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PERCEPTIONS, PRACTICES AND PROBLEMS RELATING TO SEXUAL BEHAVIOUR AMONG THE ELDERLY IN IBADAN NORTH LOCAL GOVERNMENT AREA, NIGERIA

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DEDICATION

This work is dedicated to the Glory of God Almighty, the custodian of all knowledge. To Egnr. Charles Okwudiri Odor and the entire family, in whom I am highly indebted, many thanks for the inspiration and encouragement.

ABSTRACT

Most studies on sexual behaviour in Nigeria have focused on young people and adults with limited attention paid to the elderly. There is dearth of information about elderly persons' reproductive health challenges, including sexual dysfunction, and their involvement in risky sexual activities. This study therefore determined the perceptions, sexual practices and reproductive health problems of the elderly in Ibadan North Local Government Area, Oyo State, Nigeria.

The study, which was descriptive and cross sectional in design consisted of 400 male and female elderly persons aged 65 years and above who were selected using a four-stage sampling technique. A validated questionnaire, which was designed from findings obtained from six Focus Group Discussions (FGD) - three each for male and female participants, was used to obtain information from the participants. The FGDs were recorded on audio-tape, transcribed and themes were developed. The data from the questionnaires were analysed using descriptive and Chi-square statistics.

The participants' mean age was 71.8 (± 6.7) years. Slightly more than half, (50.5%) of them were males. A majority were Yoruba (91.3%) and Christians (63%). A total of 76.2% males and 12.6% females had their last sexual intercourse in the two years preceding the study. A total of 25% of the participants had had sex with persons other than their spouses since they attained the age of 65 years. Among this subgroup that had extra-marital sex, very few (6.8%) used a condom. More males (5.3%) than females (1.5%) had used a condom during their last episode of extra-marital sex ($p<0.05$). The low level of condom use was attributed to the belief that condom is not necessary (34.5%) and the perception (50%) that condom is not meant for the elderly. Death of spouse (78.5%) and loneliness (80.8%) were the main reasons for engaging in extra-marital sexual relationship. Majority (68.8%) of the participants were of the view that having sex with a virgin could serve as an immunity against sexually transmitted infections including Human Immunodeficiency Virus; those who held this view comprised 65.1% males and 34.9% females. More than half of the males (56.4%) and females (66.7%) agreed that indulgence in sexual intercourse has a healing effect on the elderly. Approximately 31.3% of the males reported early ejaculation and erectile dysfunction as the major sexual problems, while inadequate vaginal lubrication (10.3%) and menopausal changes (26.5%) were the main sexual problems reported by the females. Majority of the FGD participants across both sexes said that having difficulties in reaching orgasm and painful sex were other sexual and reproductive health problems of the elderly.

There was unanimity of opinion among male and female FGD participants that sexual dysfunction among this population was as a result of ageing.

An appreciable proportion of the elderly were involved in risky sexual practices. Therefore, health education intervention programmes such as training on safe sex practices and counselling services are needed to address the problem.

Key words: Elderly people, Sexual behaviour, Sexual dysfunction, Perception of condom use.

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CERTIFICATION

I certify that this work was carried out by King Obinna **ODOR** in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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GLOSSARY OF ACRONYMS IN THE TEXT

AIDS -	Acquired Immune Deficiency Syndrome
CBOs -	Community-Based Organisations
CODESRIA -	Council for Development of Social Science Research in Africa
CSWs -	Commercial Sex Workers
HBC -	Home Based Counselling
HIV -	Human Immunodeficiency Virus
HRT	Hormone Replacement Therapy
ICPD -	International Conference on Population and Development
LGA -	Local Government Area
FGD -	Focus Group Discussion
KAP -	Knowledge, Attitude and Practice
MDGs -	Millennium Development Goals
NCI -	National Cancer Institute
NGO -	Non Governmental Organization
NHIS -	National Health Insurance Scheme
SRH -	Sexual and Reproductive Health
STD -	Sexually Transmitted Diseases
STIs -	Sexually Transmitted Infections
WHO -	World Health Organization
UN -	United Nations
UNICEF -	United Nations Children's Fund
UNDP -	United Nations Development Programme
SPSS -	Statistical Package for the Social Sciences
SSRIs -	Selective Serotonin Reuptake Inhibitors

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OPERATIONAL DEFINITION OF TERMS

Elderly people:	People over 65 years old and above
Gerontological sexology:	Study of the elderly sexuality
Geriatrics:	Relating to elderly people
Sexual dysfunction:	Persistent sexual problems
Sexually Active:	Those elderly who had sexual intercourse in the two years preceding the study

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The United Nations defines elderly people as those over 60 years of age. Definitions vary, however, depending on culture, life expectancy and people's own perceptions of age, some may include all adults over 50 (HelpAge, 2003). According to United Nations (2002) the proportion of older persons (those aged 65 years and above) rose to 10% of the world population in 2000. It is projected that in the next 50 years the proportion of older persons will double, reaching 21%. The overall number of older persons will increase from 606 million in 2000 to 1.9 billion in 2050. About 394 million older persons will live in the developed countries by 2050, up from 232 million in 2000. In the developing regions of the world the number will reach 1.5 billion in 2050, a fourfold increase from 375 million in 2000.

Research indicates that older people make up a significant proportion of the poorest of the poor, and even without the added threats created by diseases; many older people struggle to survive and suffer poverty, social exclusion and age discrimination. In most African countries, older people have few forms of support outside their families (Heslop, et al 2002). In terms of demography, 54.6% of Nigerians are within the 15-64 years age bracket and 3.1% within the 65 years and over bracket. Nigeria's birth rate is 40.65 births/1,000 people, death rate is 17.18 deaths per 1,000 people and the population growth rate is 2.37%. Infant mortality rate is 98.8 deaths of 1,000 live births (UNDP, 2005).

Age is one of the characteristics of social differentiation, the perception of age is nevertheless socially constructed. In some regions of the world, older persons are treated with respect and are well-regarded. In other parts of the globe, societal value is given to youth and signs of age have a rather negative image. Isolation, exclusion and marginalization of older persons are the usual consequences of age discrimination, which not only undermines the status of older persons in the society but also threatens overall societal development.

Nevertheless, people the world over continue to work and support themselves and their families well into old age. Despite the exclusion they face, older people provide a vast pool of social capital as knowledge bearers and educators, as well as taking on the triple roles of caregiver, homemaker and income earner in many households (HelpAge, 2003). Within communities, older people often act as educators and moral guides. However, without correct information about sexual behaviour, they are often unaware that some traditional practices (such as wife inheritance and sexual cleanings) – "*sexual cleanings is the practice in which a*

widow has sex with another man following the death of her husband, to purge the husband's spirit" carry the risk of sexually transmitted infections (STIs) including HIV infection. So if elderly people were informed, they could help reshape practices and beliefs in the family and community (HelpAge, 2003).

The fact remains that even though this century has witnessed some revolutionary studies in human sexuality (Masters & Johnson, 1970), the area is still considered fairly taboo by many researchers, and we therefore have far too many questions and too few answers about all areas of human sexuality. One area that has been particularly neglected is sexuality in the elderly. Considering that today the elderly people are living longer and that their segment of the population is increasing more than any other, more emphasis ought to be placed on their quality of life, which for many includes sexuality (Schlesinger, 1996). Furthermore, throughout most of the history of sexological research, and all of the history of research on sexuality in the elderly, very few significant and plausible studies have been offered to help conceptualize, explain and predict the wide range of sexual behaviour in the elderly human species.

In Africa particularly Nigeria, literature review has shown that elderly people suffer disproportionately from sexual and reproductive health (SRH) negligence, yet there are almost no programmes to address this problem (Samba, 2005). Elderly people's SRH negligence as compared to young people has been over emphasized in the recent past. Donor agencies and development partners, governments and even NGOs focus their huge resources on getting young people to the levels that will ease their sexual behaviour. The elderly are not considered a serious subject, the assumption is that, their sexual behaviour, life experiences and maturity automatically give them "clean bill of health". Moreover, studies have also shown that people show lukewarm attitudes around issues of sexual health behaviour among the elderly. This is probably due to health deterioration and age discrimination which leads to non discussion of these issues despite interest from this population. According to Alliance, (2004) instead of exclusion, include older people in Sexual and Reproductive Health issues, rather than considering them as potential obstacles to discussion around sexual matters but this should be done in an age-and culturally-sensitive perspective.

However, HelpAge, (2003) reported that ageing with related deterioration of health status was perceived to contribute to the elderly problem. Evidence also exists that, elderly people have difficulties relating to sexual behaviour and as a result are dying silently from the epidemic (Madina, 2005). Moreover, engagement in risky sexual activities is prevalent among the elderly and this could lead to HIV infections. Similarly, the underlying assumption, supported by emerging empirical study by Mohammed-Ali (2005) in a study in

Ethiopia, is that sex with elderly people increases the young people's risk of becoming infected with HIV/STIs. This finding partly explains the higher vulnerability of young people to HIV and Sexually Transmitted Diseases (STDs) in Bugna district. This is usually because sexually active young girls are at increase risk of STD due to the organisms causing STD penetrate more easily the cervical mucus of girls than that of older women (McCauley et al, 1995 in Iwuagwu et al, 2000). Yet there is inadequate information on elderly involvement in risky sexual practices. Moreover, the quality and accurate research into sexuality, including sexuality in the later years, has been lacking for a long time. In addition to a lack of empirical data, there has also been a dearth of coherent theoretical approaches to this area of sexual gerontology. This study has attempted to bridge this gap by applying scientific procedures in eliciting information from the elderly people. This survey therefore, contributed to new body of knowledge about elderly sexual behaviour. This would help us to appreciate the underlying information about the geriatric sexual activities and the mechanisms by which these activities vary and also sheds light on how these changes affect the development of human sexuality.

1.2 Statement of the Problem

Sexual risky behaviour is a public health problem and a formidable barrier to achieving optimal health in developing countries, various researches have confirmed this global. In Nigeria, people pay little attention to issues of sexual health among the elderly, the elderly are not considered serious on priorities of sexual matters. However, the elderly have difficulties relating to sexual activities including suffering sexual dysfunctions. Moreover, there is concern about those who engage in risky sexual activities including sex with multiple partners without condom use and condom is perceived to mitigate against sexual gratification. As a result of this, the elderly people are disproportionately affected by undesirable outcomes of sexual problems including STIs/HIV pandemic. Previous studies (Phanjoo, 2000) show that majority of the elderly engage in sexual activity for strengthening their love. However, it has also been asserted in many quarters that majority of them complained having one sexual dysfunction or the other, although there are marked variations among this population. Specifically, there is no information available to determine the sexual problems they experience (Williams, 2005).

Furthermore, in Nigeria today, statistics that amplify elderly people's continued engagement in risky sexual behaviour and practices (Muruko, 2005) is mostly not available. For instance in Ibadan, virtually no research information is available on the sexual and reproductive health information and services which would contribute to ameliorating the elderly people's sexual problems and dysfunctions, including risky practices and behaviour.

This study therefore aimed at narrowing this undesirable gap. Moreover, if a downward trend in the level at which elderly persons engage in risky sexual activity is to be achieved, there is need for reduction in negative sexual perception. Although, there is limited information on sexual behaviour among the elderly in Nigeria, the risky sexual behaviour is a public health problem and the health consequences are not ignorable. With the advent of HIV/AIDS in Nigeria, many elderly people are saddled with the adverse effects of the scourge, resulting from risky sexual practices including extramarital sexual relationship.

This study therefore, examined the perception of sexual behaviour of the elderly people ranging from 65 to 102 years old. The results and findings would be useful and also assist in planning an effective elderly health programmes.

1.3 Rationale for the Study

Nigeria and other African countries are still battling with the problems of STIs/HIV/AIDS yet the heavy burden imposed by the preventable consequences of the elderly engagement in risky sexual behaviour. Considering the health dangers of this, there is need for concerted geriatric health intervention to be initiated. Because without the provision of adequate SRH services that would take into cognizance the geriatric special needs, they would continue to face sexual challenges resulting from ageing and engagement in risky practices. This is so because of gap in sexual and reproductive health knowledge among the elderly, which always sets the stage for risky sexual practices due to their perception about sexual practices. To this end therefore, for any intervention programmes to be intensified, an effort should be first of all made to examine the gap in sexual Knowledge, Attitude and Practice (KAP) including sexual perception and dysfunction prevalent among this population.

In Nigeria there is inadequate research information on gerontological sexology and behavioural antecedent of the elderly. This area has been a neglected area of research in Nigeria and Africa as whole. There are also limited literature reviews world over on geriatrics while majority focus entirely on young people. The elderly have not actually received the desired attention which they deserve. This explains the dearth of research information in all the issues of sexuality among the elderly in Ibadan. The purpose of this baseline survey therefore, was to produce valuable information on the area of geriatric sexual health which has been neglected overtime. It is also envisaged that the outcome, would assist in designing programmes that would benefit the health of the elderly persons in Nigeria.

The information generated from this study is important in many ways: first and foremost it would serve as baseline information for the design of evidence-based SRH development programmes for the elderly. Also, through political will it would be a useful

framework for policy development on geriatric sexual health. In addition, such information is important in that it would assist bilateral and multilateral agencies, development partners including Organizational institutions in mainstreaming the elderly people's SRH in their programmes. This is especially in strengthening programme implementation, policy formulation and advocacy. Finally, the information would be useful in explaining the sexual experiences the elderly persons had passed through because it was against this rationale that the study set out to examine and thereby suggested further studies and interventions.

1.4 Research Questions

The research was designed to provide answers to the following questions:

1. What is the prevalent sexual behaviour of the elderly people in Ibadan North LGA?
2. What are the perceptions of the elderly on risky sexual behaviour?
3. What are the factors responsible for elderly engagement in risky sexual behaviour?
4. What are the sexual problems of the elderly people?
5. Are there relationship between the socio-demographic characteristics of the elderly and their sexual behaviour?

1.5 General Objective

The broad objective of this study was to examine the sexual perception, practices and problems among the elderly in Ibadan North Local Government Area (LGA).

1.6 Specific Objectives

The specific objectives of the study were to:

1. Identify prevalent sexual behaviour of the elderly people in Ibadan North LGA.
2. Document perceptions of the elderly on risky sexual behaviour.
3. Determine factors influencing elderly engagement in risky sexual behaviour.
4. Identify the sexual problems of the elderly people.
5. Determine the relationship between the socio-demographic characteristics of the elderly and their sexual behaviour.

1.7 Organization of the Text

The entire text is divided into five chapters. Chapter 1 is the introduction to the entire text. It covers the statement of the problem, study rationale, research objectives, and the research questions. Chapter 2 is a review on the thematic subject of elderly people's sexual behaviour. The chapter ends with conceptual framework and hypotheses. Chapter 3 describes

the methodology employed in the study. The study design, study area, sampling and data collection procedures were all described. The chapter also describes the validity and reliability of instruments utilized in the study, data analysis, ethical considerations and limitations of the study. Chapter 4 shows the findings of the Focus Group Discussions (FGDs) and report of the survey study in prose and as well as in tables while the tests of hypotheses are reported in pari-passu. Chapter 5 discusses the findings, make conclusions, recommendations and suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Preamble of Sexual Behaviour

Globally, this century has witnessed some revolutionary studies in geriatric sexuality, the area is still considered fairly taboo by many researchers, and we therefore have too many questions and too few answers about all areas of human sexuality (Masters & Johnson, 1970). One area that has been particularly neglected is sexuality in the elderly. Considering, today the elderly people are living longer, therefore more emphasis ought to be placed on their quality of life, which for many includes sexuality (Schlesinger, 1996). However, throughout most of the history of sexological research, and all of the history of research on sexuality in the elderly, very few significant and plausible studies have been offered to help conceptualize, explain and predict the wide range of sexual behaviour in the elderly human species.

In Africa, available studies have it that people show lukewarm attitudes in all issues of sexual behaviour among the elderly. However, HelpAge, (2003) reported that ageing with related deterioration of health status contributes to elderly problem. While in Nigeria, literature review has shown that elderly people suffer disproportionately from sexual and reproductive health (SRH) negligence (Samba, 2005), yet there are almost no programmes to address this problem. Elderly people's SRH negligence as compared to young people has been in disparity to the advantage of younger persons.

Evidence also exists that, elderly people have difficulties relating to sexual behaviour and therefore dying silently from the epidemic (Madina, 2005). Moreover, engagement in risky sexual activities is prevalent among this population and this could lead to HIV infections. Yet there is inadequate information on elderly involvement in risky sexual practices. There is limited research into sexuality in old age for a long time in Africa. In addition to this dearth of empirical data, there are inadequate coherent theoretical approaches to sexual gerontology. In this study therefore, related literature were reviewed according to the thematic issues. This helped us to appreciate the underlying information about the geriatric sexual activities and the mechanisms by which these activities vary and also sheds light on how these changes affect the development of human sexuality.

2.2 Sexual Behaviour

Major historical themes from the European Middle Ages regarding the sexuality of the elderly were identified in literature, art, and historical works. It is proposed that thoughts on the ages of life excluded the elderly from having normal sex lives. Also proposed is that the church of the Middle Ages defined sexual behaviour by the elderly as immoral (Covey, 2004). In addition the sexual behaviour of elderly people is more often the target of jocularity or ridicule than the subject of serious scientific research. As a consequence, relatively little is known about the sexual behaviour of the over-65s and such information as is available shows a polarization according to gender for instance, male sexual behaviour and dysfunction are viewed very much in the light of physical problems, whereas women's sexual behaviour revolves around attitudes towards sexuality and the psychological effects of ageing. However, sexual behaviour among the elderly in African context is conspicuously very scanty. In Nigeria for example the majority of previous studies on sexual behaviour have focused on young people, primarily because of the relatively easy access of this population (Olaseha et al, 2004) little is known about the elderly sexual behaviour.

To this end therefore, a wide variety of negative attitudes exist within societies concerning sexual behaviour among elderly people which have influenced the thinking and practices of elderly people themselves (Spence, 1992). In America for instance, Winn and Newton (1982) used Human Relations Area Files to compare the sexuality of elderly people in 106 cultures. The study concluded that continuance of sexuality for elderly persons in many societies indicates that cultural factors may be key determinants in their sexual behaviour. However, in addition to the view of Winn and Newton that American society has generally been viewed as restricting the sexuality of elderly persons. A 1983 study of nursing staff in an extended care unit in America still identified much staff discomfort about sexual expression among the elderly. The only sexual behaviours viewed as being acceptable were hugging and kissing on the cheek (Szasz, 1983). In contrast, graduate nursing students and freshmen medical students in two recent studies in the same country viewed elderly persons more positively if they were believed to be sexually active (Damrosch, 1984; Damrosch and Fishman, 1985).

But several studies about sexuality and elderly persons have revealed the negative, ageist, and custodial attitudes of staff, particularly in nursing homes. These studies highlight the need for education for caregivers to promote attitudinal changes and, therefore, more therapeutic and holistic care to ensure the rights of older residents to sexual expression (Deacon, et al 1995). Similarly, Older residents who display any form of sexual expression are often regarded by staff as having a behavioural problem and may even be tranquilized

(Brown, 1989). This attitude towards elderly sexual behaviour is a negation to their expression which shows continuation of active sexuality. This is the reason White (1982) reviewed the literature on sex and aging and concluded that sexual behaviour and attitudes in old age reflect a continuation of lifelong patterns, hence those who are most sexually active in their younger years tend to continue this pattern in their later years. However, negative attitudes toward sex learned at a young age may seriously impair the ability to enjoy sex in later life (Deacon, et al 1995). In addition to this, they concluded that sexual activity was related to sexual attitudes and behaviour, level of sexual interest, and prior frequency of sexual activity.

Another aspect of human life which usually affects sexual behaviour is the knowledge one has. Although, this might not be true in some quarters, as some studies (Hojer, 1999; Varga, 1999) have shown, there is little evidence that knowledge of the consequences of risky sexual behaviour like Sexually Transmitted Infections (STIs) changes sexual behaviour. If this is so, then the above statement raises an important question: Why are old people unable to avoid the negative consequences of sexual behaviour despite the relevant information, education (formal and informal) and communication programmes to which they have been exposed? The answer if one may suggest is, knowledge alone cannot bring about changes in behaviour otherwise the HIV epidemic would have been brought under control. For instance, public health promotion programmes, clearly communicated say in tobacco control demonstrates that knowing the negative consequences of behaviour, is not really enough to deter some people from smoking. In addition, personal, ethical, economic, religious, biological and socio-cultural reasons act as barriers to prevent the adoption of safe behaviours. Similarly, Caldwell (1999) suggested existing messages regarding the connection between sexual behaviour and HIV/AIDS. These tend to portray prevailing sexual norms among the elderly as unacceptable, thus eliciting resistance from those who are not willing to change such sexual behaviour. Despite what appeared to be widespread information dissemination, there is still reluctance to talk about sexual issues at almost every level of the society, particularly among elderly people, including community and religious leaders. This invariably contributes to the superficial level of knowledge of sex and sexuality, particularly among the elderly men and women.

2.3 Sexual Behaviour of the Elderly in Institutional Settings

In an institutional setting in developed countries especially in the USA and Europe, where majority of the elderly people are cared for. Sexual expressions are relegated thereby resulting to a significant number of elderly people who require institutional care suffering

from either physical or mental impairment of such a degree that it is no longer safe for them to live a healthy sexual life. In an institutional setting, in America for instance, sexual behaviour becomes linked to questions relating to privacy, attitudes of the nursing staff, and cultural expectations of other residents. According to Phanjoo (2000) sexual disinhibition may be present in about 7% of cognitively impaired older people. There is an ongoing conflict between protecting patients' dignity and the patients' desire to fulfill their sexual needs. Nursing home staff as well as visitors or family may feel embarrassment when confronted with the sexuality of older people. Sometimes this may lead to older people being treated like children and being forbidden to have any sexual outlet. This, in turn, may provoke anger and frustration in the patients. People with dementia may become less interested or more interested in sex. They may become more childlike and less subtle in their sexual demands. They may undress and/or masturbate in front of other residents or visitors (Phanjoo, 2000).

