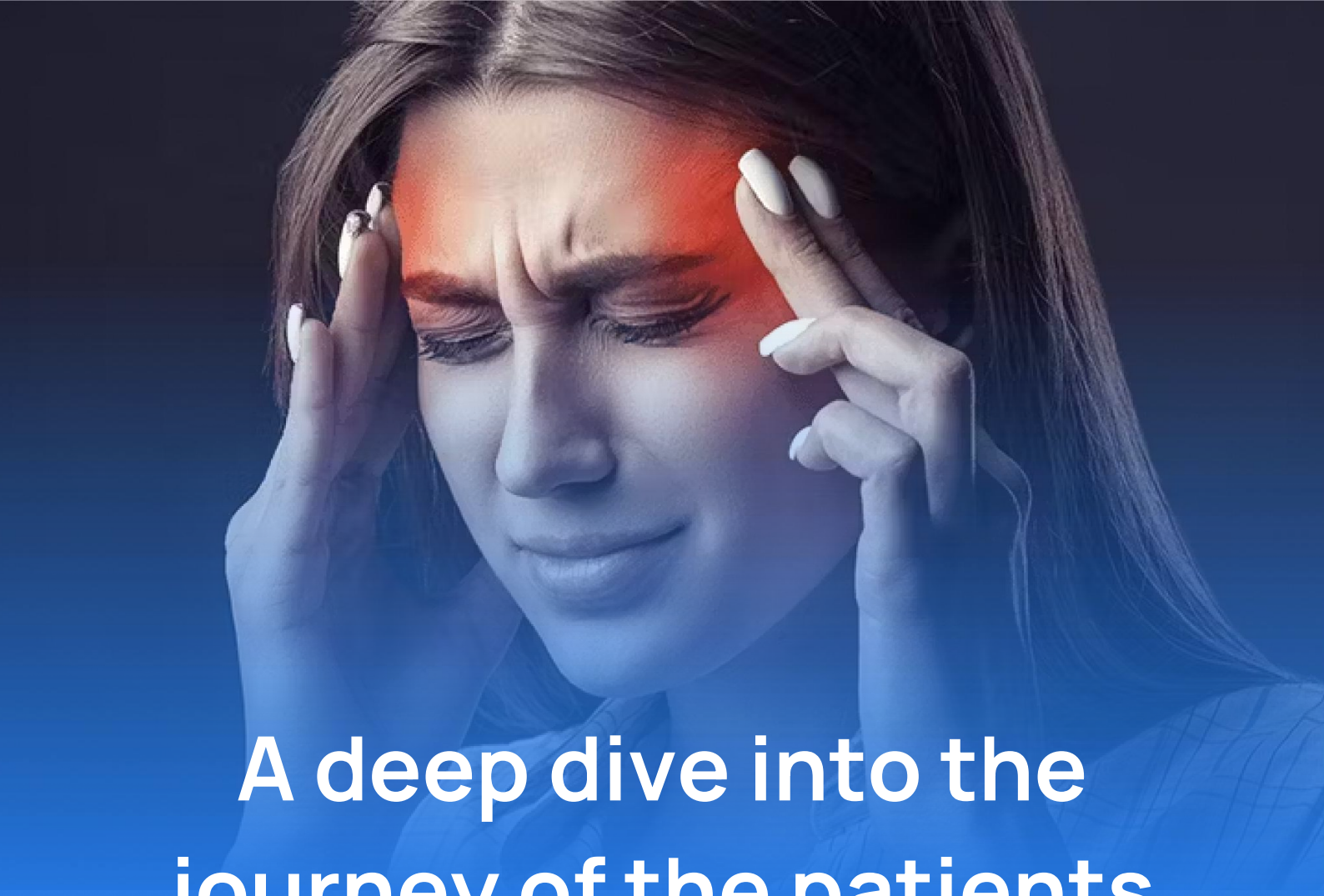

A deep dive into the journey of the patients living with migraine

A multicountry survey on the quality of life, diagnostic odyssey, and treatment journey of patients in Latin America

AHF
Americas Health Foundation

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This report was developed by Marcela Santos and Dr. Mariana Rico-Restrepo.

Introduction

Migraine is a chronic, disabling neurological disorder that affects over 1 billion people globally and ranks among the leading causes of years lived with disability[1]. Despite this, it remains underrecognized and undertreated in many health systems. In Latin America, the burden of migraine is especially prominent. People living with the disease report frequent diagnostic delays, stigma, inadequate treatment, and major barriers to specialist care.

To document these realities, Americas Health Foundation (AHF) designed a comprehensive, cross-country survey of people with moderate to severe migraine in seven Latin American countries: Argentina, Brazil, Chile, Colombia, Costa Rica, Mexico, and Peru. The survey was conducted online between February and August 2025. It ensured anonymity and voluntary participation and assessed eight key areas of the patient journey: sociodemographic and socioeconomic profile, diagnostic journey, symptoms and phases of migraine, psychological and emotional impact, impact in quality of life, work and productivity, financial implications, access to healthcare, and education and awareness. Participants included adults with either a formal diagnosis of migraine or self-reported symptoms consistent with internationally recognized diagnostic criteria.

This multi-country survey confirms that migraine disproportionately affects women, with a female-to-male ratio of 13:1, above the global 3:1 prevalence. Most participants were in their most productive years, juggling work and caregiving responsibilities, yet many endured prolonged diagnostic journeys. Nearly one in three waited more than five years for a diagnosis, and over half reported their symptoms were dismissed by healthcare providers. Even after receiving care, only one in three participants were satisfied with their treatment, and almost half (47%) reported frequently adjusting their medication on their own, raising risks of medication overuse.

The impact extended well beyond physical pain. Migraine disrupted quality of life, work, and emotional well-being. More than 73% reported that attacks interfered with daily or leisure activities, 62% reported frequent sleep disruption, and nearly half had difficulty eating during episodes. Psychological impact was also evident: seven in ten felt persistent frustration or anger, more than half experienced sadness or depression, and 69% reported others minimized their condition. Financial stability was further threatened, with half of participants interrupting treatment due to cost and four in ten reporting moderate to severe financial instability due to migraine.

The findings provide a regional snapshot of the lived experience of migraine in seven countries of Latin America. They reveal a paradox: patients are highly engaged with healthcare and invest heavily in treatment, yet remain underdiagnosed, underserved, dissatisfied, and profoundly

[1] *GBD 2019 Diseases and Injuries Collaborators. Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet. 2020;396(10258):1204–22.*

burdened. These results highlight the need for coordinated action to expand specialist availability, update clinical guidelines, improve treatment affordability, and strengthen education and support networks to address the true burden of migraine in the region.

Recruitment was made possible thanks to the support of patient advocacy organizations, healthcare professionals, and social media outreach. We are especially grateful to *Fundación para la Lucha contra las Enfermedades Neurológicas de la* Infancia (FLENI) and the *Asociación de Pacientes con Cefaleas de Argentina*, the *Associação Brasileira de Cefaleia e Enxaqueca* Solidária *(ABRACES),* Fiorella Martin Bertuzzi (Headache and Migraine Association of Argentina), Dr. Maritere Reyes (ASOLAC Perú), and Dr. Carlos Alva (HNDAC, UNMSM, Peru), whose collaboration was essential to achieving high participation in the survey.

Key Findings

The results of this survey highlight critical gaps in diagnosis, treatment, access, and quality of life for people living with migraine in Latin America. These are the most significant findings:

- **Migraine overwhelmingly affects women:** 93% of participants were female, a ratio of 13 to 1 compared with the global 3 to 1 prevalence.
- **Brazil reported the highest proportion of women with migraine,** with 97% of participants identifying as female. However, all countries showed similarly high female representation, with even the lowest, Peru, reporting 82%.
- **Participants were in their prime working years,** with 77% aged between 25 and 54.
- **Timely diagnosis remains a major challenge:** 30% of participants waited over 5 years, 56% had their symptoms dismissed, and 25% were misdiagnosed.
- **Symptoms are severe and long-lasting**: 70% reported light and sound sensitivity, throbbing pain, and prolonged attacks. Almost half (49%) had episodes lasting more than 24 hours, and 28% lived with chronic migraine.
- **Migraine attacks were reported the longest in Brazil and Chile**, where more than half of participants (55% and 51% respectively) reported episodes lasting longer than 48 hours.
- **Daily life is disrupted:** 73% reported migraine interfered with leisure activities, 67% with everyday tasks, 62% with sleep, and 44% with eating.
- **The emotional toll is staggering:** 70% felt persistent frustration or anger, more than half (57%) reported sadness or depression, and 69% indicated others minimized their condition.
- **Migraine impacts work and finances:** nearly half (45%) missed work in the past month, 41% reported reduced performance, 50% interrupted treatment due to cost, and 42% faced financial instability.
- **Migraine treatments often fail to meet patient needs:** despite heavy reliance on medication, only 34% were satisfied with current treatments. Nearly half (47%) reported adjusting their medication on their own, and 64% visited the emergency room at least once in the past year.
- **Access to care is a major barrier:** 58% reported seeing a specialist was difficult, 58% reported their healthcare system lacked resources, and 61% considered treatments costly or very costly.
- **Peru stood out for access:** 100% of participants had health insurance and 68% secured an appointment with a specialist within two weeks, while Brazil had the highest uninsured rate at 18% and the longest wait times.
- **Disease awareness and support are almost absent:** 1 in 3 (34%) felt poorly informed about treatment options, and only 7% had ever participated in a support group.

