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EVALUATION OF SEXUAL FUNCTION IN MENOPAUSAL WOMEN TREATED AT A PUBLIC HEALTH SERVICE

AVALIAÇÃO DA FUNÇÃO SEXUAL EM MULHERES MENOPAUSADAS ATENDIDAS EM SERVIÇO PÚBLICO DE SAÚDE

EVALUACIÓN DE LA FUNCIÓN SEXUAL EN MUJERES MENOPAUSADAS ATENDIDAS EN EL SERVICIO PÚBLICO DE SALUD

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ABSTRACT

Despite its direct impact on women's quality of life. The aim of this study was to assess the sexual function of menopausal women treated in public health services in São Luís (MA), analyzing the clinical, social and emotional factors that influence this experience. This is an exploratory, descriptive study with a qualitative and quantitative approach, carried out using questionnaires and interviews with women aged 60 or over. The results showed that the perception of worsening sexual function is related not only to hormonal factors, but also to the presence of chronic diseases, low schooling, limited income and sociocultural taboos.

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Revista ARACÊ
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The low level of adherence to hormone therapy and the invisibility of the issue in care reinforces the need for strategies that promote qualified listening, health education and comprehensive care. The study contributes to the debate on the importance of including sexual health on the agenda of public policies aimed at older women, promoting well-being, autonomy and the recognition of sexuality as a right throughout life.

Keywords: Sexuality. Menopause. Women's Health.

RESUMO
A sexualidade feminina na menopausa é um tema frequentemente negligenciado nos serviços de saúde, apesar do seu impacto direto na qualidade de vida das mulheres. Este estudo teve como objetivo avaliar a função sexual de mulheres menopausadas atendidas em serviços públicos de saúde em São Luís (MA), analisando fatores clínicos, sociais e emocionais que influenciam essa vivência. Trata-se de uma pesquisa exploratória, descritiva, com abordagem quantitativa, realizada por meio de questionários e entrevistas com mulheres menopausadas. Os resultados apontaram que a percepção de piora na função sexual está relacionada não apenas a fatores hormonais, mas também à presença de doenças crônicas, à baixa escolaridade, à renda limitada e a tabus socioculturais. A baixa adesão à terapia hormonal e a invisibilidade do tema nos atendimentos reforçam a necessidade de estratégias que promovam a escuta qualificada, a educação em saúde e o cuidado integral. O estudo contribui para o debate sobre a importância de incluir a saúde sexual na agenda de políticas públicas voltadas à mulher menopausada, promovendo o bem-estar, a autonomia e o reconhecimento da sexualidade como um direito ao longo de toda a vida.

Palavras-chave: Sexualidade. Menopausa. Saúde da Mulher.

RESUMEN
La sexualidad femenina durante la menopausia es un tema que a menudo se descuida en los servicios de salud, a pesar de su impacto directo en la calidad de vida de las mujeres. El objetivo de este estudio fue evaluar la función sexual de mujeres menopáusicas atendidas en servicios públicos de salud en São Luís (MA), analizando los factores clínicos, sociales y emocionales que influyen en esta experiencia. Se trata de una investigación exploratoria, descriptiva, con un enfoque cuantitativo, realizada mediante cuestionarios y entrevistas a mujeres menopáusicas. Los resultados indicaron que la percepción de empeoramiento de la función sexual está relacionada no solo con factores hormonales, sino también con la presencia de enfermedades crónicas, el bajo nivel educativo, los ingresos limitados y los tabúes socioculturales. La baja adherencia a la terapia hormonal y la invisibilidad del tema en las consultas refuerzan la necesidad de estrategias que promuevan la escucha cualificada, la educación en salud y la atención integral. El estudio contribuye al debate sobre la importancia de incluir la salud sexual en la agenda de políticas públicas dirigidas a las mujeres menopáusicas, promoviendo el bienestar, la autonomía y el reconocimiento de la sexualidad como un derecho a lo largo de toda la vida.

Palabras clave: Sexualidad. Menopausia. Salud de la Mujer.

