ANA LÚCIA RIBEIRO VALADARES FERNANDES

SEXUALIDADE EM MULHERES ENTRE 40 E 65 ANOS E COM ONZE ANOS OU MAIS DE ESCOLARIDADE: ESTUDO DE BASE POPULACIONAL

Tese de Doutorado

ORIENTADOR: PROF. DR. AARÃO MENDES PINTO NETO
CO-ORIENTADOR: PROF. DR. DÉLIO MARQUES CONDE

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Tese de Doutorado apresentada à Pós-Graduação da Faculdade de Ciências Médicas da Universidade Estadual de Campinas para obtenção do Título de Doutor em Tocoginecologia, área de Tocoginecologia.

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Dedico este trabalho...

À Luti,
minha amada filha e meu grande estímulo.

Aos meus pais, Alzira e Sindulfo,
que já se foram, mas me deixaram um legado valioso.

Ao Philippe,
pelo grande incentivo e apoio.

Ao Eduardo, Eugênia, Frederike e Juliene,
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por me ajudar a entender a vida.

Ao Dr. Lucas Viana Machado,
pelo exemplo de vida.

"Não sei ...se a vida é curta
Ou longa demais para nós,
Mas sei que nada do que vivemos
Tem sentido, se não tocarmos o coração das pessoas"
Cora Coralina

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Sumário

Símbolos, Siglas e Abreviaturas

IC 95%	Intervalo de confiança a 95%
95% CI	*95% confidence intervals 95% CI*
PR	Prevalence ratios
RP	Razão de Prevalência
SPEQ	*Short Personal Experiences Questionnaire*

Resumo

Objetivos: Avaliar aspectos da sexualidade e seus fatores associados em mulheres de meia-idade, com 11 anos ou mais de escolaridade. **Métodos**: Estudo populacional de corte transversal, com questionário anônimo auto-respondido por 378 mulheres brasileiras residentes em Belo Horizonte, Minas Gerais, entre 40 e 65 anos, com 11 anos ou mais de escolaridade, no período de maio a setembro de 2005. O instrumento de avaliação baseou-se no *Short Personal Experiences Questionnaire (SPEQ).* O escore de sexualidade foi calculado através da análise multivariada de sete componentes: presença de fantasias sexuais, grau de desejo, freqüência de atividade sexual, satisfação nas atividades sexuais, freqüência de excitação, orgasmo e a autoclassificação da vida sexual. Considerou-se escore de sexualidade abaixo da mediana como sexualidade ruim e maior ou igual à mediana como sexualidade boa. Para se investigar os fatores associados, os dados foram analisados usando-se a análise bivariada, com aplicação dos testes qui-quadrado e exato de Fisher. Por último, a análise por regressão múltipla de Poisson foi realizada. A razão de prevalência (RP) e o respectivo intervalo de confiança de 95% (IC 95%) foram calculados. **Resultados**: 276 questionários foram avaliados e, destes, 219 mulheres relataram ter parceiro sexual. A mediana do escore de

sexualidade foi 9,0 (variação: 2,45-13,77). A análise de regressão múltipla mostrou que a prevalência de escore de sexualidade abaixo da mediana foi maior nas mulheres com mais idade e naquelas com insônia. Ter parceiro sexual e sentir-se bem indicaram efeito protetor contra baixo escore de sexualidade. Em mulheres com parceiro sexual, a prevalência de escore abaixo da mediana foi maior nas que moravam com o parceiro, que estavam na transição menopausal ou na pós-menopausa e nas hipertensas. Ter relações sexuais com penetração e satisfação com o parceiro como amante indicaram efeito protetor contra escore de sexualidade abaixo da mediana. **Conclusões**: Mulheres com mais idade e que relataram insônia tiveram maior chance de ter sexualidade ruim, enquanto as com parceiro sexual e que se sentiram bem tiveram maior probabilidade de apresentar sexualidade boa. No grupo de mulheres que tinham parceiro sexual, a sexualidade foi negativamente associada ao fato de residir com o parceiro, estar na transição menopausal ou pós-menopausa e ser hipertensa. A satisfação com o parceiro como amante e ter relações sexuais com penetração diminuíram a probabilidade de apresentar sexualidade baixa.

Palavras-chave: Sexualidade; meia-idade; sintomas climatéricos; satisfação sexual; parceiro sexual.

Summary

Objectives: To evaluate aspects of sexuality and associated factors in middle-aged women with 11 or more years of formal education. **Methods:** with living in Belo Horizonte (Minas Gerais), between 4, in the period between May and September 2005. The evaluation instrument was based on the *Short Personal Experiences Questionnaire (SPEQ)*. Sexuality score was calculated from the multivariate analysis of the seven components: presence of sexual fantasies, intensity of desire, frequency of sexual activities, satisfaction in sexual activities, frequency of arousal, orgasm and self-classification of sexual life. The sexuality score below the median was considered bad sexuality and equal or higher than median as good sexuality. To investigate associated factors, data were analyzed using bivariate analysis and chi-squared and Fisher's exact tests were applied. Finally, Poisson multiple regression analysis was performed. The software used was Stata 7.0. Prevalence ratios (PR) and their 95% confidence intervals (95% CI) were calculated. **Results:** 276 questionnaires were evaluated and from these 219 women reported having sexual partners. The median sexuality score was 9.0 (range: 2.45-13.77). Multiple regression analysis showed that the prevalence of below median scores was higher in older women and in those with insomnia.

Having a sexual partner and feeling well was associated with a protective effect against a below median sexuality score. In women with sexual partner, the prevalence of below median scores was higher in women who lived with their sexual partner, were in the menopausal transition or postmenopausal and in hypertensive women. Sexual activities involving penetration and a score of 6 for satisfaction with partner as a lover were indicative of a protective effect against below median sexuality score. **Conclusions:** Older women and those with insomnia were more likely to have a bad sexuality, whereas the ones with a sexual partner and who felt well were more likely to have a good sexuality. In the group which had sexual partner, the sexuality of women in midlife was negatively associated with the fact of living with a sexual partner, being in the menopausal transition or postmenopausal and being hypertensive. Satisfaction with the sexual partner as a lover and having sexual activities with penetration decreased the chance of poor sexuality.

Key-words: Sexuality; middle-age; climacteric symptoms; sexual satisfaction; sexual partner

1. Introdução

A disfunção sexual é altamente prevalente na população, sendo as mulheres mais acometidas que os homens (Laumann *et al.*,1999). A menopausa é um período de alterações que têm impacto sobre a saúde e o bem-estar. Do início da transição da menopausa até uma etapa mais tardia, o índice de disfunção sexual aumenta significativamente (Dennerstein *et al.*, 2002a). Entretanto, grande número de mulheres permanecem ativas, sem disfunções sexuais, contradizendo crenças de que se aposentam sexualmente ou apresentam declínio do interesse sexual com a menopausa e o aumento da idade (Palacios *et al.*, 2002).

A transição menopausal dura alguns anos e é acompanhada por mudanças biológicas, psíquicas e sociais. As alterações biológicas estão ligadas à diminuição da produção de estrogênios pelos ovários. Isto pode associar-se ao aparecimento de sintomas como alterações no humor, no sono e função cognitiva (Avis *et al.* 2000; Basson, 2000; Blümel *et al.*, 2000; Bachmann e Leiblum, 2004). A deficiência estrogênica inicialmente se manifesta por alterações do padrão menstrual, seguida de diminuição da lubrificação vaginal. Com a persistência da perda estrogênica,

freqüentemente ocorrem mudanças nos sistemas vascular e urogenital. Essas mudanças podem contribuir para a diminuição da auto-estima, do desejo e das respostas sexuais. Fatores não hormonais também podem afetar a sexualidade. Os mais citados são: presença de parceiro sexual, idade e saúde do parceiro, tempo de relacionamento, sentimentos em relação ao parceiro, nível de função sexual no passado, estresse, personalidade, atitudes negativas em relação à menopausa, doença, saúde, uso de medicamentos, condição socioeconômica e diferenças culturais (Bachmann,1994; Dennerstein *et al.*, 2002a; Bachmann e Leiblum, 2004; Dennerstein e Lehert., 2004; Avis *et al.,* 2005; Dennerstein *et al.*, 2005 a). A presença de disfunção sexual no parceiro é uma das variáveis que mais influem na sexualidade feminina. Muitas mulheres referem dificuldades sexuais devido ao problema do parceiro com ereção ou mesmo por diminuição do desejo sexual dele (Kinsberg, 2002).

Um outro aspecto que pode influenciar a sexualidade é o nível educacional dos indivíduos. Para alguns autores, a baixa escolaridade estaria associada à piora da sexualidade (Laumann *et al.*,1999; Abdo *et al.*, 2004), enquanto que para outros o alto nível educacional é que comprometeria a função sexual (Sidi *et al.*, 2007). O aumento dos problemas sexuais em ambos os sexos também pode estar associado a dificuldades econômicas (Laumann *et al.*,1999). Em relação ao meio cultural, podem existir diferenças marcantes na sexualidade. Lock (1998), por exemplo, comparou o comportamento de mulheres no Japão, Canadá e Estados Unidos. Verificou que as japonesas aceitam o envelhecimento e a perda da atratividade sexual como um processo normal, enquanto isto pareceu ser mais

difícil para as canadenses e norte-americanas. O fato é que a sexualidade é uma interação complexa de necessidades individuais (intimidade, afeto, conexão, prazer e auto-imagem) com o contexto do meio ambiente. As mudanças que surgem com o envelhecimento devem ser analisadas separadamente das doenças que com freqüência surgem nessa fase da vida. Dada a maior longevidade da mulher, é muito provável que muitas delas envelhecerão sozinhas, o que não significa o fim de sua sexualidade ou a perda da necessidade de intimidade, toque e afeto (Kaiser, 2003).

Vários estudos contribuíram para um melhor entendimento da sexualidade humana, assim como para uma melhor conceituação da sexualidade feminina (Gelfand, 2000). Em pesquisa populacional nos Estados Unidos, Kinsey *et al.* (1948) constataram que distintas práticas sexuais ocorriam, e envolviam não somente os genitais como também de forma ampla os corpos de ambos os parceiros. Por outro lado, Masters e Johnson (1984) desenvolveram na década de 1960 um modelo para o entendimento do ciclo da resposta sexual humana, com base em estudos decorrentes do comportamento sexual do homem e da mulher. Dividiram o ciclo em quatro fases: excitação, platô, orgasmo(s) e resolução. A busca do orgasmo é preconizada como a guia principal da orientação sexual. O orgasmo na mulher de meia-idade é igual ao da mulher jovem, porém com diminuição do número de contrações vaginais, mas a ausência do período refratário e a presença de orgasmos múltiplos podem ser compensatórios. Foi Kaplan (1974) quem modificou a visão do ciclo original da resposta sexual humana. Mostrou que o desejo antecede a fase de excitação e que o platô não se

justifica, tendo em vista ser a excitação crescente o que conduz ao orgasmo. O novo esquema compunha-se, portanto, de três fases: desejo, excitação e orgasmo. Na década de 1980, Rose Marie Muraro (1983), em trabalho sociológico brasileiro, relatou que camponesas e operárias desconheciam o desejo e habitualmente tinham relações sexuais somente para satisfazer o parceiro. Este estudo mostrou que a motivação para o ato sexual nem sempre foi o desejo.

Uma nova visão da sexualidade feminina foi proposta por Basson (2000), enfatizando o valor da intimidade como motivação para o sexo. Seus conceitos levaram à proposição de um novo modelo (Basson, 2000; Basson *et al.*, 2003) que visou a aumentar o entendimento da sexualidade feminina, de forma a proporcionar melhorias nos tratamentos das desordens sexuais. Segundo ela, a atividade sexual pode se iniciar por motivo não necessariamente sexual, com ou sem consciência do desejo. A excitação subjetiva com resposta física acontece muitas vezes desencadeada pelo estimulo erótico, em contexto adequado. Com o evoluir da excitação subjetiva a consciência do desejo muitas vezes aflora. O aumento gradativo dessa excitação e do desejo, por sua vez, pode ou não levar ao orgasmo. Se existe uma satisfação fisica e emocional no relacionamento haverá possivelmente uma maior receptividade para os futuros atos. Nos relacionamentos de longa duração, de acordo com essa autora, o desejo sexual feminino é muito mais responsivo do que espontâneo. Nesse contexto, o relacionamento sexual pode ser dificultado pelo declínio da atratividade feminina, desfavorecendo o desejo masculino. Ficam assim, portanto, comprometidos a interação entre os parceiros e o início dos jogos sexuais (McCoy, 2001).

