wọ̀nyí:

3. Dr. Adeboye Ayinde, Department of Psychology, Obafemi Awolowo University, Ile-Ife, Nigeria Nomba ipe: +2348028294888. Dr Ayinde jẹ́ akọ́ṣẹ́mọṣẹ́ onímọ̀ nípa èrò ọkàn. Wọn yóò dá ọ ní ẹ̀kọ́ lọ́fẹ̀ẹ́ lóri ohun tí o lè ṣe lórí ìlera ajẹmọ́-ìbálòpọ̀ àti awon ipenija ojo ogbo. Olùwádìí yóò pèsè káàdì ìpè tí ó tó ọ̀ọ́dúnrún náírà níye, tí ó jẹ́ dọ́là méjì, owó ilẹ̀ òkèèrè fún ìpè tí o bá ṣe.

4. Dr. Ibidolapo Taiwo Ijarotimi, Department of Community Health, University College Hospital Ibadan, Nigeria. Nómbà ìpè: +2348052837292. Dr Ijarotimi jẹ́ akọ́ṣẹ́mọṣẹ́ onímọ̀ nípa ètò ìlera. Wọn yóò fún ọ ní ìtọ́ni tí ó jinlẹ̀ lórí bí o ṣe lè ṣe ìtọ́jú ara rẹ̀ ní ìbámu pẹ̀lú ìlera ajẹmọ́-ìbálòpọ̀ àti bí o ṣe lè wá ọ̀nà àbáyọ sí àwọn ìpèníjà ọjọ́ ogbó. Olùwádìí yóò pèsè káàdì ìpè tí ó tó ọ̀ọ́dúnrún náírà níye, tí ó jẹ́ dọ́là méjì, owó ilẹ̀ òkèèrè fún ìpè tí o bá ṣe.

Olùwádìí:
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Alaboojuto Ise:
Prof. Leah Gilbert, Department of Sociology, University of the Witwatersrand, South Africa

Appendix M: Informed Consent Sheet (English Language Version)

I have a good understanding of the purpose of this research as well as my rights regarding participation in the study. With this understanding, I am willing to consent and participate voluntarily in this research.

Signature/Thumb print and Date

Appendix N: Informed Consent Sheet (Yoruba Language Version)

Mo ní òye kíkún nípa ìdí tí iṣẹ́ ìwádìí yìí fi ń wáyé, àti àwọn ètò tí mo ní láti kópa nínú wọn. Pẹ̀lú òye tí mo ní yìí, mo gbà, mo sì ṣetán láti kópa fúnra mi nínú iṣẹ́ ìwádìí yìí.

Ìbuwọ́lùwé/Ìtẹ̀ka àti déètì

Appendix O: Consent for Recording the Session (English Language Version)

I will kindly request that you allow me to record the proceedings on tape. This is to capture all the discussion in detail and avoid the omission or misinterpretation of your important views during the session. I will protect your identities and maintain confidentiality in handling the information shared during this discussion.

Signature/Thumb print and Date

Appendix P: Consent for Recording the Session (Yoruba Language Version)

Mo fẹ́ bẹ̀bẹ̀ pé kí ẹ gbà mí láàyè láti gba ohùn yín sílẹ̀ nínú fọ́nrán. Yóò fún mi ní àǹfààní láti gba gbogbo ohun tí ẹ bá sọ sílẹ̀ láìsọ ọ̀kankan nù, bẹ́ẹ̀ ni n kò ní lè fún àwọn nǹkan pàtàkì tí ẹ bá sọ nínú ìjíròrò yìí ní ìtumọ̀ tí ó yàtọ̀ sí ohun tí ẹ bá ní lọ́kán. N ó pa gbogbo ohun tí ó jẹ mọ́ yín àti gbogbo àlàyé tí ẹ bá ṣe fún mi nínú ìjíròrò yìí mọ́ fínnífínní.

Ìbuwọ́lùwé/Ìtẹ̀ka àti déètì

Appendix Q: Ethical Clearance Certificate (University of the Witwatesrand, South Africa)

Appendix R: Ethical Clearance Certificate (Obafemi Awolowo University, Ile-Ife, Nigeria)