Methodology

Design and Study Instrument

This study used a cross-sectional design using a structured, anonymous, multiple-choice survey developed by Americas Health Foundation (AHF) to document the lived experiences of people with moderate to severe migraine in Latin America. The survey consisted of 62 multiple-choice questions and was tailored to assess eight key aspects of the patient journey: sociodemographic and socioeconomic profile, diagnostic journey, symptoms and phases of migraine, psychological and emotional impact, impact in quality of life, work and productivity, financial implications, access to healthcare, education and awareness.

Following a literature review that identified these eight categories, AHF designed the survey, which was subsequently refined in collaboration with healthcare professionals to ensure clarity and relevance. The questions were structured to collect standardized, comparable data across countries while remaining accessible and easy to understand for participants.

Participants

The survey was conducted online using Crowdsignal between February and August 2025 in seven countries: Argentina, Brazil, Chile, Colombia, Costa Rica, Mexico, and Peru. Dissemination occurred through patient advocacy organizations, healthcare professionals, and targeted social media outreach. Participation was anonymous and voluntary.

A total of 2,027 participants responded to the survey. To ensure the inclusion of people living with migraine, participants were screened using self-reported diagnostic criteria aligned with the International Classification of Headache Disorders[2]:

Self-reported diagnostic criteria:

- At least 5 or more attacks over their lifetime
- Headache lasting between 4 and 72 hours
- At least 2 of these 4 characteristics:
    - Unilateral location (one side of the head)
    - Pulsating quality (throbbing sensation)
    - Moderate or severe intensity
    - Worsened by or causes avoidance of routine physical activity
- At least 1 of the following symptoms:
    - Nausea and/or vomiting
    - Photophobia (extreme sensitivity to light)
    - Phonophobia (extreme sensitivity to sound)

[2] Headache Classification Committee of the International Headache Society (IHS). The International Classification of Headache Disorders, 3rd edition. Cephalalgia. 2018;38(1):1–211. https://doi.org/10.1177/0333102417738202

On average, 79% of participants met these criteria, resulting in a final analytical sample of 1,716 participants. National datasets were generated for each country; the present report analyzes the regional dataset, created by aggregating all country responses. The following graph shows the number of participants and those who met the diagnostic criteria in each country:

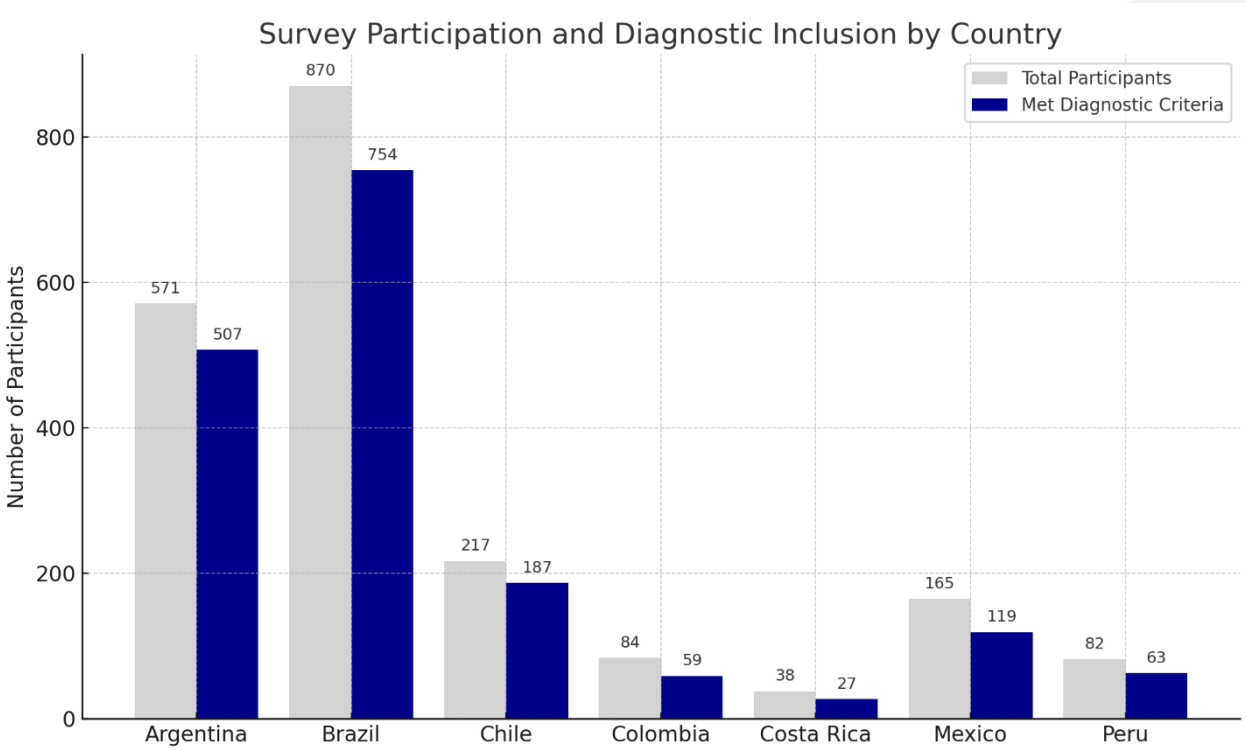

Figure 1. Survey Participation per Country

Data Analysis

Survey responses were collected and recorded anonymously. After data collection, responses from each country were exported and analyzed individually. A regional dataset was then created by aggregating all eligible responses, which serves as the basis for the present report. This approach allows for both national insights, available in separate country reports, and comparative findings at the regional level.

For each question, absolute frequencies and percentages were calculated. Regional tables were generated by summing responses across countries. Due to rounding, percentage totals may not always correspond exactly to the sum of individual figures.

Results:

Participants' Sociodemographic Characteristics

Key takeaways:

- Women made up 93% of participants with a 13:1 female-to-male ratio, far above the global 3:1 prevalence.
- Most participants were in their most productive years, with 77% aged 25–54.
- Almost half (46%) reported having children under 18, adding to caregiving responsibilities.

In line with global evidence showing that migraine predominantly affects women, the regional sample reflected the same pattern: 93% of participants were women, resulting in a female-to-male ratio of approximately 13:1, far exceeding the global 3:1 prevalence[3] and consistent with the gender distribution observed in national reports. Brazil reported the highest proportion of female participants (97%).

Figure 2. Biological Sex of Participants

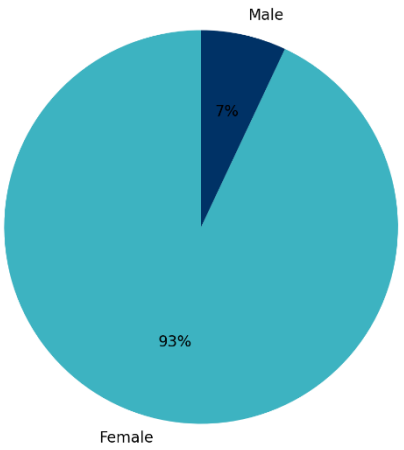

Figure 2. Biological Sex of Participants

Participants were overwhelmingly in their prime working years, with 77% aged between 25 and 54 (Table 2). The largest age group regionally was 35–44 (32%), followed by 25–34 (22%) and 45–54 (23%). This strongly supports global evidence that migraine predominantly affects adults during their most productive years[2,4].

Chile had the youngest sample, with 51% of participants aged 18–24 and 83% under 35. In contrast, Costa Rica had the oldest age distribution, with more than 68% of participants aged 45 or older, followed by Peru (57%). Argentina and Brazil most closely mirrored the regional pattern, with the majority concentrated in the 35–54 age range. Very few participants were younger than 18 (1% regionally), and only 3% were aged over 65.

Educational levels were generally high across the sample: 77% of participants reported having completed university or postgraduate studies, with particularly elevated levels in Costa Rica, Colombia, and Chile. Costa Rica had the highest proportion, with 95% of participants having completed university or postgraduate education (Table 8), followed closely by Colombia (94%) and

[3] Vetvik KG, MacGregor EA. Sex differences in the epidemiology, clinical features, and pathophysiology of migraine. Lancet Neurol. 2017;16(1):76–87. https://doi.org/10.1016/S1474-4422(16)30293-9
[4] Tonini MC. Gender differences in migraine. Neurol Sci. 2018;39:77–8. https://doi.org/10.1007/s10072-018-3378-2

Chile (93%). In contrast, the Brazilian sample had the lowest levels of educational attainment, with 32% of participants having completed only primary or secondary school.

In terms of employment, 54% of participants were employed by a company, 23% were self-employed, and 23% were not working at the time of the survey (Table 9). This reflects a predominantly active working population, despite the impact of migraine. Costa Rica reported the highest employment levels, with 92% of participants either employed by a company or self-employed, while the Peruvian sample had the highest unemployment rate (24%).

Almost half of participants (46%) reported having children under 18, adding layers of emotional and financial burden of living with migraine (Tables 7–9). Marital status varied across countries, but regionally, the largest group of participants were married (47%), followed by single (37%).

