





Knowledge and attitudes regarding sexuality according to sociodemographic and economic characteristics of older adults

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Abstract

Objective: To evaluate the knowledge and attitudes of older adults regarding sexuality according to sociodemographic and economic factors. **Methods:** This quantitative, observational, cross-sectional study was conducted with 219 older adults in Uberaba, Minas Gerais, Brazil, through telephone contact between October 2020 and May 2021. Data were analyzed using statistical software. **Results:** Among all respondents, the mean age was 74.5 years, with a predominance of women; individuals who were married or living with a spouse or partner; those with incomplete primary education; Catholics; White individuals; and those with a household income below two minimum wages. Knowledge and attitudes regarding sexuality were associated with sex, marital status, and educational level. Male participants, those who were single, and those with higher levels of education demonstrated greater knowledge about sexuality. Regarding attitudes, women, widowed individuals, and those with lower educational levels exhibited a more conservative stance. **Conclusion:** The findings indicate that older adults' knowledge and attitudes regarding sexuality are associated with their sociodemographic characteristics. Healthcare professionals should be attentive to factors such as sex, marital status, and educational level, considering group differences related to sexuality. Health education initiatives and multidisciplinary, holistic approaches, free from stigma and prejudice, may contribute to the advancement of health policies directed at older adults, including the right to discuss the topic and experience sexuality with quality across different stages of life.

Keywords: Health of the Elderly. Sexuality. Sexual Health. Health Knowledge, Attitudes, Practice. Older Adults.

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INTRODUCTION

Certain physiological changes that naturally occur with advancing age, such as weight changes, reduced skin elasticity, and slowed metabolism, are commonly associated with a negative connotation of old age within the social context¹.

Although sexuality in later life can promote well-being and improve quality of life, it is often viewed solely as an attribute associated with youth and fertility, which leads to the neglect of the sexual needs of older adults^{2,3}.

When addressing this complex and challenging topic, it is essential to deconstruct the prejudices and stereotypes surrounding expressions of sexuality, recognizing them as a human right regardless of age group³.

However, due to limited understanding of the physiological changes that occur during this stage of life, many older adults may withdraw from maintaining an active sexual life. The lack of understanding of these changes can result in misinterpretations regarding their capabilities⁴.

Moreover, beyond biological factors, psychological, cultural, and social elements may influence how older adults experience and perceive sexuality⁴. Understanding these determinants contributes to the development of health actions aimed at reducing the negative impacts related to sexuality and encouraging older adults to discuss the topic, thereby demystifying existing taboos⁴.

Conversely, limited knowledge about sexuality may lead to more negative attitudes and conservative views⁵.

From this perspective, studies assessing the knowledge and attitudes of older adults regarding sexuality have predominantly focused on sexually transmitted infections (STIs) and their impact on health^{5,6}. However, there is a scarcity of studies addressing sexuality while considering the sociodemographic and economic characteristics of older adults. These aspects are relevant because they may directly affect self-esteem, relationship quality, and sexual satisfaction⁷.

Therefore, addressing this gap in the scientific literature may provide insights into how older adults experience sexuality, contributing to a broader understanding within this group, society, and healthcare professionals regarding sexual aptitude and desire during this stage of development⁸. This will enable healthcare professionals to better equip themselves to meet the needs of this age group more comprehensively, rather than limiting their focus solely to biological changes⁹.

Thus, the present study aims to describe the sociodemographic and economic characteristics of the participants and to assess the knowledge and attitudes of older adults regarding sexuality according to sociodemographic and economic factors.

METHODS

This was a quantitative, observational, cross-sectional study. Data were collected in the urban area of Uberaba, Minas Gerais, Brazil, between October 2020 and May 2021.

The sample is part of a larger project titled “Survey on sexuality in older adults – ISI Project.” A preexisting list was used from the project “Active Aging, Global Functionality, and Quality of Life among Older Adults in the Uberaba (MG) Health Microregion,” conducted between May 2017 and June 2018, which provided contact information for 803 older adults who were able to answer telephone calls and respond to questions.

Individuals of both sexes aged 60 years or older were included in the study. In total, 219 older adults participated. The reasons for exclusions and losses were: 31 individuals had died; 45 were not in condition or were unable to respond by telephone due to illness, hearing impairment, or inability to verbalize; 98 chose not to participate; 195 could not be contacted due to phone number changes or invalid numbers; and 215 were not reached after at least six attempts made by interviewers on different days and at different times, even though the phone number existed and belonged to the individual.