O fato é que a diminuição do desejo sexual é a disfunção sexual mais prevalente em mulheres. Essa diminuição parece estar ligada à redução dos níveis de testosterona e à multifatoriedade do desejo. Ele é determinado pela interação de três componentes: vontade (componente biológico, resultado de mecanismos neuroendócrinos que levam a um interesse sexual espontâneo, endógeno), crenças e valores (componente social que provoca toda uma expectativa e idealização da atividade sexual) e motivação (depende de fatores interpessoais e emocionais). O entendimento de que a vontade é componente do desejo torna-se fundamental para o tratamento e abordagem da disfunção sexual. Esta distinção é relevante para a compreensão da sexualidade feminina. Em muitas mulheres, principalmente aquelas na transição menopausal, a vontade sexual diminui e deixa de ser o primeiro passo para a atividade sexual. Na maioria das vezes a estimulação faz esse papel (Kinsberg, 2002).

Embora existam lacunas nos estudos de disfunção sexual comparando as mulheres na pré e pós-menopausa, a maioria sugere que a transição menopausal tem um impacto negativo na função sexual. Um dos pioneiros em estudos sobre sexualidade nas mulheres climatéricas, Hallstrom (1979), relatou alterações da sexualidade, com aumento progressivo das disfunções da pré à pós-menopausa. Outros estudos posteriores confirmaram um declínio na função sexual associada ao aumento da idade e à progressão do estado menopausal (Dennerstein *et al.*2001; Dennerstein *et al.* 2002a; Avis *et al*. 2005; Dennerstein *et al*. 2005a).

Fatores determinantes para uma melhor sexualidade na meia-idade foram ter parceiro sexual, bem-estar emocional, saúde, qualidade de relacionamento e

vida sexual prévia (Avis *et al*. 2005; Dennerstein *et al.*, 2005a e 2005b; González *et al.* 2006). O tempo de relacionamento mais longo com o parceiro (Dennerstein *et al.*, 2005a e 2005b), tabagismo e estresse (Avis *et al*. 2005) e baixo nível de educação (Abdo *et al.*, 2004; González *et al.* 2006) foram fatores relevantes para a piora da sexualidade em mulheres de meia-idade. Na maior parte da literatura sobre sexualidade no climatério, os dados avaliados estão relacionados ao coito. Infelizmente, poucas vezes são consideradas a intimidade e a afeição (Kaiser, 2003). É importante salientar que as avaliações sobre sexualidade devem ser realizadas levando-se em conta as diferenças culturais e étnicas. Esses dois fatores interferem de forma significativa na função sexual (Dennerstein e Lehert, 2004; Kang *et al.*, 2006).

Em populações latino-americanas, poucos estudos foram realizados em mulheres climatéricas (Gonzales *et al.*, 2006; Blumel *et al.*, 2003; Pedro *et al.*, 2003). Conseqüentemente, ainda existem lacunas no que diz respeito à sexualidade das mulheres climatéricas nessas populações. Observa-se também constrangimento, tanto por parte dos médicos quanto das pacientes, em relação ao tema. As pesquisas mostram que falar sobre sexualidade é exceção ao invés de regra (Kinsberg, 2002). Dessa maneira, é importante que os profissionais se habituem a abordar as queixas sexuais de maneira confortável, permitindo à paciente falar sobre o assunto (Andrews, 2000). Se isto não for habitual, os problemas não serão diagnosticados e, conseqüentemente, não serão tratados, com conseqüências negativas na qualidade da relação médico-paciente (Bachmann e Ayers, 1995).

Quase não há inquéritos populacionais abordando a sexualidade da mulher brasileira, considerando-se as variáveis relacionadas ao parceiro e à intimidade. Em relação às mulheres com escolaridade média ou superior as informações são praticamente inexistentes. Existem, assim, vários questionamentos sem respostas de como estas mulheres sentem-se em relação à sexualidade. No atendimento dessas mulheres, foi constatada freqüência elevada de queixas relacionadas à sexualidade. A situação torna-se mais difícil pelo conjunto de mudanças físicas, emocionais e sociais inerentes a esta fase da vida. Assim, foram observadas mulheres inseguras e propensas a perceber os seus problemas de forma ampliada, sentindo-se muitas vezes desamparadas. Essas observações estimularam a realização desta pesquisa, a partir da qual, nesta fase, foram elaborados dois artigos que se complementaram e auxiliaram na compreensão da sexualidade em brasileiras de meia-idade, com 11 anos ou mais de escolaridade. No primeiro artigo, o objetivo foi avaliar a sexualidade e identificar os fatores associados em uma coorte de mulheres com e sem parceiro sexual. No segundo, procurou-se identificar os fatores associados à sexualidade nas com parceiros sexuais. Espera-se que representem uma contribuição para a melhoria do atendimento dessa população em relação ás queixas referentes à sexualidade, e com isso melhorar seu bem-estar.

2. Objetivos

- Avaliar aspectos da sexualidade e os fatores associados, em mulheres de meia-idade (artigo1).

- Avaliar aspectos da sexualidade e os fatores associados, em mulheres de meia-idade com parceiro sexual (artigo 2).

3. Publicações

Artigo 1

Sexuality in Brazilian Women aged 40 to 65 years with 11 years or more of Formal Education: Associated factors

Ana L. Valadares, MD[1], Aarão M. Pinto-Neto, MD, PhD[1], Maria J. Osis, PhD[1], Délio M. Conde, MD, PhD[2], Maria H. Sousa, PhD[1], Lúcia Costa-Paiva, MD, PhD[1]

Submetido à publicação no Menopause - The Journal of The North American Menopause Society, em 22 de março de 2007. Aceito para publicação em 11 de junho de 2007. **Menopause, 15(2): 2008.**

Artigo 2

The Sexuality of Middle-Aged Women with a Sexual Partner: a Population-based Study

Ana L. Valadares, MD[1], Aarão M. Pinto-Neto, MD, PhD[1], Maria J. Osis, PhD[1], Délio M. Conde, MD, PhD[2], Maria H. Sousa, PhD[1], Lúcia Costa-Paiva, MD, PhD[1]

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3.1. Artigo 1

Menopause
Jun 11, 2007

RE: MENO-D-07-00089R1, entitled "Sexuality in Brazilian Women aged 40 to 65 years with eleven years or more of Formal Education: Associated factors"

Dear Dr. Conde:

I am pleased to inform you that your manuscript has now been accepted for publication in Menopause - The Journal of The North American Menopause Society. All manuscript materials will be forwarded to the production staff for placement in Volume 15(2) which is the March/April 2008 issue.
REMINDER: Please submit a completed copyright release form to our office if you have not already done so. The form can be found on the home page of our submission site listed below.

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With Kind Regards,

Isaac Schiff, MD
Editor-in-Chief, Menopause
Menopause - The Journal of The North American Menopause Society

Sexuality in Brazilian Women aged 40 to 65 years with 11 years or more of Formal Education: Associated factors

Sexuality in Brazilian Women aged 40 to 65 years

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Abstract

Objective: To evaluate factors associated with the sexuality of middle-aged women. Design: Cross-sectional, population-based survey using an anonymous self-response questionnaire. A total of 276 Brazilian-born women, 40-65 years old with at least 11 years of formal education participated in the study. The evaluation instrument was based on the Short Personal Experiences Questionnaire (SPEQ). Seven components were analyzed: satisfaction in sexual activities, orgasm, intensity of desire, self-classification of sexual life, frequency of arousal, sexual activity and sexual fantasies. Sociodemographic, clinical, behavioral and reproductive factors were evaluated. Data were analyzed using the chi-squared and Fisher's exact tests and the Poisson multiple regression analysis. Prevalence ratios (PR) and their 95% confidence intervals (95% CI) were calculated. Results: Median sexuality score was 9 (range 2.45-13.77). Bivariate analysis indicated that being fifty years of age or older, in the menopausal transition or the postmenopause, not having a sexual partner, reporting hot flushes, insomnia, depression, nervousness, sedentary lifestyle, arterial hypertension or urinary incontinence, and poor self-perception of health were significantly associated with a below median sexuality score. Multiple regression analysis showed that the prevalence of below median scores was higher in older women (PR= 1.03, 95% CI= 1.01-1.05) and in those with insomnia (PR= 1.46, 95% CI= 1.08-1.96). Having a sexual partner (PR= 0.68, 95% CI= 0.50-0.92) and feeling well (PR= 0.73, 95% CI= 0.57-0.94) was associated with a protective effect against a below median sexuality score. Conclusions: Older women and those with insomnia were more likely to have a low sexuality score, whereas those with a sexual partner and who felt well were less likely to have a low sexuality score.

Key words: Sexuality; Middle-aged; Menopause symptoms; Sexual satisfaction; Menopause

Introduction

Sexuality is a complex interaction of intimacy, affection, connection, self-gratification and self-image, and is related to gender and ethnic group.[1] It is influenced by the cultural context in which the individual establishes his/her sexual identity and his/her connections with sexual activities and relationships.[2,3]

During the climacteric years, changes occur that will affect sexuality. Hormone fluctuations are associated with changes in the menstrual cycle, vasomotor symptoms, and difficulties related to sleep, mood, cognitive function and general well-being.[3-7] These symptoms may be exacerbated by factors that may also affect sexuality: the presence of a sexual partner, the level of sexual function in the past, lifestyle habits, education level, stress, employment, personality, negative attitudes with respect to the menopause, sickness, health, the use of medication, and socioeconomic condition.[8-12]

Hallstrom[13] was the first to report changes in the sexuality of climacteric women, reporting a progressive deterioration from the pre to postmenopause. Avis et al[4] observed that women in the peri- and postmenopause had a reduction in sexual desire compared to those in the premenopause and greater difficulty in achieving arousal, but no differences were found with respect to sexual satisfaction. Other studies also confirmed a decline in sexual function associated with an increase in age and the progression of menopause.[3,10,14]

In Latin American populations, few studies have been carried out in climacteric women.[15-17] The Global Study of Sexual Attitudes and Behaviors[18] was conducted in various parts of the world, including Brazil and Mexico, to investigate the prevalence of sexual dysfunction and to identify the associated factors in

individuals 40 years of age or older. Statistically significant differences were found for climacteric women between regions, both with respect to the prevalence of sexual dysfunction and the associated factors. Therefore, gaps remain not only with respect to knowledge on the sexuality of women but principally regarding the evaluation of associated factors.

The objective of this study, carried out in Brazilian women with at least 11 years of formal education, was to evaluate their sexuality and correlate it with sociodemographic, clinical, reproductive and behavioral factors. The results may be useful to women and to the professionals who provide healthcare to this population.

Methods

Sample size

The target population was the female population of Belo Horizonte in the state of Minas Gerais, Brazil, aged 40-65 years, with at least 11 years of formal education, which consisted of 44,313 women in the year 2000. For the calculation of sample size, the proportion of the female population with sexual dysfunction in the climacteric was estimated at 43%[19], with an expected difference of 5% between the proportions of the study sample and the general population and a type I (α) error of 0.05. Therefore sample size was calculated at 377 women.

Subjects

A cross-sectional study in the form of a population-based survey, self-responded by participants in their homes, was carried out between May and September 2005. Research assistants, guided by maps of each census area, started at the corners of randomly selected streets, went to the homes and

verified whether there were any Brazilian-born women of 40-65 years of age living there and whether they had at least 11 years of formal education. Because of inhibitions in expressing oneself about sexuality, we considered anonymity to be very important in obtaining unbiased answers. Thus by selecting women with 11 or more years of formal instruction we selected a group more likely to be able to fill-out a self-response questionnaire. If there were eligible women residing at the address, they were invited to participate in the study. If they agreed, a questionnaire was left with them to be answered, and a date was scheduled for the completed questionnaire to be collected. If the eligible women were not at home, they were contacted by telephone and, if they agreed to participate, the questionnaire was delivered to their home. The principal investigator telephoned the participants and confirmed whether the questionnaire had been completed. If it had been, it was collected by a messenger and placed in an unidentified envelope and put into a sealed post-box. As they were delivered to the principal researcher, the area of the city and the frequency of educational level were noted to homogenize the response in the smallest geographic unit.

A total of 420 women were invited to participate in the study. Forty-two women (10%) refused to participate in the study. The reasons given for not participating in the study were: lack of time, the woman did not feel comfortable answering the questions, or her husband did not want her to fill out the questionnaire. Therefore, 378 questionnaires were returned and, of these, 276 (73%) contained answers to all the questions used in the calculation of the sexuality score. The remaining questionnaires that were returned were incomplete and were not considered in the calculation of sexuality score. Hence, 276 middle-aged women constituted the present study sample.

The questionnaire used in the study consisted of two parts. In the first part, the participants answered questions on their sociodemographic, clinical, reproductive and behavioral characteristics. In the second part, they answered questions on their sexuality.