In as much as this sexual expression is denied they may seek to engage other residents sexually. There is a conflict between supporting autonomous decision-making and protecting residents from abuse and exploitation. The resolution to the conflict is obviously easier if one or both partners, despite cognitive impairment, is aware of the implications of the relationship and able to decide whether they want to continue with the relationship or not. It is much more difficult if one or both partners are so cognitively impaired that they have no awareness of what they are doing. In such situations, according to Phanjoo, (2000) it is important that the staff have the opportunity of discussing with each client individually and involving their relatives/carers instead of adopting a blanket approach using pharmacological agents to contain such behaviour.

On the other hand, in situations where, other methods having failed, it may be necessary to use drugs as corrective measure rather than resulting to undesirable or socially unacceptable sexual behaviour. Various agents have been tried and good results have been reported with Selective Serotonin Reuptake Inhibitors (SSRIs), anti-androgen therapy and oestrogen. The use of the oestrogen patch is an excellent treatment in the management of elderly men with dementia who suffer from sexual disinhibition. There are also isolated reports on the successful use of antiandrogens in elderly women with dementia who exhibit compulsive and antisocial sexual behaviour. In response to male masturbation, interviews involving 18 nurses working in nursing homes demonstrated reactions of shock, horror and uncertainty about how to deal with it (Nay, 1992). Although nurses expressed disgust at the image of men acting sexually, what was more disturbing was their belief that women would be excluded from such behaviours (Nay, 1992). Similarly, Ehrenfeld, et al., (1997)

demonstrated that people expressed mixed emotions of confusion, embarrassment and helplessness when elderly people acted sexually. In making sense of the negative reactions of people, a categorization system was developed to help people understand different sexual expressions displayed by elderly people (Ehrenfeld et al., 1999). It was found that people were able to accept and support loving and caring behaviours but were hostile, angry and disgusted when elderly people's behaviours were openly erotic.

Additionally, sexual behaviours that were linked to romance brought on reactions of humour, ridicule and tease from people (Bauer, 1999; Ehrenfeld et al., 1999). This was supported by Bauer's (1999) phenomenological study investigating nursing home staff experiences of elderly residents' sexuality, which found that the use of humour enabled carer to communicate sexuality easily by firstly assisting them to relieve the stress of the situation, and then to understand the meaning behind the situation and the role they should play in it. If used with understanding and sensitivity, humour would be a useful strategy to safely deal with emotional and socially unacceptable incidents that would normally be uncomfortable to address directly (Robinson, 1983). However, humour could also have an opposite effect and be seen as another sanction measure used by carer to coerce elderly to conform to asexuality, and thereby concealing their genuine needs in the nursing homes (Bauer, 1999).

In Africa, particularly in Nigeria institutional homes for the elderly are not in existence. The elderly are seen on the streets and in the rural settlement not cared for. Therefore, the elderly in Nigeria are facing socioeconomic factors thereby limiting sexual interests in the hierarchy of needs. However, if residential care homes are established, culture may deter its utilization, coupled with attitudes of caregivers/staff towards elderly sexual needs. Moreover, knowledge and experience of handling sexuality in old age to propel such institution to full utlilization may be lacking. This explains why in the USA, the lack of knowledge and experiences of carer in handling sexuality in old age is one main reason for not being able to promote awareness of elderly people's sexuality in residential care homes (Lyder, 1994). Undoubtedly, the attitude and mind-set of carer remain an influential factor inhibiting sexual expression of elderly people, particularly when staff cannot comfortably talk about sexuality and hesitate when venturing into intimate discussions with elderly people and dealing with their sexual responses. If elderly people are discouraged from expressing sexual interests and activities, this can impede them from becoming fully accepted into societal living. Those elders who choose to lead a relatively active sexual life will continue to conceal their true sexual needs and desires.

2.4 Sexual Perceptions

Globally, ageism prevails in most societies; the perception that social attitudes and beliefs which consider sexual behaviour as inappropriate, repugnant or abnormal in old age contributes to the curtailment of such behaviour. No doubt elderly people have a difficult task in coming to terms with the decline in physical attributes, sexual potency and attractiveness. This phenomenon led to the elderly to adopt negative attitudes towards their sexuality. These perceived feelings by the society affect the elderly engagement in sexual activity. The society does not see elderly sexual interest as normal. In a study a study in Finland (Paunonen and Hagmann-Laitila, 1990) found that more than half of 50 residents in a nursing home did not perceived it proper for elderly people to have an active sex life; whereas 25% felt that sexual needs and desires were sinful and shameful. Even though less than a quarter of the respondents were prepared to talk to the staff about sexual matters, the staff perception towards sexual issues with the elderly were not encouraging.

In Africa for instance, cultural attitudes that revere reproductiveness and youthful good looks may contribute to the expectation that older people are, or ought to be, asexual (Deacon, et al, 1995). Although sex roles have changed and there has been more freedom of sexual expression since the 1960s, in the developed world, whereas in Africa especially Nigeria the stereotypes that older people are physically unattractive, uninterested in sex, and incapable of achieving sexual arousal are still widely held (Hall, et al, 1982). The media is an important influence on attitudes in the wider community. Social and cultural definitions of sexuality and aging reflected in the mass media influence how older people perceive themselves. Education in sexuality and aging is essential for those responsible for portraying images of older people in all forms of the media (Vasil and Wass, 1993). Unlike in nigeria where the issue is neither mentioned or given limited attention. The constraints society imposes on older people's sexual freedom are particularly evident in elder care institutions in America (Deacon, et al, 1995). To this end therefore, Kass (1981) theorized a Geriatric Sexuality Breakdown Syndrome in our society through which elderly people internalize the negative attitudes to which they are exposed and perceive themselves as nonsexual. He said that this syndrome can be broken eventually by education to change society's negative perception but more immediately by educating aging adults about their sexuality and helping them develop ways to cope with the negative attitudes they receive. This may be done through individual or group counseling or therapy as well as in educational settings.

On the other hand, the notion that sexuality is a lifelong process is against thinking of some elderly people, their children, and health care providers (Kennedy, et al, 1997). As a result of this thinking, the topic of sexuality and the elderly is generally avoided, and when it

is discussed, it is riddled with myths and misconceptions. Buying into these myths, or simply lacking an awareness of them, makes it difficult to treat, or even discuss problems of sexuality in the elderly. According to Starr (1985) he found that sex had never been openly discussed in most senior centers visited across the United States. This virtually the same everywhere in Africa, for example in Nigeria cultural settings, the elderly are given respect and hence issues of elderly sexuality will not be taken for a ride This seems to suggest that elderly people, especially retirement home residents, need more in-depth education about their own sexuality and sexual functioning including change in perception of the society about elderly sexual behaviour (Story, 1989).

In the United Kingdom, Gerontological research has shown that knowledge and attitudes toward sexuality influence perceptions about sexual needs and feelings in later life. Hillman and Stricker (1994) concluded that there is generally a positive relationship between knowledge of and attitudes toward sexuality in later life. Clearly, educational intervention is needed to dispel negative myths, stereotypes, and self-fulfilling attitudes in older people and to promote the perception that full sexual expression is part of the entire extent of adulthood. If this is promoted, it would enhance their health because there is ample evidence to suggest that sex education for older people leads to the development of more positive attitudes. In general, however, the current cohort of elderly people continues to have fewer opportunities than their younger counterparts to access education, and seldom has sex education been part of the curriculum (Deacon, et al, 1995).

2.5 Sexual Practices and Risky Sexual Activity

In reality the elderly men show more interest in sexual activity than their women counterparts, most studies find that the most important factors in the maintenance of sexual activity are the availability of the partner (Spence, 1992) and good physical health. Availability of partner means being alive and in good condition to propel the sexual interest, however, death of spouse and loneliness affects the availability of the partner while ill health is buttressed by WHO (2002) in relation to elderly people, the consequences of which can be especially serious. They are physically weaker, their bones are more brittle and their recovery takes longer, therefore, even a minor injury can have grave consequences. Down in Africa few studies have looked at the general population living in the community and relatively little is known about the wider aspects of elderly sexuality, such as healthy sexual life, intermittent physical contact, masturbation and affection. Whereas in the UK a recent study reports that 72% of men and 40% of women over the age of 65 engage in occasional masturbation (Bretschneider and McCoy, 1988) for sexual satisfaction. While other studies in the USA

have looked at poor self-image and reluctance to talk about sex (White and Catania, 1982) and sexual difficulties associated with elderly ill-health (Haddad and Benbow, 1993). In a study in Asia about Sexual behaviour and dysfunction and help-seeking patterns in adults aged 40–80 years by Alfredo et al, (2005), it was found that 82% of men and 64% of women had engaged in sexual intercourse during the year of the study. Most of the respondents considered satisfactory sex an essential means of maintaining a relationship. This cannot be explained of Africa because there are limited studies to ascertain the sexual activities engaged by the elderly people and this forms the dearth of research information on this issue.

Globally, while there are variations of elderly engagement in sexual practices, some global settings are more pronounced than the other. For instance, a survey of 800 respondents' feelings about their sexual activities revealed that elderly people defined and expressed their sexuality in more diffuse and varied ways than did younger cohorts, suggesting that changes in sexual expression and preferred sexual activity may be common with advancing age (Starr and Weiner, 1981) in this society.

In a contemporary society, majority of elderly people continue to engage in sexual activity with inadequate concern about the consequences of their actions. The resultant effect of this action is that a high proportion may engage in risky sexual activities which include unprotected sex with multiple partners. However, apart from inadequate information about these consequences; information alone is not always enough to influence risky sexual behaviour (Iwuagwu et al, 2000). Therefore, there is concern about the proportion of elderly people who may engage in risky sexual activities especially sex with multiple partners including sex workers and low or inconsistent condom use (Olaseha et al, 2004). The consequence of this is that they are disproportionately affected by the undesirable outcomes of risky sexual behaviours including STIs/HIV. This is paramount according to Adekunle and Ladipo (1992) that because of economic hardship, which expose people to indulge in risky sexual behaviour for instance, given young people resort to befriending elderly men who may on the other hand provide money and other material support for them in exchange for sex, what this means, is that the risky behaviour, could no doubt lead to unprotected sex that could mar their future. The dominant risk factor among the elderly is the same as for other age groups, and that is to say heterosexual practices. Moreover, specific risk behaviours, such as unprotected sex, multiple sexual partners, sexually transmitted infections and substance abuse are also common features among the elderly population.

2.6 Safe Sexual Behaviour and Risky Sexual Behaviour

In order to understand the context very well, the concept of safe practices entails that safer sex is any sexual practice that reduces the risk of spreading sexually transmitted infections including HIV from one person to another. The safe practices involves the following: sexual abstinence; mutually faithful relationship between two uninfected partners; using condoms for all types of intercourse – vaginal, anal and oral; non penetrative sex such as kissing, hugging, rubbing and masturbating; reducing number of sexual partners and avoiding sex when either of the partners have open sores (Liskin, 1989). Generally speaking, in any country, be it region or locality, the promotion of one or more of these elements of safer sex, depends on a number of factors, including moral, religious and political implications of the message concept vis-à-vis the extent of the risky practices and problems. However, intervention programmes trying to influence sexual behaviour nearly always arouse controversy, which either gets everyone practicing safe sex. Where such programmes get the religious and political support they deserve, the adoption of safer sex practices among vulnerable groups like the elderly persons depends on a range of behavioural factors, which would be examined later in the theoretical framework.

Having said that safe sexual practices are characterized by so many factors, the absent of which may lead to risky behaviour in order to drive the message home, sexual risky behaviour refers to unprotected sexual intercourse that may place a person or others at the risk of contacting STIs/HIV infection (WHO, 1992). Unprotected sexual intercourse in the context of STDs refers to any type of intercourse without consistent use of condoms. But risky sexual behaviour include having multiple sexual partners, frequently changing partners, engaging obvious risky partners (such as commercial sex workers), coerced sex, not using any protective measure, especially not using condoms and early sexual initiation amongst others (National Research Council and Institute of Medicine 2005). It also includes having unprotected sex with a partner of unknown sero-status. However, in a more detailed form according to Youngerman, (2005) examples of risky sexual behaviour are mostly those broken down as follows:

- Unprotected intercourse (intercourse without barrier contraceptives, like condoms etc).
- Unprotected mouth-to-genital contact.
- Early sexual activity (before age 18).
- Multiple sex partners.
- High-risk partner (partner who has multiple sex partners or uses IV drugs).
- Prostitution.

There are factors that are likely to produce these behaviours, rom the concept of the word: Risky behaviours are those that reflect sensation seeking and impulsivity, such as alcohol or drug use, and indiscriminate sexual practices. Such sexual practices are strongly linked to the spread of AIDS, and because AIDS is a highly stigmatized condition, most people who indulge in risky sexual practices are unwilling to disclose related information. Although data documenting the extent of the practice are very scanty, but in Africa for example, Singh and Bankole, (2001) provide evidence that the practice of sexual intercourse with multiple partners is widespread among young people aged 15-19 with elderly people in sub-Saharan Africa. Quite a substantial number of women reported having two or more partners over the most recent one-year period. The dynamics of sexual relations and its effect on old people's abilities to determine risks associated with sexual behaviour has not been thoroughly investigated (Blum, et al 2002), but it is known that generally, they grossly underestimate the risk of becoming infected with STIs/HIV.

On the other hand, looking at the effects in Nigeria also, in terms of number of sexual partners, Makinwa (1992) reported that among elderly urban Nigerians, more females (68%) than males (48%) had only one regular partner and males were more likely to have had sexual relations with more than one partner. This finding suggests that extramarital relationship is common among the elderly people. This empirical investigation is sequel to the observation of Orubuloye et al (1991), on sexual networking in Ekiti district in Southwestern Nigeria. According to the study, in the rural areas of the district, 56% of most recent sexual intercourse of monogamous males was outside their marriages while in urban areas the proportion rose to 67%. Regardless of gender therefore, the chances of becoming infected with HIV/STIs through sexual intercourse increases with number of sexual partners because of greater probability of intercourse with an infected person.

2.7 Condom Use and the Way forward to Condom Use

Condon use is one of the most effective measures available today to prove safer sex apart from abstinence. In the absence of a cure for HIV and of major behavioural change in risky behaviours, it is important to focus on other factors that facilitate protective behaviours. Condoms and abstinence offer the best protection; therefore it is important to understand the dynamics of condom use behaviour among old people. Although there is widespread knowledge of the protective effects of condoms, not many people, and certainly most elderly do not use condoms. In Nigeria for instance, this statement is consistent because in a study: Evaluating the sexual behaviour, barriers to condom use and its actual use by university students in Nigeria by Sunmola (2005), which the results indicated that both men and women

reported that condoms hindered their sexual satisfaction, caused health problems for them and reduced their sexual interest. This is also inline with some studies which have shown that older people tend to view condoms primarily as a contraceptive measure, and women who no longer fear unwanted pregnancy as reported by (Sunmola 2005). In order to address this problem in an African setting, first of all, we look at the attitudes to condoms which are largely influenced by general negative perceptions. This can be addressed within the contexts of community-based programmes by providing factual information. Moreover, Sunmola (2005) reported that obtaining condoms from clinics and perception that condoms do not cause health problems predicted the likelihood of condom use for both sexes. In addition, obtaining first time information from family members or relatives also predicted the likelihood of condom use for women as well (Iwuagwu et al, 2000, Olaseha et al, 2004 and Sunmola 2005).

For condom to be used consistently and persistently, the social environment should be sensitized because attitudes to condoms would be enhanced and sustained if the social environment is supportive of old people to use condom especially those who do not want sex to lead to pregnancy or infection. In these circumstances, condom promotion including messages would be accepted when they are provided by those that elderly people trust especially confidentiality should be adopted. Currently, there is limited communication about sexuality issues between elderly people and the society, but there is need of engaging the elderly in the community in promoting protective behaviours among those who are sexually active. It is likely therefore, that societal support for condoms will increase the number of sexually active elderly persons who use condoms. To engage community to support condom use would require creating awareness about old people's susceptibility to STIs/HIV/AIDS. Furthermore, the general low prevalence of condom use is related to underestimating risk and unwillingness to adopt protective behaviours. Elderly people need to be aware that their previous sexual history or those of their partners can increase their susceptibility to infection. Low condom use is also related to the inability of individuals to protect themselves even if they want to because of economic circumstances or inequalities that characterize the sexual relations between men and women. In Africa, for example women especially elderly ones are particularly at risk in this regard as the combined effects of gender inequality and poverty may considerably dis-empower them, thereby increasing their vulnerability.

Understanding the dynamics of condom use among elderly requires a better understanding of the dynamics of their sexual relationships and the context within which condoms are negotiated in sexual relations. It is therefore of interest to note that intervention efforts should make condoms freely available, and such interventions should be tailored to

overcome the relevant barriers that interfere with condom use for both elderly women and men (Sunmola 2005).

2.8 Factors Responsible for Sexual Practices among the Elderly

There is no doubt that, with advancing age, pathological conditions increase in frequency; including the living conditions of the elderly make them more prone to risk factors that might have adverse effects on their health (e.g., social isolation and accidents) - factors that can be modified to a great extent. Research and practical experience have demonstrated that health maintenance in the elderly is possible and that diseases do not need to be essential components of ageing (Phanjoo, 2000). However, the following factors are responsible for sexual practices among the geriatrics: Socioeconomic Factor, Poverty as a Factor, Death of Spouse, Availability of Partners, Loneliness and Boredom and Alcohol as a Risk Factor.

The potential socioeconomic impact on society which may result from an increasing old-age dependency ratio is an area of growing research and public debate (United Nations 2002). Factors other than social constraints, such as a disturbed relationship, physical fatigue and infirmities, psychological problems and economic worries, will also militate against a regular sex life.

According to the United Nations, 80% of elderly people in developing countries have no regular income. Furthermore, poverty rates in households with elderly people are up to 29% higher than in households without elderly people. And hence there is poverty, the purchasing power declines, households may not be able to pay their bills and provide for their necessities like food. Lack of food is a serious cause of ill health in elderly people. Elderly widows are among the poorest and most vulnerable groups in developing countries (United Nations 2002). As economic hardship bites harder in most African countries, the need to supplement the usually meagre income of most women by providing sex for money may not be limited to female hawkers. As it were many women in Nigeria engaged in non marital sexual relations with men because they needed financial support to stay going (Orubuloye et al., 1991). Similarly, Ajuwon (1990) also reported that many unmarried in Ago-Are mentioned lack of adequate financial support as the factor responsible for risky sexual activities.

Another responsible factor for elderly engagement or non engagement in sexual practices is the death of partner. For instance, the sexual adaptation of women following the loss of their marital partner was studied in the South East Asia (Malatesta et al, 1988). The increasing age of the widow was associated with less unhappiness with loss of marriage-related activities. What the elderly woman missed most could be expressed as non-sexual

heterosexual activity, such as the social company of a man. This in no small way adversely affects the elderly engagement in sexual activities. On the other hand, because of the death of a loved one could also encouraged the elderly to seek for succour elsewhere and to this effect therefore expose to extra-marital sexual relationship.

A number of factors have been identified as important in the maintenance of sexual activity. These factors are good physical health, the availability of a partner, and a regular and stable pattern of sexual activity earlier in life all these put together predict the maintenance of sexual engagement in old age. However, the proportion of sexually active married people declines from 55–60% in 60- to 74-year-olds to 25% in the over-75s (Phanjoo, 2000). In a similar findings from a study by Spence, (1992) he reported that a further point that needs to be discussed as a factor which influences sexual functioning in the elderly relates to opportunity. This may be affected by the availability of a sexual partner and the living circumstances of the individual or couple.

Gender differences in life expectancy may affect the sexual experiences of this population. Demographic data by the United Nations indicate that there are many more women than men over the age of 65. therefore, if marital status or living with a partner is a measure of "increased opportunity structures" for sex, heterosexual women have more limited opportunity for sexual expression (Deacon, et al, 1995). On the other hand, decline in sexual activity for men is less likely to be due to the lack of a partner. This is so because even when partners are available there are other conditions that affect elderly sexual expression and practices. For instance, it was reported that the lack of privacy in nursing homes is a major obstacle to sexual expression by the elderly. Not surprisingly, older residents report that because of a lack of privacy and inhibiting staff attitudes, they have little opportunity to experience intimacy (Deacon, et al, 1995).

Garrison (1989) outlines other psychosocial factors which affect the sexual functioning of older people. Many elderly couples have to deal with problems of "sameness" and boredom with their long-term relationship. This may adversely affect the sexual relationship. A loveless relationship or marriage in the old age can undermine a sexual experience or relationship when a later opportunity arises (Deacon, et al, 1995). Changes in lifestyle relating to retirement, and the associated role changes and adaptation problems, also need to be considered as factors affecting the elderly sexual engagement (Spence, 1992). However, conventional roles for elderly male cohorts emphasize the initiating, active, and performing aspects of work and social relationships. Having given up one’s active work role upon retirement and experiencing changes in his sexual performance, the elderly male may suffer some loss of self-esteem (Deacon, et al, 1995).

Another important factor especially in the African setting of late, is the issue of religion, it is reported that religious sanctions which restrict sex to the purposes of reproduction only and ignore the importance of intimacy, love, and sexual pleasure for well-being also deny important human needs (Deacon, et al, 1995); which may invariably trigger off sexual behaviour either negatively or positively.

