"We will die having sex" – perspectives on sex, sexuality and HIV among older adults

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Extended Abstract

Background

Perceptions and meanings ascribed to sexuality are both individually and socially constructed (Gagnon and Simon 1973; Nagel 2003), with older people in the African setting usually viewed through the lenses of elders and custodians of upholding culturally ascribed sexual behaviours of young people (Anarfi and Owusu 2011). Although sexuality is often associated primarily with sexual intercourse, it is used widely in the scholarly literature as a multidimensional construct to include sexual intimacy, affection, sensuality, physical attraction, romance, and sexual intercourse (Weeks 2002; Foucault 1978). Sexual health which encompass the right to enjoy fulfilling sexual relationship, free from abuse or coercion and the absence of disease or illness (Cook, Dickens, and Fathalla 2003), is therefore an important component of sexuality across all ages.

Current knowledge on the sexual and reproductive health needs of older adults aged 50 years and above is lacking particularly with regard to older persons in sub-Saharan Africa (Minichiello et al. 2012). Therefore, the goal of this study was to explore the attitudes, norms, perceived control and intentions regarding sex, sexuality and HIV of older people aged 50 years and older in Sub-Saharan Africa within a context of a severe HIV epidemic and co-infection with non-communicable diseases (NCDs). This study offers an opportunity to uncover the often-neglected issue of sexuality among older people amidst other ageing-related health concerns. Moreover, understanding older people's sexuality is important for informing the general public's attitude and perception of older people, and in reducing ageism and misconceptions about old age and sexuality.

Methods

Study setting

This study was conducted among community dwelling adults in KwaZulu-Natal, South Africa. The study was conducted in two purposively selected areas - Botha's Hill and Chatsworth. The former is peri-urban and predominantly habited by African population group. While the latter is urban and predominantly habited by South Africans of Indian/Asian origin. These study sites were purposively selected to give us a broad representation of the demographic, epidemiological and social context of the study area for a nuanced understanding of our study topic.

Design

This study was cross-sectional in nature and used a mixed methods approach. There were two phases to the study. Phase one of the study was a quantitative component whose aim was to examine sexual behaviour patterns and prevalence of co-morbidities such as diabetes, hypertension, renal and cardiovascular diseases among older adults aged 50+ years within a setting of high HIV prevalence. Phase one was conducted in 2016 and enrolled 435 older adults. Whereas, phase two

conducted in 2017/2018 was qualitative by design using focus group discussions (FGDs) and individual in-depth interviews (IDIs). In this analysis we present only findings from the FGD analyses. Participants in the FGDs were randomly selected from the individuals who had been enrolled for phase one of the study. In each area we conducted one FGD for men and one FGD for women. A total of 60 individuals participated in the 4 FGDs across the 2 sites.

Theoretical framework

This study was guided by the Theory of Planned Behaviour (TPB) (Ajzen 1991), which posits that people are rational and systematic (informed by information available to them) in their decision making to perform an action such as to engage or not to engage in sexual activity. According to the TPB, motivation to perform a behaviour (behavioural intention) is the most important determinant of actual behaviour. This motivation or intent is informed by the individual's attitude towards that behaviour, subjective norms around the implications of complying or not complying with that behaviour, and how much control an individual perceives to have over executing the behaviour. This theory was appropriate to study sexuality in older adults as there are many beliefs and misconceptions about sexual activity in older adults that likely influence their sexual behaviours, but which we do not fully understand. The theory was also appropriate in that it helps us to identify where and how targeted interventions could lead to sexual behaviour change in older adults to reduce sexual health problems as well as their risk for sexually transmitted infections (STIs) and HIV.

Study aim, objectives and hypothesis

The aim of this study was to explore older adult's attitudes, subjective norms, perceived control and intentions regarding sex, sexuality and HIV in older adults 50 years and older.

The specific objectives were to:

i. Explore the socially constructed norms and behaviours associated with sexuality and ageing;
ii. To uncover the perceptions of older people towards sexuality, sexual relationships and HIV
iii. Highlight the sexual health concerns and challenges including accessing sexual health information and services facing older people amidst other health concerns
iv. Gain insight into barriers and facilitators of older adults living in HIV endemic areas acting upon their sexual behaviour (or sexual activity) intensions

Hypothesis

Our overarching hypothesis was that older adults have increased chances of risky sexual behaviours and acquiring STIs including HIV, which is confounded by co-infection with non-communicable diseases, because sexuality and the sexual health of older adults is highly neglected and not adequately understood.

Inclusion/exclusion criteria

The inclusion criteria for this study were that an individual needed to:

- Be aged 50 years and above
- Be willing and able to give written informed consent
- Not be overtly cognitively impaired or terminally ill
- Have participated in phase 1 of study

The exclusion criteria was not meeting any of the above conditions.

