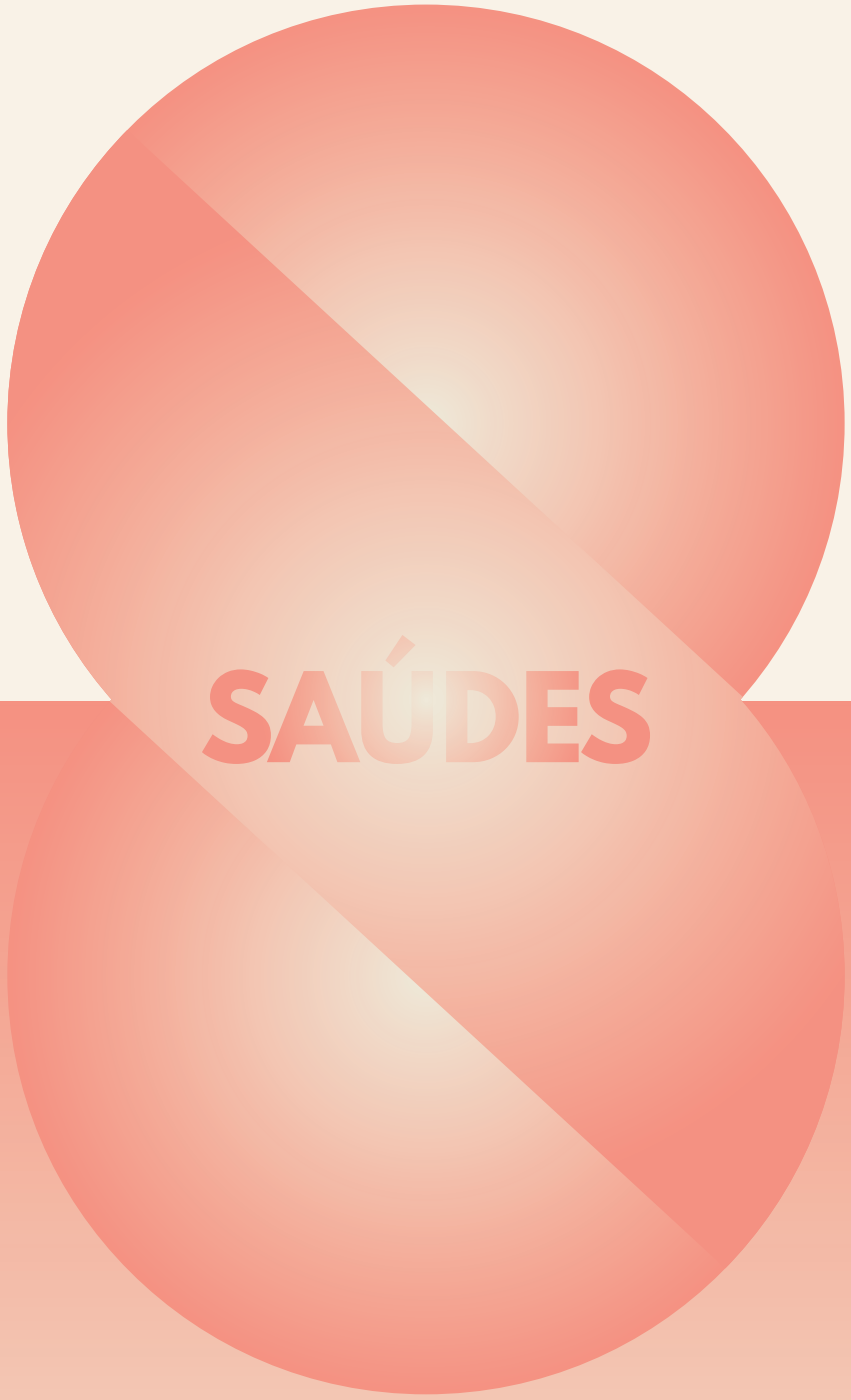
Realising the Full Potential of Women's Health and Well-being.

2022



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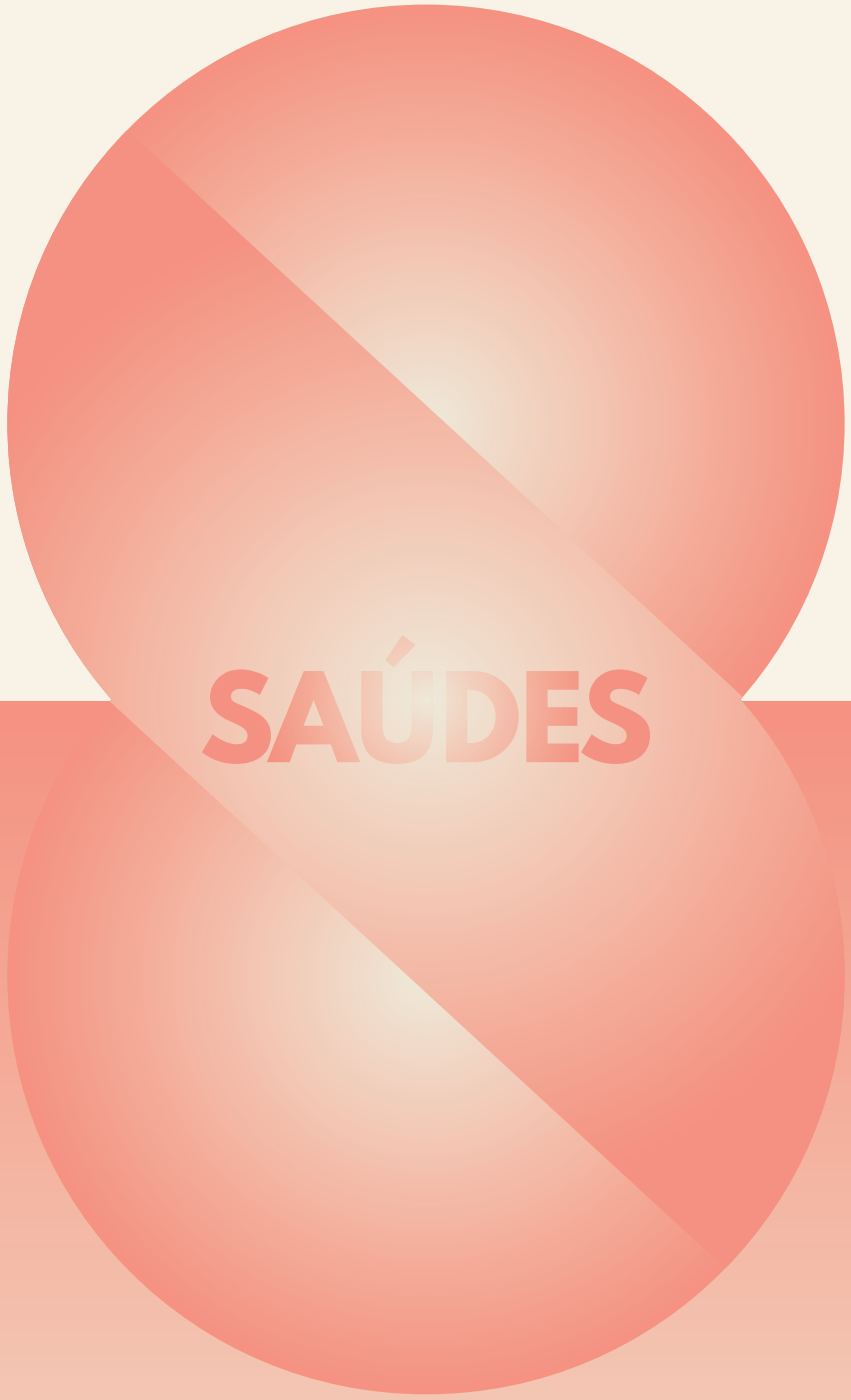

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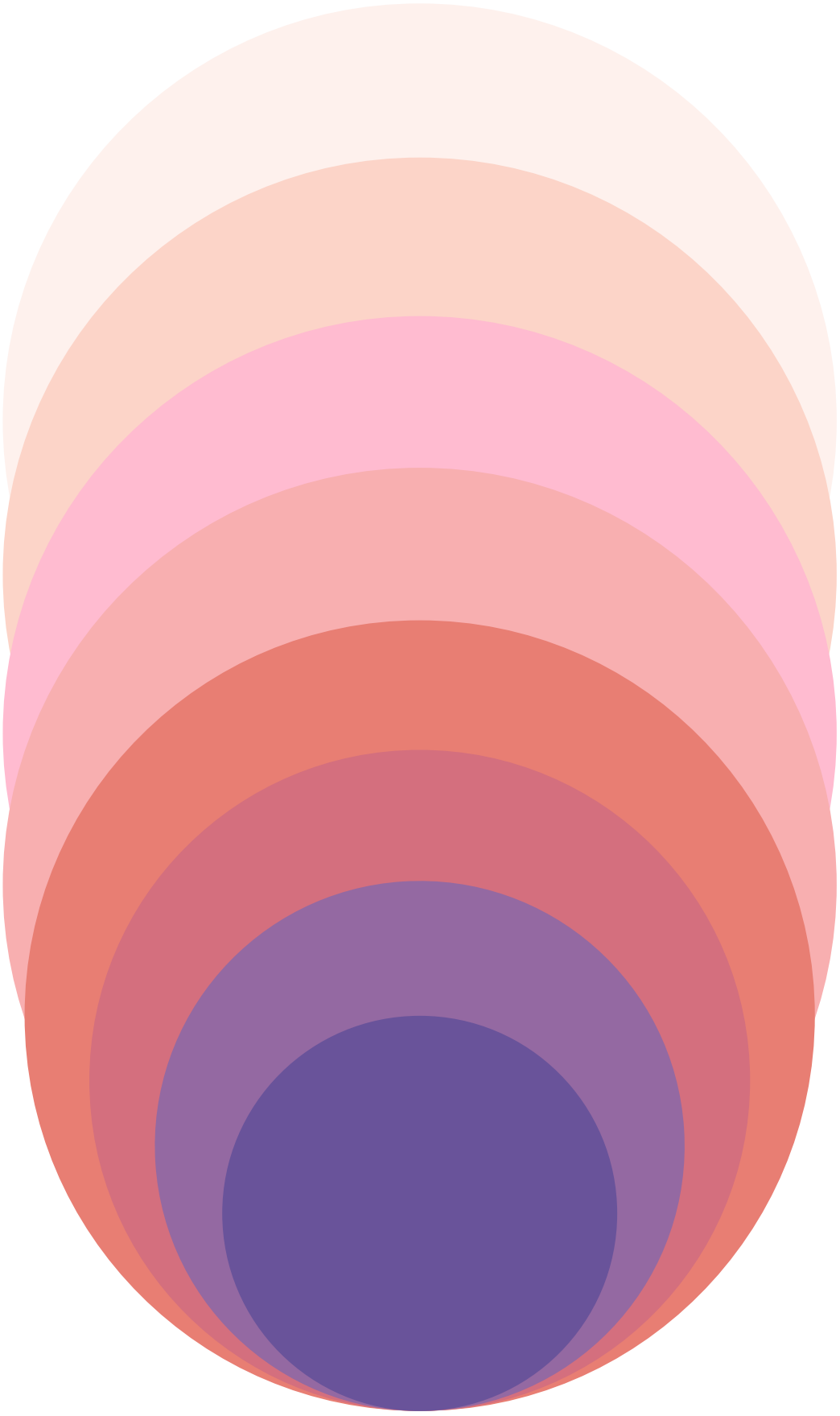


Previous Note

With this study, Women's Health and Well-being: a potential to be fulfilled, we aim to take a further step towards fulfilling the ambition and purpose of the project 'Saúdes' [Health project].