In South Africa, alcohol was seen as a risk factor in the engagement in sexual practices. According to Simbayi, et al, (2006) alcohol was implicated as a major risk factor to sexually transmitted infections including HIV because it was perceived as the main tool for transactional sex, lowering of sexual inhibitions and inconsistent use of condoms. Although it has long been established that excessive alcohol consumption can cause substantial health risk to an individual, it is only recently that researchers in South Africa have been trying to examine systematically the association between alcohol use and sexual risk-taking behaviour. A recent study by Shisana et al. (2004) in Simbayi, et al, (2006) showed a strong link between sexual risk-taking behaviour and alcohol use. Respondents with multiple partners (16.2%) were significantly more likely to report consuming alcohol (2-3 times per week) than were monopartners (8.3%), abstainers from sex in the last 12 months (5.0%) and virgins (0.5%). Condom use during the last sex act was negatively and significantly related to frequency of alcohol use. Another study conducted in Gugulethu, a township in Cape Town, reported that 94% of all places where people meet new sexual partners were formal and informal alcohol-serving establishments (Weir et al., 2003 in Simbayi, et al, 2006).

In another study, conducted in a Cape Town township, found that 42% of the patrons socializing at alcohol-serving establishments reported meeting a new sexual partner there (Simbayi, 2004) in Simbayi, et al, (2006). In addition, only 60% of the patrons reported using a condom with the most recent new partner. Similar study by Kalichman and Simbayi (2003) in Simbayi, et al, (2006) reported that having a history of engaging in an activity with higher risk for HIV infection was significantly associated with alcohol use. These researchers found that 54% of individuals who had been diagnosed with a sexually transmitted infection (STI) reported using alcohol, compared with 40% of persons who did not have an STI in South Africa (Simbayi, et al, 2006).

2.9 Sexual Problems And Dysfunction

Globally, as people age, their susceptibility to chronic and life-threatening diseases as well as acute infection increases, exacerbated by compromised immune systems. However, cancer, cardiovascular diseases, diabetes, infections and poor oral health, most notably tooth loss and severe periodontal conditions, are more prevalent among the elderly. The

consequences of these diseases and conditions are significant, leading to disabilities and reduced quality of life. In recent decades, there has been a sharp increase worldwide in the number of people surviving to older ages due to health conditions. This demographic change (UN, 2002) is proceeding more rapidly in developing countries, especially in Africa, where the health indexes are far below par. However, according to UN (2002) elderly individuals are an integral part of society and are entitled to their fair share of the health and social services that are provided. Furthermore, because of their frailty and vulnerability, old people have special needs for care (Mahfouz, 2006).

However, the incidence of sexual dysfunction increases in old age, this is primarily related to the increased rate of health problems, rather than old age per se (Spence, 1992). Because numerous endocrine, vascular, and neurological disorders may interfere in sexual function, as may many forms of medication and surgery. These health factors according to Spence, (1992) are more prevalent in elderly people and hence it is perhaps not surprising to find an increase in biologically caused sexual problems in the elderly (Spence, 1992).

Another factor as Deacon, et al (1995) indicates are the pathological factors that affect sexual function which include: cardiovascular disease, diabetes mellitus, dementia, arthritis, and surgery. They also indicate that pharmacological factors play a role in sexual problems. Drugs that affect the autonomic nervous system may interfere with sexual function. Many medications that older people use, such as antihypertensives, tranquilizers, and antidepressants, can adversely affect erectile function and libido (Deacon, et al 1995). It should be pointed out, however, that where as many drugs can adversely affect sexual function, others can enhance it (Deacon, et al 1995).

Masters and Johnson described the physiology of coitus as having four components. Excitement, plateau, orgasm and resolution, all of which show age related changes. As ageing increases, desire may not always result in sexual excitement. The triggers for sexual excitement become more specifically sexual and may require intimate body contact and manual stimulation. But a major factor to be considered is sexual dysfunction which is common among this population the elderly people. However, in a related study in Germany among the oldest men (70–80 years) 46% reported orgasm at least once a month. Brahler & Unger (1994), surveying a group of 450 elderly men and women who still had a partner, found that 65% of people aged 61–70 and 33% of those aged over 70 engaged in sexual activity. More than 20% of men and 30% of women complained of having at least one sexual dysfunction, although there were marked variations among them. The sexual dysfunctions most frequently reported were early ejaculation (20%) and erectile dysfunction (15%) among men; and a lack of sexual interest (27%), lubrication difficulties (24%), and an inability to

reach orgasm (23%) among women. Of the 948 men and 992 women who were sexually active and reported sexual dysfunctions, 45% did sought no help or advice and only 21% sought medical care. It was concluded that men and women continue to show sexual interest and activity into middle age and beyond. Although, according to the study sexual dysfunction is prevalent among these age groups, several sociocultural and economic factors therefore appear to be preventing individuals from seeking medical help for these problems (Alfredo et al 2005). To address this sexual dysfunction in old age especially within the framework of recognizing interdependence, particular attention could be given to coordinating preventive efforts in order to combat the detrimental effects of premature ageing. From birth onwards, the detrimental effects of premature ageing on the individual could be avoided by: An educational effort designed specifically to make elderly people aware of the changes which are common occurrence as they grow older; a healthy general life-style, appropriate adjustments to working hours and conditions.

Despite the fact that elderly people experience sexual difficulties, traditionally they have presented for treatment relatively infrequently, they are being more prepared to live with the problem than younger adults (Baikie, 1984; Wise, 1983). Over the past decade, however, in the UK there has been an increase in the number of elderly persons seeking treatment for sexual difficulties (Renshaw, 1983). Leiblum and Segraves (1989) suggest that older adults experience sexual problems and concerns that are not that different from young people, however biological and psychological factors may need to be looked at more closely with an aging population. In addition, it is important to mention the cognitive decline which may occur in elderly persons and which may influence their sexual activity. Cognitive deterioration relating to dementia disorders may affect sexual behaviour, thereby producing problems such as disinhibition or relationship difficulties with subsequent effects upon the couple's sexual relationship (Spence, 1992).

2.10 Age related Changes in Sexual Functioning

Changes in sexual functioning are mainly associated with age, which is normal in human development. But this is more common in elderly people, therefore, it is important the elderly people are aware of the age related changes in sexual functioning so that they may be prepared to manage these inevitable life challenges. Elderly people who lack knowledge about the normal age related changes in sexual functioning and adopt uninformed societal attitudes about sexual activity in old age could experience anxiety regarding sexual expression (Deacon, et al, 1995). Of particular relevance to elderly people is the fear and anxiety that may result from negative interpretation of the age-related changes in genital

structures and sexual response (Spence, 1992). The age related changes in sexual functioning is characterized by changes according to gender

2.11 Sexual Changes in ageing Men

A variety of changes in sexual response do occur with age which needs to be understood by elderly persons and the helping professions alike. For example, men tend to show increased time required to produce a full erection, an increase in the time that erections can be maintained prior to ejaculation, a decrease in the force of ejaculation, and an increase in the duration of the refractory phase (Spence, 1992). Similarly, changes that occur in sexual physiology of an elderly male can affect both erectile function and ejaculation alike. However, these changes need not have any functional impact on the subjective enjoyment of the sexual encounter. In addtion, knowledge that these changes are not dysfunctional with the aid of adjustment of sexual practices may be crucial in preventing dysfunction due to performance anxiety (Deacon, et al, 1995).

However, if the intensity of sexual fantasies decreases this may take a man much longer to achieve an erection with the following ejaculation more time before an erection is possible. The physiological changes in ageing men are listed in Box 1 below. In addition to this therefore, elderly men also experience anatomical changes, including thinning of the pubic hair, laxity of scrotal tissue, atrophy of the perineal muscles, loss of collagen tissue and occasionally weight gain. The phase of ejaculation undergoes changes which result in a decline in the intensity of orgasm and in the propulsive force of ejaculation. The volume of the ejaculate may be reduced by 50%. However, sex drive and performance may vary widely between individuals of the same group and the maintenance of sexual activity may depend on factors such as regular sexual activity, the presence of a willing sexual partner, the absence of a major physical illness and the integrity of the relationship. The ageing male in this case experiences a reduction in the activity of the cells of Leydig with an associated drop in testosterone of 0.4–0.8% per year after the age of 50. See Box 1 below:

Box 1. Physiological changes in ageing men

- Sexual organ atrophy
- Diminished testosterone level
- Delay in attaining erection
- Erection of poor quality
- Longer delay in achieving and maintaining a full penile erection
- Decline in intensity of orgasm
- Decreased hormone levels are associated with reduced desire

Looking at a study of 81 healthy married men aged 60–71 with no physical illness, no psychopathology and no marital problems, found that 36% of the elderly suffered from erectile failure. This is so because ageing was associated with a decline in the frequency of sexual intercourse including an increase in the frequency of masturbation (Weizman and Hart, 1987). Similarly, in Massachusetts in the USA, a sample of 319 men aged 50–80 were surveyed by a postal questionnaire, revealed that physiological potency for men aged 50–59, 60–69 and 70–80 amounted to 97%, 56% and 51%, respectively (Feldman et al, 1994). This is substantiated by a similar study in the same state, which found that 15% of 70-year-old men were completely impotent and 34% moderately impotent. It was finally concluded that the problem was associated with a significant number of physical and medication problems (Feldman et al, 1994).

2.12 Sexual Changes in ageing Women

The sexual changes are not different in ageing women, obviously it is unarguably more pronounced in ageing women than men. For example in elderly women, the physiological effects of aging on sexual function are primarily caused by decreased amounts of circulating estrogen after menopause. The rate and amount of vaginal lubrication as a result of this are decreased; hence there is general atrophy of vaginal tissue. For many women, these changes associated with menopause are more than offset by the freedom to explore and enjoy sexual activity without the worry of becoming pregnant (Deacon, et al, 1995). These genital changes during this time include reduced size of clitoral, vulvar, and labial tissue, decreased size of the cervix, uterus, and ovaries, and some loss of elasticity and thinning of the vaginal wall. At this juncture, some women may experience inadequate lubrication and intercourse may be painful if the vaginal walls become excessively thin but this does not deter elderly sexual expression and engagement (Spence, 1992).

Probably, because older women were brought up to prize modesty therefore under this condition they are reluctant to complain of sexual problems or seek any assistance. In a survey in the UK relating to urogenital ageing among 2045 British women aged between 55 and 85 found that no more than 11% were affected at any one time (Barlow et al, 1997). Of that group, 73% were sexually inactive. Of the 11% affected, only one third sought professional advice, whereas 36% resorted to over-the-counter remedies and 33% did not seek help. In a similar study in New York, Bachmann's (1990) study of 59 healthy post-menopausal women aged 60–70 reported that 66% were coitally active and 34% were abstinent. The active group reported more sexual interest, greater sexual satisfaction and on pelvic examination was noted to have less genital atrophy. Little information is available on

the sexual behaviour of elderly women in other cultures especially in Africa with preliminary investigation going on in Nigeria. But in South America a study on Chilean women, reported that 40% of women over 60 years of age were sexually active (Gramegna et al, 1998). Age-related changes in women (see Box 2 below) include thinning of the pubic hair, shrinkage of the labia, thinning of the vaginal mucosa and laxity of the perineal muscle. Furthermore, the thinning of the vaginal mucosa and the reduced lubrication may lead to dyspareunia and bleeding during intercourse. Orgasmic contractions may become painful as a result of these sexual changes.

Box 2. Physiological Changes in Ageing Women

- Changes are secondary to declining secretion of oestrogen after the menopause
- Loss of elasticity in breast tissue and loss of breast dimensions
- Cervix and uterus shrink in size
- Walls of the vaginal canal atrophy and vaginal length and width decrease
- Decrease in vaginal lubrication
- Sex steroid starvation may indirectly affect sex drive

2.13 Types of Elderly Sexual Dysfunction

The DSM–IV (American Psychiatric Association, 1994) proposes seven categories of sexual dysfunctions. The first three are related to disorders of:

1. Desire
2. Arousal and
3. Orgasm.

Categories four to six define sexual problems associated with:

4. Pain
5. Physical illness,
6. Drugs and Alcohol,
7. And category seven defines disorders that are not otherwise specified (Phanjoo, 2000).

In elderly men, erectile failure is by far the most frequently encountered problem, whereas in elderly women loss of sexual interest and motivation is the main problem. A recently published sexual dysfunction survey in the USA which involved 1410 men and 1749 women aged 18–59, of whom 79% took part. In the women category, 32% complained of a lack of interest in sex, 26% of an inability to achieve orgasm and 16% of pain during intercourse. Of the men, 31% complained of premature ejaculation, 18% of performance

anxiety and, in the 50- to 59-year-old age group, erectile failure was present in 18%. Low sexual desire was associated with general unhappiness, and sexual dysfunction was strongly associated with unsatisfactory personal relationships (Laumann et al, 1999).

2.14 Causes of Sexual Problems and Dysfunction among the Elderly

Numerous factors contribute to a varied and complex aetiology. They include:

1. The biological changes of ageing,
2. Negative cultural expectations,
3. Medical or surgical problems,
4. The effects of drugs, and
5. Mental illnesses such as depression, psychosis and dementia.

Illnesses that contribute to sexual problems in old age include cardiovascular problems, particularly hypertension, peripheral vascular disease, diabetes mellitus, renal failure, cancer, arthroses and neurological problems (Feldman et al, 1994) and the sequelae of various operations such as prostatectomy, hysterectomy, mastectomy and various ostomies. The effects of prostatectomy on sex function have been well studied. According to a study in Britain by Thorpe et al, (1994) on prostatectomy is associated with major erectile failures in 12% and absent ejaculation in 24% of cases. The sexual dysfunction found in prostate cancer patients is largely due to the effects of treatment, with radical prostatectomy carrying the highest risk (Helgason et al, 1996). Finasteride, which is used in prostatic enlargement, is associated with loss of libido, erectile failure and reduced volume of ejaculate in 5–6% of men (Gormley et al, 1992). Illnesses that result in disability, such as stroke and dementia, invariably lead to important changes in sexual behaviour (Boldrini et al, 1991). There is little evidence that post-stroke patients are routinely given an opportunity to discuss their sexuality openly with their physician. Changes in sexuality after a stroke are often due to a change in role function because of the increased dependency of the afflicted partner (Burgener and Logan, 1989).

The most common mental disorders affecting elderly people are depression, dementia, delusional disorders and delirium. Sexual behaviour may change significantly in depression (Feldman et al, 1994) and dementia (Haddad and Benbow, 1993). Delusional disorder may be associated with pathological jealousy, which may cause severe distress to the other partner as well as endangering his or her well-being. Sexual problems may be further compounded in this group of patients by the use of psychoactive agents.

The effects of chronic alcohol misuse on sexual function are well recognised by Wagner and Jensen, (1981). According them, in small doses, alcohol acts as an anxiolytic and

may improve performance, but larger doses will result in retarded orgasm and erectile failure. Drugs like cocaine and amphetamines increase sexual interest and activity initially because of their enhancing effects on mood and energy, but the long-term effects are usually detrimental.

There is significant information on the sexual side effects of antidepressant drugs – according to a literature review by Ellison, (1998). Of all the types of antidepressants, including monoamine oxidase inhibitors, tricyclics and Selective Serotonin Reuptake Inhibitors (SSRIs) are implicated in a variety of sexual problems affecting libido, arousal and ejaculation. Depression per se is also associated with sexual problems and it is, therefore, important for clinicians to enquire carefully as to what specific phase of the sexual response cycle is affected. There are now specific diagnostic criteria for antidepressant-induced sexual dysfunction in DSM–IV, subsumed under category 292.89. It is likely that up to 50% of patients treated with SSRIs may develop sexual dysfunction, mainly related to delayed or absent ejaculation or orgasm. These drugs may also be involved in erectile failure.

Once an antidepressant-induced sexual dysfunction has been established, appropriate treatment may involve a reduction in the offending medication, a 'drug holiday' or a change to a different antidepressant. The antidepressants that are least likely to affect sexuality are nefazodone, mirtazapine and reboxetine. Occasionally, patients treated with SSRIs may report increases in sexual desire. The drugs implicated here are trazodone, bupropion and, much less frequently, venlafaxine, paroxetine and fluoxetine. Trazodone is the drug most frequently associated with priapism (Warner et al, 1987). This problem has also been reported with phenothiazines, butyrophenones and benzisoxazoles (Patel et al, 1996). Antipsychotic drugs, however, have a predominantly depressant effect on sexual function through their effects on the dopaminergic system. Non-psychotropic medication may also have a negative influence on sexuality. Anticonvulsants, antihypertensives, H2 blockers and thiazide diuretics (O'Keefe & Hunt, 1995) as well as cimetidine, digoxin and metoclopramide (Guay, 1995) are known to cause erectile failure.

2.15 Management of Elderly Sexual Dysfunction

Assessment of a sexual dysfunction requires a careful history from the client with a corroborative history from the spouse/partner. Hawton (1985) summarized the important features of a sexual history as:

1. Establishing a language that is mutually comfortable;
2. Using a mixture of closed and open questions;
3. Getting an accurate description of what is actually wrong;
4. Taking a longitudinal perspective;

5. Interviewing both partners jointly and separately; and
6. Taking a medical history including a complete list of drugs that the client is taking.

Many elderly couples need accurate information about the physiological changes associated with ageing. Box 3 below highlights some of the best practices in the management of elderly sexual dysfunction.

Patient education should therefore be an integral part of the management of sexual dysfunctions (Bachmann, 1990). The range of treatments available comprises psychosexual counselling, hormonal therapy, drug treatment, mechanical devices and vascular surgery. See Box 3 below.

Box 3. Treatment options

- Basic education and advice
- Psychosexual counselling
- Hormonal therapy
- Drug treatment
- Mechanical devices
- Vascular surgery

Psychosexual counselling is an important aspect of any management plan since sexual dysfunctions, whatever the underlying cause, usually has a psychological overlay. It is therefore, recommended that pharmacological treatment be combined with counselling.

An example of hormonal treatment for the management of sexual dysfunction among the elderly is the use of testosterone supplements to treat the viropause (male menopause) though very controversial. The proportion of elderly men with a significantly reduced testosterone level is low. Large epidemiological studies have shown that total testosterone remains steady until the age of 50 and then declines by approximately 0.4–0.8% per year (Gray et al, 1991). Administration of testosterone to eugonadal men leads to a small increase in sexual interest but it is no more effective than placebo in improving sexual dysfunction (Schiavi et al, 1997).

On the other hand, according to Morley et al, (1993) there are numerous reports in the literature attesting to the benefits of androgen supplements in hypogonadal men. Libido, arousal and ejaculatory capacity all show improvements (Morley et al, 1993). The empirical use of exogenous androgens in eugonadal elderly men should not be encouraged as such treatments potentially could induce polycythaemia, worsen coronary artery disease and exacerbate benign prostatic hypertrophy (Seidman and Walsh, 1999). In women the use of hormone replacement therapy (HRT) is widespread although still controversial. It reverses

the physiological changes associated with sex steroid starvation. Post-menopausal women who suffer from loss of libido in addition to the physiological changes associated with oestrogen deficiency may benefit from the gonadomimetic tibolone. Phanjoo, (2002) suggested that problems of sexual attitude and behaviour should be discussed openly. As life span increases and older people become healthier, they will have increasing expectations regarding their sexuality. Clinicians and professional helpers need to be aware of such problems, be ready to educate and advise older people on how best to adapt to physiologically altered responses and, in some cases, treat them by psychosexual counselling or chemotherapy as well as alleviate any physical problems.

2.16 Conclusion

Elderly people continue to show interest in sexual behaviour even though society sees them as sexually inactive. However, review of related literature in this study has shown that even at old age the elderly are still coitally active and have engaged in several sexual activities including risky sexual practices. On the other hand, sexual dysfunction seems to affect their sexual behaviour and this may actually lead to engagement in harmful practices like drug indulgence and alcohol intake in order to enhance sexual performance and excitement as reviewed in this chapter. Therefore, adequate education according to Phanjoo, (2002) on geriatric sexuality, especially changes in sexual functioning as they grow old should be intensified. In addition to this, Home-based counselling services to encourage help-seeking behaviour in the management of sexual dysfunction of the elderly are needed to address the problem. See Box 4 below, it summarizes the management of elderly sexual dysfunction:

Box 4. Peculiar Features

- Sexual problems are common in old age, but older people are reluctant to seek help
- Sexual problems are associated with the biological changes of ageing, physical illness, the effect of various drugs and the negative sociocultural ethos
- Older people need basic education and advice concerning their adjustment to age-related physiological changes in their sexuality
- Pharmacological treatment is highly effective in erectile failure regardless of aetiology

2.17 Theories developed to explain Sexual Bahaviour

Assessing sexual behaviour of elderly people is a complex process because it takes a diverse stages, although, many models were suggested, reviewed and even grouped in an attempt to explain the purpose of effective assessment of sexual behaviour of the elderly. Below is the combination of articulated models developed to better explain the problematic and behavioural antecedents of the elderly persons in relation to sexual behaviour.

Conceptual and Theoretical Framework

According to (NCI, 2005) Contemporary health promotion involves more than simply educating individuals about healthy practices. It includes efforts to change organizational behaviour, as well as the physical and social environment of communities. It is also about developing and advocating for policies that support health, such as economic incentives. It concluded by saying that health promotion programmes that seek to address health problems across this spectrum employ a range of strategies, and operates on multiple levels. In this study therefore, the Ecological Perspective was identified and applied for this purpose.

The Ecological Perspective emphasizes the interaction between, and interdependence of, factors within and across all levels of health problems. It highlights people's interaction with physical and socio-cultural environments. Two key concepts of Ecological perspective help to identify intervention points for promoting health:

1. Behaviour both affects, and is affected by, **Multiple levels of influence**,
2. Individual behaviour both shapes, and is shaped by, the social environment **Reciprocal Causation**.