Although Latin America is a racially diverse region, the majority of participants identified as White or Caucasian (60%) or Morena-mestiza (26%), reflecting the most commonly reported categories across countries (Table 3). Representation of other racial or ethnic groups was minimal in the survey results.

Diagnostic Journey

Key takeaways:

- Most participants had a formal headache diagnosis (83%), but 3 in 10 had to wait over five years to receive it.
- Only 18% were diagnosed within six months, and 38% saw three or more doctors before diagnosis.
- Over half (56%) reported that their symptoms were dismissed, and 1 in 4 were misdiagnosed, most often with stress, anxiety, or sinusitis.

Most participants in the region (83%) had received a formal headache diagnosis from a physician (Table 11). However, national disparities were notable: Peru (94%), Argentina (90%), and Chile (89%) reported the highest diagnosis rates, while fewer participants in Mexico (61%), Costa Rica (63%), and Colombia (67%) had received a physician-confirmed diagnosis, suggesting gaps in access or healthcare-seeking behavior.

Among those diagnosed, migraine was by far the most common condition (87%), followed by tension-type headache (7%) and cluster headache (4%) (Table 12), consistent with global prevalence patterns [2].

Of participants without a formal diagnosis who completed the self-assessment (17%), 68% met diagnostic criteria for migraine (Table 13), highlighting underdiagnosis not necessarily due to atypical symptoms, but rather limited recognition or access to care. Delays in diagnosis were widespread: 30% waited over five years, 19% waited one to three years, and only 18% were

diagnosed within six months (Table 14). Chile reported the longest delays, with 42% waiting over five years, followed by Argentina (31%) and Brazil (30%).

Multiple consultations were often required before achieving a diagnosis. Only 17% of participants were diagnosed at their first visit, while 38% saw three or more physicians before receiving a diagnosis (Table 15).

Dismissal of symptoms by healthcare professionals emerged as a common experience among participants, with 56% reporting that their migraine symptoms had been minimized or not taken seriously (Table 16). Such findings underscore persistent gaps in clinical recognition and validation of migraine symptoms, aligning with global evidence that migraine is frequently underestimated in healthcare settings[5].

Additionally, a quarter of participants reported being misdiagnosed before receiving a migraine diagnosis (Table 17). Common misdiagnoses included stress (23%), anxiety (18%), sinusitis (17%), and tension-type headache (17%) (Table 17.1), underscoring the overlap in symptoms and the diagnostic challenges migraine presents.

These findings reveal that migraine diagnosis in the region is often delayed and complicated by identification, repeated consultations, and symptom dismissal. In line with global evidence, this underscores the need for earlier identification, improved physician training, and greater awareness of migraine's diagnostic criteria[2].

Symptoms and Phases of Migraine

Key takeaways:

- Hypersensitivity to light and sound, unilateral throbbing pain, and prolonged headache attacks were the most frequent and severe symptoms, reported by 7 in 10 participants.
- Nearly half of participants (49%) experienced migraine attacks lasting more than 24 hours.
- Postdrome symptoms, such as fatigue, brain fog, and mood changes, were reported often or always by 78% of participants.

Migraine in the region was characterized by frequent, prolonged, and multi-phase attacks. The most common pattern was 4–14 migraine days per month (40%), followed by 1–3 days (23%) (Table 18). Chronic migraine, defined by the International Headache Society (2018) as having 15 or more headache days per month, affected 28% of participants, 10% experienced daily attacks and 19% reported headaches on more than 14 days per month, underscoring the high disease burden across the region.

[5] Buse DC, Reed ML, Fanning KM, Bostic R, Dodick DW, Schwedt TJ, et al. Healthcare utilization and migraine diagnosis: Results from the American Migraine Prevalence and Prevention Study. *Headache*. 2019;59(1):36–50. https://doi.org/10.1111/head.13462

These frequent episodes were often long-lasting. Nearly half of participants (49%) reported migraine attacks extending beyond 24 hours, including 17% whose episodes lasted more than 72 hours (Table 21). Brazil and Chile stood out, with 55% and 51% of participants respectively reporting migraine attacks lasting more than 48 hours, among the highest rates in the region.

Beyond frequency and duration, migraine presented with a wide range of symptoms. The most common were hypersensitivity to light and sound (79% experienced it frequently or always), unilateral throbbing pain (73%), and prolonged headache attacks (71%) (Table 19). Nausea was also prominent (42%). Additionally, neurological and sensory symptoms, such as decreased level of consciousness (28%), tinnitus (22%), and motor weakness (21%), were reported frequently or always by at least 2 out of 10 participants. The following Heatmap showcases the percentage of Frequency of Migraine Symptoms in All Countries:

Heatmap of Frequency of Migraine Symptoms in All Countries

SYMPTOM	Never	Rarely	Sometin	Frequen	Always
Prolonged headache attack (4–72 hours)	1,34%	5,36%	22,84%	41,78%	28,67%
Unilateral throbbing pain	2,56%	3,61%	20,80%	36,25%	36,77%
Nausea	4,95%	15,38%	38,05%	24,88%	16,72%
Vomiting	25,52%	31,76%	27,91%	10,20%	4,60%
Hypersensitivity to light and sound	1,81%	4,20%	14,63%	27,27%	52,10%
Scotoma (partial loss of vision)	44,23%	20,05%	19,64%	9,79%	6,29%
Blindness	87,18%	7,11%	3,61%	1,40%	0,70%
Numbness	41,14%	22,90%	23,43%	8,68%	3,85%
Tingling sensation	30,83%	24,77%	29,60%	10,37%	4,43%
Dysarthria (difficulty speaking)	51,11%	18,36%	19,23%	7,46%	3,85%
Vertigo	31,06%	22,09%	28,32%	11,54%	6,99%
Tinnitus (ringing in the ears)	31,47%	20,80%	25,29%	13,58%	8,86%
Hearing loss	61,25%	15,56%	15,97%	5,19%	2,04%
Diplopia (double vision)	55,42%	18,94%	16,78%	6,93%	1,92%
Ataxia (lack of coordination)	46,15%	19,93%	22,03%	8,62%	3,26%
Decreased level of consciousness	36,13%	15,03%	21,15%	15,68%	12,00%
Motor weakness	33,45%	21,21%	24,07%	12,12%	9,15%

Figure 3. Heatmap of Frequency of Migraine Symptoms in All Countries

Symptom severity followed similar patterns. Prolonged attacks and throbbing pain were most often rated as severe or very severe (66% and 60%, respectively), followed by hypersensitivity to light and sound (51%) (Table 20). On the other hand, symptoms like tingling sensations, vomiting, and blindness were generally considered less severe or not applicable, suggesting they are less disabling for many.

Migraine symptoms were frequent and varied, often occurring on multiple days per month. Over half of participants experienced symptoms on at least eight days each month (Table 22), and 28% met criteria for chronic migraine. Additionally, many struggled to understand or manage their

disease: 37% found it easy or very easy to identify their triggers, while nearly 30% found it difficult (Table 23). These findings underscore the complexity of understanding migraine patterns, which can hinder timely management and preventive strategies.

Prodrome symptoms, early warning signs, were reported often or always by 75% of participants (Table 24), while aura symptoms, neurological disturbances like visual changes, sensory alterations, or speech difficulties, were more variable: 36% experienced them frequently, but 38% rarely or never (Table 25). The headache phase itself lasted more than 24 hours for 40% of participants (Table 26), reinforcing the extended nature of many attacks. Importantly, migraine symptoms didn't end when the headache subsided. Postdrome symptoms, such as fatigue, brain fog, or mood changes, were reported often or always by 78% of participants (Table 27), confirming that recovery from a migraine episode can be prolonged and debilitating.

Collectively, these findings reflect migraine as a complex neurological disorder with distinct but overlapping phases, prodrome, aura, headache, and postdrome, each contributing to the overall disease burden [1, 2]. These findings reinforce the need for treatment approaches that address the full spectrum of migraine phases, not just the headache itself, and that prioritize early intervention, symptom management, and patient education.

Impact on Quality of Life

Key takeaways:

- Migraine often disrupted daily life: 73% reported it frequently or always interfered with leisure activities, and 67% reported the same for everyday tasks.
- Basic functions were also affected: 62% had frequent or constant difficulty sleeping, and 44% struggled to eat during attacks due to nausea.

Migraine severely disrupts daily life across participants. Leisure activities such as reading, exercising, or socializing were the most affected: 73% of participants indicated migraine often or always interfered with these activities, and over one-third (34%) reported constant disruption (Table 29). Everyday responsibilities, including housework, shopping, and caregiving, were similarly compromised, with 67% reporting frequent or constant interference (Table 30). As previously stated, almost half of participants (46%) also reported having children under 18 (Tables 7–9), intensifying the emotional and logistical burden of managing migraine alongside caregiving duties. These findings highlight how migraine extends beyond physical pain to significantly affect functional capacity, daily tasks, and family life.

Migraine also interfered with essential biological functions. Two-thirds of participants (62%) reported difficulty sleeping often or always during attacks, and nearly 3 in 10 (28%) reported this happened every time (Table 31). Nausea-related loss of appetite was similarly disruptive: 44% experienced difficulty eating frequently or always, and 21% reported it occurred during every

migraine episode (Table 32). These data point to the far-reaching impact of migraine on self-care and physical well-being.