Procedures

Approval for this study was obtained from the South African Medical Research Medical Council Ethics committee. Selected participants were visited at their homesteads for an introductory briefing of the qualitative study including the expected procedures to be performed. Those that expressed interest to participate in the study were then booked an appointment to come to the research site from where the rest of the study procedures were completed including the informed consent process. Focus group discussions (FGDs) were conducted in a quiet room at the site, and in the case of Botha's Hill the FGDs were conducted at a community hall near the site due to construction work that was going on at the research site. Each FGD lasted approximately 70 minutes and was tape recorded.

Discussions were conducted using semi-structured interview guides that elicited responses and experiences related to the following domains: 1) General health concerns among older people; 2) norms regarding sex, sexuality and HIV in old age; 3) attitudes towards sexual activity and HIV in older people; 4) perceived behavioural control; and 5) facilitators and barriers to sexual behaviour including access to sexual health information. Sample questions included: *what would say are the main health concerns of older people in this community? What are your views on sexual relationships and having a partner for people of your age group? Tell me about sex in older people of your age group; is it a good or bad thing for older people to engage in sexual activities? Why or why not? Are you sexually active? Are older people able to engage in sexual activity if they desired? Why or why not? Who do you normally turn to when you want to discuss or share matters relating to your sexual feelings or desires? Have you personally received any kind of advice or counselling about safe sex?*

Data analysis

The recorded FGD audio files were transcribed verbatim into the language of the interview, which was isiZulu for all FGDs except the female FGD at Chatsworth as all participants were of Indian-origin and comfortable in English. The transcribed focus group discussion files were translated into English and back translated to the native language by experienced native language speakers. The transcripts were then quality controlled by a third person to ensure accuracy in the translations and back translations before being imported into NVivo for data management and analysis. A priori themes based on the interview guide were reviewed from which using thematic analysis we identified salient themes and relationships in the data. The codebook was then finalised, and each transcript coded. Thematic analysis was used to identify salient themes and relationships guided by the theoretical framework. Findings from the focus groups were triangulated with data from the quantitative phase one study to further reflect on the perception and attitudes of participants regarding sexuality, sexual behaviour and HIV in older adults.

Results

A total of 60 individuals (30 women, 30 men) participated in the four focus group discussions. The mean age of the study participants was 58.2 years (standard deviation (6.5). Most of the study participants were black African (78.3%), currently married (58.3%), had primary (45.0%) or higher (41.7%) level of education, were unemployed (81.7%) and were receiving a government grant (66.7%). Furthermore, 63.3% said they were sexually active, and one-in-five of the study participants were HIV positive.

A number of themes emerged from this analysis. In this report we will focus on the theme of sexual activity and behaviour among older people.

Perspectives on sexual activity in older people

Participants expressed their views on relationships and sexual activity in older persons. Participants discussed types of relationships, fidelity and intergenerational relationships among older persons, whether older people were sexually active including frequency, preferences, and barriers and facilitators to acting on their sexual intentions. Participants also discussed alternative sexual practices and beliefs.

Participants were asked whether older people like themselves were involved in sexual activity. The initial response in all FGDs was laughter by all before proceeding to answer the question. Men were united in saying "*Yes, they are still sexually active" [**all laughing**].* Men also believed *"Yes, the energy [for sex] never runs out!* (All speaking at same time). A 75-year-old man said men do not get old for sex "*They do **[engage in sex]** but in a respective way both of you and there is no one who is stupid, they have to do it in silence they say the man does not get old"* (male 75). A 71-year-old man added that they would not stop having sex as along as their health condition allows until they die "*Yes, we are still sexually active, **we will die having sex** (laughing). As long as the situations allow me, I would continue to have sex"* (male 71). Echoing this sentiment, a 64-year-old man said he was born to have sex as a woman was created for this purpose "*I don't know what is it really, but there is a problem, God make a woman and create this thing* [sex] *intentionally, you sex till you die and go to graveyards and if you don't find it like you are madman. I was born for it" (male 64).*

Men said they are sexually active and like sex – "*Ehh … we speak the truth, do not hide anything we do, don't say you don't do something. Concerning sex, I do it but not like other time"* (Male 55); "*I do it, I won't lie I like women and I do sex"* (Male 64). A 70-year-old man added "*I agree with other brothers that we still do sex (laugher) perfectly and there is no difference but for my other brother who still have many girlfriends (laugher) but we still do it* (male 70).

It was not only men, however, that said they were sexually active. A 59-year-old woman said "*it is not about age*" because "*there are people out there that are still having [sex]* (female 59). A 51-year-old woman concurred by saying ""*Yes, you do have sex, but it is not a regular thing"* (female 51). For a 53-year-old woman from BH she said she only did sex "…*so that he doesn't go outside to get it from others, you do it but your heart is not in it"* (female 53). However, there are clear gender differences regarding sexual activity with the predominant view among men being that "*Yes, sex is important*" (male 69), but among women "*It [sex] is not important" (women speaking at same time)*. A 59-year-old woman said "*So people as they are older they are having sex because older men, they say, they are crazier for sex than women"* (female 59).