The efficiency and quality of the health system as a whole depends not only on the infrastructure and capabilities (technical and human) in place, and the access to it, but also on health literacy levels. And that's what we aim to tackle with the project 'Saúdes'. Launched in 2021, amidst the celebration of Médis' 25th anniversary, this project emerges from the desire to activate our mission 'to do good for everyone's health' by providing a useful and relevant contribution to the production of knowledge and to stimulate public reflection on the health theme. Its purpose is to complement the numerous studies (clinical and/or statistical) with a sociological perspective and the individual and subjective vision, which affects (and often conditions) the behaviour of each one when it comes to health.

In Portugal, as in most of the world, the average life expectancy of women is higher than men. However, data from The Health of the Portuguese: an ID – 2021, the first study of the project 'Saúdes', shows us that, in Portugal, women have a higher prevalence of disease and greater emotional pressures to contend with. The study proves this, although women are generally more vigilant and more committed to improving their health than men. It is precisely from this contradiction that this research emerges. The coordination of Return on Ideas, to whom we have handed over the full conduct of the study, and the scientific follow-up by Professor Miguel Oliveira da Silva, to whom we are very grateful, assure the excellence and the independence of the work presented here.

Rather than providing definite answers, we attempt to understand and seek explanations. These could provide us with valuable information to change what research shows clearly: women's well-being is deficient compared to men's, and its potential is far from being fulfilled at different stages of their life cycle.

**If we change tomorrow's health today, then,
it's time to get together and realise the full potential
of women's health and well-being in Portugal.**

Eduardo Consiglieri Pedroso
Chief Healthcare Ecosystem Officer
Grupo Ageas Portugal

Preface

Miguel Oliveira da Silva

Professor of Medical Ethics at the Medical School of the University of Lisbon and obstetrician-gynaecologist at Santa Maria Hospital. First President-elect of the National Council on Ethics for Life Sciences (2009-2015), he is coordinator of three projects on sexual and reproductive health in the European Union (2003-2010) and Vice President-elect of the European Council Department of Bioethics (2018-2019).

Strictly speaking, *health* and *well-being* concepts are not the same, although the classic and outdated definition of health by the WHO (1948) looks to health as an unattainable ideal: a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

In this document, *Realising the Full Potential of Women's Health and Well-being*, a dynamic vision of health pervades, and that's positive. A monolithic vision of health as fixed in time and age doesn't or shouldn't exist; health is a process. In this monograph, there are, above all, two perspectives that intersect, and it is important to emphasise them.

Firstly, we study, discuss, and talk about the health of women, women in plural, real-life women who tell their life stories in the first person. Secondly, we think about the health of these women throughout their life cycle, considering and acknowledging the fact that the state of optimal health will vary for the same person, in the same lifetime, as the years go by.

The fact that they are subject to a stormier life cycle (because they reproduce) than men does not necessarily mean that women must 'accommodate the discomfort and normalise suffering', as in some cases undoubtedly happens, for cultural, educational, and idiosyncratic reasons, perhaps, as if by fate, it was unavoidable.

In terms of self-rated health (p. 22), women score slightly worse than men and more women consider themselves unhealthy (17% vs 13%); chronic pain prevalence is indisputably higher among women (33% vs 19%); and, concerning mental health, women are more likely to experience burnout or depressive episodes (50% vs 31%)—always considering the 40 to 74 age group. Also, considering their subjective well-being—as of the indicator developed here—women are at a disadvantage compared to men (p. 34), as they experience less frequent, or more inconsistent, feelings of tranquillity or energy and score lower in terms of optimism or self-esteem, regardless of the differences in how men and women build their perceptions about themselves or their lives.

As for scientific research, this is clearly an area that has been historically overlooked. Medicine, in an immense gender bias, absorbs and reinforces socially constructed gender divisions. Most researchers and research subjects are men, as if extrapolation of clinical data in men would not raise delicate scientific questions for women in the day-to-day lives of those who have, at least until the natural menopause, a large variation in the levels of hormones produced in the hypothalamus, pituitary, and ovary.

This study thoroughly details essential aspects of the physiognomy of the specific life cycles of any woman (with no male equivalent), such as menstruation, hormonal cycles, menopause, ageing, weight gain, and self-image. All of these aspects are surrounded by countless myths ('myth is the nothing that is everything', as Pessoa wrote in Message), prejudices, and preconceived ideas that should be deconstructed, as this report does, and well, in many cases.

Let's start from the beginning; more men are born than women (51% of births are male newborns), but women live longer than men (life expectancy at birth is 83.3 years for women and 77.6 years for men). Yet, this does not mean that women live well as they get older, free from disease or significant limitations.

Although women's greater capacity for survival is a remarkable characteristic of female biology (who knows, a key to human longevity), the theme remains poorly researched. It is still rather speculative today to know why women live longer than men. Some, within a biological paradigm, argue that it is due to an immune system (stimulated by various female hormones, including pregnancy-specific hormones) more likely to destroy cancer cells and one that thus provides greater protection for certain pathologies. Others, within a cultural paradigm, try to explain that the higher

and earlier male mortality rate is due to various and cumulative risk factors: work, lifestyle, inadequate nutrition, greater stress. Perhaps the scientific truth, always provisional, will stand on both sides, interdependent, and not isolated.

On menstruation and menopause, there is currently no scientific reason for these to be viewed with apprehension, anxiety, or fear of unpleasant symptoms as a condition that is more propitious to depression and emotional instability.

From a clinical and pharmacological point of view, it is now very easy to advise on healthy lifestyles and prescribe medicines that prevent menstrual pain (let alone having an adolescent and an adult woman who face pain that limits them from carrying out current tasks, for example)—and in Spain there is now even a legal framework for menstrual leave. As for perimenopause and menopause (last menstrual period), the hormonal changes and associated signs and symptoms are also nowadays entirely easy to prevent, treat, care, even in primary healthcare and, if necessary, by consulting a specialist—which does not necessarily happen, primarily due to limited accessibility.

In the cases where a woman has become pregnant and a mother, my first finding, based on decades of clinical experience in these areas, is that no woman is the same after she has been pregnant, whatever the outcome of that pregnancy.

Firstly, from a biological point of view, there are specific hormones that only exist in pregnancy and their positive effects can persist for many years, shaping several receptors (neuronal, mammary, for example) for a long time, even influencing behaviours. It has been known for a long time that reaching full-term pregnancy before the age of 28 significantly protects against the risk of breast cancer, for example.

Of course, motherhood is not a mandatory destination for every healthy woman—it is valid for a woman, in a heterosexual couple, to choose not to have children (for reasons that would be interesting to research more considering the biological and cultural aspects). But, in most cases, becoming pregnant voluntarily, being a mother and breastfeeding, may enrich the life of a woman, leaving aside the debate about whether there is a feeling of ′spontaneous unconditional love' (p.96), something that has been debated by several psychoanalytical trends.

In any case, normalisation of malaise must be prevented, and the negative and traumatising experiences of pregnancy, labour induction, labour, breastfeeding, and sexuality in the puerperium must not be accepted.

There is still a considerable lack of information, especially for first-time pregnancies, and many calls for support (p. 107) are often not met due to poor organisation and implementation of global and humanised healthcare (and not only technical)—not to mention the excruciating debate on the prevention of so-called obstetric violence and the debate around birth plan, considering a new, dynamic and necessary balanced framework between maternal autonomy and foetus well-being. It would be useful here to share different experiences from Portuguese public and private hospitals and from other European countries.

It is true that this is not always the case. Therefore, unfortunately, there are many women who suffer and who are traumatised by the way their pregnancy (even if voluntary), birth, breastfeeding, and maternity occurred—either because their available healthcare was inadequate, or due to the negative family dynamics or psychological or professional problems that may have emerged or become dominant during this period.

Portugal suffers today from a huge demographic winter, and the 80,000 to 85,000 deliveries (in 2021, there were only 79,500 due to the pandemic) that we've been having annually are clearly insufficient to compensate the much higher number of deaths; nobody reinvents the wheel. If we do not want to live in an increasingly ageing society, with increasingly unwell old people, with ever higher costs at different levels, we need the resident population to have more children and earlier, and/or we must favour young immigration, preferentially that which is qualified and socially and culturally integrated.

What's more, women often gain weight as they age, and two in three women admit to having been subjected to pejorative comments. But weight gain is sometimes overexaggerated (it is often within the adequate body mass index). Though, it is also a fact, that underlying this conflict with the body is an ideal of beauty, a beauty industry that perpetuates stereotypes, an obsession with ideal weight, and a cult of thinness.

Other areas—such as contraception and female sexuality (see annexes)—are addressed in this monograph through an innovative transdisciplinary approach that covers the main stages of women's lives. This is an excellent study that offers numerous insights and must not fail to prompt new and concrete initiatives to be implemented.

About the research

In the research The Health of the Portuguese: an ID (2021), which inaugurates the SAÚDES project, gender differences in relation to health were found. Women showed a higher prevalence of disease and psychological disarray than men, and, at the same time they monitor their health the most. Women also scored a higher 'average life expectancy' but fared worse in the 'average healthy life expectancy' indicator. These contradictions raised a number of questions:

'Can biological aspects and the sexual and reproductive life of women alone explain their health deviation when compared with men? Are there other factors, related to their role in the family, such as increased household tasks and their role in supporting others, harming their health? Or is there, as some researchers suggest, a historical devaluation of women's health as a whole, or even, a connotation of weakness that leads not only health professionals, but women themselves to see women as being (more) fragile?'.

This research emerges from these questions and aims to create a new perspective on the female health experience, thus mobilising society for solutions and initiatives that contribute to the improvement of women's well-being in Portugal.

Although it focuses on women, and not on gender differences, the study had to consider and understand the differences between men and women. In terms of disease incidence, pain and health self-perception, deficits in relation to men are confirmed. In terms of attitudes and behaviours, in relation to health in general or to specific diseases, the comparison between genders is inconclusive because it is difficult to isolate the gender aspect from each one story. The personality and biography of each person seem to be more determinant than gender in the relationship with his or her health.

Several investigations suggest that the differences found between the brains of women and men can be put down to the uniqueness of human beings. Research carried out on boys and girls reveal few psychological differences between the sexes and indicate that such differences will result more from culture than biology. The big questions about the influence of sex on health remain unanswered and, especially regarding the biological differences that explain behaviours and what the brain will be more programmed to do, are still in the field of speculation.

However, as much we may bear in mind this closeness between the sexes, the fact is that if we want to improve women's health and well-being, we must understand how health is affected by the biological differences and gender stereotypes to which it is exposed and from which it is not yet socially disconnected. There are explanations for the differences in health between the sexes, even if some results remain grey areas.