These findings reflect the pervasive and multi-layered nature of migraine's toll on quality of life. The high proportion of participants reporting symptoms "always" interfering with sleep, leisure, or eating underscores that for many, migraine is not an occasional disruption but a persistent condition affecting daily functioning, relationships, and autonomy. Addressing these limitations, beyond pain control, is essential to improving overall well-being for people living with migraine[2].

Psychological and Emotional Impact

Key takeaways:

- Migraine triggered intense emotions: 7 in 10 felt frequent frustration or anger; over half reported sadness or depression.
- Stigma and anxiety were widespread: 69% felt others minimized their condition, and 61% feared the next attack.
- Support came with guilt: 43% felt well supported, but just as many often felt like a burden.

Migraine took a significant emotional toll on participants across the region. 70% reported feeling frustrated or angry often or always during migraine episodes, with 45% indicating they always experienced these emotions (Table 33). Feelings of sadness or depression were also common: 57% indicated they felt this way frequently, and one in three (33%) reported these emotions every time they had an attack (Table 34). These findings are consistent with literature linking migraine to mood disorders and chronic emotional distress [4, 6].

Perceived stigma and anticipatory anxiety were both widespread among participants. Over two-thirds (69%) reported that others often or always minimized or dismissed their migraine, with 35% reporting it happened every time (Table 35). This perceived invalidation contributes to emotional distress and social isolation. In addition, 61% of participants experienced frequent anticipatory anxiety or stress about their next migraine attack, including one-third (33%) who always felt this way (Table 36). These findings reveal that the psychological burden of migraine often extends beyond the attacks themselves.

Support networks were mixed. While 43% of participants reported receiving quite a lot or very much support from family or friends, the most common response was "moderate" support (30%), and just over 20% reported they received little or no support (Table 37). At the same time, 43% reported often or always feeling like a burden to others, and another 23% experienced this feeling sometimes (Table 38). These findings point to a dual emotional strain: participants depended on

[6] Minen MT, Begasse De Dhaem O, Kroon Van Diest A, Powers S, Schwedt TJ, Lipton R, et al. Migraine and its psychiatric comorbidities. J Neurol Neurosurg Psychiatry. 2016;87(7):741–9. https://doi.org/10.1136/jnnp-2015-312233

their support systems, yet many felt guilt or pressure about the toll their condition might take on those around them.

These results collectively highlight that people living with migraine in the surveyed Latin American countries face not only a physically disabling condition but also one that is emotionally and socially complex. The combination of high levels of frustration, persistent sadness, stigma, and anticipatory anxiety underscores the need to integrate mental health support into migraine care. Addressing these emotional and relational dimensions is essential for providing comprehensive, patient-centered treatment [5, 4].

Impact on Work, Productivity, and Financial Implications

Key takeaways:

- Migraine disrupted work for nearly half of participants, with 45% reporting absences and 41% reporting it reduced their performance.
- 1 in 2 participants interrupted or delayed treatment due to cost, despite 73% regularly paying out-of-pocket.
- Financial stability was affected for 4 in 10, with many spending over 10% of their income on migraine care.

Migraine significantly disrupted work life across the region. 45% of participants reported being absent from work due to migraine in the past month, including 12% who missed 3–5 days and 6% who missed 6 or more. This translates to 12–24 missed workdays per year for those absent 1–2 days monthly, and 36–120 days for those missing 3 or more, amounting to months of lost productivity (Table 39).

Presenteeism added another layer of burden. 41% reported migraine reduced their work performance, and 19% reported missing work frequently. A smaller but notable share (8%) had to change jobs or professions entirely due to migraine, while others reported missed promotions or being excluded from key projects (Table 40). This reduced performance, or presenteeism, represents a substantial hidden productivity loss that adds to absenteeism-related costs, consistent with evidence showing that migraine significantly impairs work capacity even when individuals remain on the job [4].

Migraine imposed a considerable financial strain on participants across the region. Out-of-pocket expenses were routine: nearly half (48%) reported always paying for migraine-related treatment themselves, and another 25% reported they did so often (Table 43). As illustrated in Figure 4, a stacked bar chart comparing all countries, Brazil, Chile, and Argentina had the highest proportions of participants who “always” paid out-of-pocket, underscoring how routine these costs are across the region. These ongoing costs translated into a notable share of monthly income: 22% of participants spent 5–10% of their income on medical care, and 15% spent over 30% (Table 41).

Despite these investments, half of participants (50%) reported interrupting or delaying treatment due to cost (Table 58).

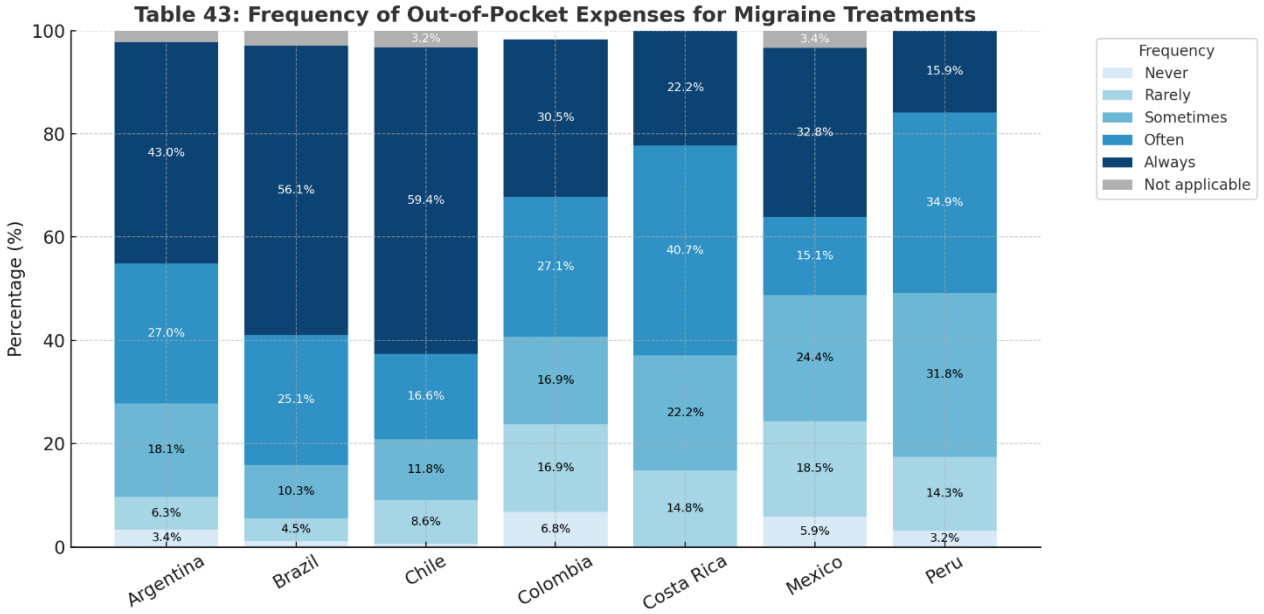

Figure 4. Frequency of Out-of-Pocket Expenses for Migraine Treatments

This financial pressure was reflected in how participants rated the impact on their overall financial stability. 42% of participants reported moderate to extreme financial disruption, while 30% reported migraines did not affect their finances (Table 42). The most frequently cited burdens included increased healthcare costs (35%) and the need to hire additional household help (23%) (Table 44). These findings confirm that the cost of managing migraine goes beyond medications or consultations, affecting long-term financial security, treatment continuity, and household dynamics.

Treatment

Key takeaways:

- Most participants relied on pharmacological treatment, but satisfaction remained low. Only 34% felt their current treatment was effective.
- Daily or near-daily medication use was common (29%), and nearly half adjusted their treatment on their own, raising concerns about medication overuse.
- Emergency care was often required: 47% visited the ER at least once in the past year, and 17% went more than five times.

Access to healthcare strongly influenced participants' treatment experiences. Nearly half of participants (49%) reported having private insurance, 20% were covered by public systems, and 18% had a combination of both. However, 12% lacked insurance altogether, highlighting a major barrier to consistent care (Table 51). Brazil's sample had the highest rate of uninsured participants (18%), while Peru's participants reported full coverage (0% uninsured).

Pharmacological approaches dominated migraine management. Prescription medications were the most commonly used treatment (39%), followed by over-the-counter options (24%) and lifestyle changes like diet or exercise (24%) (Table 46). Participants clearly prioritized medications as the most important factor for controlling migraine: 60% ranked them as most effective, ahead of adequate sleep (18%) or stress management strategies (10%) (Table 49).

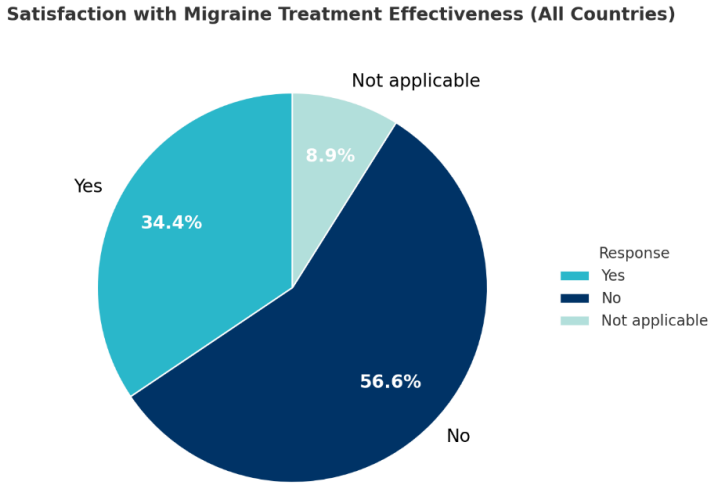

Figure 5. Satisfaction with Migraine Treatment Effectiveness

Despite widespread treatment use, satisfaction with effectiveness remained low (Figure 5). Only 34% of participants reported being satisfied with how well their treatment worked, while more than half (57%) were not (Table 45). These low satisfaction levels may relate to irregular use or challenges with adherence: 27% of participants reported they frequently adjusted their medication on their own, and 20% did so occasionally (Table 47). Such self-modification practices increase the risk of medication overuse headache[7].