Poor health was said to be the reason that would stop older people from engaging in sex. For men erectile dysfunction was the main health problem mentioned for lack of sexual activity - "*If your manhood is not working [cannot get erection] then your energy levels are low, if there are no issues with your manhood then you would not stop"* (male 61). Participants discussed having erectile dysfunction (**male 71, male 58, male 66**) and low libido problems (**female 58**), which many attributed to chronic conditions like BP and diabetes. A 53-year-old woman said "*Things change between the two of you because you are now old. He is also diabetic, you are no longer sexually active as you were when you both were young" (female 53). Another female aged 58 years said "You sometimes…..when you are diabetic, I don't have sex, I don't like it"* (female 58). A 54-year-old man said, "*Old women are having health problems for example diabetes, it is a big problem, even other men complain about it to me saying it affects their sex life"* (male 54). In another FGD, a71-year old man said, "*We do sex as they say but I am diabetic maybe twice a month..., you don't get erection when you have BP and diabetic*" (male 71). An 80-year-old man attributed lack of sexual activity to erectile dysfunction caused by chronic morbidity (diabetes), which was leading to other chronic

conditions (hypertension) "*Yes I hear you the way you talk about it, am far from having sex, why? Am diabetic I cannot get erection (laugher). They always ask in hospital how is it going and I tell them it's bad can't get erection (laugher) that is why my BP is high (laugher)"* (male 80). A 64-year-old man said he could not engage in sexual activity due to not being able to get an erection *"because it erect, sometime it don't erect"* (male 64). An 80-year-old man considered himself useless for his inability to have sex "*because if you above 50 years old you wish to do it but there is no erection, If they is no erection they is no sex, it's bad. I used to prick it with a stick hoping it will erect but it refused, it just l lay (laugher). Now am just myself just waiting for my time to die because am useless now and I can't proceed my man hood by having sex"* (male 80). Other participants experienced joint pains that prevented them from having sex.

Among women in addition to chronic conditions, low libido, physical exhaustion and child-bearing were some other reasons given for lack of sexual activity. A 57-year-old woman said "*When you are old you have problems with your knees, you have painful ankles, you become exhausted. And also, the issue of sex, sometimes you don't like it"* (female 57). Another woman added that *"We sweat a lot and have Blood Pressure"* (female 65), which prevents them from having sex. A 53-year-old woman believed it was not good for older people to be having sex because they are old "*You can't be old and be busy with sex that's not a good thing at all"* (female 53).

Participants described some cultural changes with regard to sexual activity in relationships. A 56-year-old woman said "*In the past, you couldn't just* ***ukudushela abakhwekazi*** *(have sex). People would fall in love and be in relationships, but they had thigh sex and avoided sex at all costs. No one would want to go back to that era these days" (female 56). A 63-year-old male expressed a similar view "Today things are done differently because in our times we would be in relationships, we were womanizers, but we were not impregnating girls because we practised thigh sex, we were not after sex. We had many girlfriends the only thing we were scared of then was* ***"ilumbo"*** (a traditional practice that is used by male partners on their girlfriends or wives as a method of ensuring that they are not having sex with other men. If they do, they would die or those who had sex with them would die or experience sexual problems – it is a method used to guard their partners)*" (male 63)*.

Discussion & conclusion

In this study we explored the attitudes of older persons aged ≥50 years on sexual relationships and activity among older people. The study examined through the theory of planned behaviour the barriers and facilitators to older adults acting on their sexual intentions. Our findings show clear differences between older men and women regarding sexual perceptions and norms. While men believe sex is very important for older persons, women did not view it as important. Men believed they will die having sex – meaning they could go on having sex for as long as they live. Men perceived themselves to have behavioural control over their sexual intentions, whereas women may engage in sexual activity involuntary to please the man or for fear of losing him to other women. Chronic morbidity especially diabetes and hypertension were mentioned as barriers to sexual intentions and desires among older people.

Older people in Africa face challenges of declining physical and cognitive health as well as being infected and affected by HIV (Nyirenda et al. 2012; Xavier Gomez-Olive et al. 2010; Nyirenda et al. 2013; Govender and Barnes 2014). The assumption often made is that older persons are no longer sexually active and thus not in need of sexual and reproductive health. To the contrary, older adults do engage in sexual activity much more than is widely believed and some do remain very sexually active even to very advanced ages (Minichiello et al. 2012; Wang et al. 2015). As people continue to live longer and remain sexually active (Nyirenda et al. 2018), and as the practice of re-partnering in

later life following divorce or widowhood becomes more common and acceptable (Freeman and Anglewicz 2012), sexuality and sexual behaviour in older adults needs to be brought to the attention of policy and programme makers. Health professionals in particular need to acknowledge sexuality in old adults and to incorporate sexual health needs of older people as part of the general health care delivery.

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