Data were obtained through telephone contact conducted by 10 trained interviewers, and responses

were recorded directly on an online electronic form. After data collection, the information was transferred to an electronic spreadsheet. The questionnaire, which included sociodemographic and economic variables (sex, age, marital status, educational level, household income, number of individuals dependent on the income, race/ethnicity, and religion or belief), was developed by the researchers.

The Aging Sexual Knowledge and Attitudes Scale (ASKAS) is an instrument designed to better understand how older adults perceive and experience sexuality based on physiological and sociopsychological aspects. It contains 28 statements with response options structured on a Likert-type scale. Of these, 20 statements refer to the “knowledge” domain (true = 1, false = 2, do not know = 3), and the remaining eight statements correspond to “attitudes” (responses ranging from strongly disagree = 1 to strongly agree = 7). Lower scores indicate a higher level of knowledge on the subject. Regarding attitudes, lower scores suggest a more liberal perspective, whereas higher scores indicate a tendency toward more conservative views. The scale does not aim to identify the sexual profile of the older adult but to assess knowledge and attitudes toward sexuality at this stage of life.¹⁰

The study considered sociodemographic and economic variables, including sex (classified as female and male); age in years; and marital status (with or without a partner). Educational level was assessed based on formal schooling, including those who had never attended school, those with incomplete primary education, and those with complete primary education or higher.

Household income was expressed in minimum wages (MW) and categorized as less than two, two to three, and four or more. Self-reported race/ethnicity included the following options: Black and mixed-race (“Pardo”) population, White, Asian, and Indigenous. Religion or belief included the categories Catholic, Spiritist and Kardecist, other religions or beliefs, no religion/belief, or agnostic. For all variables, the option “not reported” was available when the older adult preferred not to answer, with occurrences in marital status, educational level, number of individuals dependent on income, and religion/belief ($n = 1$), and in household income ($n = 2$).

Knowledge and attitudes were measured using the total score obtained on the ASKAS, allowing the evaluation of participants’ level of information and whether their views were conservative or liberal.

For data analysis, categorical variables were presented using absolute and relative frequencies. Numerical variables were analyzed using measures of central tendency and dispersion with R software, version 4.0.0. Considering a finite population of 803 individuals and a 5% margin of error, a minimum of 261 participants was estimated to ensure statistically reliable estimates. However, due to restrictions imposed by the COVID-19 pandemic, responses were obtained from 219 individuals. With this sample size, the margin of error increased to 5.66%, as determined by statistical calculation.

Statistical analyses were conducted in R (RStudio). After assessing data normality through statistical tests and visual inspection of Q-Q plots, the Mann-Whitney test (or Wilcoxon test for independent samples) and the Kruskal-Wallis test were applied for comparisons between two or more groups, respectively. For multiple comparisons following the Kruskal-Wallis test, Dunn’s post hoc test was used to identify which groups differed from one another. To control Type I error due to multiple comparisons, p-values were adjusted using the Bonferroni method. Effect size for the Mann-Whitney test was calculated as r (`wilcox_effsize()`, `rstatix` package) and converted to Cohen’s ($d = 2r/\sqrt{1-r^2}$) to estimate test power using `pwr.t2n.test()` (`pwr` package). For the Kruskal-Wallis test, effect size was estimated using eta-squared ($\eta^2 = (H - k + 1)/(n - k)$), where H is the test statistic, k is the number of groups, and n is the sample size. Test power was estimated by approximation to an ANOVA using the effect size converted to f ($f = \sqrt{\eta^2/(1-\eta^2)}$) and the function `pwr.anova.test()` (`pwr` package). Effect size r for the Mann-Whitney test was interpreted as small ($r \approx 0.10$), moderate ($r \approx 0.30$), and large ($r \geq 0.30$). For the Kruskal-Wallis test, eta-squared values were interpreted as small ($\eta^2 \approx 0.01$), moderate ($\eta^2 \approx 0.06$), and large ($\eta^2 \approx 0.14$). A significance level of 5% was adopted, and tests with power greater than 80% were considered capable of detecting true differences between groups.

The project was approved by the Human Research Ethics Committee of the Universidade Federal do Triângulo Mineiro (UFMT), CAAE 07786819.2.0000.5154, under ruling no. 4,342,951. It complied with the recommendations set forth in Resolutions No. 466/2012 and No. 510/2016 of the National Health Council. The informed consent statement was read and subsequently sent via email or WhatsApp. At the time of the initial contact, the telephone number and email address of the principal investigator were also provided. Participants received prior information regarding the study objectives and procedures, data confidentiality, and the anonymity of their participation. Any questions raised were then addressed. Interviews began only after verbal consent was obtained from the participants.