To explain the first key of the ecological perspective, multiple levels of influence, McLeroy et al (1988) identified five levels of influence for health-related behaviours and conditions defined in table 1., these levels include: (1) intrapersonal/or individual factors; (2) interpersonal factors; (3) institutional/or organizational factors; (4) community factors; and (5) public policy factors. The diagram (Table 1) below shows the framework for the model, which has five stages:

Table 2.1 An Ecological Perspective: Levels of Influence

Concept	*Definition*
Intrapersonal Level	Individual characteristics that influence behaviour, such as knowledge, attitudes, beliefs, and personal traits
Interpersonal Level	Interpersonal processes and primary groups, including family, friends, and peers that provide social identity, support, and role definition
Community Level	
Institutional Factors	Rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviours
Community Factors	Social networks and norms, or standards, which exist as formal and informal among individuals, groups, and organizations
Public Policy	Local, sand practices for disease prevention, early detection, control, and management, and federal policies and laws that regulate or support healthy actions

In practice, addressing the community level requires taking into consideration institutional and public policy factors, as well as social networks and norms. *Figure 1 below illustrates how different levels of influence combine to affect population health.* This model was designed by Smedley and Syme (2000) in diagnosing community behavioural practices. Each level of influence can affect sexual bahaviour according to NCI, (2005). For instance if an elderly person frowns at getting condom for safe sex:

1. At the individual level; his inaction may be due to fears of what would be people's perceived feelings seeing him with the product or the sex partner's perception that s/he is at risk of STIs/STDs infection.

   At the interpersonal level, the chemist/pharmacist who may provide this preventive/contraceptive may want to advise him to be using it consistently and persistently or the elderly may have friends who would say they do not enjoy or believe it is important to use condom.

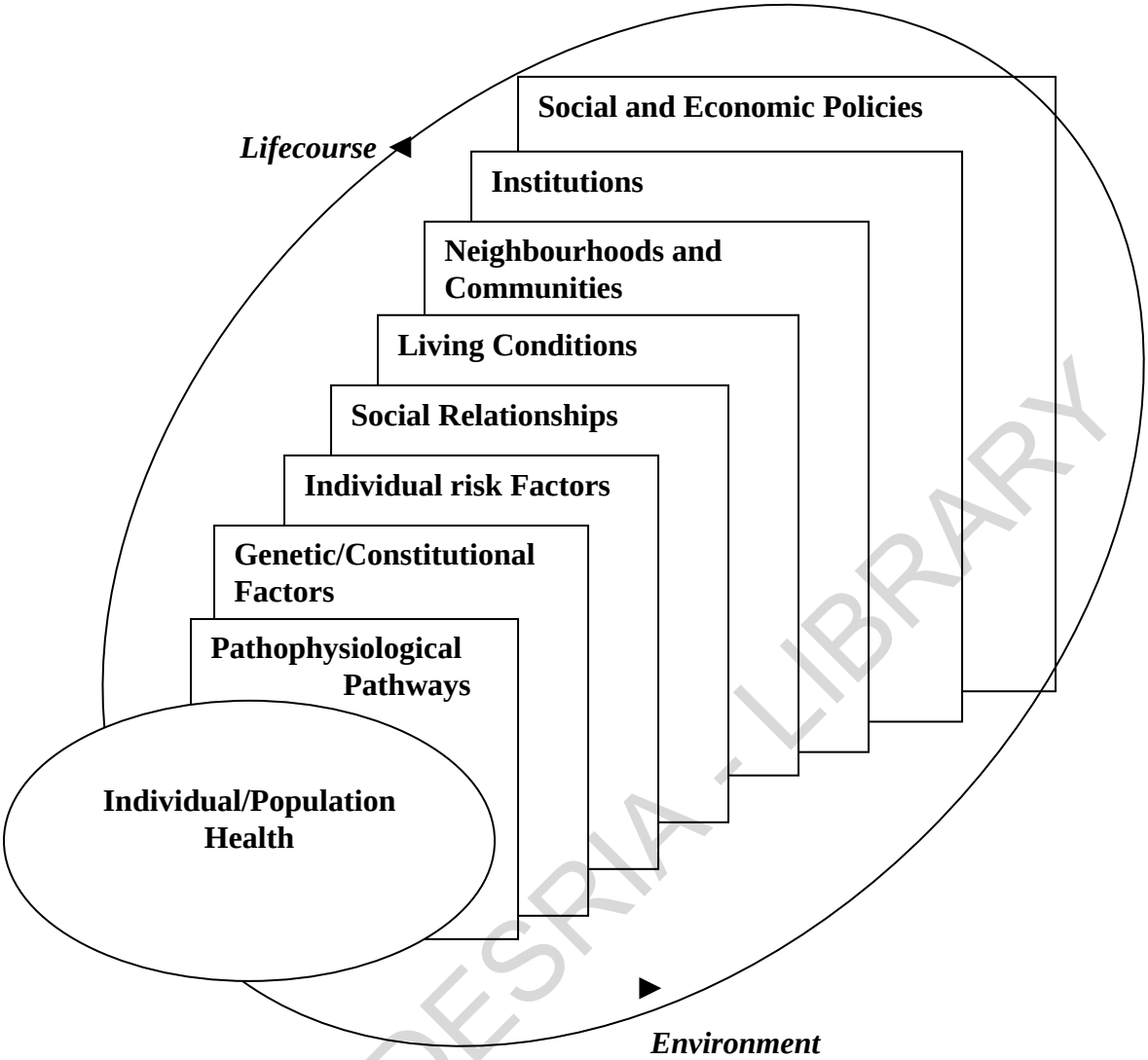

Figure 2.1 A Multilevel Approach to Epidemiology

Source: Smedley BD, Syme SL (eds), Institute of Medicine, Promoting Health: Strategies from Social and Research, Washington, DC.:,National Academies Press, 2000

2. At the organizational level it may be too cumbersome to procure condoms at health facilities because of the processes involve ranging from consultancy, prescription and final procurement or in the other hand the perceived contextual discrimination resulting from an elderly going to health facility just to secure condom. Sunmola (2005) reported that obtaining condoms from clinics and the perception that condoms do not cause health problems predicted the likelihood of condom use for both sexes. In addition, obtaining first time information from family members or relatives predicted the likelihood of condom use for women (Iwuagwu et al, 2000, Olaseha et al, 2004 and Sunmola 2005).

3. At policy level: The elderly may lack insurance coverage like the newly introduced National Health Insurance Scheme (NHIS) - insurance policy that will ensure access to healthcare services, including accessing contraceptive e.g. condom on demand at health facility or even Home-Based Care (HBC) service delivery, therefore may be unable to secure one easily to get rid of the discrimination.

Thus, the outcome: the elderly failure to secure condom, may result from multiple factors, which may likely influence his/her sexual behaviour negatively thereby resulting in the engagement in unprotected coital sex or positively which may promote a safer sexual practice by been abstinent and faithful. Since attitudes to condoms are largely influenced by general negative perceptions, this according to Sunmola (2005).would be addressed within the contexts of community-based programmes by providing factual information.

The second key concept of an ecological perspective, **reciprocal causation**, suggests that people both influence, and are influenced by, those around them; For example elderly person with multiple sexual partners may find it hard to adapt "AB" (Abstinence and Be Faithful) preventive measures suggested by a healthcare provider or religious leader in the community because his/her peers encourage multiple sexual partners. To comply with the health worker or religious leader advice, s/he may try to change environment by asking the peers to change their negative sexual behaviour, or hence they may separate following refusal to change behaviour, if s/he decides to change the risky behaviour by sticking to "AB" measures. Those of the peers around the elderly may be encouraged to change their risky behaviour too vis-à-vis being "faithful and abstinent especially from multiple sex in order to maintain the peer relationship. To this end therefore, the "peer environment" may compel this elderly person to change the sexual behaviour, but also the new habits would ultimately bring about change to the peers as well. An ecological perspective therefore shows the advantages of multilevel interventions that combine behavioural and environmental components.

2.18 Hypotheses

1. There is no significant relationship between educational level and perception of risky sexual behaviour of the elderly.
2. There is no significant difference between gender and engagement in risky sexual practices among the elderly.
3. There is no significant difference between gender and being sexually active.
4. There is no significant association between religion and factors responsible for risky sexual behaviour.
5. There is no significant association between gender and sexual dysfunction.

CHAPTER THREE

METHODOLOGY

This chapter describes the methodology that was employed in the study. It contains the study design, description of the study area, study population, research instruments, sampling and data collection procedures, validity and reliability of instruments, ethical consideration, data management and analysis.

3.1 Study Design

The study was a community-based household descriptive and cross-sectional survey designed to assess the sexual perception, practices and problems among the elderly people.

3.2 Study Area

Ibadan was formally a virgin forest land known as "Igbora-Ipara" which means the forest of Ipara. This forest acted as a boundary between towns where the Ijebus, Egbas, and the Oyos occupied. Lagelu who comes from Ile-Ife was the first to settle there, he called the part of the forest where he settled "Eba Odan" which means a place near the savannah forest. As more people moved to settle there its name was changed to Ibadan. It is the capital city of Oyo State, and it lies within latitude 70 N, 40 S. Ibadan lies at 200m above sea level with a humid tropical climate (27^0C average), rainy season is between March – October (1250mm) followed by a mild dry season. Ibadan consists of eleven Local Government Areas (LGAs).

3.2.1 Description of the study Area

Ibadan North Local Government Area is one of the local government areas in Ibadan. It has a current population of 306,795 people, the population of the male and female being 153,039 and 153,756 respectively (2006 Population Census). Ibadan North LGA was founded on the 27th of September, 1991 and carved out of the former Ibadan Municipal government. It is a transitional urban area. Its headquarters is temporarily at Government Reserved Area (GRA) at Agodi where the LGA secretariat is located. The local government consists of Multi-ethnic groups, which is predominantly Yorubas, others include the Ibos, Edos, Urhobos, Itsekiris, Ijaws, Hausas, Fulanis and foreigners from Europe, America, Asia and other parts of the world. Majority of the population of the LGA are in the private sector, mainly traders and artisans while a good number of workers are civil servants. There are six

major markets in the local government. They are Bodija, Sango market, Mokola, Sabongeri, Gate and Ijokodo/Gbaremu markets. (O'Gbenga, 2001)

Ibadan North LGA is surrounded by other LGAs – in the north by Akinyele LGA, in the west by Ido, Ibadan North-West and Ibadan South-West LGAs, in the south we have Ibadan South-East LGA and in the east by Ibadan North-East LGA.

Table 3.1 Population distribution by Age and Sex

Age	Both Sexes	Males	Females
65 – 69	2,433	1,139	1,294
70 – 74	2,021	946	1,075
75 – 79	889	355	534
80 – 84	971	356	615
> 85	990	365	625
Total	11, 835	5, 209	6, 626

Source: National Population Commission Final Result of 1991 Population census of Nigeria: Ibadan North LGA of Oyo State

3.2.2 Selection of Sample for the Survey

The exact proportion of elderly people aged 65 years and above who have sexual perception, dysfunction and engaged in sexual practices in Nigeria is very limited and mostly not available to the researcher. It was assumed that elderly persons in Nigeria had engaged in sexual practices in the month preceding the survey with 50% assumption rate.

3.3 Sample Size Determination

Based on the assumption that 50% or 0.50 of elderly people were exposed to sexual behaviour. The sample size for the study was drawn using male and female elderly people in Ibadan North Local Government Area. In order to obtain an appropriate minimum sample size for the study, the standardized formula applied:

$$n = \frac{Z^2 pq}{d^2}$$

Where: n = desired sample size

z = the standard normal deviate at 1.96 corresponding to 95% confidence level

p = proportion in the target population estimated to have a particular characteristics.

Assuming the proportion who are exposed in sexual behaviour to be 50% or 0.50

- Since the target population exposed to sexual behaviour was not known, using 50% assumption was adopted (Araoye, 2003). = 50/100 = 0.5

q = 1 – 0.5 = 0.5

d = degree of accuracy (precision limit) at 95% confidence interval

= 100 – 95 = 5%

= 5/100 = 0.05

Therefore using the formula:

$$n = \frac{Z^2 pq}{d^2}$$

$$= \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2}$$

$$= \frac{3.8416 \times (0.25)}{0.0025} = \frac{0.9604}{0.0025}$$

= 384

However, for us to have a meaningful and representative sample size and as well make room for non-response, a sample size of 400 was used for the study.

3.4 Sampling Procedures

Ibadan North LGA is made up of 12 geo-political wards, which comprises of six low and middle-income wards each. The Multi-stage stratified simple random sampling technique was adopted for the study. This is to give every member of the target population an equal and independent opportunity of being selected for the study (Araoye, 2003). The following four-stage sampling procedures were performed using the following steps:

Step 1: Out of the 6 middle-income in the LGA three wards were selected using simple random technique involving balloting method. The selected wards were wards 5, 9 and 12

Step 2: Out of the 6 low-income wards in the LGA three wards were also selected using simple random technique involving balloting method. The selected wards were wards 3, 7 and 8

Step 3: In the selected 3 middle-income wards, five communities were randomly selected by balloting. The selected communities were Agbowo, Ashi, Bashorun, Ikolaba and Mokola. In the selected three low-income wards, five communities were also selected randomly by balloting. The communities selected were Adeoyo, Ijokodo Oremeji Sango and Yemetu; totaling ten communities in all. (See table 3.2 below) it contains the ten selected communities and population of the respondents). Then the calculated sample size of 400 was proportionally distributed among the ten selected communities (see table 3.2).

Step 4: In order to get the 400 respondents in their houses in each community, a purposeful sampling technique was adopted to reach the respondents in their households. The researchers moved from one house to another in the selected community. For convenience sake, respondents that were available in a household during the data collection were used. Any household that did not have the eligible respondent (65 years and above) was skipped to the next household. At the end, 400 participants who consented participated in the study.

In total, respondents selected for the study were 202 males and 198 females. The breakdown is shown in table 3.2 below:

Table 3.2 Population of the Elderly People and Proportional distribution of participants

S/N	Selected Communities	Male		Female		Total	
		n	(%)	n	(%)	n	(%)
1.	Adeoyo	165	5.5	179	6.0	344	5.9
2.	Agbowo	914	30.7	927	31.1	1841	30.9
3.	Ashi	139	4.7	143	4.8	282	4.7
4.	Bashorun	83	2.8	86	2.9	169	2.8
5.	Ijokodo	56	1.9	40	1.3	96	1.6
6.	Ikolaba	136	4.6	132	4.4	268	4.5
7.	Mokola	351	11.8	343	11.5	694	11.7
8.	Oremeji	59	2.0	63	2.2	122	2.0
9.	Sango	840	28.2	819	27.5	1659	27.9
10.	Yemetu	233	7.8	247	8.3	480	8.0
Total		2976	100%	2979	100%	5955	100%

Proportional distribution of study Participants in the selected study Communities

S/N	Selected Communities	Male		Female		Total	
		n	(%)	n	(%)	n	(%)
1.	Adeoyo	11	5.4	12	6.1	23	5.75
2.	Agbowo	61	30.2	62	31.4	123	30.75
3.	Ashi	9	4.5	9	4.5	18	4.5
4.	Bashorun	6	2.9	6	3.1	12	3.0
5.	Ijokodo	4	2.0	2	1.0	6	1.5
6.	Ikolaba	9	4.5	9	4.5	18	4.5
7.	Mokola	24	11.9	23	11.6	47	11.75
8.	Oremeji	4	2.0	4	2.0	8	2.0
9.	Sango	58	28.7	54	27.2	112	28.0
10.	Yemetu	16	7.9	17	8.6	33	8.25
Total		202	100%	198	100%	400	**100%**

Source: National Population Commission Final Result of 1991 Population census of Nigeria: Ibadan North LGA of Oyo State.

3.4.1 Inclusion Criteria

1. The respondent was (at the time of the study) an elderly person aged 65 years or above.
2. The respondent was either an elderly male or female from the communities randomly selected for the study.
3. Must be a resident of the study communities during the period of the study.

3.5 Instrument for Data Collection

The instruments for data collection comprised both qualitative and quantitative methods. They are:

i) Qualitative Method

Focus Group Discussion (FGD) was used as a diagnostic tool to elicit information to improve the quality of the quantitative instrument. The FGD guide comprised 9 questions which focused on the perception, practices and problems of sexual and reproductive health among the elderly. Six FGDs were held altogether, three each for both males and females in the selected communities. Six-to-eight males and females constituted the FGD session, one gender group in each rural and urban area respectively. Participants were randomly selected from the study communities and were brought together voluntarily to discuss the key issues. The investigator observed all the sessions and 6 Research Assistants (3 males and 3 females) were used in all the sessions. Tape recorders were also used in all the sessions to complement notes documented by the field assistants.

ii) Quantitative Method

Information gathered from the FGD served as a guide in developing the quantitative instrument, which is the semi-structured questionnaire. It contained both open-and-closed-ended questions and was interviewer-administered. The questionnaire comprised 50 item questions written in simple English language (see appendix B for details). The questionnaire was divided into four sections: Sections A to D. Section A was to collect information on Socio-demographic characteristics of the respondents, Section B: sexual perception, Section C: sexual practices and Section D: sexual problems of the elderly and suggestions on how to improve their sexual health behaviour.

3.6 Measures taken to ensure Reliability of the Instruments

To ensure that the data obtained is reliable, the following measures were carried out:

1. The interviewers (retired civil servants) were given adequate training as discussed under procedure for data collection.
2. Male interviewers attended to male respondents while female interviewers attended to female elderly person(s). This was to address openness, gender disparity and ensure respondents' confidence.
3. The instruments (qualitative and quantitative) were translated into Yoruba, the language widely spoken in the study area, which the respondents understand. Translation and back translation were carried out because of the assumption that many of the respondents have limited education and may not be able to communicate fluently in English language.

3.6.1 Validity and Reliability

Several measures were taken to ensure the validity and reliability of the instrument. Firstly, the instrument after been validated by experts in the faculty of public health, went through two stages of pre-testing: It was first pre-tested among experts in the fields of Health Promotion and Education, University of Ibadan for its content validity. The second and final pre-test was among 40 elderly people (21 males and 19 females) (i.e. 10% of the sample size) in Ido Local Government Area (LGA). This LGA has similar characteristics with Ibadan North LGA. Both LGAs share in terms of cultural, ethnic and religious similarities. To ensure the reliability of the instrument most of the questions were modified and reframed after the pretest, because of the sensitivity of the study variables which the respondents declined to respond. The instrument also underwent measures of internal consistency, to confirm its validity. Test – retest analysis was done using the analysis (Cronbach's alpha coefficient) of the SPSS (Version 14.0). Alpha (Cronbach) is a model of internal consistency, based on the average inter-item correlation. Result showing correlation coefficient of 0.5> is said to be reliable. The result was 0.617 which is greater than 0.5 was reliable.

3.7 Procedure for Data Collection

Relevant correction was made before using the questionnaires on the study population. Retired Civil servants (elderly) were recruited for data collection. Training was conducted for four Field Research Assistants (2 male and 2 female) to ensure that they have adequate understanding of the instruments prior to commencement of data collection. The training focused on the objectives and importance of the study, sampling processes, how to

secure respondents informed consent, and review questions to ensure completeness including how to collect data through FGD and how to conduct face-to-face interviews with the respondents. The Field Assistants were involved in the pre-testing of the FGDs and questionnaires to create opportunity for them to learn. Six interviewers were trained using the FGD guide and draft questionnaire for data collection. They were also trained on interpersonal skills, which included how to obtain permission from community leaders and how to obtain informed consent from respondents by providing information on study objectives, confidentiality of information and ensuring that participation is voluntary. Two interviewers worked in each of the six wards selected for the study; two research assistants joined the researcher in supervising the six wards. The interviewers worked in pairs to encourage teamwork and avoid deviation.

Data collection was carried out on daily basis. Elderly peoples' personal activities were highly considered and administration of questionnaires was on-the-spot basis. The researcher and research assistants went around monitoring these personnel. Questionnaires were submitted to the researcher on arrival from the field each day. Screening and editing of the questionnaire were done immediately before the departure of the interviewers. Questionnaires with errors were returned to the interviewer concerned for correction.

3.8 Ethical Considerations

Ethical approval was sought for and obtained from the communities' authorities through the community leaders of each community in order to gain access to the community. In addition, the study instrument contained an informed consent clause to respect the voluntary participation of the respondents and protect their individual identity. The research assistants assisted in the location and identification of the respondents. While the interviewer explained the purpose of the research, assured the respondent of confidentiality of information volunteered and his/her option to agree to participate or not. In addition, the respondents were informed of their freedom to stop the interview at any stage that they were no longer comfortable with the interview.

Finally, the interviewer formally requested for the participation of the respondents and when consented, the appropriate column listed for the informed consent clause was marked. The purpose of this is to ensure that this study conforms to the generally accepted scientific principles and international ethical guidelines required in human subjects research.

3.9 Data Management and Analysis

Focus Group Discussion

Regarding focus group discussions, major trends and concepts expressed were recorded and transcribed. The FGD discussions were recorded on audio tapes, transcribed and analyzed using the thematic approach. Responses were summarized into themes and were developed and compared between and within groups. The audio tapes were carefully stored in a safe place.

Questionnaire

Administered questionnaire were carefully stored in a safe place. Serial numbers were written on the administered questionnaires for easy identification and recall. A coding guide was developed and administered questionnaires were coded using the guide. Four hundred selected study participants were met at home and had their questionnaires correctly filled and accepted for analysis. Current version of statistical software-data package was adopted for analyzing the quantitative data (questionnaires) and finally entered into computer for statistical analysis using Statistical Package for the Social Sciences SPSS. Data entry was done twice (independently) and cleaned. Frequency distribution and percentages were computed for all the variables. Contingency tables were constructed and analyzed using X^2 test where applicable to compare sexual behaviour with socio-demographic factors like gender and education. Other independent variables were only used for comparing statistical relationships using the Chi-square test, the significance level of test result was set at $P<0.05$.

3.10 Limitations of the Study

This study covered only the elderly people in Ibadan North Local Government Area (LGA). The area is one out of the eleven LGAs in Ibadan and hence the results cannot be generalized. Moreover the limited time and resources available for the study, made it impossible to go around. Another major limitation was the sole reliance on reported responses by respondents which may not be verified. The information cannot be reliable because people underreport what they do and therefore, there is no way to corroborate the information. According to Orubuloye, et al, (1991) the correctness of information may not be totally reliable especially females may tend to under report their sexual behaviour.