Patterns of medication use further underscored the high burden of disease. Over one-quarter (29%) reported taking migraine medication every day, and another 31% took it on 8 to 15 days per month or more, suggesting chronic or poorly controlled symptoms (Table 48).

Gaps in outpatient care were also evident. While 35% of participants had not visited the emergency room for migraine in the past year, 47% reported between one and five visits, and 17% reported they had required emergency care more than five times (Table 50). These high numbers indicate that a substantial proportion of patients still rely on emergency services to manage acute migraine attacks, often a sign of inadequate preventive or routine care. This pattern may also reflect limited access to timely outpatient consultations, insufficient patient education on self-management strategies, or a lack of effective long-term treatment plans, factors that can drive patients to seek urgent care rather than manage symptoms earlier and more effectively in less acute settings. Beyond its implications for individual well-being, this overreliance on emergency care represents a significant financial burden on the healthcare system, diverting resources from more efficient and sustainable forms of migraine management.

The evidence shows that despite actively seeking treatment, a substantial number of participants remained dissatisfied with their care. Many adjusted their medications without clinical guidance

[7] Sarchielli P, et al. Medication-overuse headache: Pathophysiological insights and clinical management. *Front Pain Res*. 2023;4:1194134. https://doi.org/10.3389/fpain.2023.1194134

and continued to rely on emergency services for acute episodes. These patterns reveal significant discontinuities in care and point to deeper systemic issues in treatment accessibility, adequacy, and follow-up.

Rather than benefiting from structured, preventive management, many individuals appear to navigate their condition through trial and error, often without sufficient support or information. This fragmented care not only undermines patient well-being but also places avoidable strain on emergency services and healthcare budgets. Closing these gaps will require coordinated efforts to improve continuity of care, ensure equitable access to effective treatments, and promote proactive management strategies.

Access to Healthcare

Key takeaways:

- Nearly 6 in 10 participants (58%) indicated access to a migraine specialist was difficult or very difficult, while few (18%) found it easy.
- Over half (58%) believed their healthcare system lacks adequate resources or guidelines for migraine care, and only 3% reported complete adequacy.
- 61% of participants reported treatments are costly or very costly, compared with just 16% who found them affordable.

Access to migraine care across Latin America revealed significant barriers throughout the healthcare system. Specialist access was particularly restricted: 29% of participants indicated it was very difficult and 28% indicated it was difficult, totaling 58%, while only 13% found it easy and just 5% very easy (Table 52). Confidence in physician preparedness was also low. The largest group (43%) believed some physicians are prepared but not all, while 32% believed they are not well prepared or updated, and only 6% believe most physicians are well prepared and updated (Table 53). These perceptions were consistent with broader system-level concerns, as more than half of participants (58%) reported that healthcare systems lack adequate resources or clinical guidelines for migraine care, and only 3% indicated resources were fully sufficient (Table 54).

Insurance coverage for migraine treatments was often insufficient. Over a third of participants (37%) indicated their treatments were only partially covered, 34% reported no coverage at all, and just 9% had full coverage (Table 55). Costs were another major obstacle: 31% described treatments as costly and 30% as very costly, while only 14% considered them affordable and 2% very affordable (Table 56).

Appointment wait times added another layer of difficulty. Nearly a quarter of participants (24%) waited more than six weeks to see a physician, 19% waited four to six weeks, and 18% waited two to four weeks. Only 23% were seen within two weeks (Table 57). Peru stood out as the country with the quickest specialist access, where 68% of participants secured an appointment in less than two weeks (43% within one week and 25% within one to two weeks). This finding is consistent with the

fact that 100% of participants in Peru reported having health insurance, reflecting stronger system capacity for timely access compared with the rest of the region. In contrast, Brazil (32%) and Chile (24%) reported the longest waiting times, with more than six weeks to secure an appointment, higher than the rest of the countries surveyed.

These findings reveal a regional care landscape marked by poor specialist access, low confidence in provider preparedness, inadequate insurance coverage, high costs, and long wait times. These barriers not only delay care but also lead to avoidable suffering and greater strain on emergency services. Addressing them will require coordinated efforts to expand coverage, train providers, reduce financial burdens, and ensure timely, equitable access to quality migraine care.

Education and Awareness

Key takeaways:

- Participants requested more information on treatment options (19%), followed by general education (15%) and lifestyle changes (13%).
- Only 7% participated in a support group, while 74% did not know such groups existed.

The survey revealed uneven levels of migraine-related knowledge among participants across Latin America. The largest group felt somewhat informed (29%), followed by very well informed (12%). In contrast, 22% reported they were poorly informed and 12% not at all informed, while nearly a quarter (23%) remained neutral (Table 59). These results suggest that although a segment of participants feel they have access to adequate information, a substantial proportion continue to lack the knowledge needed to manage their condition effectively.

When asked about priority areas for more education, participants showed strong interest across multiple domains. Because they could select more than one option, the 1,716 respondents generated a total of 7,043 responses, highlighting the extent of unmet educational needs. Treatment options emerged as the most frequent area (19%), followed by information and education about migraine (15%) and lifestyle changes (13%). Other important areas included public awareness (12%), pain management (11%), psychological support (10%), information for family members (10%), and support groups (10%) (Table 60). This pattern reflects a clear demand for both clinical guidance and self-management strategies.

Support resources were limited. A large majority of participants (85%) reported receiving no financial assistance for prescribed treatments, while fewer than 8% had access to some type of support (Table 61). Engagement with patient organizations or support groups was also minimal: nearly three in four respondents (74%) did not know such groups existed, 19% were aware but not involved, and only 7% had ever participated (Table 62).

These findings highlight the urgent need to strengthen patient education initiatives, expand public awareness, and increase access to support resources. Improving knowledge of treatment options

and self-management strategies, while promoting the visibility of patient networks, could help empower people living with migraine and improve treatment adherence and outcomes across the region.

Conclusion

This regional survey across seven Latin American countries reveals migraine as a widespread yet underrecognized public health problem with profound personal, social, and economic consequences. Despite high engagement with healthcare systems, people with migraine continue to face long diagnostic delays, inadequate treatment, limited access to specialists, financial strain, and stigma. These findings call for urgent multisectoral action to improve recognition, affordability, and continuity of care.

Disproportionate Impact on Women

Migraine in Latin America is overwhelmingly a women's health issue. Women represented 93% of participants, a ratio of 13 to 1 compared with the global 3 to 1 prevalence. Most were in their most productive years, and over half had children under 18, adding caregiving duties to their disease burden. Gender bias persists: more than half reported that their symptoms were dismissed before diagnosis. Addressing these biases is essential to improving the quality and timeliness of care for women with migraine.

Delays and Gaps in Diagnosis

Although 83% had a physician diagnosis, nearly a third waited more than five years, and only 18% were diagnosed within six months. More than a third consulted three or more doctors before receiving a diagnosis, showing gaps in physician training and referral systems. High rates of misdiagnosis with stress, anxiety, or sinusitis further complicate the patient journey.

Severe Multi-phase Disease Burden

Migraine in the region is characterized by frequent, long, and disabling attacks. Almost half of participants reported episodes lasting more than 24 hours, and 28% lived with chronic migraine (≥15 headache days per month). Beyond headache, most experienced prodrome and postdrome symptoms, with fatigue, brain fog, and mood changes prolonging recovery. These findings underscore that migraine is not an episodic headache but a complex, multi-phase neurological disorder that demands comprehensive management.

Insurance and Access to Treatment

Most participants had some form of health insurance (49% private, 20% public, 18% mixed; 12% uninsured), yet this did not translate into adequate coverage for migraine care. Treatment coverage was frequently insufficient, with only 9% reporting full coverage and large shares reporting partial coverage or none at all. High out-of-pocket costs were common, most rated

treatments as costly or very costly, and half interrupted care due to cost. Combined with long waits and difficult access to specialists, these financial and structural barriers, not lack of patient engagement, are central drivers of unmet need across the region.

Treatment Gaps and Low Satisfaction

Despite heavy reliance on pharmacological treatment, only one in three participants were satisfied with its effectiveness. Nearly half adjusted their medication on their own, raising risks of medication overuse. Daily or near-daily medication use was common, yet 64% still visited the emergency room in the past year, showing that preventive and outpatient care remain insufficient.