The research protocol was approved by the Internal Review Board of the School of Medicine, Universidade Estadual de Campinas.

Assessment of sexuality

The instrument used for evaluating sexuality was based on the Short Personal Experiences Questionnaire (SPEQ).[20] This questionnaire permits evaluation of the sexuality of middle-aged women. The original version of this tool was provided by researchers at the University of Melbourne, Australia. Initially, the questionnaire was translated from English into Brazilian-Portuguese by two independent translators who were fluent in both languages. Next, the two translated versions were compared and a consensus version was obtained. This version was tested in a group of 50 Brazilian-born women, 40-65 years old with at least 11 years of formal education. With the objective of achieving cultural equivalence, in this phase any questions that had generated uncertainties were once again adapted and tested until the participants reported no more doubts or difficulties in answering the questions. A final version of the questionnaire in Brazilian-Portuguese was thus obtained. All the questions referred to the month preceding the date on which the questionnaire was filled out.

Dependent variable

The sexuality score contained seven components: satisfaction/pleasure during sexual activities (graded from 1 to 6 where 1 referred to the absence of

satisfaction and 6 to maximum satisfaction), frequency of arousal during sexual activities (from 1 to 6), orgasm (from 1 to 6), frequency of sexual activities (1=never, 2=less than once a week, 3=once or twice a week, 4=several times a week, 5=once a day or more), intensity of sexual desire (from 1 to 6), frequency of sexual fantasies, thoughts and desires (1=never, 2=less than once a week, 3=once or twice a week, 4=several times a week, 5=once a day or more), and self-classification of sexual life (1=terrible, 2=bad, 3=regular, 4=good, 5=excellent).

Independent variables

Age was dichotomized into < 50 years of age or ≥ 50 years of age. Menopausal status was classified as premenopausal, menopausal transition or postmenopausal. Status was defined as premenopausal when the women had regular menstrual cycles or a menstrual cycle similar to the one they had throughout their reproductive life. Women were considered to be in the menopausal transition if they had had menstrual cycles during the last 12 months, but a change had occurred in their menstrual pattern. Women were considered postmenopausal if their last period had been at least 12 months prior to filling out the questionnaire.[21] In women who had undergone a hysterectomy, menopausal status was classified as follows: women aged 40-44 years who had had regular menstruation prior to hysterectomy were considered to be premenopausal; women aged 45-48 who had irregular menstruation prior to hysterectomy were considered to be in the perimenopause; women over 48 years of age and who had been submitted to hysterectomy or women who had undergone bilateral oophorectomy were considered to be postmenopausal. Women over 48 years of age, who had been submitted to hysterectomy, were classified as postmenopausal in view of the fact that the

median age of menopause in Latin America has been reported to be over 48 years of age, more precisely 48.6 years of age.[22]

Marital status was dichotomized into those with and those without a partner; ethnic group into white or nonwhite; schooling into 11 years or more than 11 years of formal education; family income was ≤US$1300 or >US$1300 per month; physical activity was classified as none/<3 times a week or ≥3 times a week; number of pregnancies was ≤2 or >2. Body mass index (BMI) was <25 or ≥25 kg/m^2. Paid employment was dichotomized into none / ≤ 20 hours per week or >20 hours per week; use of tobacco: never smoked or history of smoking. The presence or absence (yes or no) of the following variables was also recorded: depression, arterial hypertension, diabetes, urinary incontinence, history of cancer, hot flushes, nervousness, insomnia, and presence of sexual partner in the previous month. Hormone therapy was dichotomized into “never-user” or “past or current user”. Self-perception of health status was classified into terrible/poor/regular or good/excellent.

Statistical analysis

Initially, the data analysis consisted of a multivariate principal components analysis to define sexuality score.[23] The score was calculated from the analysis of the seven components: satisfaction/pleasure during sexual activities, frequency of arousal during sexual activities, orgasm, frequency of sexual activities, intensity of sexual desire, frequency of sexual fantasies, thoughts and desires, and self-classification of sexual life. Sexuality was evaluated using the median of the sum of each variable multiplied by the respective score of the analysis of the principal components. This new variable explained 71% of the variance observed.

Next, bivariate analysis was performed, considering sexuality as the dependent variable, dichotomized by the median, according to the independent variables. The chi-squared test was applied with Yates' correction or Fisher's exact test.[24] Finally, the Poisson multiple regression analysis was applied, to identify the most predictive variables, and to obtain a final adjusted model for calculation of the prevalence ratio (PR) and the respective 95% confidence intervals (95% CI).[23] The "backward" criterion was used to select the variables.[25] For this analysis, the strata and the cluster group (primary sampling unit: first geographic unit of the sampling design) were used. The software program used was Stata, version 7.0 (Statlab). As inclusion criteria for the independent variables, only the 13 independent variables with a p-value <0.25 in the bivariate analysis and/or in the simple Poisson regression analysis were considered. P-values of 0.05 or less were considered statistically significant.

Results

In this sample, 44.6% of women were 50 years of age or older, 70.9% lived with a partner, 79.3% reported having a sexual partner, 51.4% stated that they had more than 11 years of formal education, 41.9% had a monthly family income of more than US$1300, 52.7% had two or more children and 34.3% reported practicing physical activity regularly, three or more times a week (table not presented).

Table 1 lists the values obtained for the seven components of the sexuality score. The median sexuality score was 9, ranging from a minimum of 2.45 to a maximum of 13.77. We considered scores below 9 to represent "poor sexuality" and scores ≥9 to be "good sexuality".

In the bivariate analysis, women who had a lower sexuality score (<9) were found to be more likely to have the following characteristics: to be 50 years of age or older (p=0.008), in the menopausal transition or postmenopause (p=0.003), to have a sedentary lifestyle (p=0.007), to report depression (p=0.001), arterial hypertension (p=0.031), urinary incontinence (p=0.011), hot flushes (p=0.038), nervousness (p=0.034), or insomnia (p=0.001), to have a poor perception of their own health (p<0.001) and not to have a sexual partner (p<0.001) (Table 2). The other variables evaluated were not significantly associated with sexuality scores below the median.

Multiple regression analysis showed that older age (PR=1.03, 95% CI= 1.01-1.05) and insomnia (PR= 1.46, 95% CI= 1.08–1.96) were significantly associated with scores below the median. Conversely, women "who felt well" (PR= 0.73, 95% CI= 0.57-0.94), and women with a sexual partner (PR= 0.68, 95% CI= 0.50-0.92) were less likely to have a low sexuality score (Table 3).

Discussion

The objective of this study was to collect information on the sexuality of middle-aged Brazilian women and the factors associated with their sexuality.

An internationally recognized questionnaire, the SPEQ[20], adapted to the Brazilian-Portuguese language, was used. To our knowledge, this specific questionnaire for the evaluation of sexuality has not yet been validated for use in Brazil; however, rigorous adaptation procedures were carried out until the final version was considered adequate, i.e. until the participants reported no more doubts or difficulties in answering the questions. Since only women with 11 years or more of formal education were included in this study, it was impossible to

evaluate the sexuality of women with lower education levels. Conflicting data have been published in the literature with respect to the relationship between education level and sexuality. Previous studies have shown that women with higher education levels have impaired sexual function.[26,27] Nevertheless, other investigators have reported an association between sexual dysfunction, orgasmic difficulties and lower educational level.[15,28] It is possible that the differences in the results reported may be due to cultural differences in the populations studied.

Another possible limiting factor is that the menopausal status of hysterectomized women was assessed according to age and previous menstrual pattern as no hormonal proof was available. The sample failed to reach the calculated size, i.e. 378 women responded to the questionnaire but, of these, 276 responded to all the questions relating to sexuality. However, significant associations were identified between sociodemographic, clinical, reproductive and behavioral factors and the sexuality of middle-aged women. Nevertheless, it is possible that some null findings may be related to the fact that the sample size calculated for the study was not achieved.

Sexuality is a term that refers to many concepts and behaviors, including issues on gender, preferences, attitudes, experiences, activities, feelings and perceptions.[29] Therefore, we consider that the use of a score obtained from responses to seven questions regarding various aspects of sexuality allowed a better evaluation of a woman's sexuality.

In this study, sexuality scores below the median were found for older women. This supports the findings of several previous studies. The Australian longitudinal cohort study reported a negative and highly significant effect of age on

the frequency of sexual activity, on interest, and on aspects of sexual response such as excitation, pleasure and orgasm.[10] The Women's International Study of Health and Sexuality, a multinational, cross-sectional study carried out in Europe and in the US, found a steep decline in all aspects of sexual function with an increase in age.[30] In a longitudinal study, Ford et al[31] reported that increased age was associated with a deterioration in sexuality. In a cross-sectional study carried out in 231 Colombian-born women 40-62 years of age, Gonzalez et al[15] found that increased age had a significantly negative effect on desire and orgasm.

The women in this sample who reported insomnia were more likely to have a sexuality score < 9. Blümel et al[32] evaluated 300 women aged 40 to 59 years and also reported that these complaints were related to sexual dysfunction. Studies carried out in Massachusetts[33] and Harvard[34] also reported that symptoms of depression were more frequent in women with vasomotor symptoms. The presence of hot flushes may be a triggering factor for insomnia[35] that, in turn, leads to reduced energy and depression, which has a negative effect on sexual function. In a longitudinal study, Mallon et al[36] reported that insomnia may increase the risk of depression, and that the use of medication, when necessary, may also affect sexual function. Selective serotonin reuptake inhibitor antidepressants may reduce desire, libido or orgasm.[36,37] These factors may explain the association seen in our study between insomnia and lower sexuality score. It should be emphasized that the present study is a cross-sectional study that permits identification of associations; however, it does not permit temporal or causal relationships to be made.

Healthy life habits may lead to an improvement in well-being and may positively influence sexuality. Feeling "well" or "excellent" in the month prior to filling

out the questionnaire was correlated with a higher sexuality score. This is consistent with other studies. In a study carried out by Avis et al[3], an association was found between well-being and sexual satisfaction. The Melbourne Women's Midlife Health Project[29] found that lifestyle and humor significantly affected sexual function. After evaluating postmenopausal women, Asbury et al[38] suggested that the regular practice of physical exercise improves general well-being. A cross-sectional study carried out in Italy in 355 women of 40-60 years of age showed that physical well-being and mental health, more than menopausal status itself, were the factors that most influenced sexual health in this age-group.[39] In another study carried out in England, Scotland and Wales[40], investigators concluded that psychological symptoms and the stress of life were the most important factors associated with sexual dysfunction. Conversely, a sedentary lifestyle, arterial hypertension, urinary incontinence and self-perception of poor health were associated with lower sexuality scores.

In the current study the presence of a sexual partner was associated with a higher sexuality score. In a study on climacteric women carried out in 12 European countries, Dennerstein et al[11] found that the factors that most influenced sexual response were the presence of a sexual partner, well-being, parity and the practice of physical exercise. In the North American Study of Women's Health Across the Nation (SWAN)[3], the objectives were to examine sexual function in women of different races and cultures, to compare premenopausal women with women undergoing early-onset perimenopause and to identify the factors related to sexual function. The study demonstrated that married women or those with a sexual partner more frequently reported an active sex life in the six months preceding the interview, and fewer evaluated sex as being of little or no importance. It is known

that sexuality may be affected not only by the presence or absence of a sexual partner, but also by the quality of the relationship. Previous studies carried out in different cultural contexts have described the importance of the quality of the relationship and of the feelings of one partner for the other with respect to sexuality[41-43], emphasizing that middle-aged women value this aspect of the relationship.[43] These data suggest the need to evaluate the quality of the relationship in future studies on the sexuality of women in midlife.

Conclusions

This study showed that age and menopause symptoms, particularly insomnia, negatively interfere in a woman's sexuality. Women with a sexual partner and those feeling "well" were less likely to have a low sexuality score. This study suggests that healthcare providers can help peri- and postmenopausal women by minimizing menopause-related symptoms and emphasizing the importance of a healthy lifestyle.

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Table 1. Sexuality score of middle-aged women

Variable	Range	Minimum	Median	Maximum
Sexual satisfaction	1-6	0.50	-	3.03
Frequency of arousal	1-6	0.49	-	2.95
Orgasm	1-6	0.49	-	2.93
Frequency of sexual activities	1-5	0.14	-	0.72
Intensity of sexual desire	1-6	0.39	-	2.31
Frequency of sexual fantasies	1-5	0.20	-	1.02
Self-classification of sexual life	1-5	0.23	-	1.15
Sexuality score	-	2.45	9.00	13.77

Table 2. Variables associated with the sexuality of middle-aged women.