CHAPTER FOUR

RESULTS

The findings of this study are presented in this chapter. Firstly the findings of the Focus Group Discussions (FGDs); secondly the results of the survey including the socio-demographic characteristics of the respondents, sexual perception and practices of the respondents; factors influencing respondents' sexual risky behaviour and dysfunctions of the respondents are also presented.

4.1 Findings of Focus Group Discussions (FGDs)

Majority of the discussants in all the male and female group sessions expressed the view that sexual practices diminish with age and most of them do not take sexual practices as priorities any more. However, the majority of female discussants felt that they engaged in sex to strengthen the relationship with their spouse. One female discussant stated thus:

> *"An elderly woman who is the only wife in her husband's house should have sexual intercourse with her spouse as he demanded, so that it does not ruin her marriage"*.

4.1.1 Respondents' Sexual Perceptions

Most discussants in all the group sessions were of the opinion that having sex when one is sick could bring about healing effects to the body. Majority of the female discussants said:

> "*If an elderly woman is sick or have any sickness, having sexual intercourse at least once in 2 or 3 months could bring healing effects to her body system*".

A few male discussants strongly felt that some elderly women would have sickness if they do not engage in sexual intercourse. As per frequency of sexual activity, few male discussants were of the opinion that any old man who had more than one round of sex at a go may have stroke; While a few female discussants posited that a woman who has reached menopause is likely to have bad sight and body pain which could likely cause stroke and eventually death if engaged in sex.

The opinion of majority of male discussants was that an elderly man who engages in sexual intercourse with a virgin could boost his immunity against any infection. However they added that an elderly who continually have extramarital sexual relationship may experience sexual infections, since most old men do not like to use condom.

Most discussants in the female sessions said that sexual intercourse is not so common among the elderly, however, they occasionally engage in sex to strengthen the love they have for their spouses. There was agreement among most of the discussants irrespective of gender that in order to overcome family problems, sexual needs of the spouse must be satisfied by the elderly partner. One of the female discussants confessed that she engaged in sexual practices because she did not want her spouse to engage in extramarital sexual relationship if she denied him sex. Some male discussants also confessed that most of their spouses could no longer satisfy their sexual needs, hence they go out for extra-marital sexual relationship.

Majority of the female discussants pointed out that it is not wise to think that when money is spent on women, it would warrant men to force women to have sex with them. Contrarily, the majority of the male discussants believed that women who receive money from men will be ready to pay the prize. As a male discussant put it:

"Some of these women are hit-and-run ladies, they will eat the man's money and run away whereas they should be ready to pay for it".

A few female discussants agreed that it is not good for a woman to extort money from men without satisfying them sexually. One of the female discussants bluntly put it this way:

"Money for hand, back for ground"

Most discussants in all the groups were of the opinion that, most of the elderly women resorted to exchange of money for sex as a method of gratification from sexually active elderly men seeking sexual satisfaction from extramarital relationship. In their own words some of the males put it this way:

"Influential elderly rich men in the community rarely experience rejection because women preferred them due to their money. They added that while the elderly needed sexual satisfaction the ladies would prefer cash and kind."

A few elderly females said that reasons why some women refused to give sex to elderly men were that they made promises and brought nothing. However, a few female discussants felt that women should be blamed for wanting money for sex. A particular elderly woman put it this way:

"*Women accept gifts from men for sex, but at times, would demand unaffordable things (jewelries, shoes, money etc) in order to send the men they did not want away".*

4.2 Sexual Practices of the Respondents

Most female and male discussants believed that elderly women sexual need is greatly reduced than their male counterparts. However, a few female discussants disagreed with that opinion because they believed that there are some old women who are still very active.

Majority of the female discussants believed that many elderly men are sexually active, even when they were over 70 years of age. According to a female discussant:

> "*This thing (Sex) is gift; there are some old men that are more sexually active than some young men*".

A few female discussants believed that the problem of the elderly women is that they lose the urge for sex because they have become physically weaker than their husbands. One female discussant put it this way:

> *"At old age their bodies become so weak, this usually lead to termination of sexual intercourse because of the stress involved but unfortunately their spouses are still very sexually active"*.

In addition, some of the female discussants believed that most elderly woman's sexual organs become dry and tight at old age and this usually cause pains during sexual intercourse, thereby reducing their sexual engagement and excitement.

Non-condom use is common among the elderly; the findings of the FGD discussion, revealed that majority of the male and female participants did not believe condom was important to use during sexual intercourse. One of the male discussants expressed his believe this way:

> "*My own view about it is that the condom is not like flesh and it may cause injury when it is used during sex"*.

Majority of both the elderly male and female discussants did not believe that the use of condom is not necessary for sex at old age, because they echoed that condom was a new technology that never existed during their time, coupled with the strong believe in local herbs for prevention of both pregnancy and diseases. Whereas few still believed that condom use is only useful to those elderly men who are still sexually active and engage in extra marital relationship. However, one of the male discussants who believed that condom use is not useful for old men supported his opinion thus:

> *"Sperm is life it would be wrong to be deposited in a rubber sheath and later thrown away"*.

For some male and female discussants, their feeling was that they have been with their spouses for a long time without engaging in extra-marital relationship, therefore condom use to them is unnecessary. Majority felt that:

> "*Sex at elderly age could not lead to pregnancy, and many of us have not used condom for sexual activity before, because condom use is relatively new product which had not existed during our time."*

They concluded that condom use is for younger generation and not for the elderly. However, a few male and female discussants believed that non-condom use by the elderly people was because they have confidence in traditional herbs, which they perceived as highly efficacious and strong protection against infectious diseases and unwanted pregnancies. Majority of the male and female discussants said that sexual practices tremendously reduced at old age. They added that they have had sex a long time ago since sexual intercourse is no longer priority for them, while a few male and female discussants claimed that they are still sexually active and they engaged in the act in the one-year preceding the study. They concluded that some of the elderly people are still sexually active and engaging in coital activities for sexual excitement and gratifications.

Majority of female discussants said that elderly men made promises, which they did not fulfill but at times gave items to their partners in order to induce them for sex. However, most of the elderly men said that women usually chased them because of money they would get from them. However, some of the female discussants revealed how women usually reached out for their sexual partners as well as how they engaged in sexual negotiation, this they said was usually through what they called "sexual networking" which involves men and women calling parties to attract opposite sex for the purpose of meeting and making sexual transactions. A few women discussants said that women deliberately dress gorgeously to seduce men and sometimes the sexually active elderly men could not resist their appeal. A few female discussants added that:

> *"Some women even put towel to enlarge their buttocks, and would be shaking the buttocks to seduce men".*

4.3 Sexual Problem of the Respondents

There was unanimity of opinion among male and female discussants that some of the sexual problems of the elderly include difficulties in reaching orgasm, painful sex and inability to perform beyond one round of sex at a go, except stimulants are used to enhance performance were major sexual and reproductive health problems of the elderly. However, majority of the discussants felt that sexual dysfunction among the elderly was as a result of ageing. A few female discussants added thus:

> "*Elderly women, who engage in sexual intercourse, usually have hypertension and other diseases because a sperm which should be flushed out during menstruation accumulate in their body system"*. In conclusion, one male discussant expressed his opinion this way: *elderly men would experience back pain and arthritis after engagement in sexual intercourse"*.

4.3 Findings from Survey

Socio-demographic Characteristics of the Respondents

Slightly more than half of the respondents 202(50.5%) were males and 198(49.5%) were females (Table 4.1). A large majority, 302(75.5%) were between 65 and 74 years of age; 154(38.5%) were males and 148(37.0%). While 73(18.2%) were between 75-84 years, which comprised 35(8.7%) males and 38(9.5%). A few 20(5.0%) were between 85 and 94 years, comprising 11(2.8%) males and 9(2.3%) females. While very few 5(1.3%) were between 95 years and above, where males were 2(0.5%) and females 3(0.7%) respectively. The mean age was 71.8 (±6.7) years. The age distribution is shown in (Table 4.1). Half of the respondents 200(50.0%) had no formal education; while more than one third 148(37.0%) had primary education; 36(9.0%) had secondary education; very few 2(0.5%) had NCE; 13(3.3%) had B.Sc or HND and 1(0.3%) had Postgraduate education.

Majority of the respondents 252(63.0%) were Christians; while over one third 148(37.0%) were Muslims. A large majority 365 (91.3%) were Yorubas. There were a few 32(8.0%) Ibos, and very few 3(0.7%) were Hausas (Table 4.1). The distribution of the respondents by occupation shows that slightly more than two third 269(67.9%) were traders; 26(6.6%) were civil servants, while 37(9.3%) were retired civil servants; 31(7.8%) were farmers; and 27(6.8%) were doing nothing, while few 5(1.3%) were house makers. The remaining 1(0.3%) was self employed (Table 4.1).

Table 4.1 Demographic attributes of Respondents

Gender	Frequency		Percent (%)		Total	
					n	%
Male	202		50.5		202	50.5
Female	198		49.5		198	49.5
Total	400		100		400	100
Age (In years)	**Male**		**Female**			
	n	**(%)**	n	**(%)**		
65-74	154	38.5	148	37.0	302	75.5
75-84	35	8.7	38	9.5	73	18.2
85-94	11	2.8	9	2.3	20	5.0
95 years and above	2	0.5	3	0.7	5	1.3
Total	202	50.5	198	49.5	400	100
Educational Level						
No Formal Education	85	21.2	115	28.8	200	50.0
Primary	86	21.5	62	15.5	148	37.0
Secondary	21	5.2	15	3.8	36	9.0
NCE	-	-	2	0.5	2	0.5
HND/B.Sc	9	2.3	4	1.0	13	3.3
Postgraduate	1	0.3	-	-	1	0.3
Ethnic Group						
Yoruba	365		91.3		365	91.3
Ibo	32		8.0		32	8.0
Hausa	3		0.7		3	0.7
Occupation						
Trading	269		67.9		269	67.9
Civil Servant	26		6.6		26	6.6
House maker	5		1.3		5	1.3
Farmer	31		7.8		31	7.8
Retired Civil Servant	37		9.3		37	9.3
Nothing	27		6.8		27	6.8
Self Employed	1		0.3		1	0.3

4.4 Perception of the Elderly about Sexual Practices

Respondents' Perception about Sex and Immunity against Sexual Infections

The survey findings show that majority 275(68.9%) of the respondents perceived having sex with virgin could boost their immunity against Sexually Transmitted Infections including HIV/AIDS, while a sizeable proportion 64 (16.6%) said it is unreligious to have sex with virgin and a few 61 (14.5%) said it could be risky for the virgin. Among those who believed sex with virgin could serve as immunity against infection, comprised 174 (55.1%) males and 101 (45.1%) females. Those that believed that having sex with virgin is unacceptable were 15 (24.5%) males and 49 (28.3%) females; while few 13 (20.4%) males against 48 (26.6%) females believed it could be risky for the Virgin (Table 4.2).

Respondents' Perception about the relationship between Sex and Healing Process

Majority 246 (61.5%) of the respondents believed that sex at elderly could bring healing effect when one is sick. Less than one quarter 85 (26.5%) perceived sex at elderly age to weaken the body system; while 69 (12.0%) posited that it could sustain life. Of those that said sex could bring healing effect, comprised of 114(56.4%) males and 132(66.7%) females. Less than one third 53 (26.9%) of the females and few males 32 (15.7%) said it could weaken the body. Whereas more males 56 (27.9%) than few females 13 (6.4%) believed it could sustain life. (Table 4.2).

Respondents' Perception about Extra-marital Sex

More than one quarter 159 (39.8%) of the respondents perceived extramarital sex as normal and okay, if the spouse could not satisfy the partner. Of this, majority 117 (61.1%) were males and very few 42 (21.9%) were females. On the hand, more than half 215 (53.8%) of the respondents said it was immoral. This comprised of fewer males 74 (33.5%) and majority 141 (70.5%) of females; while 26(6.5%) of the respondents perceived extra-marital sex as Health Risk to both partners. Of this number however, more 15(7.6%) were females while few 11(5.4%) were males respectively. (Table 4.2).

Respondents' Perception about Transactional Sex

The findings of the survey showed that few 48 (12.0%) of the respondents perceived that a man has right to force a lady to have sex with him if he has spent money on her. Of this number, 37 (18.3%) were males and 11 (5.6%) were females. Overwhelming majority 319 (79.8%) said it is bad and improper to force a lady to have sex with a man if he has spent money on her; among the majority who said this, 142 (70.3%) were males and 177 (89.4%)

were females. While a few 33(8.3%) of the respondents believed it is unacceptable. This comprised 23(11.4%) males and 10(5.1%) females (Table 4.2).

Respondents' Perception about Transactional Extramarital Sex

Forty-six (11.8%) of the respondents said that it is normal for an elderly person to engage in transactional extra-marital sex. Those who said it is normal, 38 (18.8%) were males while very few 8 (4.3%) were females. Majority 325 (81.2%) reported that it is a taboo and uncultured to engage in extra-marital sex in order to get money from the partner. In comparison, 145 (71.8%) were males and 180 (90.9%) were females; while a few 29(7.0%) of the respondents were of the view that it is infidelity, and this comprised 19(9.4%) males and 10(4.8%) females respectively. (Table 4.2).

Table 4.2 Perception of the Elderly about Sexual Practices

Having sex with virgin or adolescent could serve as:						
Perception	**Male**		**Female**		**Total**	
	n	%	n	%	n	%
Immunity against STIs/HIV	174	55.1	101	45.1	275	68.9
Unacceptable	15	24.5	49	28.3	64	16.6
Risky for the Virgin	13	20.4	48	26.6	61	14.5
Total	202	100	198	100	400	100
Sex at Elderly age especially when one is sick could bring about:						
Healing effects	114	56.4	132	66.7	246	61.5
Weaken the body	32	15.7	53	26.9	85	26.5
Sustain life	56	27.9	13	6.4	69	12.0
Total	202	100	198	100	400	100
Elderly could engage in extra-marital sex if the spouse could not satisfy the partner						
Normal and Okay	117	61.1	42	21.9	159	39.8
Immoral	74	33.5	141	70.5	215	53.8
Health Risk	11	5.4	15	7.6	26	6.5
Total	202	100	198	100	400	100
A man has right to force a lady for sex if he has spent money on her is:						
Right thing	37	18.3	11	5.6	48	12.0
Bad	142	70.3	177	89.4	319	79.8
Unacceptable	23	11.4	10	5.1	33	8.3
Total	202	100	198	100	400	100
Elderly engagement in transactional extramarital sex is:						
Normal	38	18.8	8	4.3	46	11.8
Taboo	145	71.8	180	90.9	325	81.2
Infidelity	19	9.4	10	4.8	29	7.0
Total	202	100	198	100	400	100

Respondents' View about Condom use by Educational Level

Respondents' views about condom use showed that educationally 4(2.0%) of the respondents with no formal education perceived condom use as reducing sexual drive; and 53(26.5%) reported it is nonsense; while more than one quarter 107(53.5%) said condom was not meant for the elderly; 3(1.5%) held it is harmful using the product and 8(4.0%) believed it is not useful for them; while 7(3.5%) had not experienced it before. Respondents with Primary education 15(10.15%) said there is no sexual drive; 39(26.4%) said it does not make sense using it; and 72(48.6%) reported it is not meant for the elderly while 11(7.4%) said it is not useful to them; and 2(1.4%) had not experienced condom use before. Also 5(14.3%) in Secondary education had no sexual drive for using condom; 8(22.9%) said it is nonsense; and 15(42.95%) perceived condom is not meant for the elderly; while just 1(2.9%) respondent said is not useful at all. In NCE category only 1(50.0%) said condom was not useful while the remaining 1(50.0%) viewed it as nonsense. Respondents 3(23.1%) with HND or B.Sc qualifications reported no sexual drive using the product, and 2(15.4%) said it is nonsense; 5(38.5%) not for the elderly, while 2(15.4%) claimed that condom is not useful at all. One postgraduate (100.0%) respondent reported that it is not for the elderly people. (Table 4.3).

Table 4.3 Respondents' View about Condom use by Level of Education

Response	**Educational Level**						**Total**
	No formal Education	Primary	Secondary	NCE	HND/B.Sc	Postgraduate	
No sexual drive	4(2.0%)	15 (10.1%)	5(14.3%)	-	3(23.1%)	-	27(100%)
Not for Elderly	160(53.5%)	111 (48.6%)	23(42.9%)	1 (50.0%)	7(38.5%)	1(100.0%)	303(100%)
Harmful	3(1.5%)	-	-	-	-	-	3(100%)
Not Useful	8(4.0%)	11 (7.4%)	1(2.9%)	1 (50.0%)	2(15.4%)	-	23(100%)
No Interest	7(3.5%)	2(1.4%)	-	-	-	-	9(100%)
No Response	18 (9.0%)	9(6.1%)	6(17.1%)	-	1(7.7%)	-	34(100%)
Total	200	148	35	2	13	1(100.0%)	400(100%)

*Multiple Responses

4.5 Sexual Practice of the Respondents

Respondents' reported last Sexual Intercourse by gender

From the findings of the survey, a total of 126(25.0%) of the respondents had extramarital sex, which comprised more males 99(24.7%) than females 27(6.8%). However, further report from the survey reveals that among those who had extramarital sex, a total of 41(32.5%) of the respondents had it with inherited spouses, among those who engaged in the extramarital sex during this period 33(26.1%) were males and few 8(4.5%) were females. The breakdown of the extramarital sex also shows that few 6(4.8%) had extramarital sex with their friends and this comprised only males 6(4.8%) which had sexual intercourse with friends; while on other hand very few 4(3.2%) engaged in extramarital sexual intercourse with commercial sex workers, comprising more 3(2.4%) males than a female 1(0.8%). (Table 4.4).

Table 4.4 Respondents' Engagement in Extramarital Sex

Extramarital Sex	Male		Female		Total	
	N	%	n	%	n	%
Yes	99	24.7	27	6.8	126	25.0
No	103	25.7	171	42.8	274	75.0
Total	202	50.4	198	49.6	400	100
Type of Partner during Extramarital Sex						
Inherited Spouse	33	26.1	8	6.3	41	32.5
Friend	6	4.8	-	-	6	4.8
Commercial Sex Workers (CSWs)	3	2.4	1	0.8	4	3.2
No Response	57	45.2	18	14.3	75	59.5
Total	99	78.6	27	21.4	126	100

Respondents' Frequency of Extramarital Sex

As shown in Table 4.5, a total of 82(65.1%) of the respondents engaged in extra-marital sex once, this comprising 70(55.5%) males and 12(9.5%) females; while 22(17.5%) engaged twice since they attained the age of 65 years. Of this number, 15(11.9%) were males and 7(5.6%) were females that enagegd in the extramarital sex; whereas a few 16(12.7%) engaged in the act more than twice. In addition, it was clear that more males 11(8.7%) than females 5(4.0%) engaged in extramarital sex more than twice. However, 6(4.8%) of them could not remember how many times they engaged in the extramarital sex since they attaining the age of 65 years. See Table 4.5 below.

Table 4.5 Respondents' frequency of Extramarital Sex since attaining 65 years

Frequency of Extramarital Sex	Male		Female		Total	
	N	%	n	%	n	%
Once	70	55.5	12	9.5	82	65.1
Twice	15	11.9	7	5.6	22	17.5
Many	11	8.7	5	4.0	16	12.7
Can't Remember	3	2.4	3	2.4	6	4.8
Total	99	78.5	27	21.5	126	100

Respondents' Condom Use since attaining 65 years old

The elderly people who were sexually active during the period of the survey were 204(51.0%) comprising 154(76.2%) of the males and few 50(12.6%) females; while slightly less than half 193(48.3%) were not sexually active in the two years preceding the survey. Majority 148(65.9%) of these were females and few 45(23.8%) males respectively. However, among those who were sexually active during the period of the survey, including those who had engaged in multiple sex since they attained the age of 65 years, only few 27(6.8%) used condom; while the majority 343 (85.8%) did not. Of the number that used condom during the period 24(11.9%) were males and very few 3 (1.5%) were females. However, by contrast, those who did not use condom during the period, comprised close to half 96(47.8%) of males and a few 24(13.4%) females respectively. Moreover, more than a quarter 120(30.0%) engaged in multiple sex. See table 4.5.1 below.

Table 4.5.1 Respondents' Active Sexual Engagement

Sexually Active	**Male**		**Female**		**Total**	
	n	%	n	%	n	%
Two years preceding the survey	154	76.2	50	12.6	204	51.0
More than two years preceding the survey	45	23.8	148	65.9	193	48.3
No Response	-	-	3	1.5	3	0.7
Total	202	100	198	100	400	100
Condom Use						
Yes	24	11.8	3	1.4	27	13.2
No	96	47.1	24	11.8	120	58.8
No Response	34	16.6	23	11.3	57	27.9
Total	154	75.5	50	24.5	204	100

Respondents' Reasons for Non Condom Use

The survey finding shows that the reason for non-use of condom was that slightly more than half 61(50.8%) of those who did not use condom during sex in the two years preceding the survey did not like to use condom. This number comprised of 52(43.3%) were males and 9(7.3%) were females. Also a sizeable proportion 27(22.5%) reported that their partners did not like to use, this comprised of 25(20.8%) males and 2(1.7%); while few 12(10.0%) who did not think of condom during sex, were 5(4.2%) males and 7(5.8%) females. A few 13(10.8%) viewed condom as not necessary; this was reported by 9(7.5%) males and 4(3.3%) females. However, on accessibility and availability a few 3(2.5%) of the respondents did not have anyone at hand; while only a male 1(0.8%) respondent reported he could not get one (Table 4.6).