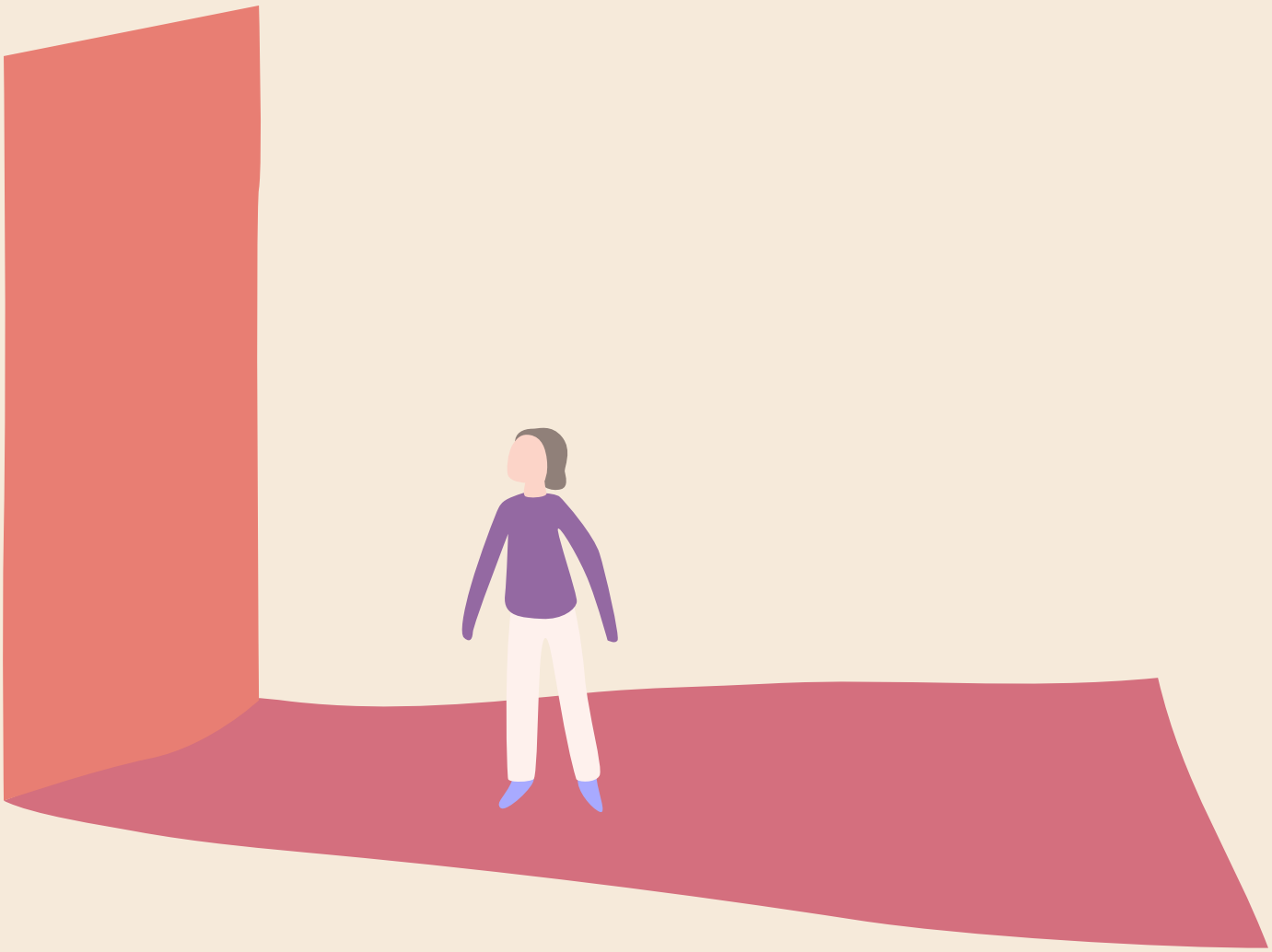
READING NOTE:

To analyse differences between the sexes, a control group of men between 40 and 74 years was added to the sample to have a naturally representative population of men with disease. Although the sample of women is representative of the population between 20 and 74 years, by correction of analysis, whenever the objective is the comparison between sexes, a sub-sample of women between 40 and 74 years of age is used.

This research has two purposes; on the one hand, to better understand the objective and subjective variables that may explain the health differences between the sexes. And on the other hand, to grasp the reasons for the lack of interest or ambition towards women's well-being, with women themselves included in this.

The intention is not to portray the health of Portuguese women to date, nor to understand a specific health issue, but to offer a vision of women's health throughout their life cycle.

This approach aims to identify when women tend to feel more fragile (because they are women), to understand the major contributing aspects for the ill-being and suggest calls for action to improve their well-being.



Women vs men: what are the gaps?

On Health

Disease

Women live longer than men almost all over the world. Life expectancy at birth is 83.3 years for women and 77.6 years for Portuguese men.[1] A newborn female is statistically more resistant than a male; boys are estimated to have a 10% higher risk of death than girls. This capacity for survival follows women throughout their lives and is more evident in old age; considering the available lists of super-centenarians, women greatly outnumber men. Something in a woman's body and psychology makes her naturally better designed to survive.

In addition to cultural pressures, which often mean men engage more in riskier behaviours, answers that may explain the difference in survival rate have been looked for in biology. Some suggest that having two versions of a gene (X chromosome) may protect women from some diseases. Others argue that it is possible the hormonal changes affecting a woman's immune system during pregnancy may also work during their menstrual cycle.

Although there are not enough studies, this hypothesis suggests that because women can become pregnant, they have a more robust immune response. It doesn't mean that women can't fall unwell; but diseases don't kill women as easily or as quickly as they kill men. This could be an explanation (in addition to alcohol and tobacco habits) for the fact that the number of COVID-19 fatalities is higher among men (76.4 vs 62.5 per 100,000 inhabitants) and that they die at a younger age (79.9 vs 83.4 years)[2].

Despite having a longer average life expectancy, women are not healthier than men. On the contrary, statistically, they fall ill more frequently and often more severely.

Among the senior population, the percentage of women who have at least one limitation in personal care or regular domestic activities is always higher compared to men, and within the EU, Portugal is the country where the difference between men and women is at its the greatest (68% of women vs 53% of men aged 65 and over).

Women also tend to experience more painful muscle and joint disorders. These can be related to the physical impact of gestation or to hormonal changes that take place during menopause, among other causes. It is also known that women tend to process food in the intestines more slowly, that they have a higher percentage of fat mass and a lower average height than males, which eventually makes them an easier target for certain pathologies.

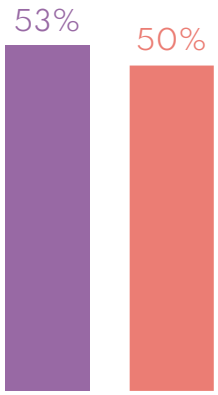
[1] Pordata Data

[2] Deaths that the underlying cause of death, i.e. the disease that started the chain of pathological events leading to death, was COVID-19 disease, in the year 2020, INE

Disease Prevalence

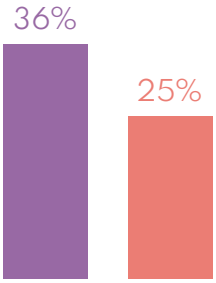
DISEASE

Has a medically diagnosed disease



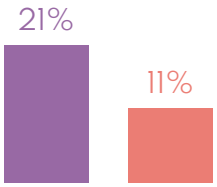
SEVERE DISEASE

Has a specific diagnosis of a very severe, severe or moderate disease



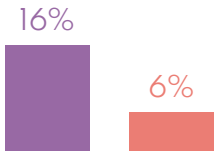
MORE THAN 2 DISEASES

Has 3 or more diseases medically diagnosed



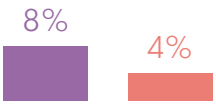
MENTAL DISORDER

Medically diagnosed (In case of disease)



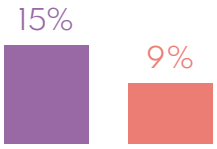
AUTOIMMUNE DISEASE

Medically diagnosed (In case of disease)



OBESITY

Medically diagnosed (In case of disease)



Q: Do you have any medical diagnosis?

Women
40 to 74 years old
N=478

Men
40 to 74 years old
N=253

45%
N=707

of women have at least one disease medically diagnosed

Some researchers believe that part of the reason there are more women with poor health may be that women have survived in conditions that would have killed men.

On the other hand, a more powerful immune system will be more likely to attack the cells themselves, making women more prone to autoimmune diseases or to developing more severe symptoms when faced with an infection.

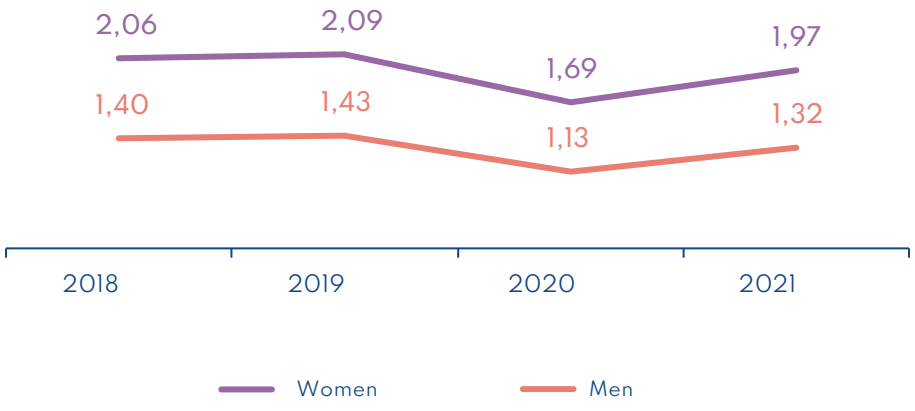
Regardless of the hypotheses put forward, there is increasing consensus that it is not possible to isolate the biological aspects from other effects that influence health. Living conditions, education, and the environment can have a much greater impact on health than biology. A woman who postpones going to the doctor when she has chest pains is more the product of a culture that emphasises heart problems in men rather than a biological bias; a woman who sacrifices her dinner so that her husband and children eat better isn't obeying a genetic instruction but rather following a socially constructed impulse.

The current study confirms that there is a gender gap concerning health, to the detriment of women, regarding chronic pain, chronic diseases, or mental disorder. And although women tend to be more vigilant about their health, they do not seem to give in more than men do to claiming illness.

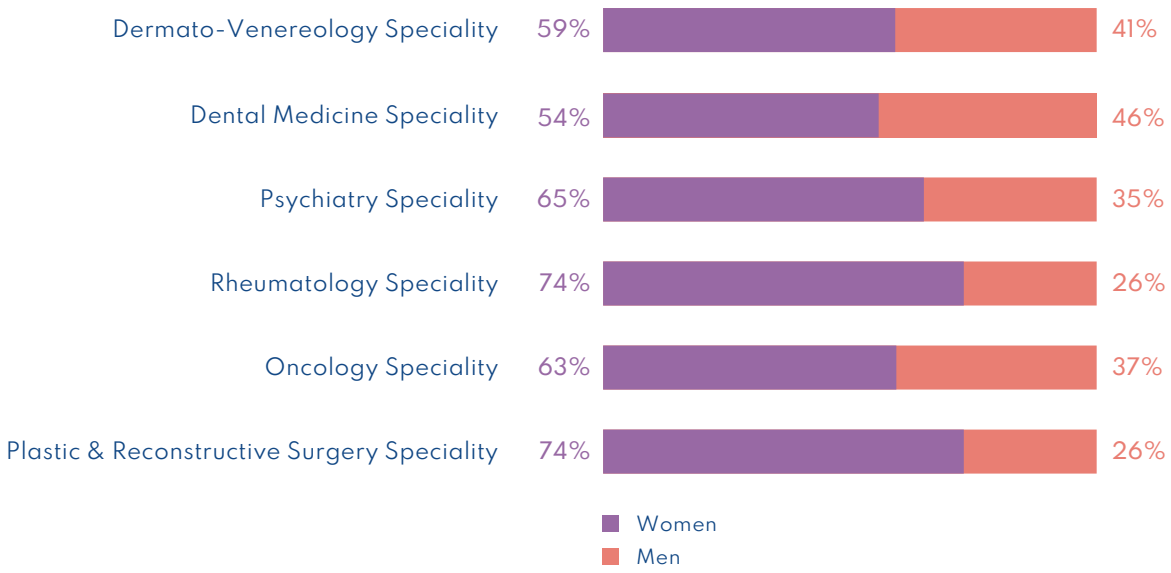
Women are more vigilant about their health

Médis Clients: analysis of medical acts using health insurance

Speciality consultations' average number (Women vs Men)



Distribution of men and women by speciality consultations (data from 2021)



Source: Médis internal data

Pain

A study conducted in Portugal[1] estimated that about 37% of the Portuguese adult population experiences chronic pain. The study showed an unequal distribution of pain prevalence, demonstrating that nearly 46% of women and 27% of adult men will have pain complaints consistent with the IASP definition of pain ('an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in such terms').