Impact on Daily Life, Work, and Emotional Well-being

Migraine severely disrupted participants' quality of life: over 70% indicated it interfered with leisure activities, 67% with everyday tasks, 62% with sleep, and 44% with eating. The emotional toll was equally high, with 70% reporting persistent frustration or anger, 57% sadness or depression, and 69% feeling their condition was minimized by others. Nearly half missed work in the past month, and 41% indicated performance was reduced. These results highlight migraine as both a productivity crisis and a mental health issue.

Financial and Systemic Barriers

Financial burden was substantial. Half of participants (50%) interrupted treatment due to cost, and 42% reported moderate to severe financial instability linked to migraine. Out-of-pocket spending was routine, while insurance coverage was often partial or absent. At the system level, 58% reported specialist access was difficult, 58% felt healthcare systems lacked adequate resources, and 61% considered treatments costly or very costly. These gaps reflect insufficient system capacity, inadequate insurance coverage, and poor physician preparedness.

Unmet Needs in Disease Awareness and Support

Knowledge about migraine in Latin America is uneven. While some participants felt informed, a substantial proportion reported being poorly informed or neutral, and many expressed strong demand for more information on treatment options, lifestyle strategies, and general education. Support resources were even more limited: three in four participants were unaware of support groups, and only 7% had ever joined one. In addition, 85% reported receiving no financial assistance for prescribed treatments. These findings highlight the need to expand patient education, increase public awareness, and strengthen peer and financial support systems to empower people living with migraine.

Recommendations

The following recommendations highlight the urgent need for coordinated action to reduce the burden of migraine in Latin America. Effective solutions require collaboration among healthcare providers, policymakers, insurers, employers, patient organizations, and the pharmaceutical industry to improve diagnosis, treatment, education, and support for people living with migraine.

Increase migraine awareness among physicians, policymakers, and the public

- Launch public awareness campaigns to position migraine as a neurological disease that requires timely and consistent care.
- Educate policymakers on the public health and economic impact of migraine to encourage investment in comprehensive care pathways.
- Promote understanding of migraine among the general public to reduce stigma and improve symptom recognition, with particular focus on the high proportion of women and mothers affected.
- Strengthen collaboration with patient organizations to expand education, outreach, and advocacy at the regional and national levels.

Improve early detection and reduce diagnostic delays

- Train general practitioners and frontline providers to recognize migraine symptoms early and provide timely referrals to specialists.
- Incorporate migraine education into continuing medical education and national clinical guidelines.
- Address gender bias by training healthcare professionals to validate women's migraine symptoms and avoid dismissive or inaccurate diagnoses.
- Reduce wait times to see specialists by expanding the number of headache-trained professionals and optimizing referral systems.
- Improve access to diagnostic tools and standardized care pathways in both public and private health systems.

Expand access to effective, evidence-based treatments

- Broaden insurance coverage for pharmacological and non-pharmacological therapies, including newer, evidence-based options.
- Reduce out-of-pocket costs by expanding patient support programs and prioritizing access for uninsured or underinsured individuals.
- Ensure equitable access to affordable treatments across all levels of the healthcare system, particularly in underserved and rural areas.

Integrate mental health and patient-centered care

- Include mental health services as a routine component of migraine care to address anxiety, depression, and anticipatory stress.
- Promote non-pharmacological strategies such as stress management, sleep hygiene, and lifestyle adjustments as part of holistic care.

- Encourage multidisciplinary collaboration between neurology, mental health, and primary care services.

Address socioeconomic and caregiving challenges

- Recognize the added burden on women and mothers living with migraine by developing support strategies that address childcare needs during severe attacks.
- Integrate social services and community programs to assist families where migraine significantly impacts daily caregiving responsibilities.

Advance patient education and support

- Develop patient education tools on treatment options, safe medication use, lifestyle changes, and pain management, reflecting the top unmet educational needs identified in the survey.
- Expand general information about migraine and provide tailored resources for family members to improve understanding and reduce stigma.
- Increase awareness and visibility of support groups, given that three in four participants were unaware of their existence and only 7% had participated.
- Strengthen access to psychological support and empower individuals with migraine to take an active role in their care through targeted education and peer networks.
- Expand financial support resources for treatment, addressing the widespread lack of assistance for prescribed medications.

Promote workplace accommodations and protections

- Encourage employers to recognize migraine as a legitimate health condition and adopt accommodations to reduce productivity loss and absenteeism.
- Support flexible work arrangements, such as remote work options and access to quiet spaces, to help employees manage migraine attacks without jeopardizing employment.

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Regional Survey Tables

Table 1: Biological Sex (n=2027)

Biological Sex	#	%
Female	1879	92,70%
Male	148	7,30%

Table 2: Age range (n=2027)

Age Range	#	%
< 18 years	15	0,74%
18 - 24 years	186	9,18%
25 - 34 years	441	21,76%
35 - 44 years	641	31,62%
45 – 54 years	475	23,43%
55 – 64 years	201	9,92%
> 65 years	68	3,35%

Table 3: Racial or ethnic categories (n=2027)

(Participants could select multiple responses)

Racial/Ethnicity	#	% of total responses
Total responses: 2099		
Morena-mestiza (mixed race)	541	25,77%
White or Caucasian	1267	60,36%
Indigenous	18	0,86%
Afro-descendant / Afro-Mexican / Black	61	2,91%
Afro-Indigenous	9	0,43%
Asian descent	8	0,38%
Rom population	9	0,43%
None of the above	68	3,24%
Other	53	2,53%
Prefer not to answer	65	3,10%

Table 4: Sexual Orientation (n=2027)

(Participants could select multiple responses)

Sexual Orientation	#	%
Total responses: 2043		
Heterosexual	1827	89,43%
Bisexual	87	4,26%
Other	14	0,69%
Prefer not to answer	56	2,74%
Gay or lesbian	34	1,66%
Asexual	14	0,69%
Pansexual	8	0,39%
Queer	3	0,15%

Table 5: Disability (n=2027)

Disability	#	%
No	1919	94,67%
Yes	67	3,31%
Does not apply	41	2,02%

Table 6: Marital Status (n=2027)

Marital Status	#	%
Single	749	36,95%
Married	956	47,16%
Divorced	125	6,17%
Widowed	25	1,23%
Cohabiting	121	5,97%
Other	51	2,52%

Table 7: Children < 18 years (n=2027)

Children < 18 years	#	%
Yes	938	46,28%
No	1089	53,72%

Table 8: Education (n=2027)

Education	#	%
Primary	34	1,68%
Secondary	424	20,92%
University	914	45,09%
Postgraduate or Master's	655	32,31%

Table 9: Employment Status (n=2027)

Employed	#	%
Employed by a company	1098	54,17%
Self-employed	473	23,33%
No	456	22,50%

Table 10: Unpaid Work (n=2027)

Unpaid Work	#	%
Yes	880	43,41%
No	1147	56,59%

Table 11: Physician Headache Diagnosis (n=2027)

Response	#	%
Yes	1685	83,13%
No	342	16,87%

Table 12: Type of Headache Diagnosis (n=1685)

Response	#	%
Migraine	1468	87,07%
Cluster headache	71	4,21%
Tension-type headache	120	7,12%
Unknown	27	1,60%

Table 13: Self-Assessment of Migraine Diagnostic Criteria (n=369)

Meets diagnostic criteria	#	%
Yes	249	67,48%
No	120	32,52%

Table 14: Time to Migraine Diagnosis (n=1717)

Time	#	%
< 6 months	309	18,00%
6–11 months	173	10,08%
1–3 years	329	19,16%
4–5 years	140	8,15%
>5 years	520	30,29%
I don't have a diagnosis	194	11,30%
Not applicable	52	3,03%

Table 15: Number of Physicians Consulted Before Migraine Diagnosis (n=1717)

Number of Physicians	#	%
None, diagnosed at first visit	293	17,06%
1-2	500	29,12%
3-5	391	22,77%
>5	261	15,20%
I don't remember	146	8,50%
Not applicable	126	7,34%

Table 16: Perceived Dismissal of Symptoms by Healthcare Professionals (n=1717)

Dismissal of Symptoms	#	%
Yes	967	56,32%
No	497	28,95%
Not sure	253	14,74%

Table 17: Previous Misdiagnosis Before Migraine Diagnosis (n=1717)

Previous Misdiagnosis	#	%
Yes	425	24,75%
No	1171	68,20%
Not applicable	121	7,05%

Table 17.1: *Type of Previous Misdiagnosis Before Migraine Diagnosis* (n=425)
(Participants could select multiple responses)

Type of Previous Misdiagnosis	#	% of total responses
Total responses: 1110		
Stress	251	22,61%
Tension-type headache	189	17,03%
Anxiety	199	17,93%
Sinusitis	190	17,12%
Other	141	12,70%
Depression	107	9,64%
Epilepsy	17	1,53%
Meniere's disease	10	0,90%
Lyme disease	1	0,09%
Stroke	5	0,45%

Table 18: Frequency of Migraine Attacks (n=1716)

Frequency of Migraine Attacks	#	%
1 day per month	119	6,93%
1–3 days per month	401	23,37%
4–14 days per month	681	39,69%
More than 14 days per month, but not every day	321	18,71%
Every day	163	9,50%
Not applicable	31	1,81%