DATA AVAILABILITY

The dataset supporting the findings of this study is available upon request from the corresponding author.

RESULTS AND DISCUSSION

Among the 219 participants, females predominated (62.1%) (Table 1), corroborating studies conducted in Brazilian cities^{11,12}. The higher participation of older women may be related to their greater life expectancy, resulting from behavioral differences between sexes, considering that men often exhibit higher-risk behaviors such as alcohol and drug use, involvement in traffic accidents, and lower attention to health care¹³.

The mean age was 74.5 years, with $SD = \pm 7.9$ years, median = 73 years, $CV = 11\%$, $Q1 = 69$ years, and $Q3 = 80$ years, consistent with the increased longevity of Brazilians over recent decades, achieved through advances in health promotion policies, which include protective, preventive, and early disease detection measures¹⁴.

Regarding marital status, most participants (53.7%) reported not having a partner (Table 1), diverging from studies conducted in Brazil with older adults^{7,12}. This finding may be explained by the fact that, in the present study, participants

without partners included individuals who had never married or cohabited, single individuals, widowed, separated, legally separated, or divorced. When assessed separately, following national trends, there is typically a predominance of married individuals. A literature review identified that partnership is associated with the experience of sexuality among older adults. Among older women, the lack or loss of a partner, such as in widowhood, appears to negatively affect engagement in sexual practices¹⁵.

Participants had a low educational level, with the highest percentage reporting incomplete primary education (64.7%) (Table 1), similar to findings from studies conducted in Brazil^{7,12}. The low educational level among older adults may be attributed to cultural influences prevalent during their childhood and youth. At that time, education was often undervalued in comparison with priorities such as marriage, family formation, early entry into the labor market, and limited access to educational institutions¹⁶.

A total of 65.6% of respondents identified as Catholic (Table 1), a profile similarly observed in the Brazilian Northeast.¹⁷ Older adults who follow Catholicism may often hold more traditionalist views about sexuality, reflecting principles that guide conservative attitudes among these adherents^{5,15}. In this sense, religion may act as a guiding authority, as it establishes norms that define what is considered acceptable or unacceptable behavior and shapes individuals according to predetermined rules¹⁸, which may influence, although not investigated in this study, their perspectives on sexuality.

Analysis of the race/ethnicity variable showed that 55.7% of participants self-identified as White. Regarding household income, most respondents reported an income below two minimum wages (43.1%). In addition, 42.5% of the participants belonged to families in which two individuals depended on the primary income (Table 1). It is worth noting that socioeconomic status influences the degree of knowledge about sexuality. Individuals with lower incomes have fewer opportunities and resources to acquire in-depth knowledge on the subject, and this limited access to appropriate information results in reduced understanding of sexual matters¹⁹.

Table 1. Sociodemographic and economic profile of older adults participating in the study. Uberaba, Minas Gerais, Brazil, 2020–2021.

Variables	n (%)	95% CI*
Sex		
Female	136(62.1)	56.4 - 67.8
Male	83(37.9)	32.2 - 43.6
Marital status		
Without partner	117(53.7)	48.0 - 59.3
With partner	101(46.3)	40.7 - 52.0
Educational level		
No formal education	16(7.3)	1.7 - 13.0
Incomplete primary education	141(64.7)	59.0 - 70.3
Complete primary education or higher	61(28.0)	22.3 - 33.6
Household income (in minimum wages)		
< 2	93(43.1)	37.4 - 48.7
2 - 4	87(40.3)	34.6 - 45.9
4 or more	36(16.7)	11.0 - 22.3
Number of people who depend on the household income		
1	47(21.6)	15.9 - 27.2
2	93(42.5)	36.8 - 48.2
3	44(20.2)	14.5 - 25.8
4 or more	34(15.6)	9.9 - 21.3
Race/ethnicity		
Black population (Black and Mixed-race)	84(38.4)	32.7 - 44.0
White	122(55.7)	50.0 - 61.4
Asian and Indigenous	13(5.9)	0.3 - 11.6
Religion or belief		
Catholic	143(65.6)	59.9 - 71.3
Spiritist / Kardecist	34(15.6)	9.9 - 21.3
Other religions/beliefs	30(13.8)	8.1 - 19.4
No religion/belief or Agnostic	11(5.0)	0.0 - 10.7

*CI: Confidence interval. **Source:** Survey data.