In this study, 33% of women and 19% of men between the ages of 40 and 74 answered yes to the question: 'Do you suffer from any health condition that causes chronic or persistent pain, i.e. a recurrent pain or that persists for months or years?'

Several studies argue that pain affects more women than men. Women have an increased risk of developing chronic pain; they suffer from predominantly or exclusively female pain conditions (when linked to diseases related to female health, such as endometriosis) and, even in some diseases not linked to the female sex—migraine, fibromyalgia, temporomandibular joint, irritable bowel syndrome, among others—the pain prevalence is higher among women.

As pain is influenced by biological, psychological, and emotional aspects, it is difficult to define and assess as a concept.

How each person perceives and deals with pain is intimately linked not only to his or her physical health, but also to his or her mental health, and to his or her way of experiencing the world. For that reason, the fact that women are more vulnerable to depression or anxiety (as confirmed by this study) can offer an explanation as to why women experience worse pain symptoms.

From what can be inferred, there are differences between genders in how pain is experienced. Women are usually more sensitive to pain when they are submitted to laboratory tests. Psychological and sociological phenomena, as well as hormones (or menstrual cycle interference), are mechanisms that seem to explain, at least in part, these differences.

Finally, the manifestation of pain will be different between genders. On the one hand, it is possible that the sensation of pain itself is different. Studies suggest more neuropathic sensations [i.e. affecting nerves or the peripheral nervous system] in a woman's pain experience, leading to more exuberant pain descriptions. The 'shooting', 'sharp', 'stabbing' pain ['as if a knife was stabbing'] were expressions spontaneously reported by various women who were interviewed.

On the other hand, adjusting to gender norms, which establish that men must be stoic and tolerate painful experiences and woman more sensitive, ends up conditioning the approach to the complaint of pain. In the male case, this leads the patient to disregard the pain. In the female case, the association of women with physical and mental frailty may lead to their complaints being undervalued by the doctors themselves and therefore undertreated. Several studies identify this bias, particularly concerning acute pain. In our study, the women suffering from chronic pain can better recognise how doctors or healthcare practitioners may have already devalued their complaints (22% 'often', vs 13 % of the aggregate sample).

[1] Epidemiology of Chronic Pain, by Luís Filipe Azevedo, referred to by Dr. Ana Pedro, president of APED (Portuguese Association for the Study of Pain), who was interviewed during the research to evidence the ideas presentd here.

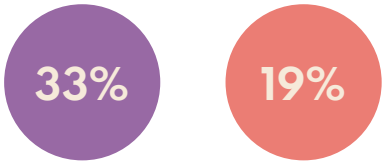
Women vs Men

40 to 74 years old

Women
40 to 74 years old
N=478

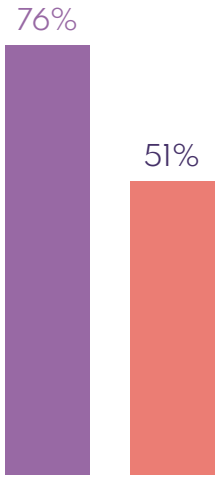
Men
40 to 74 years old
N=253

SUFFER FROM CHRONIC PAIN



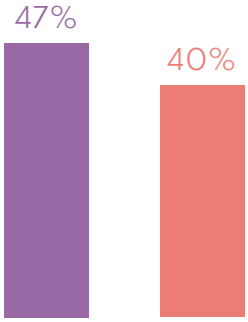
EXPERIENCED PAIN RECENTLY

(that day or in the previous month)



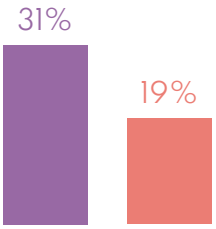
2 OR MORE PAINS

In case of chronic pain or having experienced pain recently (N=502)



INTENSE, VERY INTENSE OR UNBEARABLE

In case of chronic pain or having experienced pain recently (N=502)



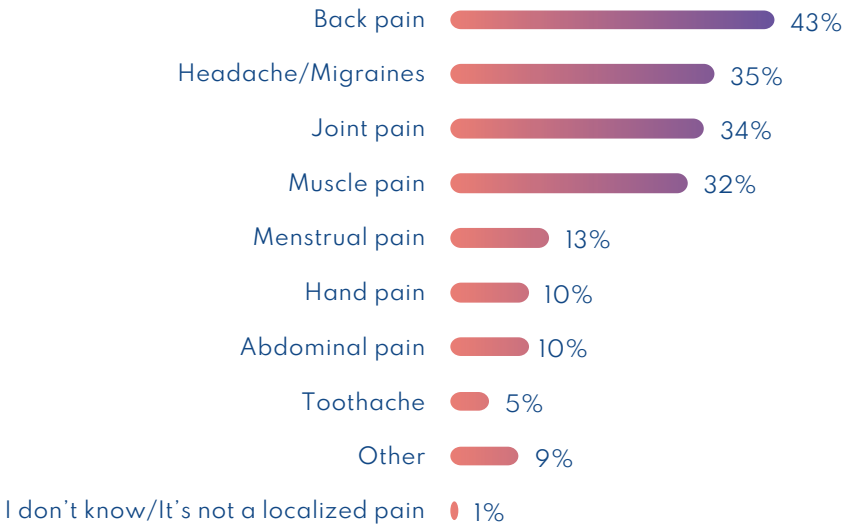
76%

Of women experienced pain recently (in the previous month)

N=707

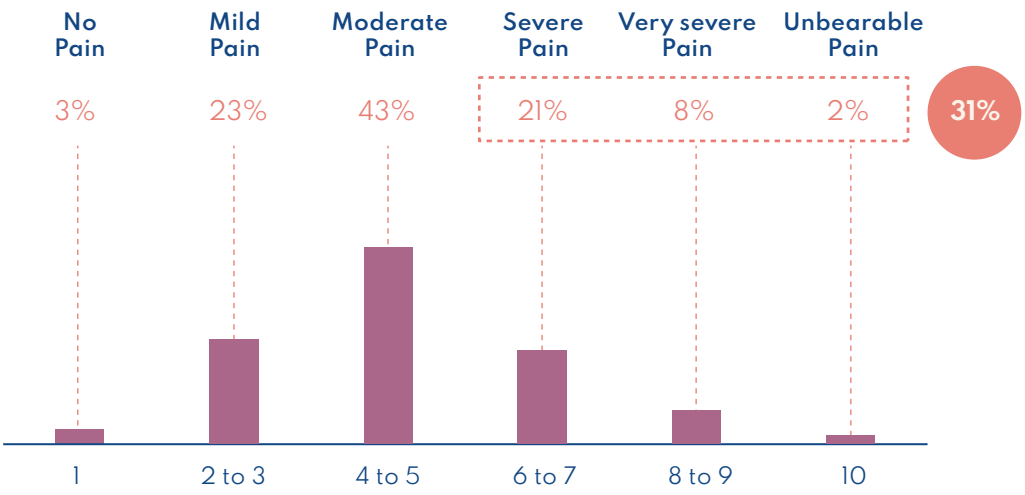
What kind of pain?

N=544



What is the intensity level of the pain you are mentioning?

(N=544, scale from 1 to 10)



Chronic Pain

N=707

30%

of them don't have a medical diagnosis.

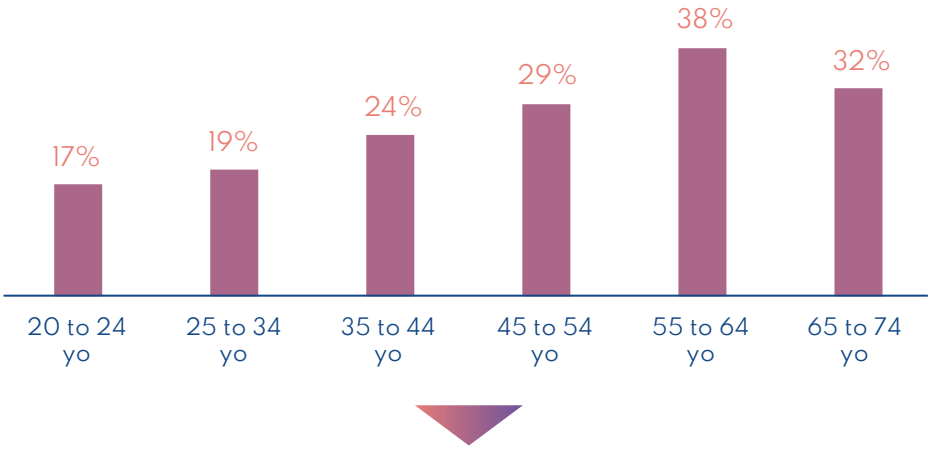
N=198

53%

of them are experiencing menopause

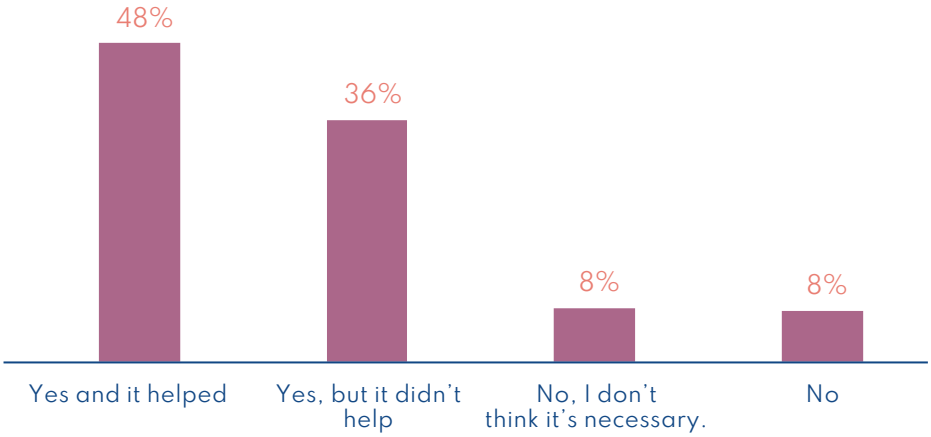
N=198

Q: Do you suffer from any health condition that causes chronic or persistent pain. i.e. recurrent pain or that persists for months or years?



Did you seek professional help for treatment/pain relief?

N=198

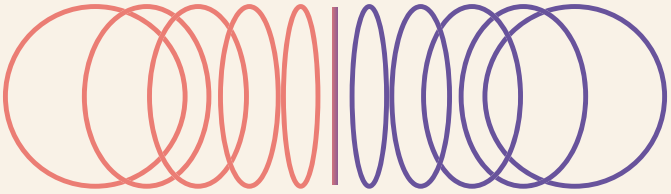


In our conversations with women, they reported the appearance of pain with surprising frequency. There were several reports of women experiencing ongoing pain over the years, far beyond the events in which it is expected for them to feel pain and, in several cases, having begun before menopause, when some types of pain become more frequent.