Table 19: Frequency of Migraine Symptoms

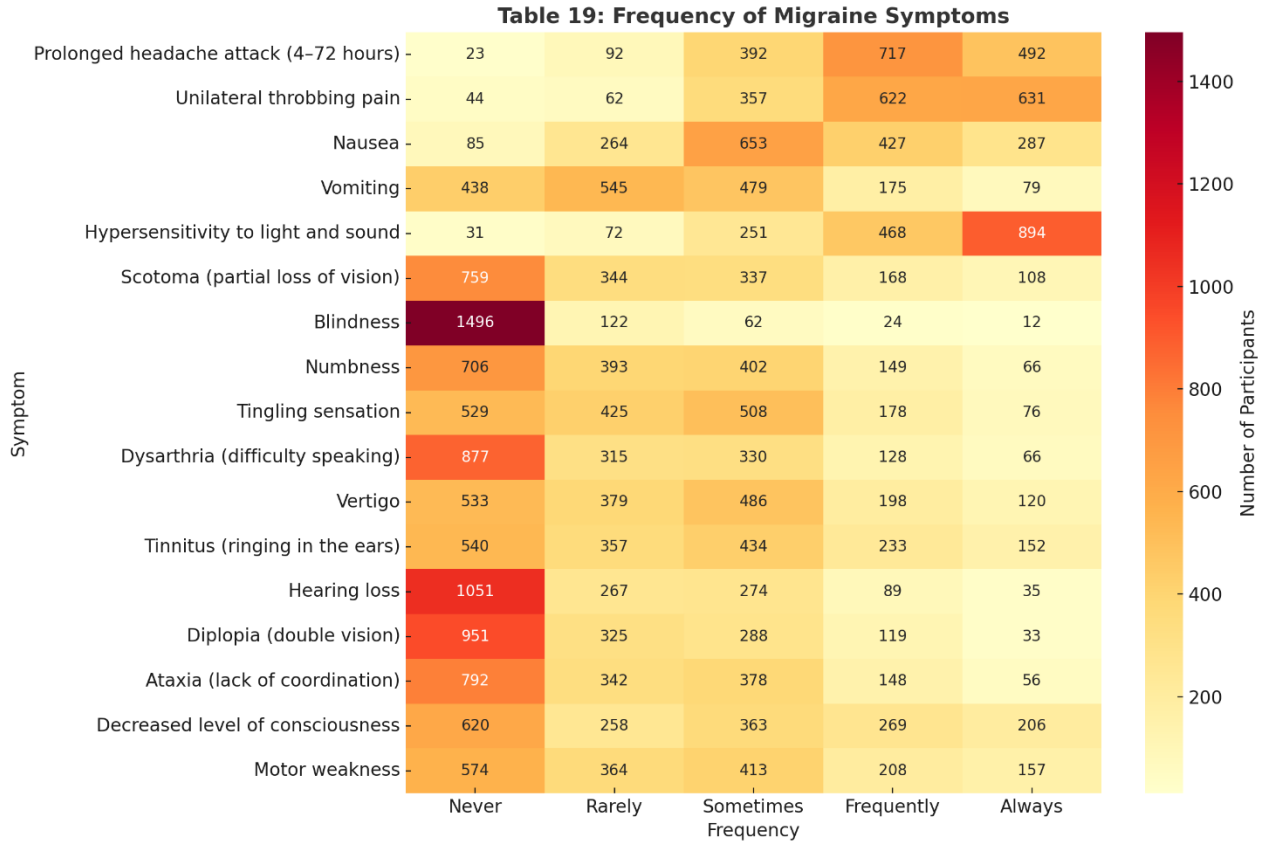

Table 20: Severity of Migraine Symptoms

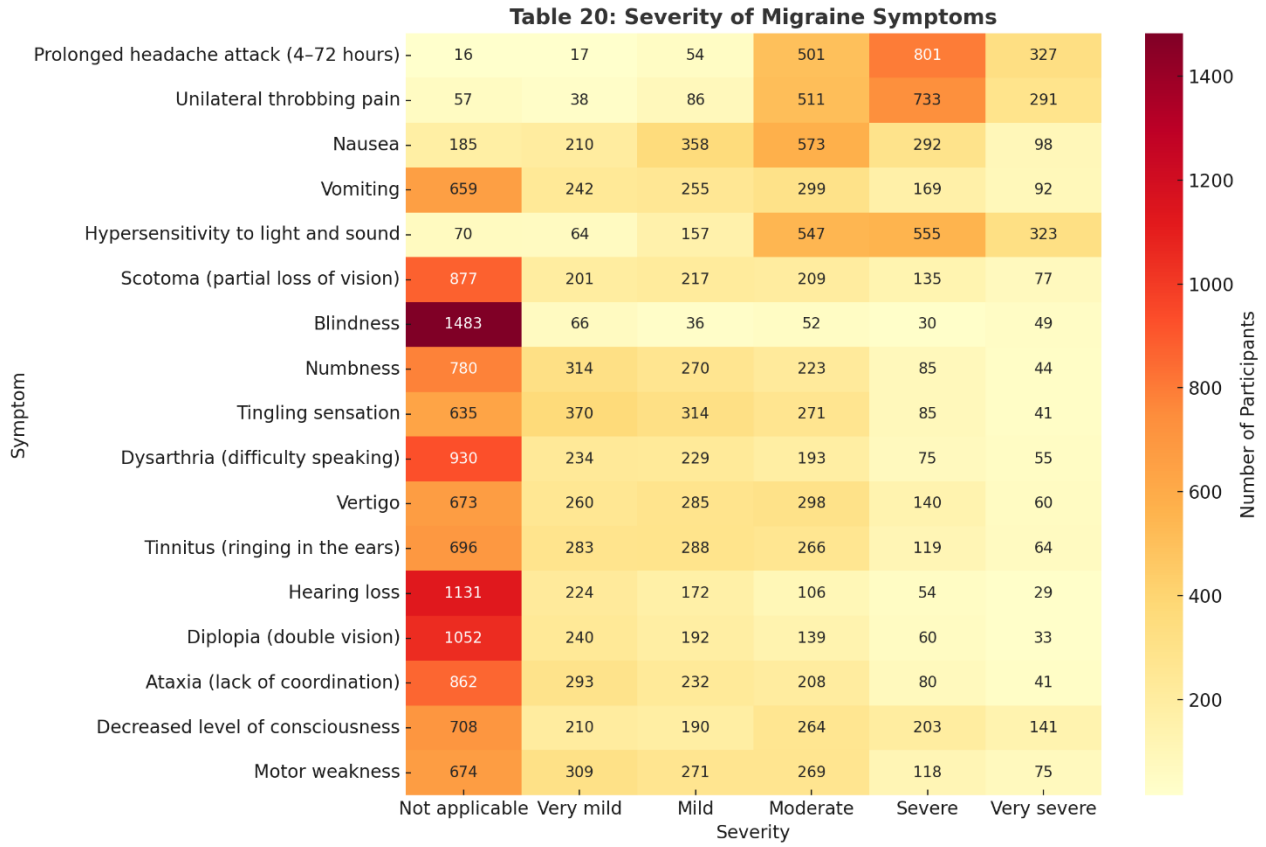

Table 21: Duration of Migraine Attacks (including all symptoms, not just headache) (n=1716)

Duration	#	%
≤4 hours	140	8,16%
5–8 hours	254	14,80%
9–12 hours	212	12,35%
13–24 hours	267	15,56%
25–48 hours	287	16,72%
49–72 hours	266	15,50%
>72 hours	287	16,72%
Not applicable	3	0,17%

Table 22: Number of Days per Month with Migraine-Related Headache (n=1716)

Number days	#	%
< 1 day	96	5,59%
1–7 days	687	40,03%
8–14 days	456	26,57%
≥ 15 days (chronic migraine)	477	27,80%

Table 23: Ease of recognizing migraine triggers (n=1716)

Ease	#	%
Very easy	241	14,04%
Easy	400	23,31%
Neutral	559	32,58%
Difficult	304	17,72%
Very Difficult	205	11,95%
Not applicable	7	0,41%

Table 24: Prodrome Phase Symptom Frequency (n=1716)

Frequency	#	%
Never	62	3,61%
Rarely	102	5,94%
Sometimes	263	15,33%
Often	532	31,00%
Always	754	43,94%
Not applicable	3	0,17%

Table 25: Aura Phase Symptom Frequency (n=1716)

Frequency	#	%
Never	318	18,53%
Rarely	333	19,41%
Sometimes	407	23,72%
Often	339	19,76%
Always	286	16,67%
Not applicable	33	1,92%

Table 26: Headache phase duration (n=1716)

Duration	#	%
≤4 hours	188	10,96%
5–8 hours	333	19,41%
9–12 hours	249	14,51%
13–24 hours	249	14,51%
25–48 hours	251	14,63%
49–72 hours	233	13,58%
>72 hours	207	12,06%
Not applicable	6	0,35%

Table 27: Postdromic Phase Symptom Frequency (n=1716)

Frequency	#	%
Never	24	1,40%
Rarely	78	4,55%
Sometimes	273	15,91%
Often	504	29,37%
Always	833	48,54%
Not applicable	4	0,23%

Table 28: Migraine Interference with Family and Friend Relationships (n=1716)

Frequency	#	%
Never	61	3,55%
Rarely	138	8,04%
Sometimes	516	30,07%
Often	649	37,82%
Always	352	20,51%

Table 29: Migraine Interference with Leisure Activities (such as reading or exercising) (n=1716)