Bivariate analysis

Variable	N[a]	Sexuality (%)		p-value[b]
		Score<9	Score≥9	
Age (years)				*0.008*
<50	153	42.5	57.5	
≥50	123	59.3	40.7	
Menopausal status				*0.003*
Premenopause	90	36.7	63.3	
Menopausal transition or postmenopause	186	56.5	43.5	
Hot flushes				*0.038*
No	192	45.3	54.7	
Yes	80	60.0	40.0	
Insomnia				*0.001*
No	168	41.7	58.3	
Yes	105	63.8	36.2	
Depression				*0.001*
No	170	44.1	55.9	
Yes	80	67.5	32.5	
Nervousness				*0.034*
No	126	42.9	57.1	
Yes	147	56.5	43.5	
Arterial hypertension				*0.031*
No	196	45.4	54.6	
Yes	70	61.4	38.6	
Urinary incontinence				*0.011*
No	205	45.4	54.6	
Yes	67	64.2	35.8	
Physical activity				*0.007*
None or less than 3/week	178	56.7	43.3	
≥3 times a week	93	38.7	61.3	
Self-perception of health				*<0.001*
Terrible, poor, regular	112	63.4	36.6	
Good, excellent	162	40.7	59.3	
Sexual partner				*<0.001*
No	47	72.3	27.7	
Yes	219	44.3	55.7	

[a]Some values may not add up to n= 276 because of missing data.

[b]Yates correction to chi-squared test.

Table 3. Variables associated with sexuality scores below the median (<9) in middle-aged women. Multiple analysis[a]

Variable	PR	95% CI	p-value
Age (years)	1.03	1.01–1.05	0.003
Insomnia in the last month (yes)	1.46	1.08–1.96	0.017
Sexual partner in the last month (yes)	0.68	0.50–0.92	0.017
Self-perception of health status (good/excellent)	0.73	0.57–0.94	0.018

[a]Poisson regression; PR= prevalence ratio; CI= confidence interval.

3.2. Artigo 2

2007/10/1, Délio Conde <condedelio@uol.com.br>:
Oct 01, 2007

RE: MENO-D-07-00203R1, entitled "The Sexuality of Middle-Aged Women with a Sexual Partner: a Population-based Study"

Dear Dr. Conde:

I am pleased to inform you that your manuscript has now been accepted for publication in Menopause - The Journal of The North American Menopause Society. All manuscript materials will be forwarded to the production staff for placement in Volume 15(4) which is the July/August 2008 issue.

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The Sexuality of Middle-Aged Women with a Sexual Partner: a Population-based Study

Running title: Sexuality of Middle-Aged Women with a Sexual Partner

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A stract

Objective: To evaluate the factors associated with the sexuality of middle-aged women with sexual partners. Design: A cross-sectional, population-based study was carried out using an anonymous, self-response questionnaire completed by Brazilian-born women, 40-65 years old with 11 years or more of formal education who had a sexual partner. Of the 378 women who agreed to participate in the study, 219 answered all the questions used for calculation of the sexuality score and reported having a sexual partner. The instrument was based on the Short Personal Experiences Questionnaire (SPEQ). Seven components were analyzed: satisfaction in sexual activities, orgasm, intensity of desire, self-classification of sexual life, and frequency of arousal, sexual activity and sexual fantasies. Sociodemographic, clinical, behavioral, reproductive and partner-related factors were evaluated. Poisson multiple regression analysis was performed and prevalence ratios (PR) with their 95% confidence intervals (95% CI) were estimated. Results: Median sexuality score was 9 (range 2.45-13.77). The prevalence of below median scores was higher in women who lived with their sexual partner (PR=2.07; 95% CI=1.17-3.69), who were in the menopausal transition or were postmenopausal (PR=1.69; 95% CI=1.08-2.65) and in hypertensive women (PR=1.65; 95% CI=1.19-2.30). Sexual activities involving penetration (PR=0.48; 95% CI=0.31-0.73) and a score of 6 for satisfaction with partner as a lover (PR=0.34; 95% CI=0.20-0.60) were indicative of a protective effect against poor sexuality. Conclusions: In this cohort, the sexuality of women in midlife was negatively associated with the fact of living with a sexual partner, being in the menopausal transition or postmenopausal and being hypertensive. Therefore, greater attention should be paid to identifying these factors, and measures should be adopted to minimize their repercussions on the sexuality of middle-aged women.

Key words: Menopause; Midlife; Sexual activity; Sexual partner; Hypertension

Introduction

Sexuality is an important and complex domain of quality of life[1]. Both women and men may report deterioration in sexual function with increased age, although the reasons for this appear to be gender-specific[2]. The sexual function of middle-aged women may be negatively associated both with aging and with the menopausal transition.[3,4] During the menopausal transition, a reduction in estradiol[3] and dehydroepiandrosterone sulfate (DHEAS)[5,6] levels may interfere negatively with sexual function. In addition, sociodemographic[1,7,8] and partner-related factors[4,8-13] may contribute towards a deterioration in the sexual function of women in midlife.

The hormonal alterations that occur in the menopausal transition lead to changes in the menstrual cycle accompanied by vasomotor and genital symptoms, sleep difficulties and changes in mood, cognitive function and in general well-being[14-17]. These symptoms may negatively affect the quality of life[14,17] and sexuality of women in midlife[1,4,8,11]. In addition to these symptoms, sexual function may be compromised by the absence of a sexual partner[4,8,12,17], by the health and sexual performance of the partner[8-10], the woman's level of sexual function in the past, living habits, education, personality, what the menopause means to the woman and her partner, comorbities[7,18-20], the use of medication[2,10] and socioeconomic conditions.[16,21-24]

The findings of the Melbourne Women's Health Midlife Project[25] showed that the aging process and the duration of the relationship with the partner are associated with a decline in sexual function. The authors of this study reported that the most important factors influencing sexual function were previous sex life, losing a sexual partner or acquiring a new sexual partner, and feelings for

the partner. Klussmann[26] observed that there is a decline in sexual activity and satisfaction during the course of a relationship, and that sexual desire decreases in women while longing for affection decreases in men and increases in women. Avis et al[17] described a decline in sexual function with aging, reporting that the determining factors for this decline were having or not having a sexual partner, emotional well-being, stress, health, the quality of the relationship and previous sex life. Gonzalez et al[8] reported that the principal intervening factors in desire and orgasm in middle-aged women were age, education level, degree of satisfaction with emotional closeness to the partner, and vaginal lubrication. Despite some cultural differences between the populations studied, one consistent finding in these studies is the positive effect of having a partner on female sexuality. However, sexual behavior is influenced by cultural aspects that need to be taken into consideration when this issue is under discussion.

With respect to culture, according to the theory of sexual scripts, there may be guidelines in a certain culture specifying (a) which individuals are probable sexual partners, (b) under what circumstances (when and where) it would be proper to behave sexually and what type of activities would be allowed (what and how), and (c) the reasons that lead individuals to behave sexually in a certain way.[27,28]

Information on the sexual function of women in developing countries is sparse. There are few data resulting from population-based studies on sexuality in midlife. Most studies were carried out in developed countries with sociocultural differences that may affect not only individuals' experience of sexuality but also their perception of the menopausal transition. In a previous population-based study[12] carried out by our group in which women in midlife with or without a sexual

partner were evaluated, having a sexual partner was found to be a protective factor against poor sexuality. However, doubts remain with respect to which factors may be negatively associated with the sexual function of women with a sexual partner. To answer this question, we carried out the present study to investigate the factors associated with the sexuality of middle-aged women with a sexual partner.

Methods

Sample size

In the previous study[12], the sample size was calculated at 377 women, based on an estimate of 43% of the female population with sexual dysfunction[29], with an expected absolute difference of 5% between the sample and population proportions and a type I error (α) of 0.05. In the present study, in which only the sub-population of women with a sexual partner was considered, sample size was recalculated to evaluate the possible loss of precision resulting from this reduction. Therefore, a sample size of at least 216 women referred to an absolute expected difference of 6.6%.

Subjects

A cross-sectional, population-based study, self-responded by participants in their homes, was carried out between May and September 2005, in the city of Belo Horizonte in the state of Minas Gerais, Brazil.

Implicit stratification was carried out in nine regions, and the primary sampling unit (PSU) consisted of a geographical area referred to as the weighted area (WA). Each WA consisted of various census sectors[30,31]. Eighteen WA

were randomly selected and probability was proportional to the size of each area. In each one of the WA selected, five census sectors were randomly chosen (secondary sampling unit). Next, five corners of these census sectors were randomly selected at which to initiate visits. The variables of sampling plan: strata and PSU were considered in the data analysis.

The city of Belo Horizonte was divided into 62 weighted areas, containing a total of 2,563 census sectors.[30,31] All the sectors were included in the randomization process. The selected sectors were visited by research assistants, who were guided by maps of each selected census area. They started at randomly selected corners, went to each home and verified whether there were any Brazilian-born women of 40-65 years of age living there and whether they had at least 11 years of formal education. Because of inhibitions with respect to expressing oneself about sexuality, anonymity was considered to be very important in obtaining unbiased answers. Thus by selecting women with 11 or more years of formal instruction, we selected a group more likely to be able to fill out a self-response questionnaire. If there were eligible women residing at the address, they were invited to participate in the study. If they agreed, a questionnaire was left with them to be answered and a date was scheduled for the completed questionnaire to be collected. If the eligible women were not at home, they were contacted by telephone and, if they agreed to participate, the questionnaire was delivered to their home. The principal investigator telephoned the participants and confirmed whether the questionnaire had been completed. If it had been, it was collected by a messenger and placed in an unidentified envelope and put into a sealed post-box. As they were delivered

to the principal researcher, the area of the city and the frequency of educational level were noted to homogenize the response in the smallest geographic unit.

Figure 1 shows the recruitment of study participants. A total of 420 women were invited to participate in the study. Forty-two women (10%) refused to participate and did not, therefore, receive the questionnaire. The reasons given for not participating in the study were: lack of time, the woman did not feel comfortable answering the questions or her husband did not want her to fill out the questionnaire. Therefore, 378 women agreed to participate in the study and received the questionnaire. The questionnaire was collected by a messenger from all the women who agreed to participate in the study. Of the 378 questionnaires that were returned, 102 were incomplete and were not considered in the calculation of the sexuality score, whereas 276 contained answers to all the questions used to calculate the sexuality score. Of the 102 women who failed to complete the questions, only 18 reported having a sexual partner. Of the 276 women who responded to all the questions used in calculating the sexuality score, 57 were excluded because they reported having no sexual partner, while the remaining 219 all reported having a sexual partner. Therefore, these 219 middle-aged women constituted the present study sample.

Comparing the 276 women who answered the questions used for calculation of the sexuality score with the 102 who did not, those who answered the questions were more likely to be younger ($p<0.001$), to be premenopausal ($p=0.019$), to be married/living together ($p<0.001$), to have a higher income ($p=0.037$) and to have a sexual partner ($p<0.001$), but did not differ significantly in other reproductive-, lifestyle-, or sociodemographic-related factors.

The questionnaire used in the study consisted of two parts. In the first part, the participants answered questions on their sociodemographic, clinical, reproductive and behavioral characteristics. Next, they answered questions on their sexuality. The research protocol was approved by the Internal Review Board of the School of Medicine, Universidade Estadual de Campinas.

Assessment of sexuality

The instrument used for evaluating sexuality was based on the Short Personal Experiences Questionnaire (SPEQ)[32]. This questionnaire permits evaluation of the sexuality of middle-aged women. The original version of this tool was provided by researchers at the University of Melbourne, Australia. Initially, the questionnaire was translated from English into Brazilian-Portuguese by two independent translators who were fluent in both languages. Next, the two translated versions were compared and a consensus version was obtained. This version was tested in a group of 50 Brazilian-born women, 40-65 years old with at least 11 years of formal education. With the objective of achieving cultural equivalence, in this phase any questions that had generated uncertainties were once again adapted and tested until the participants reported no more doubts or difficulties in answering the questions. A final version of the questionnaire in Brazilian-Portuguese was thus obtained. All the questions referred to the month preceding the date on which the questionnaire was filled out.

Dependent variable

The sexuality score contained seven components: satisfaction/pleasure during sexual activities (graded from 1 to 6, where 1 referred to the absence of satisfaction and 6 to maximum satisfaction), orgasm (from 1 to 6), intensity of sexual desire (from 1 to 6), frequency of sexual activities (1=never, 2=less than once a week, 3=once or twice a week, 4=several times a week, 5=once a day or more), frequency of arousal during sexual activities (from 1 to 6), frequency of sexual fantasies, thoughts and desires (1=never, 2=less than once a week, 3=once or twice a week, 4=several times a week, 5=once a day or more), and self-classification of sexual life (1=terrible, 2=bad, 3=regular, 4=good, 5=excellent).