Our survey showed that, 28% of Portuguese women stated that they live with chronic pain.

It seems that many complaints related to pain are being inadequately treated. Whether this is because the incidence of pain is still neglected by women and some health professionals, or because it becomes difficult to tackle its cause, because there is a lack of public health therapies, or because women themselves are reluctant to take painkillers.

The result accommodates the discomfort and normalisation of suffering.



"I have lumbar hyperlordosis, a sclerosis down here, and another one up here. I'm already so used to be in pain. At 16 I knew I had this problem. (...) Since then, I had to learn how to live with pain."

W, 53 years old, divorced, three children, in menopause

"I cannot say that I'm 100% healthy, I have a lot of pain. There is pain that I can manage with medication and other that I feel every day. I live with them, I accept them. It's physical pain, in the spine, because I work many hours, 12, 14 hours a day. But I have another kind of pain ... an aching soul, that comes from the emotions we carry throughout life and that have never been treated, and which afterwards also become physical pain."

W, 60 years old, divorced, one children, in menopause

"I found out I had fibromyalgia. I take a lot of medication; I feel a horrible pain from time to time. I work normally, I don't have a customised schedule ... there are days that I can barely move, but most people don't know. The only person who really realises that I am in pain is my husband."

W, 53 years old, unmarried partnership, no children, in menopause

"This mindset comes already from our grandmothers' time. If I'm in pain, I must endure the pain, but if it was for my doctor, I would take a painkiller every day. I don't do it, because then we increase the dosage and I'll get addicted to it."

W, 57 years old, married, one children, in menopause

Self-Rated Health

In the research, The Health of the Portuguese: an ID, an indicator was created from the self-appreciation that each person makes of his or her state of health. In 2021, women scored slightly worse than men, and the main difference concerned the proportion of those who considered themselves unhealthy (17% women vs 13% men). Among women, there was also a greater sense of lack of control over their state of health, and more importance was placed on psychological issues compared with men. Instability and the feeling of not being able to control their emotions were not exclusive but distanced the women from the men.

In the present study, women's health is not only worse compared to last year but in comparison with men the gap has increased. The number of women who consider themselves unhealthy rose from 17% in 2021 to 23% in 2022. Among women aged 40 or over, this percentage rises to 25% versus 13% of men in the same age group, in both physical and mental health.

Apart from the 20 to 24-year-old demographic, who were already in a worse state of health, there are noticeable drops in women's health among all age groups. Women between the ages of 35 and 44 experienced the greatest loss at all levels, with a very pronounced blow to mental health [see following pages].

These results go hand in hand with other studies that show how the consequences of the pandemic have disproportionately affected women. According to the Headway 2023 Mental Health Index[1], 83% of women acknowledge that the pandemic has negatively impacted their mental health, compared with 36% of men, in EU and UK countries. 'Pregnant women, postpartum women or victims of trauma, such as miscarriage or abuse by close partners, were considered the most vulnerable to the psychological impacts of the pandemic. The weight of household chores and childcare also had a significant impact on the mental well-being of women: 44% of women with children under 12 reported being difficult to perform domestic chores compared with only 20% of men,' the report says.

This Perceived Health indicator does not measure health as opposed to disease, but how far it stands from a health ideal, which differs from person to person. Health is a process and women are not resigned to their current state of health. Impossibility of improvement is only a fatality for 4% of women; 85% have the ambition to improve it, even if half of them admit it is difficult.

[1] Headway 2023 Mental Health Index, developed by The European House - Ambrosetti in partnership with Angelini Pharma (2021)

Women vs Men

40 to 74 years old

Women
40 to 74 yo
N=478

Men
40 to 74 yo
N=253

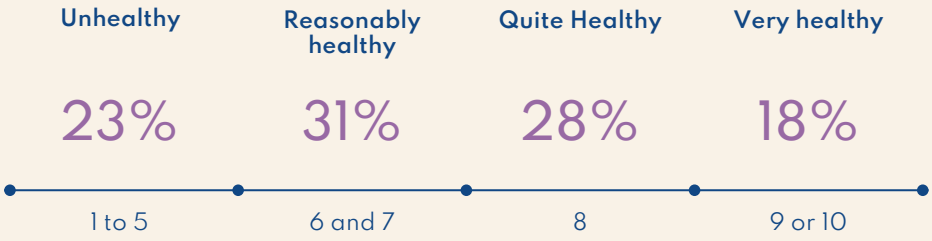
Average value

Women

Self-rated health

on a scale from 1 to 10
N=707

7,3	6,9
Average value	Average value
2021	**2022**



Q: Using a scale of 1 to 10, where 1 is 'very unhealthy'and 10 to 'very healthy', how would you rate your current health status? N= 707

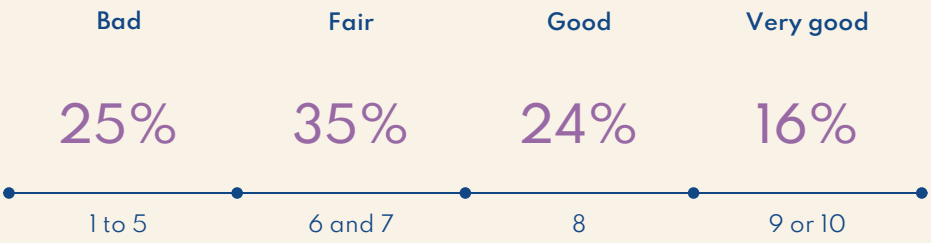
Self-Perceived Health Indicator

A concept of health status with worse or better performance on an axis that indicates the well-being potential of each person at a given moment. It is based on the assumption that there is a life timeline that defines a certain health potential, always different for each person. By determining their position on the axis, each person rates how far away they are from what they believe to be their health or well-being potential.

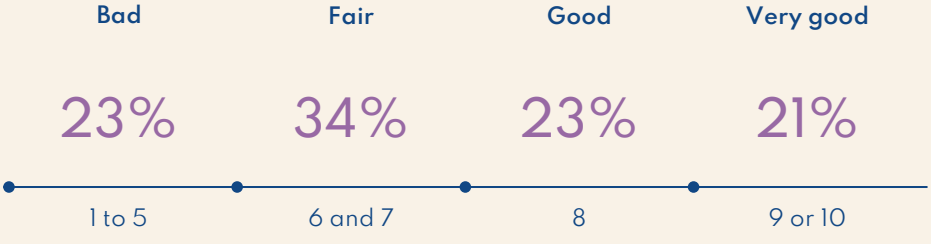
Women
N=707

On a scale of 1 to 10
how would you rate your current

PHYSICAL HEALTH



MENTAL HEALTH



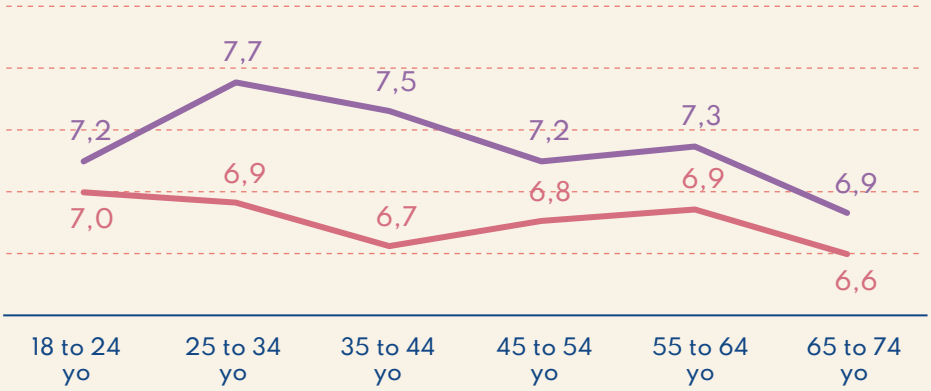
Q: On a scale of 1 to 10, where 1 is 'bad' and 10 'very good', how would you rate your physical heath and your mental health, respectively?

Distribution by age

PHYSICAL HEALTH

7,3 2021

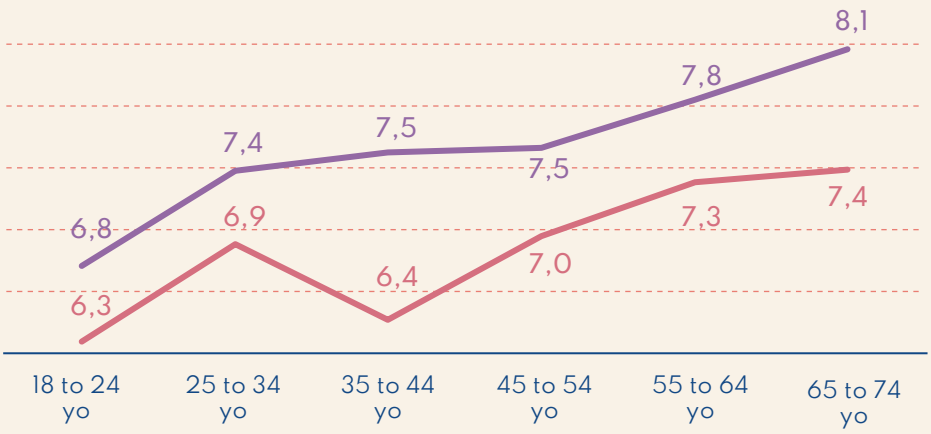
6,8 2022

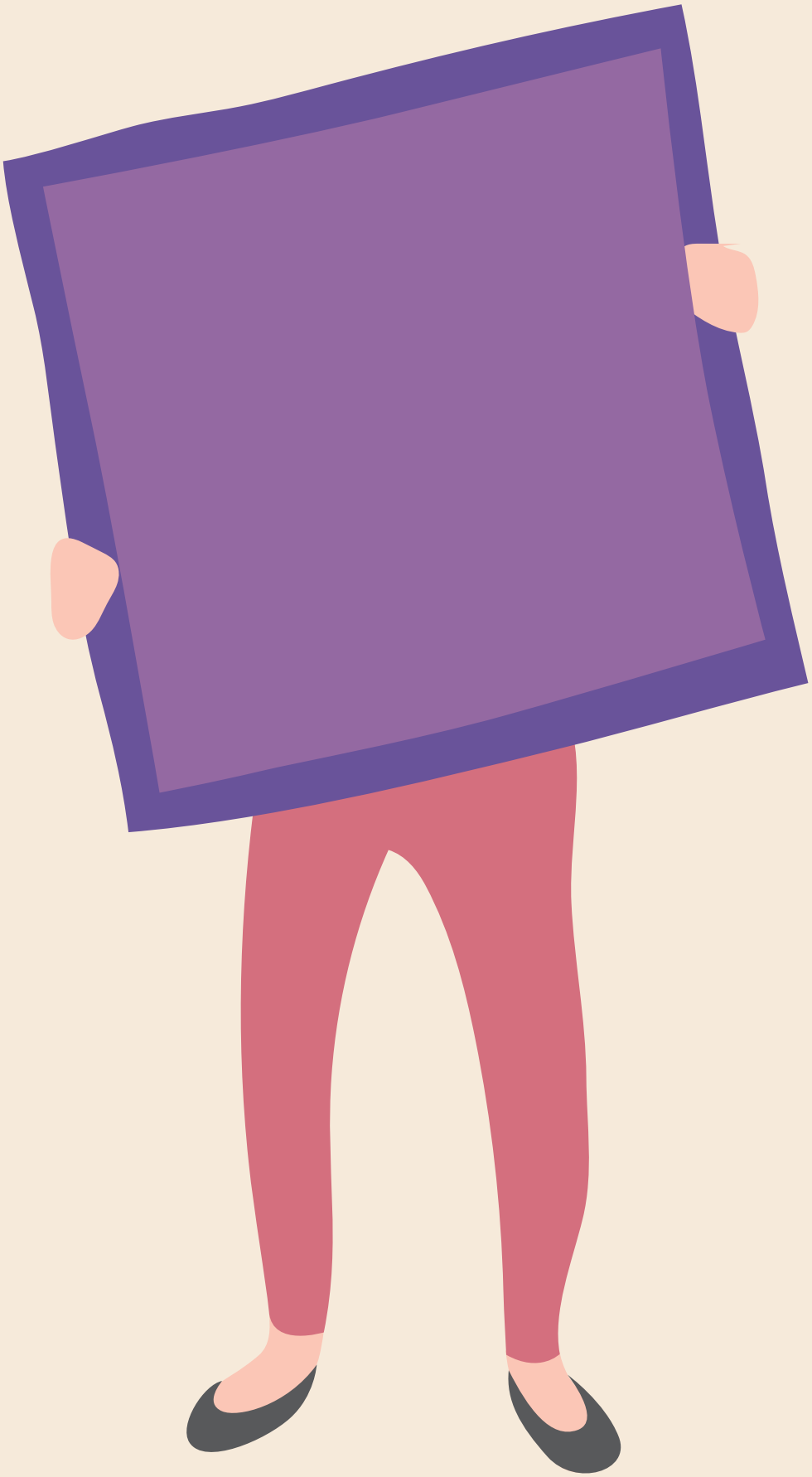


MENTAL HEALTH

7,6 2021

6,9 2022





Women vs men: what are the gaps?