Revista ARACÊ
ISSN: 2358-2472

1 INTRODUCTION

Menopause is considered a milestone and is characterized by the “absence or lack” of menstruation for at least 12 consecutive months. During this phase, women undergo natural changes that directly affect their sexuality. The most common symptoms of menopause are hot flashes, vaginal dryness, difficulties with arousal and orgasm, and, as a result, changes in sexual function. Each woman experiences this period differently, not limited to biological issues, as a complex set of other factors (lifestyle habits and personal history, for example) are also associated with this experience (Crema; Tilio; Campos, 2017).

Studies by Weinberger et al. (2019) and Sarmento et al. (2022) indicate that postmenopausal women with vulvovaginal atrophy (VVA) are more likely to develop sexual dysfunction, including difficulties related to sexual desire, arousal, lubrication, and orgasm. Estrogen deprivation leads to VVA, with decreased vaginal mucus and thinning of the vulvar and vaginal tissues. Patients with VVA often complain of irritation, vaginal discharge, itching, dryness, dysuria, and dyspareunia. Despite the worsening of sexual function during the menopausal transition, it remains unclear whether this is caused by lower levels of ovarian hormones, aging, or both (Weinberger et al., 2019; Sarmento et al., 2022).

In addition to physical changes, vasomotor symptoms, such as hot flashes and night sweats, can also affect these women's quality of life and, subsequently, their sexuality. The discomfort caused by these changes can minimize interest in sexual activities and affect emotional well-being (Cantilino; Nevez; Rennó Junior, 2022). Mood changes, such as sensitivity, anxiety, and irritability, which are common during this period, also negatively impact intimacy, causing women to experience difficulties in emotional and sexual relationships (Tonin, 2020).

The clinical management of hormonal changes during menopause involves Hormone Therapy (HT). In addition to HT, some strategies are also effective in reducing the effects of hormonal decline on sexual response, such as vaginal lubricants, moisturizers, and lifestyle changes. Medical follow-up and a multidisciplinary approach are essential for providing individualized support to women at this stage of life (Albuquerque; Silva, 2021).

The aging of the female reproductive system contributes to anatomical and functional changes that directly influence a woman's sexuality. Vulvovaginal atrophy is the most common, described by thinning of the vaginal mucosa, decreased elasticity, and reduced lubrication. These changes cause discomfort and pain during sexual intercourse, scientifically known as dyspareunia, in addition to increasing the risk of urinary and vaginal

Revista ARACÊ
ISSN: 2358-2472

infections due to changes in the microbiome and the vagina's natural protective barrier (Saraiva et al., 2020).

Chronic diseases are factors that can directly impact the sexual function of menopausal women. Diabetes mellitus (DM) is one of the diseases responsible for sexual dysfunction in this population. Diabetic neuropathy can reduce sensitivity in the genital region, blocking arousal and orgasm. DM is associated with vaginal dryness, which can increase pain during sexual intercourse (Costa, 2019). Furthermore, decreased blood flow to the pelvic region can reduce sexual arousal, making orgasm difficult (Andrade et al., 2025).

High blood pressure (HBP), in turn, can negatively influence blood circulation, affecting vascularization in the pelvic region. Reduced blood flow to the genital tissues impairs vaginal lubrication, reducing arousal during sexual intercourse. Many antihypertensive drugs can have side effects that reduce libido and hinder arousal (Mendes, 2024).

Depression is a significant psychological factor in sexual dysfunction, which can directly influence libido and sexual response. A lack of interest in pleasurable activities, common in depression, can extend to sexuality, resulting in low self-esteem and distancing from one's partner. In addition, some antidepressants, such as selective serotonin reuptake inhibitors (SSRIs), can cause side effects such as anorgasmia and reduced sexual desire.

The treatment of sexual dysfunction associated with chronic diseases should involve a multidisciplinary approach, considering both the clinical control of the underlying condition and specific strategies to preserve the sexual health of menopausal women (Mendes, 2022).

The sexual health of menopausal women is influenced by several physical, psychological, and social factors, making a multidisciplinary approach to comprehensive care essential. The gynecologist is the primary health professional responsible for the diagnosis and treatment of gynecological and sexual complaints; however, the assistance of other professionals can enhance therapeutic outcomes (Pereira, 2019).

2 METHODOLOGY

This is a cross-sectional analytical study conducted in Basic Health Units (BHUs) in the municipality of São Luís, Maranhão. These units were selected because they are the gateway to the Unified Health System (SUS) and offer primary care to menopausal women, enabling direct contact with this population for research into sexuality after menopause. The choice of UBS was based on criteria such as accessibility, flow of care for women, and

Revista ARACÊ
ISSN: 2358-2472

availability of professionals to collaborate in the research.