Independent variables

Age was continuous in the multiple analysis and dichotomized into <50 years of age or ≥50 years of age in the bivariate analysis. Menopausal status was classified as premenopausal, menopausal transition or postmenopausal. Status was defined as premenopausal when the women had regular menstrual cycles or a menstrual cycle similar to the one they had throughout their reproductive life. Women were considered to be in the menopausal transition if they had had menstrual cycles during the previous 12 months, but a change had occurred in their menstrual pattern. Women were considered postmenopausal if their last period had been at least 12 months prior to filling out the questionnaire[33]. In women who had undergone a hysterectomy, menopausal status was classified as follows: women aged 40-44 years who had had regular menstruation prior to hysterectomy were considered to be premenopausal; women aged 45-48 who

had irregular menstruation prior to hysterectomy were considered to be in the perimenopause; women over 48 years of age who had been submitted to hysterectomy or women who had undergone bilateral oophorectomy were considered to be postmenopausal. Women over 48 years of age, who had been submitted to hysterectomy, were classified as postmenopausal in view of the fact that the median age of menopause in Latin America has been reported to be over 48 years of age, more precisely 48.6 years of age.[34]

Marital status was dichotomized into those married/living together or single/separated/widowed/living alone; ethnic group into white or nonwhite; schooling into ≤11 years or >11 years of formal education; family income was ≤US$1300 or >US$1300 per month; physical activity was classified as none/<3 times a week or ≥3 times a week; and number of pregnancies was ≤2 or >2. Body mass index (BMI) was dichotomized into <25 or ≥25 kg/m^2 in the bivariate analysis. Paid employment was dichotomized into none/≤ 20 hours per week or >20 hours per week; use of tobacco: never smoked or history of smoking. The presence or absence (yes or no) of the following variables was also recorded: depression, hypertension, diabetes, urinary incontinence, history of cancer, hot flushes, nervousness, and insomnia in the previous month. Hormone therapy was dichotomized into never-user or past or current user. Self-perception of health status was classified into terrible/poor/regular or good/excellent. Age of sexual partner was continuous in the multiple analysis or dichotomized into <50 or ≥50 years in the bivariate analysis. The duration of the relationship was dichotomized into <20 or ≥20 years, and partner's sexual problems into a score of ≤2 or >2.

Satisfaction with partner as a lover, feelings in relation to this sexual partner and passion for this partner was dichotomized into the maximum score or any other score (according to the median value). Sexual activities involving penetration and lives with this sexual partner were dichotomized into yes/no.

Statistical analysis

Initially, the data analysis consisted of a multivariate principal components analysis to define sexuality score[35]. The score was calculated from the analysis of the seven components: satisfaction/pleasure during sexual activities, frequency of arousal during sexual activities, orgasm, frequency of sexual activities, intensity of sexual desire, frequency of sexual fantasies, thoughts and desires, and self-classification of sexual life. Sexuality was evaluated using the median of the sum of each variable multiplied by the respective score of the analysis of the principal components. This new variable explained 71% of the variance observed (analysis of total sample with information from all seven components). Next, a bivariate analysis was performed in which sexuality was considered as the dependent variable, dichotomized by the median according to the independent variables. The chi-squared test was applied with Yates' correction or Fisher's exact test[36]. Finally, the Poisson multiple regression analysis was applied to identify the most predictive variables and to obtain a final adjusted model for calculation of the prevalence ratio (PR) and the respective 95% confidence intervals (95% CI)[37]. The backward criterion was used to select the variables. For this analysis, the strata and the cluster group (primary sampling unit: first geographic unit of the sampling design) were used. The software program used was Stata, version 7.0 (Statlab). As inclusion

criteria for the independent variables, only the 22 independent variables with a p-value<0.25 in the bivariate analysis and/or in the simple Poisson regression analysis were considered. P-values of <0.05 were considered statistically significant.

Results

In this sample of middle-aged women with a sexual partner, 44.3% of the women were 50 years of age or older; 82.2% were married/living together; 53.0% stated that they had more than 11 years of formal education; 42.9% reported having a monthly family income of more than US$1300; 37.7% related that their sexual partners had sexual problems; 13.2% were in use of hormone therapy; and 11.9% had been submitted to hysterectomy (data not presented).

Table 1 lists the values obtained for the seven components of the sexuality score. The median sexuality score was 9, ranging from a minimum of 2.45 to a maximum of 13.77. We considered scores below 9 to represent poor sexuality and scores ≥9 to be good sexuality. A total of 97 women (44.3%) had a score <9 and the remaining 122 (55.7%) had scores ≥9.

Table 2 shows the sociodemographic and clinical factors associated with sexuality according to the bivariate analysis. A lower sexuality score (<9) was found to be more likely in women with the following characteristics: age ≥50 years (p=0.019), being in the menopausal transition or postmenopausal (p=0.003), being married/living together (p=0.006), having a sedentary lifestyle (p=0.042), reporting depression (p=0.001), hypertension (p=0.007), urinary incontinence (p=0.009), nervousness (p=0.027) or insomnia (p<0.001), and a self-perceived state of health classified as terrible, poor or regular (p<0.001).

Table 3 shows the partner-related factors that are associated with the sexuality of middle-aged women according to the bivariate analysis. The variables: age of partner ≥50 years (p=0.032), duration of the relationship ≥20 years (p=0.048), living with sexual partner (p=0.004) and sexual problems of the partner (p=0.011) were associated with a sexuality score below the median. On the other hand, the variables: sexual activities involving penetration (p=0.001), higher score for: satisfaction with partner as a lover (p<0.001), passion (p=0.001) and feelings with respect to the sexual partner (p<0.001) were associated with better sexuality. Analysis of the women who reported that their partners had no sexual problems showed no association between living with the sexual partner and a sexuality score <9.

Table 4 shows the results of the multiple regression analysis. The variables: living with the sexual partner (PR=2.07; 95% CI=1.17-3.69), being in the menopausal transition or in the postmenopause (PR=1.69; 95% CI=1.08-2.65) and being hypertensive (PR=1.65; 95% CI=1.19-2.30) were found to be significantly associated with sexuality scores below the median. Conversely, a score of 6 for satisfaction with the partner as a lover (PR=0.34; 95% CI=0.20-0.60) and sexual activities with penetration (PR=0.48; 95% CI=0.31-0.73) were indicative of a protective effect against poor sexuality.

Discussion

The objective of this study was to collect information on sexuality and to identify associated factors in a cohort of middle-aged Brazilian-born women with sexual partners. Living with the sexual partner, being in the menopausal transition or

postmenopausal and being hypertensive were found to be associated with scores below the median, whereas sexual activities involving penetration and a score of 6 for satisfaction with partner as a lover were indicative of a protective effect against poor sexuality. A significant correlation was found between sexuality scores <9 and duration of the relationship ≥20 years and also with partners of 50 years of age or more. In line with our results, other authors in different cultural contexts have reported negative correlations between increased age of partner, longer duration of the relationship and female sexual function[11,38,39]. Some possible explanations for this decrease in sexual satisfaction among couples living together include habituation, routine, gender roles and the polarization of roles and the psychological mechanisms involved in a stable relationship[26].

Bivariate analysis indicated that sexual problems of the partner and living with the sexual partner were associated with a below median sexuality score. When the women who reported that their partners had no sexual problems were analyzed separately, results showed no association between the fact of living with this partner and a low sexuality score. In the multiple regression analysis, the variable “sexual problems of the partner” was not identified as a predictor of poor sexuality; however, the fact of living with the sexual partner was independently related to a sexuality score below the median, increasing the chance of the woman having a low sexuality score 2.07-fold.

In the present cohort, being in the menopausal transition or being postmenopausal is associated with sexuality scores below the median. Whether it is perceived as a natural process or not, menopause represents the end of fertility and has social representations that vary from culture to culture[18]. Therefore, the

menopause may be perceived as being associated with a decline in or even the end of a woman's sexual life, thereby explaining in part its relationship with a low sexuality score. In line with our results, in the Massachusetts Women's Survey II, Avis et al[2] compared postmenopausal women with women in their 40s and detected a decrease in sexual desire in the postmenopause. The peri- and postmenopausal groups had greater difficulty in achieving excitation compared to the group of premenopausal women. In a longitudinal study carried out in Australia, all aspects of sexual function were found to deteriorate when women were going through the menopausal transition.[3,25]

In women with comorbities, both the disease and the treatment may interfere with sexuality.[7,19,20] In the present cohort, hypertension was associated with deterioration in sexuality. Few studies have been carried out on the sexuality of hypertensive women to investigate either the effects of the disease or the side effects of antihypertensive agents.[19,20] A previous study found that hypertensive women reported less vaginal lubrication, fewer orgasms and a greater frequency of dyspareunia compared to women who were not hypertensive[20]. These data may contribute towards increasing understanding of the relationship found in the present cohort between hypertension and a lower sexuality score. However, the type of antihypertensive medication used by the participants was not investigated; hence it was not possible to identify any associations between these medications and the sexuality of middle-aged women.

Satisfaction with the partner as a lover was positively associated with sexuality. These data are consistent with those of other studies, which found an association between sexuality and feelings towards the sexual partner[17,25]. The

Study of Women's Health Across the Nation (SWAN)[17] showed that feelings towards the partner and attitudes relating to sex and to aging had a greater effect on the majority of aspects of sexual function than the process of going through the menopausal transition. In another study, the degree of emotional closeness with the partner was positively associated with desire and orgasm[8]. The importance of the quality of the relationship and the feelings of one partner for the other with respect to sexuality have also been described in studies carried out in different cultural contexts, emphasizing that middle-aged women value this aspect of the relationship.[8,13,17,25]

In this case study, sexual activities with penetration was a protective factor against poor sexuality. This may be explained by the fact that heterosexual couples may adopt this form of sexual behavior as a common mode of sexual script.[27,40] Evidence indicates that penile-vaginal intercourse is associated with better physiological and psychological function[41], leading to an improvement in the quality of the relationship.[42] It is possible that in couples in which the woman reported sexual activities with penetration, the chance of the male partner having sexual dysfunction and its associated psychological repercussions was less. These aspects may have contributed towards a better life experience and perception of sexuality among women who reported sexual activities with penetration in the present study, decreasing the probability of having a low sexuality score. It should also be remembered that the study questionnaire was answered by the woman and did not permit definition of the type of sexual dysfunction of her partner.

This study should be interpreted within the context of its limitations. The information, which included hypertension, psychological symptoms and use of

hormone therapy, among others, was obtained by participant self-report. Although we cannot rule out recall bias, previous studies using self-reports suggest a high validity of information related to the use of hormone therapy[43] and to hypertension[44,45], indicating that women with higher education levels provide more reliable data[45]. Due to the cross-sectional design of the study, it was not possible to establish causal relationships. The participants of our study differed with respect to some variables from the women who did not answer all the questions used for calculation of the sexuality score, and this should be taken into consideration in interpreting our findings.

The population-based character of the present study should be emphasized in view of the scarcity of population-based studies on the sexuality of women, particularly of women in midlife. The use of an internationally recognized questionnaire, the SPEQ[32], which has been adapted for use in the Portuguese language, is another of the strengths of this study. Considering that sexuality includes the phases of the sexual cycle and the sexual history of these women, the use of a score based on seven components allowed a better evaluation of the sexuality of these women. To the best of our knowledge, no validation study has yet been carried out in which a cutoff point was established; therefore, we used the median value of the sexuality score calculated from the multivariate analysis of the principal components.

This study identified factors that may be detrimental to the sexuality of middle-aged women with a sexual partner. These factors should be taken into consideration by health professionals involved in the care of women in midlife.

Conclusions

In this cohort of middle-aged, Brazilian-born women with a sexual partner, the likelihood of having a sexuality score below the median was associated with the fact of living with the sexual partner, being in the menopausal transition or postmenopausal and having hypertension, whereas satisfaction with the partner as a lover, and sex with penetration were found to be protective factors against poor sexuality. These data suggest that the existence of a sexual partner may contribute towards improving sexuality, but it is insufficient in itself to guarantee a satisfactory sexual life, since even women with a sexual partner may suffer deterioration in sexuality determined by other factors.