Table 4.6 Respondents' Reasons for Non-Condom Use

Reasons	Male		Female		Total	
	N	%	n	%	n	%
None at Hand	2	1.7	1	0.8	3	2.5
Couldn't get one	1	0.8	-	-	1	0.8
Partner didn't like it	25	20.8	2	1.7	27	22.5
I don't like it	52	43.3	9	7.5	61	50.8
Not necessary	9	7.5	4	3.3	13	10.8
Didn't think of it	5	4.2	7	5.8	12	10.0
No Response	2	1.7	1	0.8	3	2.5
Total	96	80.0	24	20.0	120	100

Respondents' Views about Condom Use

The feelings of the respondents about condom use in this survey shows that 27(6.8%) of the respondents reported there is no sexual drive using condom; this comprised of 25(12.4%) males and 2(1.0%) females. Also a sizeable proportion 103(25.8%) said it is not useful, of this number, 76(37.8%) were males and 27(13.6%) females respectively. Half 200(50.1%) of the respondents said condom is not for the elderly, among those who reported this were 69(34.3%) males compared to 131(66.2%) who were females. Moreover, only 3(1.5%) of males said it is harmful; while 23(5.8%) said it is protective, this comprising of more 21(10.4%) males than very few 2(1.0%) females. Nine (2.3%) also had no interest for condom use. However, among those who had no interest for condom use more 7(3.5%) females than 2(1.0%) males reported they had no interest for condom use. (Table 4.7)

Table 4.7 Respondents Views towards Condom Use

Reasons	Male		Female		Total	
	N	%	n	%	n	%
No Sexual Drive	25	12.4	2	1.0	27	6.8
Not useful	76	37.8	27	13.6	103	25.8
Not for the elderly	69	34.3	131	66.2	200	50.1
Harmful	3	1.5	-	-	3	0.8
Protective	21	10.4	2	1.0	23	5.8
No interest/experience	2	1.0	7	3.5	9	2.3
No Response	6	2.5	29	14.6	35	8.5
Total	202	100	198	100	400	100

4.6 Negotiation in Sexual Activities by the Respondents

Sexual Transaction of the Respondents

As the findings of this study has shown, more than one quarter 23(18.3%) of the respondents engaged in extramarital sex through monetary negotiation. There were more males 20(15.9%) among those who gave out monetary items for extramarital sexual relationship than 3(2.4%) females. Eleven (8.7%) reported being kind to entice their partners, of this 10(7.9%) were males and 1(0.8%) female. Whereas 10(7.9%) used dressing and appearance to entice their partners, this comprised 9(7.1%) males and 1(0.8%) female. While more than one quarter 27(21.4%) did not use any means in engaging in extramarital sexual enticement; this number showed that more 14(11.1%) were females than males 13(10.3%) were males. (Table 4.8).

Table 4.8 Respondents means of Sexual Enticement

Sexual Enticement	Male		Female		Total	
	N	%	n	%	n	%
Money	20	15.9	3	2.4	23	18.3
Gift/Items	7	5.6	2	1.6	9	7.1
Being kind	10	7.9	1	0.8	11	8.7
Dressing/Appearance	9	7.1	1	0.8	10	7.9
None	13	10.3	14	11.1	27	21.4
No Response	40	31.7	6	4.8	46	36.5
Total	99	78.6	27	21.4	126	100

Respondents' reported period of last Sexual Intercourse

Majority 167(41.8%) of the respondents had their last sex a long time ago more than two years preceding the study; most 143(72.2%) were females with few 24(11.9%) been males. On the other hand few 41(10.3%) has sexual intercourse last night, out of this 39(19.3%) were males and 2(1.0%) were females. In addition, a total of 4(1.0%) had theirs between two to six days, 61(15.3%) had sexual intercourse one to three weeks; 29(7.3%) engage in the sex one to eleven months preceding the study while 44(11.0%) of the respondents had their last sexual encounter one to two year(s) preceding the study. Of this number, 33(16.3%) were males and very few 11(5.6%) were females. Whereas 5(1.3%) reported none, among this number, more 4(2.0%) were females and 1(0.5%) was a female. (Table 4.9) for details.

Table 4.9 Respondents' reported period of last Sexual Intercourse

Period of last Sexual Intercourse	Male		Female		Total	
	n	%	n	%	n	%
Last Night	39	19.3	2	1.0	41	10.3
2-6 days	3	1.5	1	0.5	4	1.0
1-3 weeks	54	26.7	7	3.5	61	15.3
1-11 months	25	12.4	4	2.0	29	7.3
1-2 years	33	16.3	11	5.6	44	11.0
Long time ago	24	11.9	143	72.2	167	41.8
Can't Remember	19	9.4	8	4.0	27	6.8
None	1	0.5	4	2.0	5	1.3
No Response	4	2.0	18	9.1	22	5.5
Total	202	100	198	100	400	100

Respondents' View about Improving Sexual Performance

Table 4.10 shows that a sizeable proportion 33(16.2%) of the respondents used local herbs to improve their sexual performance and 20(9.8%) of them were males and 13(6.4%) were females that used drugs to enhance their sexual performance. Few 19(9.3%) used drugs to enhance sexual performance, 17(8.3%) were males and 2(0.9%) were females. Whereas, 36(17.6%) indulged in the use of alcohol for improving their sexual performance. Of this number majority 33(16.2%) were males and very few 3(1.5%) were females. Moreover, overwhelming proportion 111(54.4%) of the respondents used nothing to enhance their sexual performance. This varied proportionally by gender with more males 82(40.2%) than females 29(14.2%) as detailed in Table 4.10 below.

Table 4.10 Respondents' View about Improving Sexual Performance

Means of Sexual Enhancement	**Male**		**Female**		**Total**	
	N	%	n	%	n	%
Use of herbs	20	9.8	13	6.4	33	16.2
Drugs	17	8.3	2	0.9	19	9.3
Alcohol	33	16.2	3	1.5	36	17.6
Nothing	82	40.2	29	14.2	111	54.4
No Response	2	0.9	4	1.9	6	2.9
Total	154	75.8	50	100	204	100

4.7 Factors Responsible for Respondents' Extramarital Sexual Behaviour

Table 4.11 shows the factors responsible for respondents engagement in extramarital sexual relationship. Among those who engaged in extramarital relationship slightly less than half 43(34.1%) of the respondents reported that loneliness was a major factor responsible for elderly engagement in extramarital sexual relationship. This factor varied with gender, more 35(27.8%) were males compared with few 8(6.3%) females expressed loneliness as a factor. However, slightly more than one quarter 41(32.5%) of the respondents identified death of spouse as a reason for elderly engagement in extramarital relationship. Among those who reported this, were 30(23.8%) males and few 11(8.7%) females.

Furthermore, majority 14(11.1%) of the respondents indicated that separated home was responsible for elderly extramarital sexual relationship. Comparatively, more 11(8.7%) males than 3(2.4%) females reported this. However, a few proportion 11(8.7%) of the respondents reported that influence of alcohol and drug were contributing factors. Among this number, more 10(7.9%) were males than 1(0.8%) who was a female. Similarly, peer pressures 5(4.0%) amounted to one of the responsible factors for extra-marital sexual engagement reported by the elderly people. This comprised 4(3.2%) males and 1(0.8%) female; while strong sexual urge was reported by 1(0.9%) a female as a responsible factor for extra-marital sexual relationship. (Table 4.11).

Table 4.11 Respondents' Reported reasons for Extramarital Sex

Reasons	Male		Female		Total	
	N	%	n	%	n	%
Loneliness	35	27.8	8	6.3	43	34.1
Death of spouse	30	23.8	11	8.7	41	32.5
Separated home	11	8.7	3	2.4	14	11.1
Influence of Alcohol/drug	10	7.9	1	0.8	11	8.7
Lack of finance	8	6.3	1	0.8	9	7.1
Peer pressure	4	3.2	1	0.8	5	4.0
Strong sexual urge	-	-	1	0.9	1	0.9
No Response	1	0.8	1	0.8	2	1.6
Total	99	78.5	27	21.5	126	100

4.8 Sexual Problems and Dysfunctions

The findings from the survey in Table 4.12 show respondents' sexual dysfunction since they attained the age of 65 years. A total of 63(15.8%) of the respondents reported that the major sexual dysfunctions among the male respondents were early ejaculation and erectile dysfunction. These sexual problems were reported by 56(27.7%) males while 7(3.5%) females said their spouse/partners also experienced the same sexual dysfunction. By contrast, overwhelming majority 21(5.3%) of the respondents reported that Inadequate Vaginal Lubrication in women were their major sexual problems and dysfunctions the early are facing. This comprised of 21(5.3%) of females while only 6(2.9%) of males reported same for their partner. In addition, a few 25(6.2%) of the respondents reported Inactive and Non Performance as sexual problems they had, this made up of 15(7.4%) of males and 10(5.1%) of females. Similarly, lack of interest for sexual intercourse was reported by majority 120(30.0%) of the respondents, this comprised of more 72(35.6%) males than females 48(24.2%). Another sexual dysfunction affecting the respondents was painful sexual intercourse, a total of 48(12.0%) of the respondents reported this. The breakdown shows that painful sex was more prevalent in females than males, and this comprised of very few 4(2.0%) males than majority 44(22.2%) of females. Furthermore, lack of sexual drive and sensitivity was also reported by majority 36(9.0%) of the rspondents. Among those who experienced this condition, were slightly more 20(10.0%) males than females 16(8.1%). Whereas very few 8(2.0%) of the respondents reported no sexual problems. (Table 4.12).

Table 4.12 Respondents' Reported Sexual Problems and Dysfunctions by Couples

Sexual Problems/Dysfunctions	Male		Female		Total	
	N	%	n	%	n	%
Early Ejaculation/Erectile dysfunction	56	27.7	7	3.5	63	15.8
Inadequate Vaginal Lubrication	6	2.9	15	7.6	21	5.3
Inactive and Non Performance	15	7.4	10	5.1	25	6.2
Lack of interest for Sexual Intercourse	72	35.6	48	24.2	120	30.0
Painful Sex	4	2.0	44	22.2	48	12.0
No Sexual Drive and Sensitivity	20	10.0	16	8.1	36	9.0
None	2	1.0	6	3.0	8	2.0
No Response	27	13.4	52	26.3	79	19.7
Total	202	100	198	100	400	100

*Multiple Responses

CHAPTER FIVE

DISCUSSION

This chapter discusses the results and findings of the study. The presentation of the discussion is grouped under five headings namely: socio-demographic characteristics, sexual perception, practice, factors influencing risky sexual behaviour and sexual problems and dysfunctions. The chapter ends with the conclusion, implications for Health Education, recommendations and suggestion for further research.

5.1 Respondents' Socio-Demographic Characteristics

The age distribution of the respondents showed that most of the elderly (75.7%) were aged 65-74 years, which corresponds with active ageing population by United Nations as those over 60 years of age. A few (5.0%) were between 85-94 years of age. Although the life expectancy in Nigeria is put at 43 years by UNDP (2005), many Nigerians still live very long. The fact that majority (91.3.0%) of the elderly were Yorubas is expected because of the study location. Ibadan is in Southwest Nigeria and is predominantly Yorubas. High proportion (50.0%) of the elderly especially in the female gender had no formal education compared to their male counterparts. This may probably be due to the fact that during their early childhood there was little attention paid to education, because the male child was seen as the heir of the family and the meager family resources should be expended on the male child's education. Culturally then, female child was prepared to become a mother whose main responsibility included housekeeping and child rearing.

In contrast, a sizeable proportion (37.0%) of the elderly had primary education, while very few (9.0%) had secondary education. On the other hand, many (46.0%) of the male children that received primary and secondary school education did not receive tertiary education. This is probably owing to inadequate tertiary institutions in Nigeria at that time, coupled with adequate opportunities for employment for primary and secondary school graduates. This has serious policy implication because evidence has it that elderly people without adequate education has been reported by Story (1989) to indulge in more risky behaviour. This also explains the negative perception the elderly people have pertaining to sexual behaviour in this study. This according to Story seems to suggest that elderly people, especially retired home residents, need more in-depth education about their own sexuality and sexual functioning. Deacon et al, (1995) had reported that there is ample evidence to suggest that sex education for older people usually leads to the development of more positive

behaviours. However, in general, the elderly people have fewer opportunities to access education than the younger people, although, education is not really enough to change people's behaviour. But it seems the elderly could still practice positive behaviour if the three groups of factors of PRECEDE Model are adopted and promoted. For instance, adequate social support and the influence of significant others would enhance the adoption and maintenance as well as sustainability of positive sexual behabviour. There were more Christians (63.0%) than Muslims (37.0%). This could be a reflection of the distribution of residents of the area by religion. As it were, in the peripheral area of Ibadan, more Christians are expected to live there, while in the inner-core, more Moslems live there. Usually there are more Moslems in Ibadan than Christians, but in this local government area there are more Christians than Moslems.

5.2 Perception of Sexual Behaviour of Respondents

The elderly people are regarded in the society as custodian of knowledge and culture. Many atimes the knowledge follow the cultural perception, beliefs and practices, which may be positive or negative. No wonder a large majority (68.8%) had reported that, having sex with virgin or adolescents could boost immunity against STIs/HIV/AIDS. Sex with tenage girls has been reported by Luke, (2003) that elderly men prefer younger sexual partners such as teenage girls and virgins because they are believed to be less likely to be infected with HIV. This perception can lead them to risky sexual behaviour because according to Youngerman (2005) example of risky sexual behaviour included early sexual activity before the age of 18 years. In some African societies in particular, men believe that having sex with a virgin or an infant girl can cleanse a man of HIV infection, as is the case in South Africa (Gupta, 2002). This is in line with the findings of this study, which implies gaps in the elderly's reproductive health knowledge and their perception about the effect of having sex with young girls. This gap in knowledge could probably becuase of low level of formal eduction among the elderly, while the negative perceptions could also be deeply rooted in cultural belief. Gerontological research has shown that knowledge and attitudes toward sexuality influence perceptions about sexual needs and feelings in later life. This is in line with the conclusion of Hillman and Stricker (1994) that there is generally a strong positive relationship between knowledge of and attitudes toward sexuality in later life.

Furthermore, an overwhelming proportion (61.5%) perceived sex at elderly age as healing process especially when one is sick, which is proportionally distributed between gender. This is also an indication of serious gap in reproductive health knowledge, perception and attitudes towards sexual activities. This is a problem that needs urgent attention. Kiragu

and Zabin (1995) reported that old people's sexual activities are based on insufficient knowledge and misconceptions rather than on a rational consideration of the consequences, and elderly persons may not have enough understanding to know how to protect themselves and even if they do, they may not have the capacity to act on the knowledge of prevention in view of their perceptions.

Less than half (39.8%) of the elderly people perceived extramarital sex as normal and okay, especially if the spouse could not satisfy the partner sexually. According to FGD findings, some male discussants confessed that most of their spouses could no longer satisfy their sexual needs; hence, they go out for extra-marital sexual relationship. More so, a few (12.0%) of the elderly perceived that a man has the right to force a woman to have sex with him if he has spent money on her. In the FGD, majority of the male discussants expressed their view that women who receive money from men will be ready to pay the prize. A female discussant bluntly put it this way: *"Money for hand, back for ground"*. While others considered it as unacceptable, majority of the female discussants did not agree with that idea. Similarly, some (4.3%) of the elderly females posited that it is normal for an elderly woman to engage in extramarital sexual transaction. All these perceptions are negative and according to Hubley (1994), negative perception combined with ignorance could encourage misunderstanding and misconception. Clearly, educational intervention is needed to dispel negative myths, stereotypes, and self-fulfilling attitudes in elderly people and to promote the perception that full sexual expression is part of the entire extent of elderly hood.

There was no significant relationship found between educational level and perception of risky sexual behaviour. However, apart from gender, which was found to be significant, other demographic variables such as age and religion were not statistically significant. This is in support of the argument of Ajzen and Fishbein (1980) that although knowledge of sexual risk behaviour varied significantly by level of education, in their findings, there was only slight variation in sexual risk status by level of education. This is also consistent with the findings of Dada (1996) that changes in knowledge do not necessarily lead to changes in behaviour. He added that those who were knowledgeable about sexual risk behaviour were faced with barriers such as lack of finance that enhance the adoption and maintenance of safe sexual behaviour. A small proportion of the elderly in this study has positive sexual behaviour, this calls for urgent need to investigate the apparent disconnection between knowledge of risk and positive behaviour (Phanjoo, 2000). This shows that knowledge only may not be adequate to make people's bahaviour positive without enabling factors such as affordability and accessibility of resources like adequate financial support and reinforcing factors such as significant others (peers, religious and community leaders etc). However,

Asuzu, (1994) and Ososanya and Brieger, (1994) reported that knowledge of sexual practice will increase with level of education.

5.3 Sexual Practice

Majority (51.0%) of the elderly especially in the age group 65-74 years were sexually active representing those active ageing population. This is in line with the findings of Brahler and Unger (1994) in their study on elderly people aged 60-75 years. However, it is inconsistent with the findings of Hall et al (1982) about the stereotypes that older people are physically unattractive, uninterested in sex and incapable of achieving sexual arousal. In this study, majority of the elderly reported that since they attained the age of 65 years, the last sexual intercourse they had was with their legal spouses, which suggests that the elderly may be faithful to their spouse. The reason could be probably at this age the elderly people were trying to settle down and they believed they have spouse at home. Another reason is usually, frequency of sexual activity is greatly reduced at elderly age, that is why in the FGD, majority of the male and female discussants expressed the view that sexual practices diminish with age and most of them do not take sexual practices as priorities any more.

In the survey, a total (25.0%) of the elderly people engaged in sexual intercourse with persons other than their spouses since they attained the age of 65 years. This suggests that many elderly still have multiple sexual partners and they may be prone to risky sexual practices. Usually as expected more males than females indulged in this act. This is so because by nature men show more interest in sex than women. For example, menopausal women have limited interest for sex than men because of menopause. Moreover, in the FGD, majority of the females stated that sexual practices diminish at menopause and that most of the elderly females do not take sexual practices as priorities any more because of the challenges pose by menopause.

However, unprotected sex and risk behaviour were predominantly common among the elderly. In this study among those who were sexually active during the period of study who had sexual intercourse, majority (58.8%) did not use condom. This could be probably the perception of condom use by the elderly people and this was substantiated in the FGD results in which majority expressed their views that condom use was for prevention of pregnancy only. This shows that the elderly are limited in their knowledge about the purpose of condom use. They also lack the understanding of its use for prevention of sexual infections. This is because according to FGD findings many elderly believed that condom reduces pleasure and excitement during sexual intercourse and this is consistent with the results of PROMACO, (2001) in a study in Burkina Faso, that elderly men and women

agreed that condom reduces sexual pleasure. In similar study by Sunmola, (2005), he also found that condoms hindered elderly sexual satisfaction, caused health problems and reduced their sexual interest. These attitudes to condom use were largely influenced by general negative perceptions, however this could be addressed within the contexts of ecological model by providing information that would erase negative perception and barrier at all levels.

The fact that (12.7%) of the elderly engaged in extramarital sexual relationships many times have negative effects on healthy ageing. According to FGD findings majority of the females posited that elderly women, who engage in multiple sexual intercourse, usually have hypertension and other diseases because according to them sperm, which supposed to be flushed out during menstruation, accumulate in the body system and cause several health problems. Whereas some males on the hand were of the view that elderly men who engage in sexual intercourse would experience back pains and arthritis.

5.3.1 Condom Use and Non Use

A few (13.2%) sexually active elderly who engaged in multiple sex used condoms since attaining the age of 65 years. This is particularly the case among elderly men (11.8%) than women (1.4%) in this study. This differential by gender is well known, as studies by Akinrinola et al (2007) have shown that men often tend to report more condom use than women, even among the elderly in marital relationships. However, it is still unclear whether this is due to actual difference in use or reporting error, as it may be argued that women may fail to report condom use because their partner, not they, put the device on. In this study, more elderly men (76.2%) reported more interest in sex in the two years preceding the study than women (12.6%). Actually, by nature, men show more interest in sex than women as discussed earlier, but this could also be probably because of culture, which seems to restrict females from sexual expression and safe sexual negotiating power when compared to their male counterparts. This cultural norm is prevalent in many African countries, especially in Nigeria as reported in some quarters such as in a rural community in Nigeria where men could have extramarital sexual relationships while their wives abstain (Ajuwon, et al., 1994).

This sexual negotiating disparity may result in non-condom use, which has already been reported earlier that condom hindered their sexual gratification. Although, negotiation to use may be difficult since suggesting the use of it is often seen as a sign of mistrust in a sexual relationship. In addition, the ability of elderly female to negotiate the use is made difficult if they have received gifts or money (Amuyunzu et al 2005), and more so, they lack the negotiating and communication skills about condom use, other reasons according to MacPhial and Cambell, (2001) included dislike of the product and fidelity. According to the

FGD findings elderly men and women reported that they felt safe with their partner. Yet, in the view of Guiella and Madise (2007), feeling safe depends very much on the type of partner and whether or not there are other concurrent sexual relationships. However, despite extensive efforts in promoting condom use among the elderly, some still engaged in risky sexual behaviour and condom use remained relatively low. Although, a multitude of factors might impede elderly people's ability to protect themselves by using condoms, which according to Akinrinola et al (2007) included attitudes towards condoms and ineffective use of the method. Numerous studies found that elderly people's perceptions of condom tend to be negative (Muyinda et al 2001) and studies have also documented that elderly people have concern about condom safety as well as its negative effects on sexual enjoyment (Nzioka, 2001). These reasons could be regarded as myths, as such. Fear of side effects as reasons has always been a major reason why they do not use contraceptives including condom (Oronsaye and Odiase 1983; Nichols et al 1986). This unfounded fear of side effects probably explains why most elderly resorted to non-use. This is line with a study in Western Uganda, where some sections of the population were reluctant to adopt condom use allegedly because it is incompatible with their sexual styles (Kibombo et al 2007). This implies that the elderly especially the females should be adequately educated on the safety and effectiveness of condom use, because of its dual protection of preventing pregnancy and infections. Condom is a popular method being promoted for preventing unwanted pregnancy and STIs including HIV/AIDS for sexually active people. But socioeconomic circumstances or gender inequalities characterized by sexual relationships between men and women could hinder adherence and consistent use. Reason is that women tend to be at risk in this regard, as the combined effects of gender inequality and poverty considerably dis-empowered them, thereby increasing their vulnerability. For elderly people, many of which had multiple sex irregularly, the method is particularly appropriate because it is coital dependent. It could provide effective protection against risks and however only correct and consistent use of the method can achieve this goal. Therefore it is not enough to encourage them to use it, it is equally important to help them to be effective users of the methods (Akinrinola et al 2007). According to Guiella and Madise, (2007) this attitude of non-use has strong negative influence and this is a great challenge for prevention programmes to develop efficient strategies to convince the elderly that non-use can jeopardize their lives. More so, tackling misperceptions is a challenge for programme and policy aimed at increasing safe sex practices among the elderly who are sexually active in order to help them live a healthy sexual life (Akinrinola et al 2007).