Data collection took place between January 2024 and January 2025, ensuring an adequate period for obtaining sufficient information for analysis. During this interval, interviews were conducted with menopausal women, addressing aspects of sexual life, gynecological complaints, the impact of chronic diseases on sexuality, and access to health care focused on this topic. In addition, health professionals were consulted to understand the approach used in caring for these patients and to identify possible gaps in the care provided.

The research followed all ethical guidelines for studies involving human subjects, respecting the privacy and anonymity of the participants. Before data collection, each woman received detailed information about the study and signed an Informed Consent Form (ICF). This ensured that participation was voluntary and based on an understanding of the objectives and relevance of the topic to the quality of life of this population.

The study population consisted of menopausal women treated at primary healthcare centers in the municipality of São Luís, Maranhão. Women who had undergone natural menopause, were registered and monitored at the selected primary healthcare centers, and had adequate cognitive abilities to answer questions about their sexual and gynecological health were included in the study.

The sample size was determined based on the availability of participants during the data collection period, ensuring sufficient representativeness for analysis of the findings. The sample was intentionally composed, considering the socioeconomic diversity and access to health services among women treated at the UBS, allowing for a broader view of sexuality after menopause and the challenges faced in this context.

Based on this preliminary estimate, the sample size was calculated using the statistical program STATA 15.0 (Stata Corp., College Station, Texas, USA). In this study, a significance level (α) of 5%, a test power of 80%, a tolerable error of 4%, and 10% of possible losses were considered appropriate.

The process involved the application of two questionnaires (sociodemographic and QS-F). Initially, potential participants were approached during gynecological consultations or routine visits to the UBS and invited to participate in the study after the objectives and importance of the study were explained. Those who agreed to participate signed the Free and Informed Consent Form (FICF), ensuring the ethical conduct of the research.

The questionnaires contained closed and open questions about sociodemographic

Revista ARACÊ
ISSN: 2358-2472

aspects, gynecological history, presence of chronic diseases, complaints related to sexuality, and perception of one's own sexual health. Participants were interviewed in a private setting to ensure their privacy and comfort. At this stage, the impact of menopause on sexual life, barriers to accessing gynecological and sexual care, and perceptions of the support offered by health professionals were addressed.

The data were analyzed using STATA 15.0 software (Stata Corp College Station, Texas, USA). In descriptive statistics, categorical qualitative variables included the calculation of absolute and relative frequencies (percentages). In analytical statistics, the association between explanatory variables (sociodemographic, economic, clinical) and the response variable (sexual function in women) was verified using the Chi-square test.

The study "Assessment of Sexual Function in Menopausal Women Treated in Public Health Services" is part of a larger study entitled "Health and Disease Profile of Elderly People in the Municipality of São Luís do Maranhão," which obtained a Consubstantiated Opinion No. 5,498,949 from the Research Ethics Committee of CEUMA University. Patients who agreed to participate in the study were asked to sign an informed consent form, in accordance with the guidelines and regulatory standards for research involving human subjects of the National Health Council, Resolution No. 466/2012. Study participants were guaranteed the right to withdraw from the study at any time, in addition to the preservation of their identities.

3 RESULTS

The analysis of the results presented in the tables below refers to the cross-sectional analytical study that deals with the analysis of sociodemographic and economic data on sexual function in menopausal women treated at a public health service in São Luís, Maranhão, offering an overview of the profile of the 55 menopausal women studied.

Table 1

Sociodemographic and economic data on sexual function in menopausal women treated at a public health service. São Luís (MA). Brazil, 2025

	FEMALE SEXUAL QUESTIONNAIRE - FSSQ					
	Nil to poor	**Poor to unfavorable**	**Unfavorable to fair**	**Fair to good**	**Good to excellent**	
variable	n (%)	n (%)	n (%)	n (%)	n (%)	P*
Age (years)						0,751
40 a 50	3(33,33)	6(37,50)	6(54,55)	5(35,71)	2(40,00)	
55 a 65	4(44,44)	6(37,50)	4(36,36)	4(28,57)	3(60,00)	