The Mann–Whitney U test showed a significant difference in knowledge scores between sexes ($W = 7734$, $p < 0.001$). The effect size, calculated as r , was 0.31, classified as moderate. When converted to Cohen's d , the effect corresponded to $d \approx 0.65$, reinforcing that the magnitude of the difference is of moderate intensity. Specifically, female participants had significantly higher knowledge scores compared with male participants. Considering that lower scores indicate greater knowledge about sexuality, older men demonstrated greater knowledge than

older women (Table 2). This finding aligns with the literature, showing that cultural and social norms have historically allowed men greater freedom to discuss and express issues related to sexuality and sex⁷.

The way parents address sexuality varies according to the child's gender. Women receive more restrictive messages surrounding this topic, often conveyed through euphemisms, vague terms, and risk-based narratives such as pregnancy, and are subjected to stricter moral standards than men. Consequently,

differentiated communication can significantly affect the level of knowledge on the topic, leading to a reduced understanding of their own bodies and a limited repertoire of knowledge about pleasure, consent, and other important aspects of sexuality²⁰.

In contrast, men, who receive more positive and informative messages, are more likely to develop a broader and more balanced understanding of sexual matters. Promoting equitable and informative communication for both genders may help reduce these disparities and contribute to a more robust and equitable understanding of sexuality among men and women²⁰.

Regarding older adults' attitudes toward sexuality, there was a significant difference in scores when comparing sexes ($W = 7254$, $p < 0.001$). The effect size was small ($r = 0.24$), indicating that although statistically significant, the difference had limited magnitude. When converted to Cohen's d , the effect corresponded to $d \approx 0.49$, reinforcing that the difference is small to moderate. Older women had slightly higher attitude scores than men. In other words, older men demonstrated a more liberal attitude toward sexuality than older women (Table 2), consistent with findings from a study conducted in Montenegro²¹.

This discrepancy may be attributed to inconsistent social norms applied to genders, in which female sexuality is considerably more repressed than male sexuality. As a result, women may be reluctant to express their attitudes toward sexuality in order to avoid judgments based on cultural stigmas²¹.

There was a significant difference in knowledge scores between participants with and without partners ($W = 4136$, $p < 0.001$), with a small effect size ($r = 0.26$), indicating limited magnitude. When converted to Cohen's d , the effect was $d \approx 0.53$, suggesting a small to moderate difference. Older adults without partners had slightly higher knowledge scores than those with partners, indicating lower knowledge about sexuality (Table 2).

A significant difference was also observed in attitude scores between participants with and without partners ($W = 4459.5$, $p = 0.002$). The

effect size ($r = 0.21$; $d \approx 0.44$) indicates a small to moderate difference, suggesting that participants without partners had slightly higher attitude scores than those with partners, demonstrating more conservative attitudes.

A study conducted in Germany showed that widowed men are more likely to remarry than widowed women²². Older widowed women may experience reduced sexual activity and demonstrate disinterest in issues related to sexuality, mainly due to the absence of a steady partner after the loss of their spouse²³.

After the death of their husband, many older women choose not to engage in new relationships. For cultural, religious, and social reasons, they are not encouraged to have other partners. Considering that, for many older women, sex is predominantly understood as a marital union associated with reproductive function, once they become widowed and do not have a steady partner, sexual activity is often eliminated from daily life¹⁵. Therefore, resistance to establishing new sexual relationships influences the development of more conservative attitudes among women without a partner, due to cultural expectations imposed on their behavior²⁴.

A significant difference was found in median knowledge scores among educational-level groups ($H = 8.29$, $df = 2$, $p = 0.016$). The effect size of 0.03, estimated by eta-squared ($\eta^2 = 0.03$), was small, and the test power, estimated at 62%, indicates a moderate probability of detecting a true difference among groups with the sample used. The Dunn post hoc test, adjusted by the Bonferroni method, showed that participants with incomplete primary education had lower knowledge about sexuality than those with complete primary education or higher (adjusted $p = 0.020$) (Table 2), consistent with a study conducted with older adults in Northeastern Brazil¹⁵.

Individuals with fewer years of schooling tend to have limited access to basic healthcare services and, consequently, may not sufficiently acquire technically grounded information that could be obtained in these settings. Additionally, they face greater challenges in correctly understanding the guidance provided by the healthcare team²⁵.