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Table 1. Sexuality score of middle-aged women

Variable	Range	Minimum	Median	Maximum
Sexual satisfaction	1-6	0.50	-	3.03
Frequency of arousal	1-6	0.49	-	2.95
Orgasm	1-6	0.49	-	2.93
Frequency of sexual activities	1-5	0.14	-	0.72
Intensity of sexual desire	1-6	0.39	-	2.31
Frequency of sexual fantasies	1-5	0.20	-	1.02
Self-classification of sexual life	1-5	0.23	-	1.15
Sexuality score	-	2.45	9.00	13.77

Table 2. Sociodemographic and clinical factors associated with the sexuality of middle-aged women with sexual partners. Bivariate analysis

Variable	N[a]	Sexuality (%)		p-value[b]
		Score <9	Score ≥9	
Age (years)				*0.019*
<50	122	36.9	63.1	
≥50	97	53.6	46.4	
Menopausal status				*0.003*
Premenopause	74	29.7	70.3	
Menopausal transition/postmenopause	145	51.7	48.3	
Marital status				*0.006*
Married/living together	180	48.9	51.1	
Single/separated/widowed/living alone	39	23.1	76.9	
Physical activity				*0.042*
None or <3/week	136	50.7	49.3	
≥3 times a week	79	35.4	64.6	
Depression				*0.001*
No	136	38.2	61.8	
Yes	61	63.9	36.1	
Hypertension				*0.007*
No	154	37.7	62.3	
Yes	59	59.3	40.7	
Urinary incontinence				*0.009*
No	165	38.8	61.2	
Yes	51	60.8	39.2	
Nervousness				*0.027*
No	98	35.7	64.3	
Yes	118	51.7	48.3	
Insomnia				*<0.001*
No	139	34.5	65.5	
Yes	77	62.3	37.7	
Self-perception of health status				*<0.001*
Terrible, poor, regular	91	59.3	40.7	
Good, excellent	127	33.1	66.9	

[a]Some values may not add up to n= 219 because of missing data.

[b]Chi-square test with Yates' correction.

Table 3. Partner-related factors associated with the sexuality of middle-aged women. Bivariate analysis

Variable	N[a]	Sexuality (%)		p-value[b]
		Score <9	Score ≥9	
Age of partner (years)				*0.032*
<50	93	34.4	65.6	
≥50	122	50.0	50.0	
Duration of the relationship (years)				*0.048*
<20	83	33.7	66.3	
≥20	130	48.5	51.5	
Lives with sexual partner				0.004
Yes	174	48.3	51.7	
No	41	22.0	78.0	
Sexual problems of the partner				0.011
Score ≤2	127	35.4	64.6	
Score >2	77	54.5	45.5	
Satisfaction with partner as a lover				<0.001
Score ≤5	141	56.0	44.0	
Score =6	69	17.4	82.6	
Passion for the partner				0.001
Score ≤5	130	53.1	46.9	
Score =6	83	28.9	71.1	
Feelings in relation to sexual partner				<0.001
Score ≤4	157	54.8	45.2	
Score =5	59	13.6	86.4	
Sexual activities with penetration				0.001
Yes	200	40.0	60.0	
No	15	86.7	13.3	

[a]Some values may not add up to n=219 because of missing data.

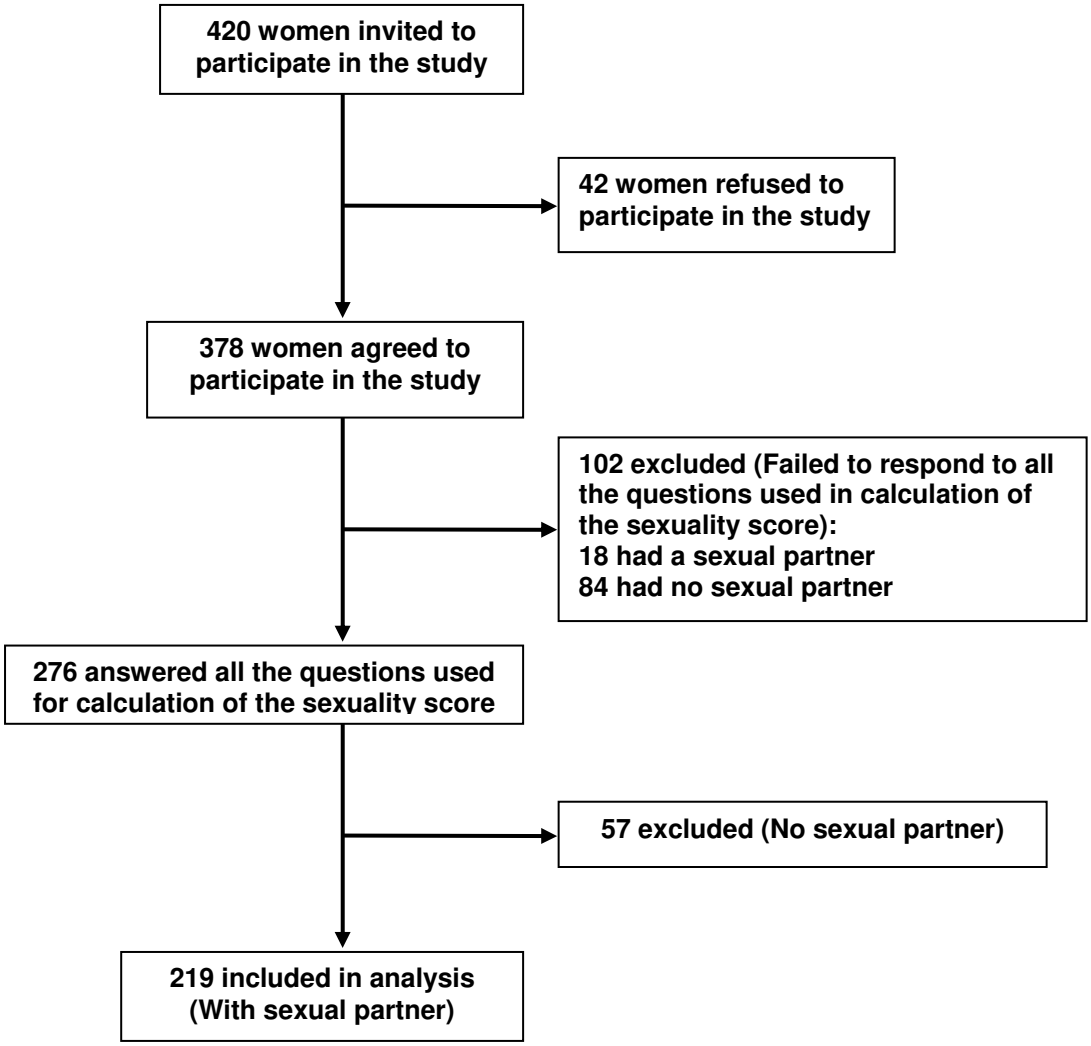
[b]Chi-square test with Yates' correction.

Table 4. Factors associated with sexuality scores below the median (<9) in middle-aged women with sexual partners. Multiple analysis[a]

Variable	PR	95% CI	p-value
Lives with the sexual partner (yes)	2.07	1.17–3.69	0.017
Menopausal status (menopausal transition or postmenopause)	1.69	1.08–2.65	0.026
Hypertension (yes)	1.65	1.19–2.30	0.007
Satisfaction with partner as a lover (score=6)	0.34	0.20–0.60	0.001
Sexual activities with penetration (yes)	0.48	0.31–0.73	0.003

[a]Poisson regression. PR= prevalence ratio; CI= confidence interval.

Figure 1. Recruitment of study participants.



4. Discussão

O objetivo desta pesquisa foi avaliar a sexualidade em mulheres de meia-idade, com 11 anos ou mais de escolaridade, e identificar os fatores associados. Para isso, utilizou-se um escore específico. A maioria das mulheres que responderam a todas as perguntas para o cálculo do escore de sexualidade relatou ter parceiro sexual (79,3%). De início, quando abordadas, muitas achavam que não poderiam participar da pesquisa por não ter parceiro sexual. Na oportunidade foi esclarecido, tanto pelas auxiliares de pesquisa quanto pelo próprio questionário, que todas poderiam ser incluídas, tendo em vista que a sexualidade pode ser vivenciada independentemente da existência de parceiro. Mesmo assim, muitas sem parceiro sexual deixaram de responder à parte do questionário relativa à sexualidade. Este fato pode apontar para uma visão de sexualidade relacionada somente à presença de parceiro.

Utilizamos o questionário SPEQ, validado internacionalmente (Dennerstein *et al.*, 2002b) e adaptado para língua portuguesa. No processo de adaptação foram acrescentadas duas perguntas: grau do desejo sexual e autoclassificação da vida sexual. A primeira foi adicionada por ser o desejo sexual hipoativo a

disfunção sexual mais prevalente, variando de 10% a 51% em pesquisas em diferentes países (Mercer *et al.*, 2003; Laumann *et al.*, 2005) e a segunda, por questionar a autopercepção da vida sexual (Dennerstein *et al.,* 2005a e 2005b). Assim, sete componentes foram analisados: satisfação nas atividades sexuais, freqüência de excitação, orgasmo, freqüência de atividade sexual, grau de desejo, presença de fantasias sexuais e a autoclassificação da vida sexual. Acreditamos que com essa adaptação obtivemos uma visão amplificada e mais global desse importante aspecto da vida dessas mulheres.

Verificamos correlação significativa entre sexualidade ruim e idade maior que 50 anos. Esses achados estão de acordo com estudos anteriores que mostraram que o declínio da função sexual está relacionado com o envelhecimento. Um estudo longitudinal australiano relatou efeito negativo da idade na freqüência da atividade sexual, no interesse, e em aspectos da resposta sexual como excitação, prazer e orgasmo (Dennerstein *et al*., 2002a). Em estudo longitudinal, Ford *et al*. (2005) também detectaram que o aumento da idade esteve associado com piora da sexualidade. O *Women's International Study of Health and Sexuality*, um estudo de corte transversal multinacional, realizado na Europa e USA, revelou um intenso declínio em todos os aspectos da função sexual com o aumento da idade (Hayes *et al*., 2004). Em outro estudo de corte transversal realizado com 231 mulheres colombianas entre 40-62 anos, Gonzalez *et al.* (2006) encontraram que o aumento da idade teve um efeito negativo no desejo e orgasmo. Assim, constatamos que também em brasileiras a idade interferiu significativamente em vários domínios da sexualidade feminina.

Estar na transição menopausal foi fator associado ao escore de sexualidade < 9. Outros estudos como o *Melbourne Women's Midlife Health Project* também mostraram que as mulheres no período de transição menopausal apresentaram diminuição na maioria dos domínios da função sexual (Dennerstein *et al*., 2001; Dennerstein *et al*., 2005b). As mulheres com insônia apresentaram maior chance de ter escore de sexualidade < 9. A presença dos fogachos freqüentes nessa fase, pode ser um desencadeador da insônia que, por sua vez, levaria à diminuição de energia e depressão, que piorariam a função sexual (Ohayon MM, 2006). Sentir-se bem ou excelente correlacionou-se com a melhora da sexualidade, dado similar ao encontrado por outros autores. Avis *et al*. (2005), em estudo de corte transversal, também observaram associação entre bem-estar e satisfação sexual. Esse fato pode estar relacionado ao estado de saúde e a hábitos de vida saudáveis. Dennerstein *et al*. (2005a e 2005b) pontuaram que quando se avaliaram os aspectos psicossociais e estilo de vida, o humor foi a única variável que afetou a função sexual. Estudo de corte transversal realizado na Itália com 355 mulheres entre 46-60 anos, mostrou que o bem-estar físico e a saúde mental, mais que o estado menopausal por si, foram os fatores que mais influenciaram a saúde sexual nessa faixa etária (Nappi *et al.,* 2002). Esses resultados são muito sugestivos da importância de intervenções que melhorem os sintomas associados à deficiência hormonal que ocorre nessas mulheres. Medidas farmacológicas sugeridas por um profissional sensibilizado e conhecedor da importância de uma sexualidade adequada na vida das pessoas, em nossa opinião, são primordiais para o bom atendimento dessa população.

A presença de parceiro sexual associou-se ao escore de sexualidade ≥ 9, achado esse concordante com outros estudos. Apesar de diferenças culturais serem importantes, a associação entre sexualidade e presença de parceiro sexual é um achado consistente em várias pesquisas (Avis *et al*., 2005, Dennerstein *et al*., 2005a e 2005b; Gonzáles *et al.,* 2006). No entanto, mulheres com parceiro sexual podem apresentar sexualidade ruim. Quando avaliamos somente as mulheres com parceiro sexual, a satisfação com o parceiro como amante e a atividade sexual com penetração associaram-se à melhora da sexualidade. Gonzales *et al.* (2006) também relataram a associação da proximidade emocional com o parceiro e presença de desejo e orgasmo. Assim, ressaltamos a importância de um parceiro que satisfaça a mulher como companheiro e amante. Essa questão é difícil de ser claramente abordada, sobretudo na América Latina, onde ainda predomina o machismo, independentemente do nível educacional ou econômico. A observação de que atividades sexuais com penetração estiveram associadas ao melhor escore de sexualidade reforça a importância da manutenção do trofismo genital para o bem-estar sexual.