5.3.2 Factors Influencing Risky Sexual Behaviour

Among reported factors influencing risky sexual behaviour among those who engaged in extramarital relationship were loneliness (34.1%) and deaths of spouse (32.5%). Apart from these two factors, separated home (11.1%) was apparently more likely to make the elderly engaged in risky behaviour. This is consistent with findings of Dada (1996) that people who live alone are more likely than others to be of high sexual risk status than others. Living alone implies that the elderly could not subject the partner's activities and movement to control, such elderly are free to associate with and visit friends of their choice and vice versa. Through frequent visits, according to Ajzen and Fishbein (1980), some of these friends may exert considerable influence on them to engage in risky behaviour. This is in line with the second level of ecological model of inter-personal influence in relationship. Loneliness may make elderly people succumb to the influence of friends; this explanation may not be valid for those whose partners are alive and they live together. The argument is that their movement will be controlled and what this suggests that a living arrangement where the couples stay together especially at elderly age will enhance restriction on extramarital relationships. Similarly, the effects of death of spouse were reported in some quarters that many older couples have to deal with problems of "sameness" and boredom, which adversely affect their sexual relationship (Garrison, 1989). According to Malatesta et al, (1988) this is more common with sexual adoption of women following the loss of their marital partner.

Moreover, females who have separated are usually very vulnerable to risky behaviour mainly for economic reasons (Asiimwe et al 2003; Amuyunzu et al 2005) because they often have to financially fend for themselves (and perhaps for their children as well) having been deprived of their former livelihoods. The implication is that with limited education and lack of access to capital resources, such females make easy prey for men according to Kibombo et al (2007) and in the conclusion, they said poverty is widely known to increase vulnerability to risky sexual behaviour. As it were, risky activities may be an indirect indication of family problems (Kiragu and Zabin 1993). However, since divorce and separation were reasons for engagement in extramarital relationship. This suggests that when couples live together and avoid circumstances that could lead to serious family crisis like extramarital affairs they could enhance the adoption and maintenance of safe sexual behaviour among themselves. It is therefore clear that elderly with broken marriages are much more likely to engage in risky behaviours than other cohorts. This increased vulnerability needs to be recognized at family, community and programme levels so that such elderly should be provided with appropriate support in terms of information and services.

Lack of finance (7.1%) was another responsible factor reported by the elderly for

risky sexual engagement. In a study conducted by Dada, (1996) (although on adults), people who turn to sexual partners for financial support are more likely than others to be of high-risk status. This finding is in line with that of Orubuloye et al (1991) that sexual networking is an index of economic networking. In addition, Ajuwon (1990) reported that some women explained that they engaged in sexual activities because of inadequate financial support, which is consistent with the findings of this study. This could be explained by two reasons. Firstly, the elderly who relied on sexual partner for financial support may find it difficult to refuse unprotected sexual intercourse; neither can they control the sexual activities of their partners. Secondly, some of them may change a partner who could not meet their financial obligations or may have more than one partner to meet such obligations. This suggests that the family and community levels in ecological model can enhance the avoidance of risk behaviour among the elderly when socioeconomic supports are provided to them.

Since the need for financial favours is a crucial determinant of sexual relationship of women, (Orubuloye et al 1991; Ajuwon 1990) it is possible that, as the elderly get older and loss of support sets in, there is corresponding increase in their financial need (since they have to bear the burden alone). However, under situations of inadequate financial support from their families, many of them especially the females may be compelled to engage in risky behaviour to meet their needs. This is substantiated in a related study by Ajuwon, et al, (1994) and Adekunle and Ladipo, (1992) that, a number of married women were found to keep extramarital sexual partners who assist them financially including accepting food or money from the older men with whom they establish casual sexual relationship. This high level of poverty according to Ajuwon and Shokunbi, (1997) forced many women in Nigeria into risky activities. The problem of poverty in Nigeria requires a holistic intervention because according to report by UNDP (2005) the percentage of Nigerians living in absolute poverty, rose from 28% at independence to 49% in 1998.

On the other hand, a few (8.7%) of the elderly reported that under the influence of alcohol and use of drug they engaged in risky sexual activities. This is not different from the findings of Lewin (1982) and Dada (1996) which reported that proportion of drinking adults who were of high-risk status was higher than their non-drinking counterparts. The implication is that under the influence of alcohol elderly people may not think of using condom which is in line with the observation of Lewin, (1982) that elderly people are more apt to engage in unprotected sexual intercourse after drinking and are more than four times as likely to be sexually active than those who do not engage in risky taking behaviour. This statement is substantiated by Kiragu and Zabin (1993) about substance abuse (including use of alcohol) by elderly people. This implies that the elderly should be discouraged from taking alcohol

and other drugs that could impair their sense of judgment. Alcohol has been reported in many quarters for influencing individual attitude towards risky behaviour including indulging in unprotected extramarital sex with multiple partners. According to Deacon, et al, (1995) factors other than social constraints, such as psychological problems resulting from depression from alcohol and drug rather than economic worries, will actually militate against a regular sex life thereby leading to exposing one to risk factors. Alcohol use by the elderly person may lead to some loss of self-esteem, which invariably affects the negotiating power for condom use and safe sex as the report concluded.

Peer pressure (4.0%) was another reported reason for engagement in extramarital affairs. This factor is consistent with other findings in other African countries that peer pressure can influence women to enter into transactional sexual relationships. While this might be deemed coercive, sex partner is not perpetrating the coercion. Women can be strategic about the sexual arrangement they make using money as a reason to have sex when love is not present, as was the case by women in Uganda (Moore et al 2007) and also in line with the findings of Meekers and Claves (1997) in Cameroon. In the report women ask for gifts sometimes to get the relationship started in Uganda while rejecting sex partners for not giving enough in Malawi.

However, there was no statistical significant association found between factors responsible for engagement in risky sexual behaviour and religion. This could be that the two religious faiths that the elderly belong (Christianity and Islam) maintain that sexual activities should only be in marriage. But it appears that few of elderly did not abide by this religious injunction. It could be according to Kiragu and Zabin (1993) religiousness among people is indifferent towards sexual activities. It is noteworthy therefore, that the behaviour of the elderly towards risky behaviour did not vary with religion. It could also be that their religious faith was not strong enough to affect their behaviour towards sexual risk. On the other, other demographic variables such as gender, age and level of education were not significant also. This is inconsistent with the findings of Kibombo et al (2007) that age is strongly (particularly among males) associated with engaging in risky behaviour. While in the same observation, Dada (1996) found that age is significantly associated with sexual risk and knowledge of sexual behaviour. It was found that sexual risk behaviour increased with age and level of education, but he concluded that there was no significant association between level of education and adults' sexual risky engagement, which is in line with the findings of this study. Although the study was among young people, there is still dearth of research information pertaining to the elderly people.

5.3.3 Sexual Negotiation, Transaction and Coercion

Majority (18.3%) of the elderly people who engaged in extramarital relationship involved in transactional sex while few (7.1%) of them exchanged gift or items for sexual negotiation and extramarital activities. This finding is not different from the findings of Moore et al, (2007) that the practice of receiving money and gifts for sex was generally perceived to be a consequence of women's poverty. Yet research on transactional sex (Nzioka, 2001; Chatterji et al 2004) found that engaging in sex for money or gifts does not appear to be mostly for economic survival. Luke and Kurz divided women's financial interest in engaging in transactional sex into three categories: economic survival, to increase long-term life chances and to increase status among one's peers. Of these various reasons, economic survival is the most coercive reason to have sex. The greater the financial dependence on the reasons one's partner provides, the more coercive the sex (Kuate-Defo, 2004). Having sex for money or gifts has frequently been linked with having sex with older partners. A research by Moore et al, (2007) found that less than a quarter of women have partners who are 10 or more years older than they are. This practice is very risky because receiving gifts and money in exchange for sex as studied by Luke and Kurz (2002) within transactional relationships, women lack power and skill to negotiate condom use or to control the use of violence. This is so because for elderly female, the ability to negotiate for condom use may be harder if they have received gifts and money. That is why Kaufman and Stavrou (2004) found in South Africa that accepting a gift meant agreeing to men's right to demand sex. This finding is consistent with results from Kenya, Tanzania and Malawi that gifs or money can be a barrier to condom use (Moore et al, 2007). Luke and Kurz (2002) concluded that for many elderly women engaging in sex for gift or money, financial rewards take precedence over fears of infections.

5.4 Sexual Problems and Dysfunctions

Since attaining 65 years of age, the elderly people reported experiencing sexual dysfunction. The sexual dysfunctions included lack of sexual interest (30.0%), early ejaculation and erectile dysfunction (27.7%) by men. While on the other hand, some (7.6%) of the elderly females reported inadequate vaginal lubrication as their major sexual problems and dysfunctions. This is consistent with the findings in ten Asian Countries by Alfredo et al., (2005) that majority of the elderly men (20.0%) and women (30.0%) complained of having at least one sexual dysfunction or the other. In this study however, a few (9.0%) reported lack of sexual drive and sensitivity. While a sizeable proportion (12.0%) reported that, their sexual problem was painful sex. A few (6.2%) indicated inactive and non-performance as other

sexual dysfunctions among the elderly people. These findings are in agreement with the findings of some studies by American Psychiatric Association, (1994), Laumann et al, (1999) and Alfredo et al., (2005) on geriatric sexual dysfunction. In these studies, the most frequently reported sexual dysfunctions among the geriatric men were early ejaculation and erectile dysfunction. In the females' category, lack of sexual interest, lubrication difficulties, and an inability to reach orgasm were the sexual dysfunctions identified. However, as the incidence of sexual dysfunction increases in elderly age, Spence (1992) argued that this is primarily related to the increased rate of health problems, rather than old age per se.

Although, the elderly expressed a number of sexual dysfunctions, however, they believed that traditional medicine could improve their sexual performance. According to the FGD, the male discussants believed that traditional medicine was efficacious in improving their sexual performance. In addition, both male and female elderly accepted using traditional drugs including concoctions to enhance their sexual drive and libido. These traditional drugs were for erectile functions, which would increase and empower them to go for multiple rounds. This is contrary to the reported cases of pharmacological factors, which play a role in sexual problems. Deacon et al, (1995) reported that drugs, which affect the autonomic nervous system, may interfere with sexual function. Many medications that older people use can adversely affect erectile function and libido. It should be noted that whereas many drugs can adversely affect sexual function, others could enhance performance. This risky behaviour among the elderly calls for urgent counselling services. This so because according to Wagner & Jensen, (1981) small doses of alcohol act as an anxiolytic and may improve performance. Larger doses will result in retarded orgasm and may cause erectile failure. Drugs with cocaine and amphetamines components initially increase the incidence of sexual interest and activity. However, Deacon et al, (1995) concluded that because of the drug and alcohol enhancing effects on mood and energy, the long-term effects are usually detrimental. There was no statistically significant association found between sexual dysfunction and age. Such other demographic variables as gender, level of education, and religion were also not statistically significant.

5.5 Conclusion

Risky sexual practice among the elderly is a growing public health problem. Government has significant roles to play. This study has shown elderly persons are still sexually active at old age, while some engaged in risky sexual activities. In addition, the sexual perception is relatively negative; this misperception may be due to knowledge gap and if not properly addressed, may adversely affect their sexual health. Moreover, as majority reported lack of

finance, loneliness and separated home as responsible factors for extramarital relationship, it is therefore suggested that intervention strategies aim at providing socioeconomic support, including health education to improve their SRH be urgently implemented. Without urgent measures to enable elderly people to protect themselves, development efforts will be in jeopardy. Investing in elderly people is one of the most cost-effective interventions in achieving Millennium Development Goals (MDGs).

5.6 Implication for Health Education

This study has shown that some sexually active elderly engaged in extramarital activities, which put them at risk. Some also engaged in unprotected sex with multiple partners and were therefore, more likely than others, to have engaged in sexual risky behaviour. This included those who were 65-74 years in the population, those who had low education, and those who may rely on sexual partners for some of their important needs. It was also found that perception of sexual behaviour was negative, while practices of some to most issues relating to sexual behaviour were risky. Therefore:

- Elderly sexual behaviour is of public health interest because they often are not mentioned or included in any prevention programmes. In Nigeria where HIV prevalence rate is not stable, health education is an important contribution to prevention strategies.
- The fact that sizeable proportion reported engaging in risky sexual behaviour, points to the need for a holistic approach in dealing with elderly SRH needs. Many SRH programmes in Nigeria focus on young people because they are considered more vulnerable. Limited attention is paid to the elderly who according to the findings of this study are a major area of vulnerability. These disparities in targeting of information and services need to be re-examined from household to programme levels so that appropriate interventions would be instituted.
- A sizeable proportion of sexually active engaged in unsafe risky sexual activities in the two year preceding the study. This is probably due to inadequate information and lack of life-saving skills. It will be of programme importance, if skills training for safe sex practices and measures to enhance their sexual excitement were implemented. This would mitigate against risky practices including unprotected multiple sex.

5.7 Recommendation

Based on the findings of this study, the following recommendations are made thus:

1. A sexuality education programme targeting on household elderly persons is urgently needed. Local health authorities, development institutions in partnership with educational authorities in the area will be useful in actualizing this programme. The aim of such programme is to fill the existing knowledge gap on sexual health, so that they would live a desirable and fulfilling sexual life through ageing.
2. In view of the reported reasons for engagement in risky sexual behaviour. Elderly people's home should be established in various communities to cater for the aged. Community-Based Organisations (CBOs) with the support of local health authorities would be very useful in this respect. To ensure the sustainability of the project, community involvement and ownership should be solicited.
3. As a matter of urgency, it will be more appropriate for government at all levels to formulate and enforce laws and policies that would promote geriatric sexual and reproductive health.
4. Government and development partners should collaborate to initiate health intervention programmes for the elderly. Part of this programme should provide home-based counselling including SRH services to meet their sexual needs.
5. Majority of the elderly reported lack of finance as a factor responsible for extramarital engagement. This calls for urgent action by all levels in the ecological model to intervene in providing sustainable socioeconomic support to the elderly persons. Measures to enhance their financial independence will enhance reduction in risky practices. The measures could be an empowerment programme, such as skills-building, micro-finance etc.
6. Finally, as sizeable proportion were involved in unsafe sexual practices. Therefore, health education intervention programmes such as training on safe sex practices are needed to address the problem.

5.8 Suggestion for Further Research

Conclusively, research evidence shows that elderly people are showing sexual interest and activity into old age. However, despite engagement in risky behaviour, sexual dysfunction is prevalent among this population. Therefore, further research needs to be carried out firstly in other parts of the country. Secondly, research is also required to fully understand the geriatric sexual needs and help-seeking behaviour, because it is only when these are examined, the elderly sexual behaviour will still not be fully identified.

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APPENDIX A

PERCEPTIONS, PRACTICES AND PROBLEMS RELATING TO SEXUAL BEHAVIOUR AMONG THE ELDERLY IN IBADAN NORTH LGA, NIGERIA.

Consent form for Survey Respondents

Name of Principal Investigator: ODOR King
Name of Organization: University of Ibadan
Name of Sponsor:

Greetings. My name is ---------- and from the Department of Health Promotion & Education, College of Medicine, University of Ibadan. I am a postgraduate (MPH) student conducting a research study on the **Perceptions, Practices and Problems relating to Sexual Behaviour among the Elderly in Ibadan North LGA.** Based on the findings of the study, it will enable policy makers initiate health programmes and policies for the utilization of the elderly people.

1. Purpose of the research:

I am planning to carry out a study to determine the elderly people's perception on sexual behaviour.

2. Duration of the research:

The duration of this research, which you are being requested to participate in, is 1 month.

3. Procedures:

We invite you to take part in this research project and participate in the questionnaire. If you accept, you will be asked to participate in the filling of the questionnaire which will be given to you. If you do not wish to answer any of the questions posed in the questionnaire, you may say so and can move on to the next question. No one else but the researcher alone will be present. The information recorded is considered confidential, and no one else except Mr. ODOR King and his colleagues will have access to the information documented during the research. You will record your answers to the questions on this questionnaire. This is done so that you can provide your own answer. Although it is important for the research that you answer all questions, if you do not wish to answer any of the questions included in the survey, you may ask to move on to the next question. Filling the questionnaire will last for approximately 15 minutes.

4. Risks and Discomforts:

There is a slight risk that you may feel uncomfortable talking about some of the topics. However, I do not wish this to happen, and you may refuse to answer any question or not take part in a portion of the interview if you feel the question(s) make(s) you uncomfortable.

5. Benefits:

There will be no direct benefit to you but the information obtained from this study will help to provide suggestions that will enable the researcher develop appropriate programme for elderly people to develop programme for their sexual and reproductive health.

6. Benefits:

You will not be provided with any incentives to take part in the research.

7. Confidentiality:

I have taken the following steps to ensure that you are safe and that the information you provide is confidential.

a) Filling of questionnaire will take place in a private place
b) The information that we collect from this research project will be kept confidential.
c) Information collected from you will be stored in a file that will not have your name on it, but a number assigned to it instead.
d) The questionnaire containing the interview will be stored for the duration of 2 years after which it would be destroyed.
e) The name associated with the number assigned to each file will be kept under lock and key and will not be disclosed to any one except colleagues working on this study.
f) You may talk to the leader of the research team in case you have any concern or question.

8. Alternative to participation:

You do not have to take part in this research if you do not wish to do so. Even if you do not wish to answer these questions you may still benefit from the study. You may stop participating in the interview at any time that you wish, and there will be no negative consequences for you in any way.

9. Who to contact:

If you have any question, you may ask this now or later. If you wish to ask questions later, you may contact any of the following:

Head of Department,

Address: Health Promotion & Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan.

 02 241 2392
E-mail: hpearhec@skannet.com Or healthpromed@yahoo.com

Or

Research Supervisor

Address: Department of Health Promotion & Education,

Faculty of Public Health, College of Medicine,

University of Ibadan,

Ibadan, Nigeria.

 0806 4629401

E-mail: gboseijama2007@yahoo.com

Print name of Participant	Date and Signature of Participant
……..	……..
	------/ -----/ ---------- (dd/mm/yy)
Print Name of Researcher/Moderator	Date & Signature of researcher/moderator
----------	----------
	------/ -----/ ---------- (dd/mm/yy)

APPENDIX B
QUESTIONNAIRE ON

PERCEPTIONS, PRACTICES AND PROBLEMS RELATING TO SEXUAL BEHAVIOUR AMONG THE ELDERLY IN IBADAN NORTH LGA, NIGERIA

Dear Respondent,

I am…… a Postgraduate student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan. The purpose of this study is to learn from the elderly people in this community their perceptions, practices and problems relating to sexual behaviour. The findings from this study will produce valuable information on an area of geriatric health that has been neglected overtime. The outcome will assist in designing programme that would benefit the Sexual and Reproductive Health (SRH) of the elderly.

Please be informed that there is no right or wrong answers to the questions I will ask you. Also I wish to inform you that participation is voluntary, your identity, responses and opinions will be kept confidential and your name is not required in filling the questionnaire. Please as much as possible try and give honest responses to the questions I will ask you which should not take more than____minutes. You are also free to ask questions as the survey progresses.

Thank you for your cooperation.

Interviewer: If respondent agrees to participate, please mark this box ☐

Survey Identification #.....
Date ……....
Interviewer Code……
Name of Community…….....

SECTION A: SOCIO DEMOGRAPHIC CHARACTERISTICS

Instruction:

I will like to ask you some questions that are a bit personal, please do not be offended. Your answers to these questions will enable me learn from you and better understand and appreciate the issues being investigated. Please kindly respond correctly to the questions below without holding back any piece of information.