Revista ARACÊ
ISSN: 2358-2472

66 a 81	2(22,22)	4(25,00)	1(9,09)	5(35,71)	0(0,00)	
Marital status						0,950
Single	3(33,33)	3(18,75)	2(18,18)	3(21,43)	2(40,00)	
Married/living together	5(55,56)	9(56,25)	6(54,55)	9(64,29)	2(40,00)	
Widowed or separated	1(11,11)	4(25,00)	3(27,27)	2(14,29)	1(20,00)	
Race (color)						0,275
White	0(0,00)	3(18,75)	0(0,00)	2(14,29)	0(0,00)	
Black	3(33,33)	3(18,75)	4(36,36)	2(14,29)	0(0,00)	
Brown	5(55,56)	10(62,50)	7(63,64)	10(71,43)	4(80,00)	
Other	1(11,11)	0(0,00)	0(0,00)	0(0,00)	1(20,00)	
Education level						0,775
Illiterate	0(0,00)	2(12,50)	0(0,00)	0(0,00)	0(0,00)	
Elementary school	5(55,26)	8(50,00)	6(54,55)	7(50,00)	7(50,00)	
High school	2(22,22)	5(31,25)	4(36,36)	6(42,86)	6(42,86)	
Higher education	2(22,22)	1(6,25)	1(9,09)	1(7,14)	1(7,14)	
Family income						0,944
Up to 1 minimum wage	6(66,67)	9(56,25)	6(54,55)	8(57,14)	4(80,00)	
2 to 4 minimum wages	3(33,33)	6(37,50)	5(45,45)	5(35,71)	1(20,00)	
More than 4 minimum wages	0(0,00)	1(6,25)	0(0,00)	1(7,14)	0(0,00)	
Religion						0,995
Catholic	5(55,56)	8(50,00)	7(63,64)	7(50,00)	3(60,00)	
Evangelical	3(33,33)	6(37,50)	3(27,27)	5(35,71)	2(40,00)	
Other	1(11,11)	2(12,50)	1(9,09)	2(14,29)	0(0,00)	
Profession						0,825
Domestic worker	4(44,44)	7(43,75)	6(54,55)	4(28,57)	3(60,00)	
Freelancer	2(22,22)	2(12,50)	1(9,09)	4(28,57)	0(0,00)	
Other	3(33,33)	7(43,75)	4(36,36)	6(42,86)	2(40,00)	
Household members						0,187
Less than 5	4(44,44)	12(75,00)	10(90,91)	9(64,29)	2(40,00)	
Up to 5	3(33,33)	4(25,00)	0(0,00)	3(21,43)	1(20,00)	
More than 5	2(22,22)	0(0,00)	1(9,09)	2(14,29)	2(40,00)	

Source: Authors, 2025

Table 2 presents the clinical data of 55 menopausal women, including age at last menstruation, use of hormone therapy, presence of diseases (diabetes, hypertension, depression), and perception of worsening sexual function after menopause.

Table 2

Clinical data on sexual function in menopausal women treated at a public health service. São Luís (MA). Brazil, 2025

	FEMALE SEXUAL QUESTIONNAIRE - FSSQ					
	Nil to poor	**Poor to unfavorable**	**Nil to poor**	**Poor to unfavorable**	**Nil to poor**	
Variable	n (%)	n (%)	n (%)	n (%)	n (%)	P*

Revista ARACÊ
ISSN: 2358-2472

Age Last Menstruation						0,184
< 35	2(22,22)	1(6,25)	3(27,27)	1(7,14)	2(40,00)	
35 to 50	4(44,44)	13(81,25)	3(27,27)	8(57,14)	2(40,00)	
> 50	3(33,33)	2(12,50)	5(45,45)	5(35,71)	1(20,00)	
Hormone Therapy						0,760
Yes	1(11,11)	3(18,75)	1(9,09)	1(7,14)	0(0,00)	
No	8(88,89)	13(81,25)	10(90,91)	13(92,86)	5(100,00)	
Diseases						0,450
No	3(33,33)	9(56,25)	6(54,55)	10(71,43)	2(40,00)	
Yes	6(66,67)	7(43,75)	5(45,45)	4(28,57)	3(60,00)	
Diabetes						0,484
No	3(33,33)	7(43,75)	7(63,64)	4(28,57)	2(40,00)	
Yes	6(66,67)	9(56,25)	4(36,36)	10(71,43)	3(60,00)	
Hypertension						0,153
No	3(33,33)	7(43,75)	5(45,45)	9(64,29)	0(0,00)	
Yes	6(66,67)	9(56,25)	6(54,55)	5(35,71)	5(100,00)	
Depression						0,361
No	6(66,67)	8(50,00)	6(54,55)	8(57,14)	5(100,00)	
Yes	3(33,33)	8(50,00)	5(45,45)	6(42,86)	0(0,00)	
Postmenopausal Sexual Dysfunction						0,709
No	3(33,33)	8(50,00)	7(63,64)	8(57,14)	3(60,00)	
Yes	6(66,67)	8(50,00)	4(36,36)	6(42,86)	2(40,00)	