As mulheres com comorbidades podem ter sua sexualidade afetada tanto pela doença como pelo tratamento (Abdo *et al.,* 2004). No presente estudo, a piora da sexualidade associou-se à hipertensão arterial. Mulheres hipertensas reportam menor lubrificação vaginal e orgasmo, quando comparadas com as mulheres sem hipertensão (Duncan *et al.,* 2000). Em outro estudo que incluiu 67 mulheres com hipertensão, 42,6% relataram disfunção sexual (Burchardt *et al.,* 2002). Observou-se neste mesmo estudo que a média de duração da disfunção

sexual era de 3,9 anos e que nenhuma das mulheres havia recebido tratamento para disfunção da sexualidade, apesar de freqüentarem serviços de saúde. A análise desses estudos sugere não só a necessidade de se considerar a presença de doenças nessas mulheres, mas sobretudo de se avaliar os efeitos das medicações utilizadas em outros aspectos de suas vidas, inclusive o sexual.

A sexualidade humana tem uma vasta gama de abordagens, que inclui aspectos filosóficos, sociais, antropológicos, psicológicos e físicos, muitas vezes inter-relacionados. Os dados coletados na presente pesquisa levaram em conta as principais questões que afetam a sexualidade no climatério, do ponto de vista médico, e esperamos que permitam que se estabeleça um diagnóstico mais abrangente sobre o problema. Muitos aspectos que geralmente ficavam ocultos por questões culturais e comportamentais tornaram-se transparentes e vieram à tona. Sendo este um estudo de corte transversal, não foi possível estabelecer relação causa-efeito. Somente verificamos associações entre as características das mulheres e o escore de sexualidade em um determinado momento. Outra limitação é que a população estudada representa apenas uma coorte de mulheres brasileiras, em um país de dimensões continentais, com população miscigenada e grandes diferenças socioeconômicas e culturais.

Este estudo avaliou a sexualidade em mulheres de meia-idade e seus resultados poderão auxiliar uma abordagem mais abrangente dessas mulheres pelos profissionais que as assistem. Uma vez que o fato de sentir-se bem pode melhorar a sexualidade, sugere-se a necessidade de medidas objetivas, como, por exemplo, a avaliação criteriosa da necessidade do uso de terapia de reposição

hormonal, o estímulo à prática de exercícios físicos e tratamentos adequados de doenças associadas, como a hipertensão. Em relação ao relacionamento com o parceiro sexual, algumas medidas de apoio podem ser tomadas, como psicoterapia e aconselhamento do casal. A visão desta fase da vida por um ângulo positivo deve ser estimulada, já que pode ser uma oportunidade para a mulher reconsiderar seus sentimentos e avaliar medidas que possam levar à melhoria da sexualidade e satisfação com a vida. Quanto ao relacionamento com o parceiro, as mudanças inerentes ao processo de envelhecimento devem ser consideradas. Futuros estudos poderão contemplar uma avaliação mais específica dos casais de meia-idade para o melhor entendimento do relacionamento sexual. Como ginecologistas, somos freqüentemente os primeiros profissionais, e muitas vezes os únicos, que as mulheres procuram para relatar seus problemas. Mais ainda, freqüentemente estabelecemos relações de longa duração com nossas clientes, comparados a outros especialistas. Por essa razão, o ginecologista está na posição ideal para atender às mulheres, de acordo com suas idades e necessidades, devendo manter atitude pró-ativa e tratando as condições apresentadas. Acreditamos ser o profissional ideal para o atendimento de mulheres com queixas sexuais. Infelizmente essas idéias ainda são muito distantes da realidade atual. Investimentos devem ser feitos na habilitação desses profissionais, para que pelo menos incluam, em suas consultas, espaço para as mulheres esclarecerem suas dúvidas relativas à sexualidade. Com isso, haverá não só melhoria significativa no relacionamento médico-paciente, bem como no bem-estar geral, inclusive do profissional.

5. Conclusões

- Mulheres com idade maior ou igual a 50 anos e com relato de ondas de calor tiveram maior chance de apresentar sexualidade ruim. Por outro lado, as mulheres com parceiro sexual e as que se sentiam bem tiveram maior probabilidade de ter uma sexualidade boa.

- Em mulheres com parceiro sexual, a satisfação com o parceiro como amante e o fato de ter relações sexuais com penetração foram associados a uma sexualidade boa. No entanto, o fato de morar com o parceiro, estar na transição menopausal ou pós-menopausa e ser hipertensa aumentou a chance de sexualidade ruim.

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7. Anexos

7.1. Anexo 1 – Questionário

QUESTIONÁRIO SOBRE O CLIMATÉRIO

PESQUISA POPULACIONAL NA CIDADE DE BELO HORIZONTE COM MULHERES DE 40-65 ANOS E COM 11 ANOS OU MAIS DE ESCOLARIDADE

ANTES DE COMEÇAR A RESPONDER É PRECISO QUE VOCÊ LEMBRE ALGUMAS COISAS:

- A sua participação é totalmente voluntária.
- Você não deve escrever seu nome.
- Use caneta para responder o questionário. Não use lápis.
- Preencha sozinha, precisamos das SUAS informações.
- Em algumas perguntas você pode assinalar várias alternativas. Leia com atenção todas as questões, observando as instruções.
- Se você quiser mudar a resposta, não utilize borracha ou corretivo. Escreva que você se enganou e destaque com um círculo a nova resposta.
- Em caso de dúvida, ligue a cobrar para a supervisora do projeto no número (31) .....
- Ao terminar coloque o questionário dentro do envelope.

Prezada colaboradora:

Você está sendo convidada a participar de um estudo tendo como pesquisadores responsáveis a Dra. Ana Lúcia Ribeiro Valadares Fernandes (médica ginecologista em Belo Horizonte, RG M 305 364, telefone 31 32279277) e o Prof. Dr. Aarão Mendes Pinto Neto (médico e professor da UNICAMP, RG 5075541, telefone 19 37889306).

O objetivo é avaliar os hábitos de vida, saúde, terapia hormonal e sexualidade na idade próxima à menopausa e na menopausa. Respondendo a este questionário você estará colaborando, para que os profissionais de saúde aumentem o conhecimento científico sobre o assunto e tenham melhores condições de ajudar as mulheres. Como esta pesquisa está sendo desenvolvida por pesquisadores de uma Universidade Pública (UNICAMP), localizada em Campinas-SP, seus resultados serão apresentados em eventos de natureza científica bem como publicados em revistas especializadas.

O telefone do Comitê de Ética em Pesquisa da FCM/UNICAMP é 19-37888936 .

Informamos que não há resposta certa ou errada. Fique portanto à vontade para responder o que de fato ocorre em sua vida.

Palavras de uso popular são às vezes colocadas ao lado de termos técnicos para melhorar a compreensão do texto. Por favor não se sinta ofendida. Nosso objetivo é facilitar o entendimento.

Este questionário foi elaborado para ser respondido anonimamente. Ninguém poderá saber quem respondeu cada questionário. Se você tiver dúvidas quanto ao preenchimento ligue para o telefone 9090 (31) ....., ligação a cobrar, horário comercial, e fale com a Sra. ....., responsável pela supervisão do projeto

Solicitamos que responda o questionário individualmente, coloque-o dentro do envelope que entregamos, feche-o e deposite-o na urna lacrada que será trazida pela supervisora em uma semana ou no horário combinado. NÃO COLOQUE SEU NOME OU ENDEREÇO a fim de preservar sua privacidade e anonimato.

Agradecemos pelo tempo que será dedicado ao preenchimento deste questionário.

1

01. Data do Preenchimento do questionário: I__I__II__I__II__I__I
dia mês ano

02. Qual é a sua idade ? I__I__I anos

03. Você atualmente é? (Faça um X na alternativa correspondente)

[1] Solteira
[2] Casada/ Vive com alguém
[3] Viúva
[4] Separada
[5] Divorciada
[6] Outro. Qual? _____

04.Qual é a renda mensal da sua família? (Assinale a alternativa correspondente)

[1] Menor que R$423,00
[2] R$ 424,00 a R$927,00
[3] R$ 928,00 a R$ 1668,00
[4] R$ 1669,00 a R$ 2803,00
[5] R$ 2804,00 a R$ 4647,00
[6] R$ 4648,00 a R$ 7792,00
[7] Maior ou igual a R$ 7793,00

05. Qual é o seu grau de instrução?

[1] Segundo grau incompleto
[2] Segundo grau completo
[3] Universitário incompleto
[4] Universitário completo
[5] Universitário completo e pós-graduação

06. Atualmente realiza algum trabalho pelo qual recebe pagamento?

[1] Sim [2] Não ➡ Passe para a pergunta 8.

07. Quantas horas você trabalha por semana, em média?

NÚMERO DE HORAS: |___|___|

08. Qual é o seu peso em quilogramas? I__I__I__I, I__I__I__I kg

2

09. Qual é a sua altura em metros? I__I,I__I__I m

10. Você é ? [1] branca [2] não branca

11. Quantas vezes você engravidou? I__I__I vezes

12. Quantos filhos você teve? I__I__I filhos

13. Quantos abortos você teve? I__I__I abortos

14. Quantos filhos moram com você? I__I__I [ ] Não tenho filhos.

15. Quantos netos moram com você? I__I__I [ ] Não tenho netos.

16. Você fuma atualmente, já fumou e parou ou nunca fumou?
[1] Já fumou e parou. ➡ Passe para a pergunta 17.
[2] Fuma atualmente. ➡ Passe para a pergunta 18.
[3] Nunca fumou. ➡ Passe para a pergunta 19.

17. Há quanto tempo você parou de fumar?
I__I__I anos e/ou I__I__I meses ➡ Passe para a pergunta 19.

18. Há quanto tempo você fuma?
I__I__I anos e/ou I__I__I meses ➡ Passe para a pergunta 19.

19. No último mês, você tem praticado atividades físicas (caminhadas, natação, musculação, hidroginástica, yoga, etc.)?
[1] Sim [2] Não ➡ Passe para a pergunta 20.

19.1. Em média, com que freqüência você tem praticado esta(s) atividade(s) física(s).
[0] Menos que 1 vez por semana
[1] 1 vez por semana
[2] 2 vezes por semana
[3] 3 vezes por semana
[4] Mais de 3 vezes por semana

3

20. No último mês como está o seu lazer (qualquer atividade que lhe dê prazer como cinema, restaurante, dança, artes, etc?

[1] [2] [3] [4] [5]

21. Como está sua menstruação ?

[1] Da mesma forma como sempre foi
[2] Mudou há menos de 1 ano
[3] Mudou há 1 ano ou mais
[4] Parei de menstruar há menos de 1 ano
[5] Parei de menstruar há 1 ano ou mais
[6] Nunca menstruei ➡ Passe para a pergunta 23.

22. Quando foi sua última menstruação?

Há I__I__I dias ou I__I__I meses ou I__I__I anos

23. Você está grávida?

[1] Sim [2] Não ➡ Passe para a pergunta 24. [3] Não sei ➡ Passe para a pergunta 24.

23.1 De quanto tempo você está grávida?

I__I__I meses e/ou I__I__I semanas [ ] Não sei

24. Você está usando algum método anticoncepcional oral (comprimido), injetável, anel vaginal ou adesivo?

[1] Sim [2] Não ➡ Passe para a pergunta 25.

24.1 Há quanto tempo você usa esse método?

I__I__I anos e/ou I__I__I meses e/ou I__I__I dias [ ] Não me lembro

25. Você está usando DIU com hormônio (Mirena)?

[1] Sim [2] Não ➡ Passe para a pergunta 26.

25.1 Há quanto tempo você usa?

I__I__I anos e/ou I__I__I meses e/ou I__I__I dias [ ] Não me lembro

4

26. Você está usando outro tipo de DIU?

[1] Sim [2] Não ➡ Passe para a pergunta 27.

26.1 Há quanto tempo você usa?

I__I__I anos e/ou I__I__I meses e/ou I__I__I dias [ ] Não me lembro

27. Você evita filhos de outra maneira?

[1] Sim [2] Não ➡ Passe para a pergunta 28.

27.1 Evito filhos usando:

[1] Preservativo [2] Coito interrompido [3] Outros métodos

27.2 Há quanto tempo você usa este método? I__I__I anos e/ou I__I__I meses e/ou I__I__I dias

[ ]Não me lembro

28. Você já se submeteu a cirurgias ginecológicas?

[1] Sim [2] Não ➡ Passe para a pergunta 29.

28.1 Qual(is) a(s) cirurgia(s) ginecológica(s) às quais você se submeteu?

[1] Histerectomia (Retirou o útero todo). Com que idade? I__I__I anos.