Educational level and gaps in knowledge regarding the modes of transmission, prevention, and treatment of sexually transmitted infections (STIs), for example, emerge as contributing factors to increased vulnerability in this population. Thus, insufficient educational measures may result in a greater propensity for risk behaviors and delays in seeking medical care, considering that in this age group unsafe sexual health practices are often adopted, increasing the likelihood of acquiring diseases^{26,27}.

Significant differences were also observed in attitude scores among educational-level groups ($H = 19.22$, $df = 2$, $p < 0.001$). The effect size ($\eta^2 = 0.08$) suggests a medium effect, indicating that approximately 8% of the variability in attitude scores can be attributed to educational level. The Dunn post-hoc test, adjusted using the Bonferroni method, showed that those with higher levels of education also demonstrated a more liberal attitude toward sexuality (adjusted $p < 0.001$) (Table 2).

In this regard, knowledge about the aging process, its particularities, and strategies to maintain healthy sexuality in this stage of life tends to foster more permissive attitudes^{5,28}. A liberal orientation is characterized by critical and independent thinking, flexibility in considering divergent perspectives, and willingness to question traditions or norms established by society. It also involves valuing inclusion and diversity, as well as respecting cultural and individual differences, aligned with principles of equality and inclusion²⁹.

This can be explained by the fact that, when exposed to a greater amount of reliable information acquired in educational settings, individuals encounter diverse ideas and perspectives that may help develop critical thinking, which in turn can reduce misconceptions and misunderstandings regarding the possibility of sexual satisfaction in older age³⁰. Such knowledge is crucial to demystify the stereotypical belief that sexuality is unimportant in old age and to influence the adoption of less conservative attitudes⁷.

Household income was not associated with knowledge about sexuality ($H = 1.48$, $df = 2$, $p = 0.476$), but differences were observed among income groups regarding attitudes ($H = 8.36$, $df = 2$, $p = 0.015$). The effect size ($\eta^2 = 0.03$) indicates a small difference, and test power was limited (44%), suggesting a low probability of detecting true differences with the sample used. The Dunn post-hoc test, adjusted by the Bonferroni method, showed that participants with household income between two and less than four minimum wages had significantly higher attitude scores than those with income below two minimum wages (adjusted $p = 0.040$), reflecting a more conservative stance (Table 2). This finding is consistent with a national study conducted with older adults ($p < 0.002$)⁵ and with a study conducted in Minas Gerais, which identified that higher income among older women was associated with the continuation of sexual activity³¹.

Table 2. Knowledge and attitude scores of older adults regarding sexuality, according to sociodemographic and economic factors. Uberaba, Minas Gerais, Brazil, 2020–2021.

Variables	Attitudes and Knowledge about Sexuality in Aging (ASKAS)			
	Knowledge***	p / effect size	Attitudes	p / effect size
Sex		<0.001*		<0.001*
Female (n=136)	35 (30; 45)	r=0.31	22 (17; 25)	r=0.24
Male (n=83)	30 (26; 36)	(moderate)	18 (14; 21)	(small)
Marital status		<0.001*		0.012*
Without partner (n=117)	35 (30; 45)	r=0.260	22 (18; 25)	r=0.210
With partner (n=101)	30 (28; 36)	(small)	19 (15; 23)	(small)
Educational level		0.016**		<0.001**
No formal education (n=16)	35 (28; 47)	h ² =0.030	22 (15; 25)	h ² = 0.080
Incomplete primary education (n=141)	34 (29; 42)	(small)	22 (17; 25)	(moderate)
Complete primary education or higher (n=61)	31 (26; 37)		17 (12; 21)	
Household income (in minimum wages)		0.476 **		0.015**
Less than 2 (n=93)	34 (29; 39)	-	22 (17; 26)	h ² = 0.030
Between 2 and < 4 (n=87)	32 (28; 39)		19 (15; 24)	(small)
4 or more (n=36)	33 (27; 41)		20 (16; 22)	
Number of individuals dependent on household income		0.324**		0.669**
1 (n=47)	32 (27; 39)	-	19 (15; 24)	-
2 (n=93)	33 (28; 40)		19 (15; 24)	
3 (n=44)	36 (30; 43)		21 (17; 24)	
4 or more (n=34)	30 (27; 38)		21 (17; 24)	
Race/ethnicity		>0.900**		0.523**
Black and Mixed-race (n=84)	33 (29; 29)	-	21 (16; 25)	-
White (n=122)	33 (28; 41)		21 (15; 24)	
Asian and Indigenous (n=13)	36 (30; 38)		19 (18; 25)	
Religion or belief		0.382**		0.182**
Catholic (n=143)	34 (28; 40)	-	20 (16; 24)	-
Spiritist / Kardecist (n=34)	31 (28; 38)		21 (15; 24)	
Other religions/beliefs (n=30)	32 (28; 41)		24 (17; 26)	

*Mann–Whitney U test; **Kruskal–Wallis test; ***Median (1st quartile, 3rd quartile). **Source:** Study data.