Source: Authors, 2025

4 DISCUSSION

In Brazil, few studies have evaluated the sexuality of middle-aged women at risk of sexual dysfunction. Silva's study (2023) indicates that about 50% of menopausal women experience risks of sexual dysfunction, especially hypoactive sexual desire and pain during intercourse. According to Peres, Sakamoto, and Silva (2023), declining estrogen levels directly influence sexual function, affecting vaginal lubrication, tissue elasticity, and genital vascularization, resulting in discomfort during sexual activity.

The integrative review article by Crema, Tilio, and Campos (2017) emphasizes that hormonal changes and lack of information about menopause are factors that significantly influence the understanding of menopause as a biological phenomenon, marked by changes in the body and desires, with implications for women's sexuality. Another integrative review article by Trento, Madeiro, and Rufino (2021) on menopause discusses women's sexuality, highlighting that decreased estrogen levels are a critical factor contributing to vaginal dryness, vaginal atrophy, and decreased sexual desire.

Age is a critical factor in sexual function, with hormonal decline (especially estrogen) during menopause affecting vaginal lubrication, sexual desire, and satisfaction. In the present study, the age distribution shows that 40% of women are between 40 and 54 years

Revista ARACÊ
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old. Similar results were found in the study by Cavalcanti et al. (2014), demonstrating that the average age of the female volunteers evaluated was 49.9 years. Younger women (40-54 years) may be more interested in maintaining active sexual function, while older women (66-81 years) may be less interested due to cultural factors or lower sexual activity.

Marital status, with p=0.950, did not show a significant association with sexual function; married women or those living with a partner predominated in all categories (64.29%). These results suggest that the presence of a steady partner is not an isolated determinant of sexual function, but may indirectly influence it through factors such as emotional support or frequency of sexual activity. The low representation of widows/separated women may reflect fewer opportunities for sexual activity or the emotional impact of losing a partner. The study by Cabral et al. (2022) shows that marital status can influence sexual function, as women with stable partners tend to have greater sexual activity, although the quality of the relationship is also a determining factor, while single or widowed women may face a greater impact on sexual function due to the absence of a partner or emotional factors such as grief or social isolation.

The race variable presented p=0.275, indicating no statistical significance; the majority (65.45%) of women identify as brown, followed by black (21.82%), white (9.09%), and others (3.64%). These data may reflect the racial composition of Maranhão, with a predominance of Afro-descendant and mixed-race populations. The social and racial aspects of this study are important for understanding the social determinants of sexual health, but they also reveal a vulnerable population, where cultural factors, access to health care, and taboos can influence sexual function as much as biological factors. Studies such as that by Huang et al. (2009) suggest that race may indirectly influence sexual function through socioeconomic factors, access to healthcare, and cultural stigma, and that women from racial minorities may face barriers in accessing treatment for sexual dysfunction.

Educational attainment had a p-value of 0.775, which is not statistically significant, with most women (52.73%) having completed elementary school, 34.55% having completed high school, 9.09% having completed higher education, and 3.64% being illiterate. These results indicate that low educational attainment is associated with less knowledge about sexual health and less access to information about hormone therapies or treatments for sexual dysfunction. Women with higher educational attainment may have greater autonomy to seek medical or psychological help, positively influencing sexual function. Similar results were found in the study by Cavalcanti et al. (2014), which found no significant association

Revista ARACÊ
ISSN: 2358-2472

between lower educational attainment and sexual dysfunction and that this difference could be explained by the fact that there is no standardization of what is considered low educational attainment.