On well-being

Subjective Well-Being

A Theoretical Framework

Well-being is a comprehensive, complex, and difficult concept to operate. Recognised since antiquity as a foundation for a healthy life, it has been a target of interest for philosophy and other social sciences and has recently been the research domain of positive psychology. Within this field, also because basic needs tend to be fulfilled, the concept of 'flourishing' or subjective well-being (SWB) has been developed, which expresses people's perception about their lives and can be an important indicator of progress.

Contrary to the tendency of psychology to study unhappiness and human suffering, subjective well-being is interested in conditions that distinguish slightly happy people from moderately happy or extremely happy people, based on the individual's internal experiences and not on external criteria or evaluations.

The aim is to form an understanding of long-term well-being states and not just momentary moods, in the search for a global evaluation that's not limited to a specific domain or stage of life.

As an indicator, it is based on the principle that just as it is assumed it is possible to identify the external circumstances that lead people to be happy, if you try and create these conditions for everyone—also by identifying the mental processes involved in high levels of life satisfaction—you can help other individuals to try and replicate them.

This approach does not aim to suggest that efforts to promote well-being focus on psychological characteristics, but that such intervention at the individual level can add to objective well-being, i.e. structural, material, and political circumstances (such as freedom, access to medical care, employment, or certain housing patterns), creating opportunities for the individual to flourish.

As it considers not only satisfaction with life, but also personal characteristics and psychological strategies when facing adversity, a subjective well-being indicator was developed in this research, inspired by a construction that allows for an international comparison. The aim is to make aspects that may be inhibiting a high level of well-being in women more visible.

More than relieving suffering, subjective well-being seeks to understand the positive factors that allow individuals to develop, thrive, and flourish.

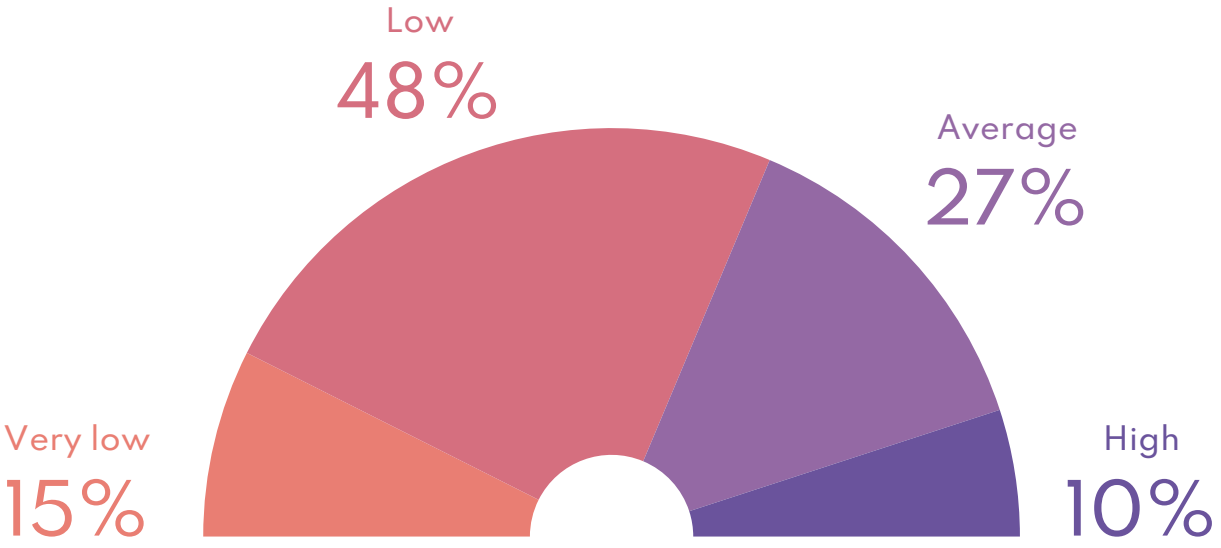
This 'flourishing rate' results from a combination of 'feeling well' and 'functioning effectively', which reveals significant well-being and good mental health.

Since this research aims at improving health, and as it has been gleaned from the previous study [The Health of the Portuguese: an ID] that health is closely related to the sensation of well-being, a subjective well-being indicator has been developed here.

Subjective Well-Being

Flourishing Rate

Results for Portuguese Women
N=707



'Flourishing Rate'

It means that only 10% of Portuguese women report a high level of mental health and well-being.

What does it represent?

Generally speaking, it refers to an assessment of what people think and feel about their life. It aims to measure the extent to which people positively judge the quality of their life as a whole, based on their own criteria.

It includes a general assessment of life satisfaction which, in theory, reflects how individuals consider themselves distant or close to their aspirations, but also an assessment of psychological characteristics and functioning, i.e. 'how well I feel' and 'how well I function'.

How is it measured?

In this study, the definition of subjective well-being is constructed as the exact opposite of depression and anxiety. Instead, looking at the absence of a mental disorder, it measures the presence of positive feelings and functions: compassion, involvement, meaning, optimism, positive relationships, resilience, self-esteem, vitality, emotional stability, and positive emotions.

In the same way that it is not necessary to have all of the symptoms of depression in order to comply with a diagnosis, only some of these characteristics are required to assume that people have a high level of subjective well-being.

Although the indicator focuses on those who fit into this high level of well-being bracket, other 'well-being levels' were also created for this exercise, in order to create different levels of distance from the well-being and mental health standards.

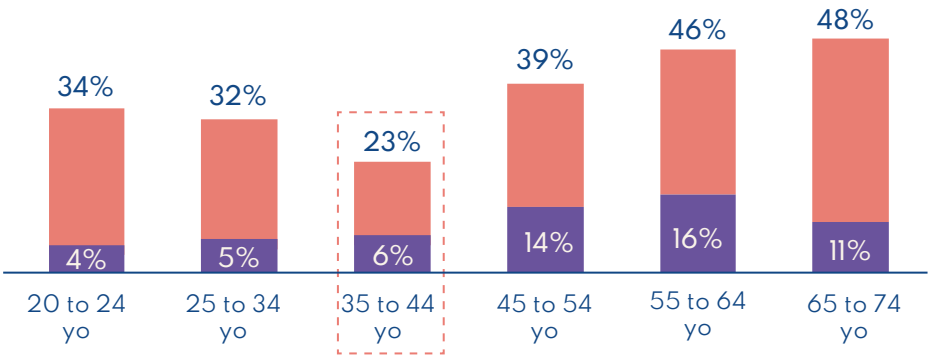
What does it reveal?

Only 10% of Portuguese women score on the 'flourishing rate', that is, they consider themselves happy with their lives and feel able to fulfil a good deal of their potential. This value aligns with the research that inspired the construction of the indicator [See annexes' page 166], which places Portugal last out of 23 European countries (at the time of the state, Portugal showed a 'flourishing rate' of 9.3%, as opposed to 40.6% in Denmark, where the highest value exists), suggesting strong associations between this low level of well-being and low level of education, the gap between rich and poor, and a low level of social confidence.

High or Average Subjective Well-Being Level

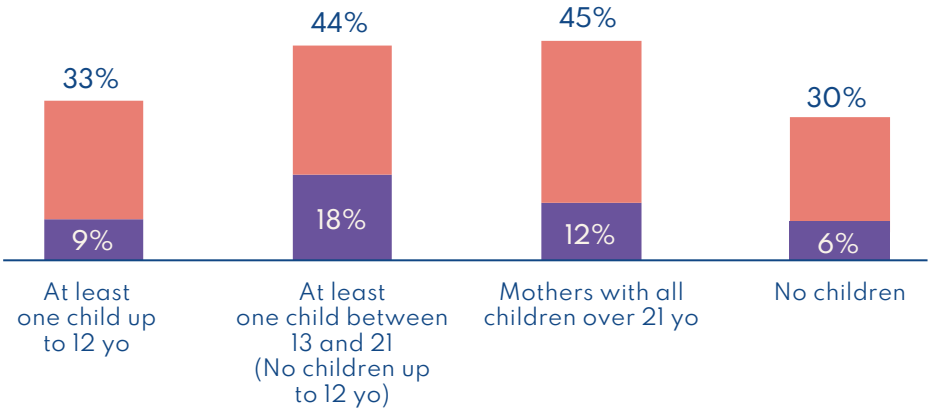
N=707

By age



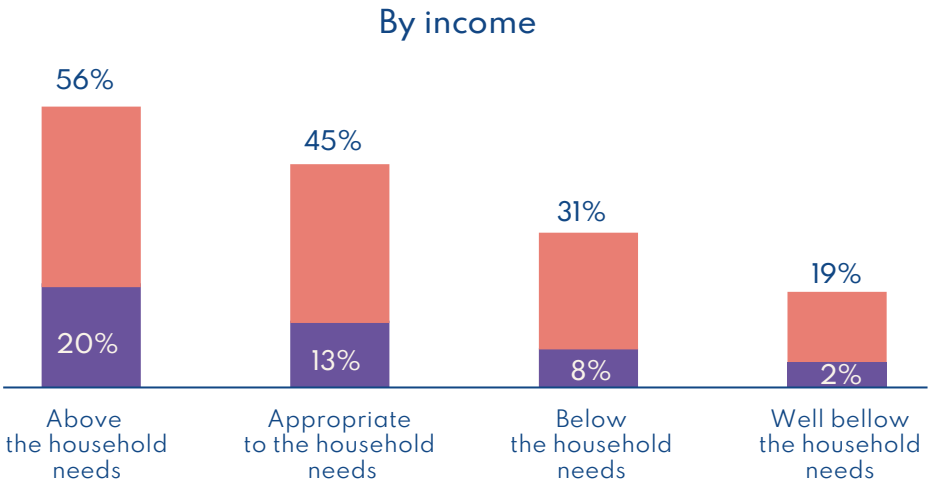
50% of women aged 35-44 have at least one child under 12 and 85% are working - either employed (76%) or self-employed (9%)

By children



High Subjective Well-Being (or flourishing rate)

Average Subjective Well-Being



Our experience of subjective well-being does not remain uniform throughout life. Some aspects point to an improvement as women age, namely regarding self-esteem and sense of purpose.