Frequency	#	%
Never	21	1,22%
Rarely	86	5,01%
Sometimes	362	21,10%
Often	659	38,40%
Always	588	34,27%

Table 30: Migraine Interference with everyday Activities (such as housework, shopping, or caregiving) (n=1716)

Frequency	#	%
Never	32	1,86%
Rarely	110	6,41%
Sometimes	429	25,00%
Often	673	39,22%
Always	472	27,51%

Table 31: Migraine-Related Difficulty Sleeping (n=1716)

Frequency	#	%
Never	65	3,79%
Rarely	140	8,16%
Sometimes	455	26,52%
Often	568	33,10%
Always	488	28,44%

Table 32: Migraine-Related Difficulty Eating Due to Nausea (n=1716)

Frequency	#	%
Never	184	10,72%
Rarely	323	18,82%
Sometimes	461	26,86%
Often	386	22,49%
Always	362	21,10%

Table 33: Emotions Related to Migraine: Frustration or anger (n=1716)

Frequency	#	%
Never	61	3,55%
Rarely	111	6,47%
Sometimes	324	18,88%
Often	436	25,41%
Always	773	45,05%
Not applicable	11	0,64%

Table 34: Emotions Related to Migraine: Depression or sadness (n=1716)

Frequency	#	%
Never	120	6,99%
Rarely	217	12,65%
Sometimes	386	22,49%
Often	418	24,36%
Always	568	33,10%
Not applicable	7	0,41%

Table 35: Perceived Minimization of Migraine by Others (n=1716)

Frequency	#	%
Never	91	5,30%
Rarely	135	7,87%
Sometimes	291	16,96%
Often	574	33,45%
Always	607	35,37%
Not applicable	18	1,05%

Table 36: Anticipatory Anxiety or Stress About Next Migraine Attack (n=1716)

Frequency	#	%
Never	84	4,90%
Rarely	174	10,14%
Sometimes	393	22,90%
Often	476	27,74%
Always	566	32,98%
Not applicable	23	1,34%

Table 37: Perceived Support from Family or Friends in Managing Migraine (n=1716)

Degree	#	%
None	64	3,73%
Little	291	16,96%
Moderate	511	29,78%
Quite a lot	459	26,75%
Very much	285	16,61%
Not applicable	106	6,18%

Table 38: Perceived Burden on Others Due to Migraine (n=1716)

Frequency	#	%
Never	258	15,03%
Rarely	285	16,61%
Sometimes	402	23,43%
Often	341	19,87%
Always	393	22,90%
Not applicable	37	2,16%

Table 39: Absences at work due to migraines (n=1716)

Days	#	%
0	609	35,49%
1-2	473	27,56%
3-5	197	11,48%
6-10	60	3,50%
More than 10	38	2,21%
Not applicable	339	19,76%

Table 40: In what ways have migraines impacted your professional career (n=1716)
(Participants could select multiple responses)

Response	#	% of total responses
Total responses: 2297		
No professional impact related to my migraines	544	23,68%
I have reduced my work performance	937	40,79%
I have missed work frequently	424	18,46%
I have been excluded from important projects or tasks	126	5,49%
I have had difficulty getting promoted	86	3,74%

I have had to change jobs or professions	180	7,84%

Table 41: Percentage of your monthly income do you estimate is spent on medical care (n=1716)

Percentage	#	%
Less than 5%	357	20,80%
5%-10%	382	22,26%
10%-20%	326	19,00%
20%-30%	201	11,71%
More than 30%	259	15,09%
Not applicable	191	11,13%

Table 42: Migraines impact Financial Stability (n=1716)

Degree	#	%
No	517	30,13%
Slightly	344	20,05%
Moderately	308	17,95%
Significantly	287	16,72%
Extremely	133	7,75%
Not applicable	127	7,40%

Table 43: Frequency of Out-of-Pocket Expenses for Migraine Treatments (n=1716)

Frequency	#	%
Never	39	2,27%
Rarely	127	7,40%
Sometimes	257	14,98%
Often	424	24,71%
Always	825	48,08%
Not applicable	44	2,56%

Table 44: Economic Burdens Caused by Migraines (n=1716)

(Participants could select multiple responses)

Response	#	% of total responses
Total responses: 2200		
Lost wages due to absenteeism	210	9,55%
Increased healthcare costs	773	35,14%
Reduced bonuses or performance pay	126	5,73%
Need for additional household help	504	22,91%
None	587	26,68%

Table 45: Satisfaction with Migraine Treatment Effectiveness (n=1716)

Response	#	%
Yes	591	34,44%
No	972	56,64%
Not applicable	153	8,92%

Table 46: Type(s) of Treatments Currently Used to Manage Migraines (n=1716)

(Participants could select multiple responses)

Response	#	% of total responses
Total responses: 3111		
Prescription medications	1201	38,60%
Over-the-counter medications	755	24,27%
Herbal or natural remedies (e.g., supplements)	327	10,51%
Lifestyle changes (e.g., diet, exercise)	740	23,79%
I do not use treatment	86	2,76%
Not applicable	2	0,06%

Table 47: Frequency of Adjusting Medication (n=1716)

Frequency	#	%
Never	518	30,19%
Rarely	316	18,41%
Yes, occasionally	344	20,05%
Yes, frequently	459	26,75%
Not applicable	79	4,60%

Table 48: Monthly frequency of migraine medication use (n=1716)

Frequency	#	%
1–3 days	258	15,03%
4–7 days	369	21,50%
8–15 days	295	17,19%
>15 days, but not every day	236	13,75%
Every day	489	28,50%
0 days	37	2,16%
Not applicable	32	1,86%

Table 49: Importance of Treatment Factors for Managing Migraines (n=1716)

(Participants ranked these from most to least important)

Response	#	% of total responses
Medications	1034	60,26%
Adequate sleep	317	18,47%
Dietary modifications	112	6,53%
Regular exercise	88	5,13%
Stress management techniques	165	9,62%

Table 50: Number of Emergency Visits Due to Migraine in the Past Year (n=1716)

Visits	#	%
0	608	35,43%
1	196	11,42%
2	181	10,55%
3	129	7,52%
4	88	5,13%
5	61	3,55%
>5	292	17,02%
Not applicable	161	9,38%

Table 51: Type of Health Insurance (n=1716)

Insurance	#	%
Mixed (Public and private)	312	18,18%
Private	834	48,60%
Public	335	19,52%
No insurance	211	12,30%
Not applicable	24	1,40%

Table 52: Ease of Access to a Migraine Specialist (n=1716)

Ease	#	%
Very easy	89	5,19%
Easy	217	12,65%
Neutral	376	21,91%
Difficult	486	28,32%
Very Difficult	504	29,37%
Not applicable	44	2,56%

Table 53: Perception of Physician's Preparedness for Latest Migraine Treatments (n=1716)

Response	#	%
Some are prepared, but not all	730	42,54%
Most are not well prepared or updated	555	32,34%
Not prepared or informed at all	189	11,01%
Yes, most are well prepared and updated	105	6,12%
I don't have a formed opinion	137	7,98%

Table 54: Perception of Healthcare System Resources and Guidelines for Migraine Care (n=1716)

Response	#	%
Yes, completely	57	3,32%
Partially	445	25,93%
No	1003	58,45%
I don't know	211	12,30%

Table 55: Insurance Coverage for Migraine Treatments (n=1716)

Response	#	%
Yes, completely	151	8,80%
Yes, partially	630	36,71%
No	584	34,03%
Not applicable	351	20,45%

Table 56: Affordability of Migraine Treatments (n=1716)

Response	#	%
Very affordable	40	2,33%
Affordable	241	14,04%
Neutral	286	16,67%
Costly	527	30,71%
Very Costly	513	29,90%
Not applicable	109	6,35%

Table 57: Time to Get an Appointment for Migraine Care (n=1716)

Time	#	%
1 week	171	9,97%
1-2 weeks	228	13,29%
2-4 weeks	310	18,07%
4-6 weeks	331	19,29%
>6 weeks	408	23,78%
Not applicable	268	15,62%

Table 58: Interrupted or Delayed Treatment Due to Cost (n=1716)

Response	#	%
Yes	860	50,12%
No	644	37,53%
Not applicable	212	12,35%

Table 59: Feeling Informed About Latest Migraine Treatment Options (n=1716)

Response	#	%
Very well informed	202	11,77%
Somewhat informed	492	28,67%
Neutral	403	23,48%
Poorly informed	384	22,38%
Not at all informed	213	12,41%
Not applicable	22	1,28%

Table 60: Areas Needing More Education or Resources About Migraine (n=1716)

Response	#	%
Total responses: 7043		
Information and education	1091	15,49%
Treatment options	1360	19,31%
Pain management	769	10,92%
Lifestyle changes	905	12,85%
Support groups	674	9,57%
Psychological support	700	9,94%
Information for family members	700	9,94%
Public awareness about migraines	827	11,74%
Not applicable	17	0,24%

Table 61: Receiving Financial Assistance or Discount for Prescribed Treatment (n=1716)

Response	#	%
Yes	132	7,69%
No	1464	85,31%
Not applicable	120	6,99%

Table 62: Participation in Support Group or Patient Organization for Migraine (n=1716)

Response	#	%
Yes	126	7,34%
No, but I know they exist	326	19,00%
No, and I don't know if they exist	1264	73,66%