1. Sex:

   1. Male… 2. Female…

2. Highest level of Education

   1. No Formal Education….. 2. Primary…. 3. Secondary…. 4. HND/B.Sc…. ..

   5. Postgraduate…… 6. Others (please specify)……

3. What is your Ethnic group?

   1. Yoruba …… 2. Ibo….. 3. Hausa…. 4. Others (please specify)……

4. What is your religion?

   1. Christianity…… 2. Muslim…... 3. Traditional……..4. Others (please specify)……

5. What is your Occupation?

   1. Trading….. 2. Civil servant….. 3. Housemaker….. 4. Farmer…..

   5. Retired civil servant….. 6. Others (please specify)…….

6. How old are you? …….....years. (Age at last birthday)

7. Marital Status: *(you may tick more than one)*

   1. Divorced/Separated..... 2. Single/Never married..... 3. Widowed.....

   4. Monogamy..... 5. Polygamy..... 6. No Response.....

8. How long have you lived in this community? _____ full years

9. Do you live with your spouse or partner?

   1. Yes 2. No

9a. How many years have you been living:

   1. With your spouse? ___ full years 2. Without your spouse? ___ full years

10. How would you rate yourself financially?

   1. Wealthy 2. Above Average 3. Average 4. Below Average 5. Poor

11. How many children live in your household? _____children

12. At this age, do you have sexual partner other than your spouse? (If No go to Ques. 13)

   1. Yes 2. No

12a. If yes how many are they? _____

13. Have you slept away from home in the last 3 months?

   1. Yes ..... 2. No.....

14. Please remember, since attaining to this age when was the last time you had sexual intercourse? _____

15. What relation to you was the person with whom you had sexual intercourse last? Your:

   1. Official wife/husband..... 2. Unofficial wife/husband.....

   3. Friend who lives separately..... 4. Someone you gave or received payment for sex.....

   5. Casual acquaintance.... 6. If someone else, please specify_____

16. How old is the person? If you don't know exactly, kindly approximate_____ full years

17. Remember, when you had sex last time at this age, did you consume alcohol or beer?

    1. Yes ..... 2. No..... 3. Can't Remember.....

18. That last time you had the sex, did you use condom? (If yes go to Question 20)

    1. Yes ..... 2. No..... 3. Can't Remember.....

19. If No why did you not use condom? [Mark all the reasons you didn't use one.]

    1. To become pregnant . . 2. Didn't have one at hand . . 3. Couldn't obtain one . . .

    4. Partner didn't wish to use it . . . 5. I don't like to use them . . .

    6. I don't think it's necessary . . . 7. Didn't think of it . . .8. Others pls specify…....

20. If you wish to use condom for sex, where do you wish to obtain one?

    1. At a store/kiosk..... 2. At a drugstore..... 3. At a clinic or hospital.....

    4. At a bar or hotel..... 5. If elsewhere, please specify…….....

21. How do you feel about having sex with condom at this age?

    1. No sexual satifaction 2. It is nonsense 3. Condom is not for the elderly

    4. Harmful. 5. It is good/useful 6. Others.....

SECTION B: SEXUAL PERCEPTION

Instruction: The table below contains some statement about perception of sexual behaviour, Please respond appropriately.

STATEMENT ON SEXUAL PERCEPTION

22. Having sex with virgin/adolescents can serve as immunity against STIs/HIV

    _____

23. Sex at this age can bring about healing process in your body system especially when you are sick _____

24. It is okay for an elderly man to have extra-marital sex if his spouse cannot satisfy him

    _____

25. It is not right for an elderly woman to have extra-marital sex if her spouse cannot satisfy her_____

26. A man has the right to force a young girl to have sex if he has spent a lot of money on her

    _____

27. It is okay for a woman who is poor to engage in extra-marital sex in order to get money

    _____

28. The use of condom should be discouraged in all situations since sperm enriches the body

    _____

29. The use of local herbs to enhance sexual drive and performance should not be encouraged, because it damages the body system_____

_____

30. Use of drug/alcohol including local concoction leads to unprotected sex resulting to STIs/HIV, therefore should be discouraged_____
31. It is risky to have extra-marital sexual relationship, since it can lead to sex_____

_____

SECTION C: SEXUAL PRACTICE

The next set of questions is about your sexual practice. Please remember that your answers are strictly confidential.

32. Have you ever been pressured since attaining 65 years old, into having sex with another person against your will?

    1. Yes 2. No

33. Since you attained the age of 65 years, about how many times have you had sex with someone other than your spouse?_____time(s)
34. Since attaining this age, have you paid or received payment for sex with another person?

    1. Yes 2. No 3. Can't Remember [If No go to 37]

35. If yes to question 34 above, how many times have you done so_____time(s)
36. Still on question 34, where did you meet the person?

    1. Brothel/guesthouse 2. Beer parlour/Restaurant 3. Friend's house 4. Others.....

37. What kind of sex partners do you mostly have?

    1. Young people 2. Casual partner 3. Sex workers 4. Old people

    5. None 6. Others please specify…….....

38. At this age, how do you negotiate for sex, how do you entice your sex partners for sex?

    1. Money 2. Gift/items 3. Being kind 4. Dressing/Apperarnce 5. Others.....

39. Now what do you do to increase your sexual pleasure and that of your sex partner?

    1. Use of Herbs 2. Drugs 3. Alcohol 4. Nothing 5. Others.....

40. Since you attained the age of 65, how long do you normally have sex?

    1. Daily 2. Weekly 3. Bi-weekly 4. Monthly (5) 2 - 6 months

    (6) 1 year and above 7. Other please specify……

41. What kind of sexual practice have you had with your sex partner since attaining 65 years old? [Mark all applicable]

    1. Kissing Yes/No, 2.Romancing Yes/No 3. Sex Yes/No 4. Touching each other Yes/No 5. Other specify.....

42. At atimes, old people patronize "Sex Workers". At what time do they do so?

    1. During occasions... 2. When spouse is unavailable..... 3. When they have money.... 4. Under the influence of drug/alcohol..... 6. Others…….....

43. At this age what do you do to avoid infection or pregnancy during sex? [Tick all applied]

    1. Herbal medicine . . . . . 2. Nothing . . . . 3. Drugs . . . . 4. Condom. . . .
    5. Concussion . . . . 6. If something else, please specify……..…….....

SECTION D: PROBLEMS OF SEXUAL BEHAVIOUR

44. What is responsible for elderly engaging in risky sexual behaviour? [Mark all reasons]

    1. Lack of finance 2. Death of spouse 3. Separated home 4. Peer pressure,
    5. Influence of drug/alcohol 6. Loneliness 7. Other please specify……...

45. What kind of sexual problems do you normally experience at this age? [Mark all applied]

    1. Early ejaculation/Non erectile function 2. Inactive/non performance
    3. Lack of interest for sexual intercourse 4. Inadequate virginal lubrication 5. Painful Sex
    6. No sexual drive/sensitivity 7. Others. Please specify…….....

46. How should the identified sexual problem(s) be eliminated?

    1. Use of Drug 2. Visiting health facility 3. Traditional Medicine 4. Others……..

47. Elderly people do have STIs including HIV/AIDS, does it affect their sexual behaviour?

    1. Yes ..... 2. No..... 3. No Response..... [If No skip 48]

48. To what extent does it affect their sexual behaviour.....

49. How do you advice elderly people in preventing STDs/HIV? [Mark all applicable]

    1. Control of Sexual Urge 2. Refrain from Sex 3. Stop marital infidelity
    4. Condom Use 5. Visiting traditional healers 6. Use of Herbs/Concotion
    7. Taking orthodox medicines 8. Other specify.....

50. How do you suggest improving the sexual behaviour of elderly people?

    1. Counselling/education 2. Refrain from Sex 3. Visit Health Facility
    4 Resting 5. Nothing 6. Alcohol 7. Meeting friends
    8. Any others specify.....
    ……..

Thank you.

APPENDIX C

ERO, ISE ATI ISORO TI O NI SE PELU IWA IBALOPO AWON AGBALAGBA IN IBADAN NORTH LGA.

Si Olukopa,

Oruko mi ni…… moje akeko Ile eko giga ti Yunifasity ti ilu Ibadan, eka Ibi ti n dena arun, ni ile eko giga ti ile iwosan nla ti UCH. Idi Pataki iwadi yi ni lati ni imo lodo awon agbalagba adugbo yii lori Ero, Ise ati Isoro ti o ni se pelu Iwuwasi eto ibalopo won. Awon esi iwadi ti a ba ri gba yio ran wa lowo lati seto ona ti a fi le se atunse lori sexual and reproductive health.

Mo fe je ki emo wipe kosi idahun ti kotona si awon ibeere ti mo ba bi yin. E jowo kikopa ninu iwadi yii je atinuwa, ki se afipase. Idanimo yin, idahun yin ati awon ero yin ni a o toju daradara, akosi nilo oruko yin ninu iwe ibeere yii. Ejowo egbiyanju lati edahun awon ibere naa tinutinu ati pelu ooto. Be eni esi ni eto lati beere ibeere lori ohunkohun ninu eto iwadi yii.

Ese fun ifowosowopo yin.

Ami Idanimo ninu Iwadi #.....
Ojo …….
Oruko eka Ikeko…….....
Oruko oludahun ibeere……

Socio Demographic Characteristics

Ilana:

N a fe lati beere awon ibeere a nipa yin, ejowo e ma fise ibinu. Idahun yin si awon ibeere yio o ran mi lowo lati mo ati lati ni imo nipa awon ohun ti a nse iwadi nipa. Ejowo ebami dahun awon ibeere naa tokantokan ati daradara lai fi ohun kohun pamo.

1. Okunrin tabi Obirin: 1. Okunrin… 2. Obinrin…
2. Kinni ipele eko yin ti o ja ju?
   1. Mi o lo si ile eko rara…….. 2. Ile eko mefa……. 3. Iwe mewa…….
   4. Gbogbo nse/Ile eko giga….. 5. Iwe eko giga ipele keji…… 6. Awon miran…….
3. Kini eya yin?
   1. Yoruba …… 2. Ibo….. 3. Hausa…. 4. Awon miran (Eso won)……

4. Kinni esin yin?

   1. Onigbagbo…… 2. Musulumi…... 3. Esin Abalaye…….. 4. Awon miran……

5. Kinni ise yin? 1. Onisono….. 2. Osise ijoba….. 3. Birikila…..

   4. Agbe….. 5. Osise Feyin ti….. 6. Awon miran (Eso won)……..

6. Kinni ojo ori yin? ……..

7. Nje eni iyano lowolowo?

   1. Benni 2. Beeko

8. Ti e ba ni iru igbayawo wo?

   1. Iyawo Osingin (eleyokan) 2. Iyawo ti o ju eyo kan lo (Meelo____)

8a. Ti e ko ba ni iyawo, nje?

   1. Ete ko iyawo yin sile ----- 2. E n dagbe, abi e o ni iyawo ri ------

   3. Iyawo tabi Oko yin ti ku ---

9. Oto bi odun melo ti eti n gbe ni agbegbe yii?

   1. Ni gbogbo aye mi..... 2. Oju odun meewa lo.... 3. Oti odun maarun si meewa

   4. Oti odun kan si odun maarun…… 5. Odin lo dun kan

10. Nje e n gbe pelu iyawo yin?

   1. Beeni 2. Beeko

10a. Ti ko ba ribe nje?

   1. Eti pinya…. 2. Oti salaisi…. 3. O wa ni Irin ajo.... 4. Enja 5. Awon miran....

11. Nje eni ore binrin miran ti ejo n ni ibasepo bi?

   1. Beeni 2. Beeko

11a. Ti o ba je beeni, meelo ni won? .....

12. Nje iyawo yin n gbe ilumiran yato si ibi tie yin n gbe tabi ti eti n sise bi?

   1. Beeni 2. Beeko

13. Nje oko/iyawo yin nsise nibi tie yin naa ti n sise tabi gbe?

   1. Beeni 2. Beeko

14. Otito bi odun meelo ti eti ngbe ni iru ipo yii? _____

15. Omo meelo ni o ngbe pelu yin ninuri ile yin?

   1. Ko to Omo o dun marun____ 2. Omo odun marun si mejila____

   3. Omo odun metala soke_____

16. Bawo lose lese eduwon eto inawo re?

   1. Olowo gidi gan 2. Ogbepele ju ilajilo 3. Ko la kosagbe

   4. Olole ju ilajilo 5. Talaka

ABALA B: ERO

Ilana: Awon ibeere ti o wa ninu ila yii nise pelu iwuwasi ati ibalopo, ejowo efala si abe idahun ti o ba sedede pelu yin.

	Ibeere Nipa Ibalopo	Beeni	Beeko	N komo
17.	Oje ohun ti o wopo fun awon agbalagba/arugbo lati ni ibalopo pelu awon eniyan?			
18.	Awon agbalagba/arugbo ma n gbadun ibalopo pelu awon eniti o ba dagba ju iyawo tabi oko won lo?			
19.	Nje awon agbalagba ti o ma ni ibalopo nita igbeyowo je ojulowo eniyan bi?			
20.	Nje awon agbalagba ma n san wo tabi sope lowo awon ore alabesepo won bi?			
21.	Nje awon agbalagba ti o n gbowo fum ibalopo je asewo bi?			
22.	Nje won ma n gbowo fun ibalopo bi?			
23.	Nje awon agbalagba ti o ni ibalopo pelu awon elomiran ma ni awon isoro bii ideyesii, Idalagara nitori awon ise ibalopo won?			
24.	Nje iyato wa laarin awon agbalagba ti o ma n ni ibalopo pelu awon asewo ati awon ti kin sebe?			
25.	Nje awon ore ma n beere lowo yin lati ba awon wa ore alabalopo bi?			
26.	Ni adugbo yin, nje elero pe awon agbalagba ma n wa lati ri awon ore alabalopo won bi?			

ABALA C: ISE IBALOPO

Awon ibeere ti o kan yi yio nise pelu ise ibalopo yin. Ejowo eranti pe idahun yin ko nil u sowo eni keni labe ati wuori.

27. Bawo ni ese ma n lo awon asiko igbafe yin? [E le mu ju idahun kan lo.]

1. Kiki awon eniyan/gbalejo . . . . 2. Lo si sinema, ile itura. .....
3. Kopa ninu ere idaraya. . …. 4. Wo ero mohun mawo ran…. . .
5. Gbadun orin orisirisi. . . 6. Na ara lo . . . 7. Simi ninu ile.....
8. Rin irinajo. . . . 9. Ti o ba ni ohun miran tie ma nse ejowo eko_____

28. Nje eti san owo lati ni ibalopo pelu oobirin ri?

    1. Benni 2. Beeko

29. Ni bi osu mefa seyin, bi e melo ni eti san wo se ibalopo pelu eniyan? (E daruko eye igba ati eniyarn)…….....

30. Nibo ni eti pade ore alabalopo yin ti e san wo fun gbeyin?

    1. Ile itura, igbafe…… 2. Ile itura, ile oti…….. 3. Ibomiran (Edaruko)……....

31. Nje elo roba idaabebo nigbati eni ibalopo keyin? 1. Benni 2. Beeko

32. Igba melo ni a ma n lo roba idabobo ti e baba elomiran yato iyawo yin ni asepo ?

    1. Nigbagbogbo…….. 2. Lopoloigba…… 3. Lee kookan…….. 4. N o kinlo rara….

33. Nje ati fipa mu yin ri lati ba elomiran lase po nigbati ko wu yin lati sebe?

    1. Benni 2. Beeko

34. Nje o tona lati ba alaboyin lasepo ni awon asiko iloyun yi bi?

    1. Osu meta akoko Benni/Beeko, 2. Osu meta aarin Benni/Beeko

    3. Osu meta togbeyin Benni/Beeko , 4. Osu iloyin ti o gbeyin Benni/Beeko

    5. Ko dara rara

35. Leyin osu meelo ti obinrin ba bimo lero wipe ole ni ibalopo? E mu eyokan:

    1. Laarin ose kan……. 2. Laarin ose kinni si ose keerin……..

    3. Laarin osu kinni si osie keji 4. Leyin osu meji (Eso)……

36. Nje eni ibalopo pelu iyawo yin nigbato loyun gbeyin?

    1. Benni 2. Beeko

37. Nje eni ibalopo pelu elomiran ni igbati iyawo yin loyun gbeyin?

    1. Benni 2. Beeko (Elo si ibeere ogoji ole kan ti idahun yin baje beeni)

38. Tani eni ibalpo pelu?

    1. Asewo Beeni/Beeko, 2. Ore kan lasan Beeni/Beeko

    3. Ojulowo ore Beeni/Beeko 4. Eso awon miran…….....

39. Bi emelo ni eti ni ibalopo pelu elomiran yato si iyawo yin?

    1. Kosi 2. Eekan 3. Bi emeji si maarun 4. Bi emefa si meewa

    5. Bi igba mokanla si ogun 6. Ju igba ogun lo

40. Iru ise ibalpo wo ni eti ni pelu ore yin/elomiran nita?

    1. Lilomoraeni ati ifenukenu Beeni/Beeko, 2. Ifonoparaeni Beeni/Beeko

    3. Ibalopo gangan Beeni/Beeko 4. Fifiowora ara eni Beeni/Beeko

    5. Awon miran (Eso).....

41. Fun bi igba meelo ni e ma n saaba ni ibalopo?

    1. Bi Ojo, kan si ojo meje….. 2. Bi ojo mejo si ose meji….. 3. Bi ose meta si nurin....

    4. Bi osu kan si meta….. 5. Ju bi osu merin lo…. 6. Awon miran (Eso)……...

42. Nigbakugba ti e ba fe ni ibalopo, iru ona wo ni e ma n gba dena awon arun abe?

1. Lo ogun….. 2. Lo roba idabobo (Condom) ….. 3. Mu appo…. 4. Mu Agbo…...

5. Noki se ohun kohun…... 6. Eso iru omiran……..

ABALA D: ISONI TI O REA NINU IBALOPO

Awon arun abe ti a le ko ninu ibalpo ni: Ti kogbo ogun, Oju ara yiyun, Arunatosi, Awon miran.

43. Ki ni elerope o ma n mu awon agbalagba kopa ninu ibalopo [E fala si gbogbo eyi ti o ba kan yin] 1. Oda owo 2. Iku aya tabi oko 3. Aigbepo 4. Ise awon ore

5. Agbara/oti lile 6. Eso Awon miran…….....

44. Iru awon isoro wo ni ema n koju? [E fala si gbogbo eyi ti o ba kan yin]

1. Ai le nkan omo kurin 2. Ai tete le nkan omo okurin 3. Ai le se ojuse eni gege bi oko iyawo 4. ko un wu o lati se 5.Ojuara gbigbe

6. Ini iyara ni ona ibalopo 7. Eso awon miran…….....

45. Ki ni e ma n se lati fopinsi awon isoro yii?.....

46. Nje Dokita tabi osise ilera kankan ti so fun yin wipe e ni arun abe/arun gbajumo?

1. Beeni ..... 2. Beeko..... 3. Kojale..... 4. Nko le ranti.....

47. Ti o baje beeni, kini oruko arun abe tabi gbajumo ti woni eni? .....

48. Nje etoju arun naa bii?

1. Beeni 2. Beeko

49. Nje eni imoran fun awon agbalagba lori bi ati le dena arun abe/gbajumo ati HIV bi?

.....

.....

50. Kini elero wipe alese lati mu iwuwasi ati ibalopo awon agbalagba wa soke?

.....

.....

Ese

APPENDIX D

Focus Group Discussion (FGD) Guide for Elderly People in Ibadan North LGA

TOPIC: Perception, Practices and Problems relating to Sexual Behaviour of the Elderly People in Ibadan North LGA

INTRODUCTION

I greet you all for accepting to participate in this discussion. My name is ODOR, King and I will be moderating our discussion today. This discussion is a research study that intends to find out perception and problems of elderly people relating to sexual behaviour. During this discussion, any view(s) expressed by study participant will not be judged right or wrong and everybody is free to express views on any issue pertinent to the discussion.

This discussion will be completely confidential and will only be used for the purpose of the research work to effect policy formulation only. Thank you for your anticipated co-operation.

DISCUSSION

1. What opinion do you have about: a. Elderly men sexual practices?
   b. Elderly women sexual practices?
2. What RH needs do elders in this community have? (probe for loneliness, death of spouses, erectile dysfunction, rejection from opposite sex etc)
3. How do elders in this community combat the RH needs? (Probe for recreation facility use of money for sex, meeting widows/widowers etc).
4. What can you say about the sexual networking patterns of the elderly? (probe for how they reach out to ladies/men, how they negotiate sex, the kinds of gift they give to attract opposite sex etc)
5. What are the specific things elders practice in their sexual act? (probe for fore play, length of time taken for penis erection/vaginal wet, oral sex, length of time before orgasm etc)
6. Do elders in this community take any risky sexual behaviour? (probe for non condom use, taking sexual stimulant before sex and types, attempting several rounds of sexual intercourse and anal sex etc)
7. Why do you take such risky sexual behaviour?
8. What are the problems of sexual behaviour of the elderly?
9. Do socio-demographic characteristics of the elderly people affect their sexual behaviour? In terms of: a. Religion b. Education c. Ethnicity

Thank you for taking time to participate in this discussion.

APPENDIX E

APERO

1. Kini ero yin nipa
   a. Ibalopo laarin awon arugbo (l'okunrin) okun rin?
   b. Ibalopa laarin awon arugbo (l'obinrin) obin rin?
2. Kini ilera ti awon arugbo adugbo yi ni nipa Ibalopo?
   (Beere fun didawa,/ dida walaaye, ara eni ti oko tabi aya ba ku, aini ipongbe fun Ibalopo, iko sile lati odo obinrin tabi okun rin etc)
3. Bawo ni awon arugbo adugbo yi se ndojuko awon ilera ni Ibalopo?
   (Beere fun ohun imulo idara ya, sisan owo fun Ibalopo, nin Ibalopo pelu opo l'obrin rin/ l'obin rin)
4. Kini e le so nipa ara ti awon arugbo nda nipa Ibalopo?
   (Beere fun bi won se nri awon omidan tabi apon, bawo ni won se nduna dura fun Ibalopo etc).
5. Kini awon oun ti awon arugbo manse nipato nigba tiwon ba n ni Ibalopo?
   (Beere fun nipa ere ife sise, nigba ti ara man dide, nipa ti oju ara ma n tutu, Ibalopo lona ti enu, O ma n to igba wo ki Ibalopo to te won l'orun)
6. Nje awon arugbo agbegbe yi ma n se iwa aibikita pelu Ibalopo?
   (Beere fun nipa ai ma ma lo roba idabobo, lilo ogun ki ara le dide fun Ibalopo, eru awon ogun wo, si se ibalopo ni lopolopo igba toju ekan lo tabi Ibalopo lati iho idi etc).
7. Kini idi ti won se ma n hu iru iwa aibikita to je mo ibaloplo?
8. Kini awon isoro ti o wa ninu Ibalopo fun awon arugbo?
9. Nje awon nkan won yi man nipa ninu iwa Ibalopo awon arugbo?

   a. Esin b. Iwe (Eko) c. Eya

Thank you for taking your time to participate in this discussion.