Younger women reveal less self-esteem, and feel significantly less purpose and emotional stability, and are also less resilient. This is the stage of life in which social relations place well-being at a disadvantage. On the contrary, it is between the ages of 25 and 34 that having a love life seems to contribute to well-being the most, although optimism is less present.

The greatest drop in subjective well-being occurs between 35 and 44 years of age. These women perceive significantly less competence, emotional stability, vitality, and positive emotions. They're not the ones who rate their general health worse, nor the ones who accumulate more disease—that tends to change with age; yet it is where one of the biggest leaps in terms of diagnosed diseases is observed (from 24% in 25 to 34 years, to 40% in 35 to 44 years). This is the largest segment of women with younger children, and they are the ones who face the greatest challenges when it comes to work-life balance.

Between the ages of 45 and 54, time control improves again, and resilience reaches its maximum. This is when professional life positively affects women's well-being the most—proof of the importance given to this aspect at this stage—but also holds great power to influence it negatively. Between the ages of 55 and 64, women begin to have a greater sense of purpose, although the importance placed on professional life begins to decline.

Between the ages of 65 and 74—in line with the thesis that older people tend to see their lives more positively —women report significantly more self-esteem, more purpose, vitality and stimulation, and they reveal more time control.

Gender nuances on Subjective Well-Being

Among the over 40s in Portugal, the 'flourishing rate' is 14% for men and 12% for women. This gap between men and women is in line with the majority of research, which suggests slight differences between the genders (with different interactions depending on age) and exposes very low levels of flourishing rates in Portugal compared to other European countries.

Despite the proximity between genders, some studies show discrepancies in the results that suggest differences in the way men and women experience well-being. In addition to having generally lower levels of well-being than men, women seem to show more variation, i.e. they show higher levels of ill-being and higher levels of well-being simultaneously, even if the overall well-being value is, on average, close to men. One of the hypotheses put forward suggests that women have more intense emotional experiences, which could explain greater vulnerability to depression, but also higher levels of happiness than men (which some researchers attribute to the fact that they perform the social role of care more often, which is more emotionally affecting).

A 2015 EU-funded study on gender differences in subjective well-being concluded that women report a higher level of life satisfaction than men, especially in countries where per capita income is higher (where men and women are more likely to experience similar conditions, e.g. in terms of income or work), but score worse on indicators that measure short-term emotions, and seem to be more exposed to mental disorders than men.

This study also shows that in short-term experience (namely in emotional stability and vitality) rather than in 'functioning', women score worse than men, suggesting that they experience less frequent or more unstable feelings of calm and serenity or energy levels. Men also seem to engage more often than women in activities that they find interesting, although there is no gender gap in the willingness to engage and learn.

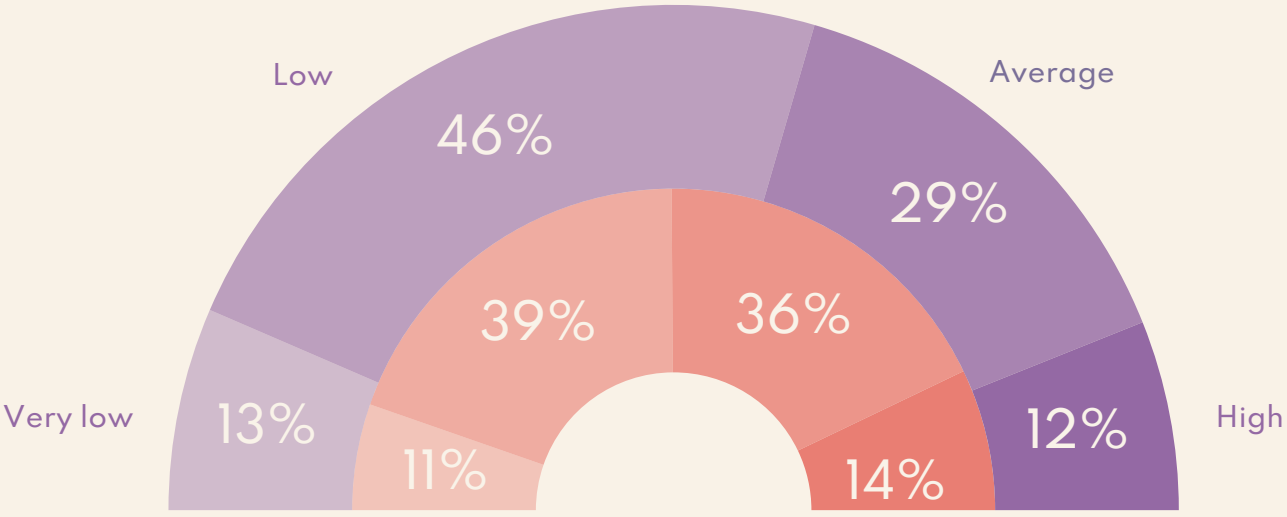
Men also outperform women with regards to assessing their personal characteristics, in particular optimism and self-esteem, which are often highlighted as important predictors of well-being and life satisfaction.

[1] Gender Gaps in Subjective Wellbeing, Claudia Senik, 2015
Fondazione Giacomo Brodolini (FGB) em parceiria com Istituto per la Ricerca Sociale (IRS).

Subjective Well-Being

'Flourishing Rate'

Women vs Men



	Low or Very Low	High
Women 40 to 74 yo N=478	59%	12%
Men 40 to 74 yo N=253	50%	14%

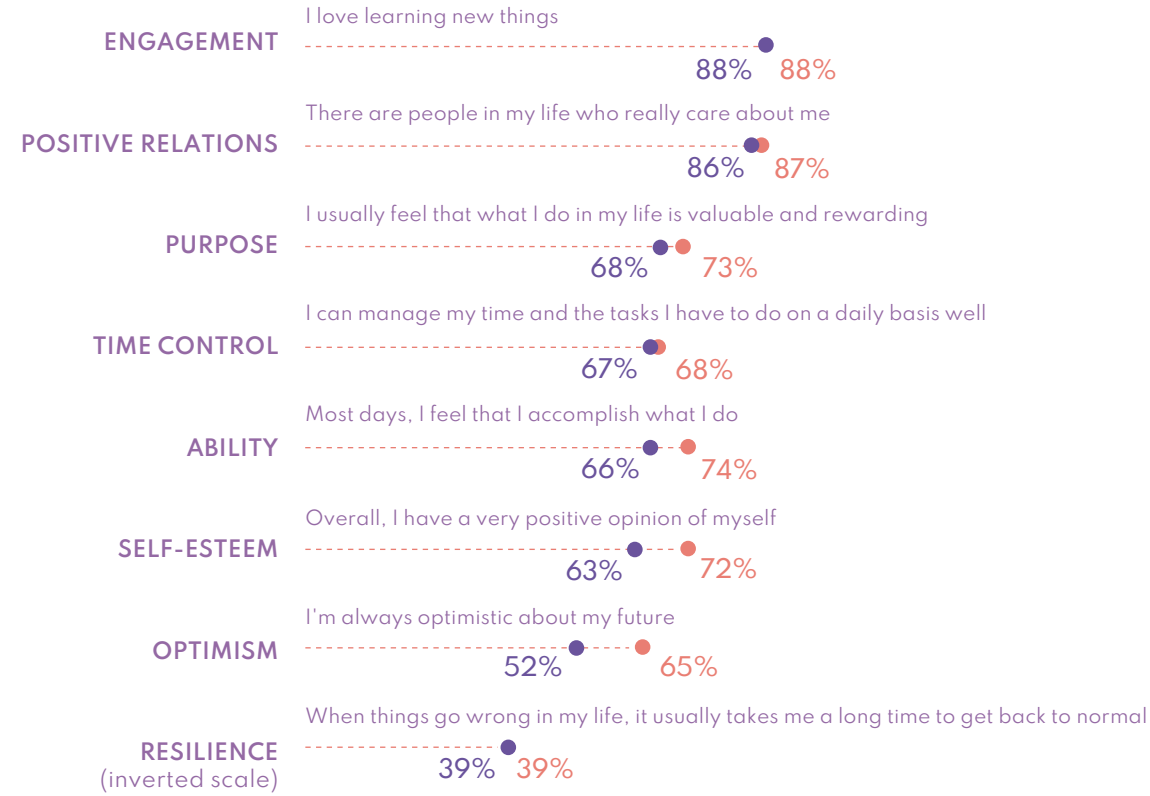
Subjective Well-Being

creating the indicator

N=731

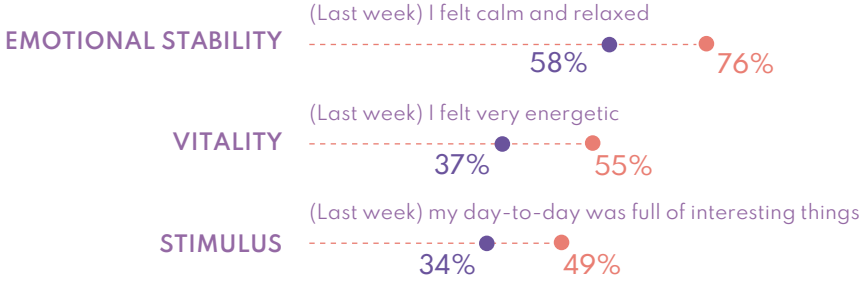
Personal Characteristics

Scale from 1 (I strongly disagree) to 5 (I totally agree). Answers TOP 2



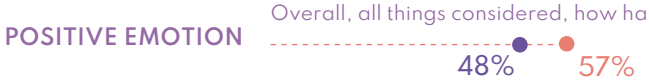
Short-term experience

Scale from 1 (never or almost never) to 4 (always or almost always). Answers TOP 2



Happiness

Scale from 0 (extremely unhappy) to 10 (extremely happy). Answers TOP 3



Women Men

Although this comparison exercise between genders enables us to conclude that there is a gap between Portuguese women and men, and men are at an advantage, there are numerous complexities involved in the analysis of subjective well-being that prevent a direct response on this matter. As suggested in many studies, the answer to the question, 'Do men experience better subjective well-being than women?', still is: it depends.

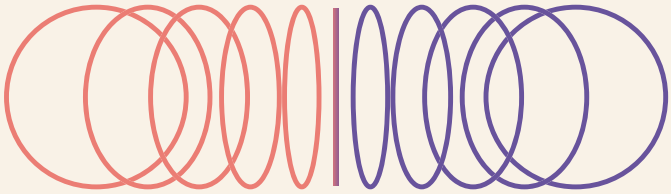
In addition to the biological aspects and evolution of the life cycle, expectations about gender roles lead to differences in how men and women build perceptions about their lives and their own characteristics. We know that life satisfaction reflects the difference between our realities and built-up expectations—and that aspects such as work, or family can vary greatly between genders (and between cultures).

Men and women do not give equal weight to the different aspects of their lives, nor do they assess themselves in the same way. Even if we can, for example, conclude that self-esteem is one of the aspects hindering the subjective well-being of women, the way men and women perceive their self-esteem is still distinct.

This does not mean that the exercise is invalid, but that there is still substantial work to be done around the topic in order to promote an understanding of gender and well-being.