With regard to family income, the majority (60%) earned up to 1 minimum wage, 36.36% earned between 2 and 4 minimum wages, and only 3.64% earned more than 4 minimum wages; p=0.944 also showed no significant association; most women had an income of up to 1 minimum wage. These results indicate that income may influence quality of life, but not directly sexual function, which depends on biological and psychological factors, with low income being a limiting factor for access to health care, including hormonal or psychological treatments for sexual dysfunction. The study by Silva et al. (2020) shows that low-income women report a higher prevalence of sexual dysfunction due to factors generated by financial stress, the historical context, and lack of access to specialized services and poorer quality of life in which women find themselves.

The variable religion did not show a significant association with sexual function, with the majority being Catholic (54.55%), followed by Evangelicals (34.55%) and other religions (10.91%). According to Coutinho and Miranda-Ribeiro (2014), religion can influence attitudes toward sexuality, with some beliefs reinforcing taboos about sexuality in menopause, especially in more conservative evangelical contexts, which can lead to less seeking of medical help for sexual problems. Religiosity can influence beliefs about sex in menopause, especially in more conservative communities. Both low education and income are factors that contribute to greater social vulnerability and possible underreporting or naturalization of sexual symptoms (Goes, 2019).

Occupation did not show a significant association; however, domestic work predominated, where the nature of the work can affect physical and mental health, but is not a determining factor for sexual function. The majority of residents (67.27%) live in households with fewer than 5 residents, 20% with up to 5, and 12.73% with more than 5. This indicates that living in households with many residents can increase stress and reduce privacy, impacting sexual life. The study by Cavalcanti et al. (2014) found results similar to those of the present study, with the majority of women included being housewives or salaried workers.

The deterioration of sexual function after menopause is evident in almost half of women (47.27%) who reported a deterioration in sexual function after menopause, while 52.73% did not notice this deterioration. This result suggests that menopause has a significant but not universal impact on sexual function and that the perception of deterioration

Revista ARACÊ
ISSN: 2358-2472

may be related to biological factors such as hormonal decline, psychological factors such as depression, social factors, and cultural taboos. The study by Bulcão (2004) reports that hormone levels and their relationship with sexual function indicate that menopause is associated with a significant drop in estrogen levels, which can lead to symptoms such as vaginal dryness, reduced sexual desire, and pain during sexual intercourse (dyspareunia).

The low adherence to hormone therapy (10.91%) among women who use hormone therapy (HT), while 89.09% do not use it, may contribute to the reported worsening, since HT is effective in improving urogenital symptoms and sexual function. The perception of worsening in 47.27% of women may be influenced by sociocultural factors, such as taboos about sexuality in menopause, common in contexts of low education and income, as observed in the sociodemographic data. Other predominant factors may be related to barriers to access in the public health system, fear of side effects such as the risk of breast cancer, or lack of information. For Haddad (2022), the low adherence to Hormone Therapy (HT) found in the sample reinforces the analysis of similar reports in developed countries where women avoid HT due to fear of oncological risks or lack of information. Current scientific evidence studied by Hage (2023) shows that, when correctly indicated, HT improves sexual symptoms, including vaginal dryness, desire, and satisfaction.

The high prevalence of diabetes and hypertension among participants, although not statistically significantly associated with sexual function, may indicate metabolic and vascular changes that potentiate the effects of hormonal decline on sexual function, causing vascular damage and side effects due to antihypertensive medications, which can reduce libido or cause difficulty in arousal. These results are corroborated in the study by Costa (2019), pointing out that chronic diseases can aggravate symptoms of sexual dysfunction in postmenopausal women, especially when uncontrolled.

The subjective perception of sexual deterioration after menopause, even without a significant association, reflects what Martins (2023) states, affirming that cultural and emotional factors shape the sexual experience of mature women. This is particularly relevant in low-income contexts, where the taboo surrounding post-reproductive female sexuality is still very present.