Given the accelerated population aging, research is essential to enhance care and to emphasize actions aimed at preventing diseases and injuries, as well as promoting and maintaining health. A study conducted with older adults in Mexico found that participants wished for the topic of sexuality to be addressed by the healthcare team during consultations. They recognized the importance of receiving guidance from reliable and specialized sources that demonstrate an empathetic understanding of issues involving

sexuality in later life and that are capable of providing advice on ways to experience it with quality¹⁸.

In another study conducted with 411 older adults, 71.29% agreed that having knowledge about sexuality was relevant, and 61.07% reported being sexually active. These findings indicate that, despite the particularities of this phase of life, such as menopause, hormonal changes, and metabolic alterations, older adults are fully capable of engaging in sexual relations

and experiencing pleasure³². However, healthcare professionals do not always discuss these topics with individuals in this age group, either due to reluctance to introduce the subject or because of the stereotype that sexuality is no longer part of older adults' lives^{33,34}.

Strategies can be developed to make conversations about sexuality more natural, for example by providing specific instructions that highlight the use of routine, confidential questions and encourage individuals to feel comfortable sharing information³⁵. By offering appropriate support, healthcare professionals can help reduce stigma and promote a holistic, inclusive, and humanized approach²⁶.

This study presents limitations related to the data collection method, which relied on telephone contact and resulted in reduced sample representativeness due to several factors, such as refusals to participate and difficulties in reaching potential participants. However, this was the feasible approach adopted to conduct the study, in order to comply with safety measures imposed during the COVID-19 pandemic and to safeguard the integrity of the collected data. Regarding refusals, most older adults stated that they declined due to the time required to participate by telephone or because of other difficulties, such as hearing problems. The topic itself does not appear to have been a barrier to participation. This contrasts with the ASKAS scale validation study, in which respondents demonstrated difficulty and embarrassment in speaking openly about the subject¹⁰. It is inferred that telephone-based data collection may have had a positive influence, since participants did not need to be face to face with the interviewer, which may have facilitated dialogue and the expression of responses.

CONCLUSIONS

The findings indicate that older women, individuals without a steady partner, and those with incomplete primary education had lower levels of knowledge about sexuality than the other groups. In addition, female sex, lower educational level, and higher income were associated with more conservative attitudes.

This study has limitations related to the high number of refusals and other losses, such as difficulties reaching part of the older population by telephone, which may affect the generalizability and interpretation of the findings. These factors reinforce the exploratory nature of the results, which should be interpreted in light of the participating population. Nonetheless, methodological rigor was maintained, following ethical principles and the recommendations in place at the time for conducting research with older adults during the COVID-19 pandemic.

Despite these limitations, the study advances knowledge in the field of Public Health by bringing to light specific data on socioeconomic and demographic factors related to the knowledge and attitudes of older adults regarding sexuality in later life. The findings are also aligned with the Sustainable Development Goals: Good Health and Well-Being, target 3.8, which calls for access to essential and high-quality health services, and Gender Equality, target 5.1, which aims to end all forms of discrimination against women, and target 5.6, which seeks to ensure universal access to sexual health.

In this regard, it is important that multiprofessional teams implement sexual health education practices, especially within the scope of primary health care (PHC), in order to promote dialogue and qualified listening, understand older adults' level of knowledge and attitudes about sexuality and the multiple factors surrounding it, and foster health care while reducing situations of vulnerability. This is fundamental to ensuring the implementation of health policies.

For future research, studies with larger samples are recommended, with emphasis on investigating the social determinants of health related to older adults' knowledge and attitudes about sexuality in different cultural and regional contexts.

AUTHORSHIP

- Regiane L. Takaoka – Formal analysis; interpretation of results; writing and review.
- Lígia F. Machado – Interpretation of results; writing and review.

- Ana Paula Fernandes – Data analysis and interpretation; review; approval of the final version for publication.
- Pollyana C. S. Ferreira – Study conception and design; writing; review; critical revision; funding acquisition; approval of the final version for publication.

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