[2] Histerectomia parcial (Retirou parte do útero e ficou o colo). Com que idade? I__I__I anos

[3] Retirou apenas um ovário. Com que idade? I__I__I anos.

[4] Retirou os dois ovários. Com que idade? I__I__I anos.

[5] Ligadura de Trompas. Com que idade? I__I__I anos.

[6] Passei por uma cirurgia, mas não sei exatamente qual. Com que idade? I__I__I anos.

[7] Outra. Qual? _____ Com que idade? I__I__I anos

29. Atualmente você tem depressão?

[1] Sim [2] Não ➡ Passe para a pergunta 30. [3] Não sei ➡ Passe para a pergunta 30.

29.1 No último mês está usando algum medicamento para tratamento de depressão?

[1] Sim [2] Não Passe para a pergunta 30. [3] Não sei Passe para a pergunta 30.

29.2 Qual ou quais medicamento(s) para depressão você está usando?.....

.....

.....

30. Você tem pressão alta?

[1] Sim [2] Não ➡ Passe para a pergunta 31. [3] Não sei ➡ Passe para a pergunta 31.

30.1 No último mês está usando algum medicamento para tratamento de pressão alta?

[1] Sim [2] Não ➡ Passe para a pergunta 31. [3] Não sei ➡ Passe para a pergunta 31.

30.2 Qual ou quais medicamento(s) para pressão alta você está usando?.....

.....

.....

5

31. Você tem diabetes?

[1] Sim [2] Não ➡ Passe para a pergunta 32. [3] Não sei ➡ Passe para a pergunta 32.

31.1 No último mês está usando algum medicamento para tratamento de diabetes?

[1] Sim [2] Não ➡ Passe para a pergunta 32. [3] Não sei ➡ Passe para a pergunta 32.

31.2 Qual ou quais medicamento(s) para diabetes você está usando?.....

.....

.....

32. Atualmente você tem tido perda de urina (perda de urina com tosse, esforço, etc)?

[1] Sim [2] Não ➡ Passe para a pergunta 33. [3] Não sei ➡ Passe para a pergunta 33.

32.1 A perda de urina tem interferido na sua rotina?

[1] Não tem interferido

[2] Tem Interferido pouco

[3] Tem Interferido muito

33. Você tem ou teve algum tipo de câncer?

[1] Sim [2] Não ➡ Passe para a pergunta 34. [3] Não sei ➡ Passe para a pergunta 34.

33.1 Qual ou quais?

[1] Câncer de mama com I__I__I anos de idade.

[2] Câncer de útero com I__I__I anos de idade.

[3] Câncer de ovário com I__I__I anos de idade.

[4] Câncer de intestino com I__I__I anos de idade.

[5] Qualquer outro tipo de câncer com I__I__I anos de idade.

34. No último mês, você vem apresentando ondas de calor?

[1] Sim [2] Não ➡ Passe para a pergunta 35.

34.1 As ondas de calor têm interferido na sua rotina?

[1] Não têm interferido

[2] Tem Interferido pouco

[3] Tem Interferido muito

6

35. No último mês, você vem apresentando nervosismo?

[1] Sim [2] Não ➡ Passe para a pergunta 36.

35.1 O nervosismo tem interferido na sua rotina?

[1] Não tem interferido

[2] Tem Interferido pouco

[3] Tem Interferido muito

36. No último mês você vem apresentando insônia?

[1] Sim [2] Não ➡ Passe para a pergunta 37.

36.1 A insônia tem interferido na sua rotina?

[1] Não tem interferido

[2] Tem Interferido pouco

[3] Tem Interferido muito

37. Em relação à Terapia Hormonal marque com um X a resposta correta em relação a você:

[1] Nunca usei ➡ Passe para a pergunta 38

[2] Não sei se já usei ➡ Passe para a pergunta 38

[3] Já use i e parei. A quanto tempo parou?

I__I__I anos e/ou I__I__I meses e/ou I__I__I dias. [ ] Não me lembro a quanto tempo parei ➡ Passe para a pergunta 38.

[4] Estou usando Terapia Hormonal.

37.1 Qual ou quais os hormônios para terapia de reposição hormonal que você está usando?

....

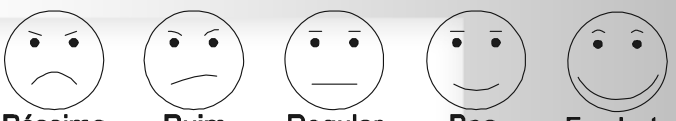
[ ] Uso hormônios, mas não sei o nome.

37.2 Há quanto tempo você iniciou a terapia de reposição hormonal?

I__I__I anos e/ou I__I__I meses e/ou I__I__I dias. [ ] Não me lembro

38. No último mês, como você se sente de maneira geral?

Marque com um X:



[1] [2] [3] [4] [5]

7

As perguntas seguintes são sobre atividade sexual. Para ter atividade sexual não é necessário ter um(a) companheiro(a). A atividade sexual compreende a auto-estimulação (masturbação) e/ou as preliminares (ato de excitação com o parceiro) e/ou a penetração. Atualmente muitas mulheres se auto-estimulam (se masturbam) como forma de terem "contato íntimo com o próprio corpo" ou de "liberarem energia sexual". Responda às perguntas com base na sua experiência pessoal.

39. No último mês, com que freqüência você tem tido qualquer atividade sexual (masturbação, excitação e/ou penetração)?

[0] Nunca
[1] Menos que 1 vez por semana
[2] 1 a 2 vezes por semana
[3] Várias vezes por semana
[4] Uma ou 2 vezes por dia
[5] Várias vezes por dia

40. No último mês, com que freqüência você tem tido fantasias e pensamentos sexuais e/ou desejo sexual?

[0] Nunca
[1] Menos que 1 vez por semana
[2] 1 a 2 vezes por semana
[3] Várias vezes por semana
[4] Uma ou 2 vezes por dia
[5] Várias vezes por dia

41. Marque um X na alternativa que corresponde ao que você sente. Quanto maior o número maior o sentimento: 1= nada e 6= ao máximo . As perguntas são relativas ao último mês:

41.1 Como tem sido a intensidade do seu desejo sexual (tesão)?

[1] [2] [3] [4] [5] [6]

41.2 Durante as atividades sexuais com que frequência você tem se sentido estimulada ou excitada (com a vagina lubrificada/úmida)?

[1] [2] [3] [4] [5] [6]

41.3 Quanto de satisfação você tem tido nas atividades sexuais?

[1] [2] [3] [4] [5] [6]

41.4 Com que intensidade você tem apresentando orgasmo nas atividades sexuais?

[1] [2] [3] [4] [5] [6]

8

42. Qual a sua preferência sexual? Faça um X no número correspondente à resposta adequada para você.

[1] Heterossexual (parceiro homem)
[2] Bissexual (parceiro homem e parceira mulher)
[3] Homossexual (parceira mulher)
[4] Nenhuma das opções anteriores ➡ Passe para a pergunta 53

43. No último mês você tem tido parceiro(a) sexual?

[1] Sim [2] Não ➡ Passe para a pergunta 53

AS PERGUNTAS A SEGUIR SÃO RELATIVAS A PARCEIROS SEXUAIS. SE VOCÊ NÃO TEM NENHUM PARCEIRO SEXUAL ATUALMENTE, VOCÊ NÃO PRECISA CONTINUAR.
SE VOCÊ TEM UM(A) OU MAIS PARCEIROS(AS) SEXUAIS, FAVOR CONTINUAR O QUESTIONÁRIO.

44. Quantos parceiros(as) sexuais você teve no último mês? I__I__I

Por favor, responda as seguintes perguntas pensando no seu parceiro sexual. Se você tem atualmente mais que um, a resposta deve ser em relação ao parceiro com quem você se dá melhor sexualmente.

45. Qual é o sexo deste parceiro(a)? [1] Feminino [2] Masculino

46. Quantos anos tem seu parceiro(a)? I__I__I anos

47. Há quanto tempo você mantém este relacionamento?
I__I__I anos e/ou I__I__I meses e/ou I__I__I semanas e/ou I__I__I dias

48. Você mora com este parceiro(a)?
[1] Sim [2] Não

9

49. Faça um X no número correspondente ao seu sentimento em relação ao seu parceiro(a).
Quanto maior o número, maior o sentimento: 1=nada e 6=máximo

49.1 Quanto você está satisfeita com seu(sua) parceiro(a) como amante?
[1] [2] [3] [4] [5] [6]

49.2 Quanto você está apaixonada pelo seu(sua) parceiro(a)?
[1] [2] [3] [4] [5] [6]

49.3 Quanto de problemas sexuais tem o seu(sua) parceiro(a)?
[1] [2] [3] [4] [5] [6]

50. No último mês você tem tido atividades sexuais com penetração?
[1] Sim [2] Não ➡ Passe para a questão 52.

51. Faça um X no número correspondente ao que você tem sentido. Quanto maior o número, maior a dor: 1=nada e 6=máximo
No último mês, durante as atividades sexuais quanto de dor você teve com a penetração?
[1] [2] [3] [4] [5] [6]

52. Em geral, como você se sente em relação a esse parceiro(a) sexual?

[1] [2] [3] [4] [5]

53. Em geral, como você classifica sua vida sexual?

[1] [2] [3] [4] [5]

10

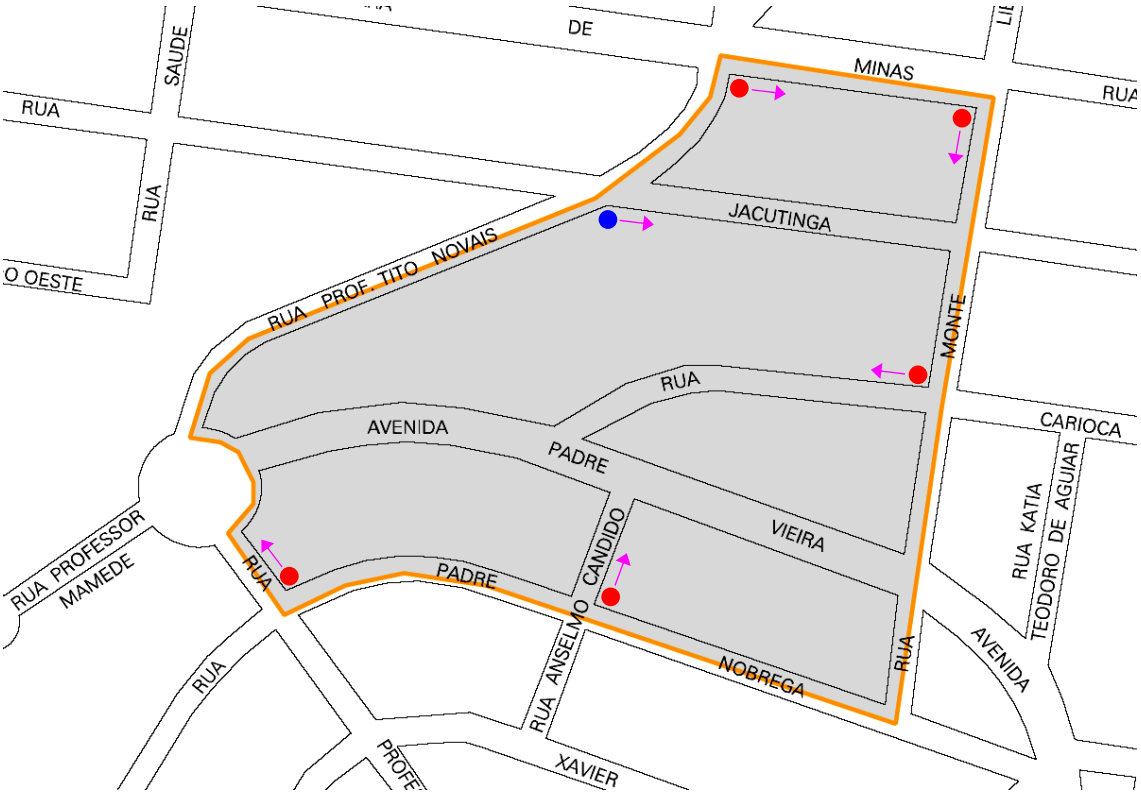
Espaço aberto a relatos/ opiniões:

Coloque o questionário no envelope e feche-o.

OBRIGADA PELA SUA COLABORAÇÃO

7.2. Anexo 2 – Exemplo de setor censitário sorteado

- Marcadores em vermelho mostram as 5 primeiras esquinas sorteadas.
- Marcadores em azul mostram a esquina sorteada após terem sido precorridas todas as casas referentes ao primeiro sorteio.



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