The age of the last menstrual period: most women (54.55%) had their last menstrual period between the ages of 35 and 50; (29.09%) after the age of 50 and 16.36% before the age of 35; The p-value indicates no statistically significant association between the age of the last menstrual period and sexual function; however, it indicates that the age of

Revista ARACÊ
ISSN: 2358-2472

menopause may influence sexual function due to the duration of exposure to reduced estrogen levels, but suggests that other factors may be more decisive in this sample. The study by Navriya et al. (2025) indicates that early menopause (before age 40) is considered a risk factor for sexual dysfunction due to the abrupt drop in hormone levels, especially estrogen, which affects vaginal lubrication, sexual desire, and genital tissue elasticity.

The presence of diseases in general 54.55% of women reported no diseases, while 45.45% had at least one comorbidity such as diabetes, which is associated with sexual dysfunction due to complications such as peripheral neuropathy, which can reduce genital sensitivity, and vascular changes, which affect vaginal lubrication. In this study, the high prevalence of diabetes in the sample suggests a significant impact on the sexual function of the respondents. The review study by navriya et al. (2025) on sexual dysfunction in female patients with diabetes reports that the presence of chronic diseases can exacerbate sexual dysfunction due to physiological factors such as vascular and psychological changes, stress, and low self-esteem.

The high prevalence of comorbidities in the sample, such as diabetes, hypertension, and depression, suggests that these factors aggravate sexual dysfunction. Diabetes can cause neuropathy and vascular changes, reducing sensitivity and lubrication, while hypertension can compromise genital blood flow, affecting arousal.

Depression is associated with lower sexual desire and satisfaction, especially in menopausal women. The study by Navriya et al. (2025) points out that sexual function may not be directly linked to age, but to other factors such as general health, psychological state, and quality of interpersonal relationships. Sexual function in menopausal women (over 65 years of age) may be associated with comorbidities or lower sexual interest.

Chronic diseases in general showed p=0.450, diabetes (p=0.484), hypertension (p=0.153), and depression (p=0.361) did not show a statistically significant association with sexual function. However, it was observed that women with hypertension (100%) and diabetes (71.43%) predominated in categories of better sexual function. The study by Ceigol et al. (2024) states that conditions such as hypertension and diabetes can impair sexual function due to vascular damage or neuropathies, but adequate control of these conditions can mitigate these effects.

The depression variable showed no statistical significance (p=0.361), with 40% of women reporting depression, a factor strongly associated with sexual dysfunction. According to Ceigol et al. (2024), depression can decrease sexual desire and satisfaction, in addition

Revista ARACÊ
ISSN: 2358-2472

to being frequently related to other menopausal symptoms, such as insomnia and anxiety.

The perception of sexual deterioration after menopause, the variable showed that 40% of women with sexual dysfunction reported mental health complaints (p=0.709) without significant association. These results may be related to cultural and educational factors or psychological adaptation to menopause. The study by Ceigol et al. (2024) reports the presence of significant impairments in quality of life that sexual dysfunction can cause in these women.

5 CONCLUSION

The assessment of sexual function in menopausal women treated in public health services highlights the complexity surrounding female sexuality during this period of life. The study offers a relevant exploratory contribution to the sociodemographic and clinical profile of menopausal women in São Luís, revealing the high impact of menopause on sexual function, aggravated by social vulnerabilities and low adherence to hormone therapy. However, methodological limitations (small sample size, lack of statistical significance, cross-sectional nature) reduce the robustness of the results, which should be interpreted as trends rather than conclusive evidence.

The results show that menopause alone is not the only determining factor in sexual dysfunction, but is part of a multifactorial context involving clinical, emotional, sociocultural, and economic aspects. The perception of changes in sexual life after menopause reveals the importance of considering not only the physical symptoms resulting from hormonal decline, but also the psychological and social impacts that influence desire, satisfaction, and the quality of affective-sexual relationships. Conditions such as depression, chronic diseases, and the absence of emotional support seem to play a relevant role in this process, which is often silent and neglected.

Factors such as low education, limited income, religious beliefs, and barriers to accessing healthcare indicate the need for integrated actions that consider sexual health as an essential part of women's overall health. The social invisibility of sexuality in maturity is still an important obstacle to be addressed, requiring sensitive listening, acceptance, and health education on the part of professionals.

This study reinforces the urgency of more inclusive and humanized public policies and care practices that consider sexuality during menopause as a right to health and well-being.

Revista ARACÊ
ISSN: 2358-2472

Recognizing this dimension contributes to promoting autonomy, self-esteem, and quality of life for women, especially those in contexts of greater social vulnerability.

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