The construction of self-esteem

Women perspective



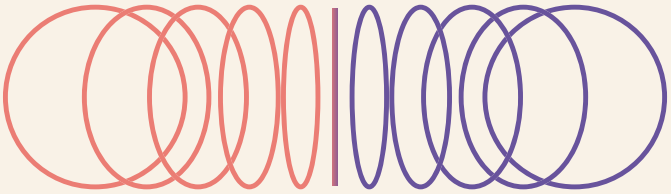
"I had always thought I wouldn't have a family ... for various reasons. Because I had never had a long-term relationship, I had lots of problems with myself, being heavy, being big. As I was telling you, I go to the doctors, and they say, 'You're heavy, but you disguise it well!'. Because I am 1.75 tall. I'm tall, but I hate that people tell me that. I'm big, I am what I am! (...)

[Being heavy] really affected me psychologically. People didn't notice it, because I never showed it ... now I can show it, but at the time, I couldn't. Shame on those who said something to me. I would be extremely offended ... but it always made me [strong]. I wore a cape and sometimes that's worst because one does not externalise how one feels...

That was something I achieved when I got together with my partner ... acceptance. If he wanted to be with me, he would have to accept me as I was. You now think that I'm about 300 kilos. It's not the case, but for me, it feels like I am."

W, 42 years old, unmarried partnership, two stepchildren, with obesity problems

Men perspective



"I think women are more competitive in comparison with men in this aspect regarding appearance. With men, I've never felt that. Men are more about behaviour. As I shared with you, I have some leadership traits … people don't see me as fat, thin, tall; they see me for who I am. Women have this comparative level, competitive level.

Say a lady in a workplace starts slimming, she becomes cuter—men are also like that, at the peak of the yo-yo, I look different—but I don't care about it. Ladies care more … the lady slims down, gets prettier, and then eight others also go on a diet. This has happened in many situations.

In my experience, it's different with men … even during the evil stages of the yoyo, I was playing football, I was always good at it, but physical condition is important. At tournaments, my opponents would ask, 'How do you play so well?'. It wasn't … you must lose weight. No, they would compliment the way I could play like that in my condition. With ladies, I think it's more like, 'She doesn't take care of herself, she's sloppy'. You get that kind of talk."

M, 50 years old, married, one child, obesity problems

Women are (still) under a lot of stress

A FFMS study on women in Portugal[1] identified three 'fronts' that significantly influence women's lives: the 'front' of paid work, the 'front' of married life, and the 'front' of children. Women who work and have children had less time for themselves. The fact that they lived as a couple did not free them from a single hour of work per day. Women with children, in a couple or single, worked around 13 hours a day, from which only a little more than seven of those were paid and around six were unpaid (this includes household chores, childcare and shopping/errands).

Another recent study by FFMS looked at young Portuguese people[2] between the ages of 15 and 34. The study found that although the gap decreases the younger the person, household tasks and those related to children are still 'much more the responsibility of women than men'.

As much as society is evolving, and even starting to recognise that men and women have different perceptions about each other's roles, there remains a gender imbalance regarding domestic tasks. It is precisely in sharing and using time that the European Institute for Gender Equality believes that gender inequalities are more pronounced in Portugal and where there is more space for improvement.

The pressures to which women are subjected is explained by reasons that go beyond their living conditions. Studies in the UK and US[3] show that while the number of hours men spend performing domestic work decreases as their contribution to the household income increases, the same is not true for women. In fact, their domestic involvement also decreases, but once their financial contribution equals or exceeds that of men, it stops decreasing and often increases again (something that some researchers read as a form of 'doing gender', that is, women compensate for their predominance in a typically male sphere).

The need to accomplish with merit all 'fronts'—personal, love, family and professional life—costs emotional well-being. In the sample, the group between 35 and 44 years old, where half of the women with at least one child under 12 years old are concentrated, are the ones who most recognise that they suffer from anxiety - 35% report living 'in a state of tension' vs 26% of the total sample; it is also the age group where women refer to work life as something that jeopardises their well-being.

[1] As mulheres em Portugal, hoje: quem são, o que pensam e como se sentem, FFMS, Feb 2019
[2] Os jovens em Portugal, hoje: Quem são, que hábitos têm, o que pensam e o que sentem, FFMS, Nov 2021
[3] Gender Gaps and Subjective Wellbeing, Research Report prepared by Claudia Senik, Publication Office of the European Union, 2015

The difference in household roles also affects references and expectations. Even among young people, managing work and personal life has become one of the aspects women value the most when they refer to the 'ideal job', which differs for men.

The veneration of the work-life balance as suggested by several studies on women, is logical and well-intentioned, but conceals some dangers.

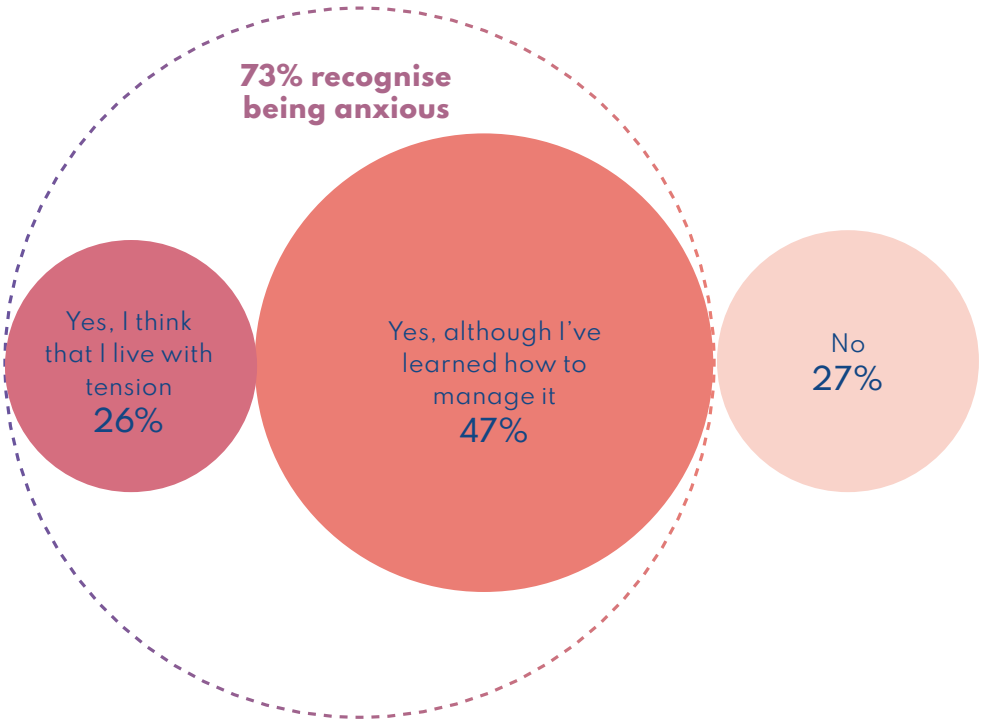
On the one hand, it suggests that balance is not only achievable, but also something that takes effort from women. This emphasis on balance can bring even more pressures and challenges to her well-being by suggesting that reconciliation is possible when it is almost unattainable in a context full of professional demands and unchanged gender expectations.

On the other hand, the balance narrative can reduce the discussion of employment and work to hours, ignoring the fact that the need for challenge and expression through work is equally valid for women and men. In fact, studies prove that work interferes with their well-being (by optimising potential and purpose), even if they tend to have less traditional 'career models' throughout their lives compared with men.

In fact, reaching gender-neutral territories will only be possible if, in addition to the participation of men at home, new success stories are created that help to alleviate the current tension between women's personal and professional identities.

Do you feel anxious, nervous, worried, or apprehensive (often in situations that do not justify it)?

N=707



'I think I live with tension'	**24% Women** 40 to 74 yo N=478	**15% Men** 40 to 74 yo N=253

Anxiety is the factor most associated with subjective well-being, ahead of serious disease, chronic pain, and even depression. 91% of women who have a very low level of subjective well-being experience anxiety.

In this respect, the gender gap is large: 24% of women between the ages of 40 and 74 admit to 'living in a state of tension' compared with only 15% of men of the same age. The physical consequence of anxiety also varies between genders, with physical-led anxiety problems not only more common, but also occurring more often in women than men.

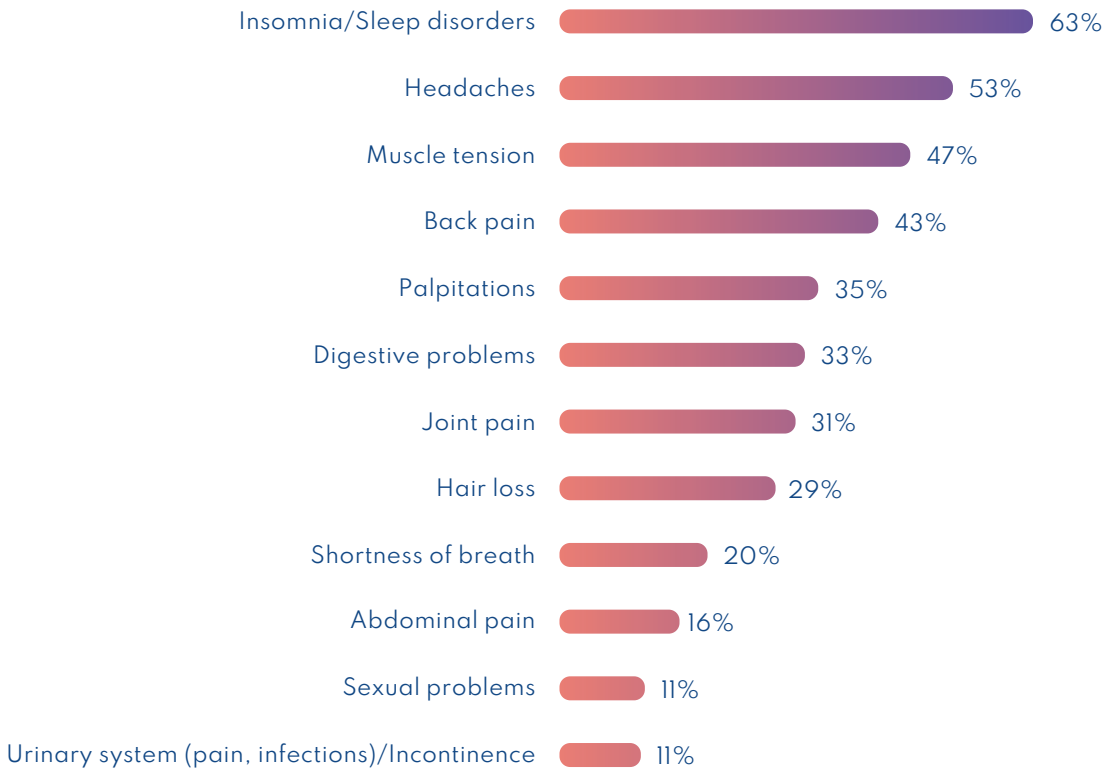
37%

of women who perceive themselves as anxious feel that their stress or anxiety is causing physical problems

N=517

What kind of physical problems?

N=319



# of physical problems you feel (in average)	**3,88 Women** 40 to 74 yo N=218	**2,83 Men** 40 to 74 yo N=82

How can they be explained?

Historical devaluation

Under-representation in research

Right from the start, women's health has been at a disadvantage when it was first passed over to men for research purposes in mapping out the human body. The earliest known account of a dissection is credited to the Greek philosopher Theophrastus (? - 287 a. C.), to whom the origin of the name anatomy is attributed, which today covers the whole field of biology that studies the form and structure of living beings. The invisibility of the female body in anatomy and research in general is echoed in the history of scientific illustration. Any Google search on anatomy (which involves dissection) over the XV, XVI or XVII centuries returns images of male bodies.

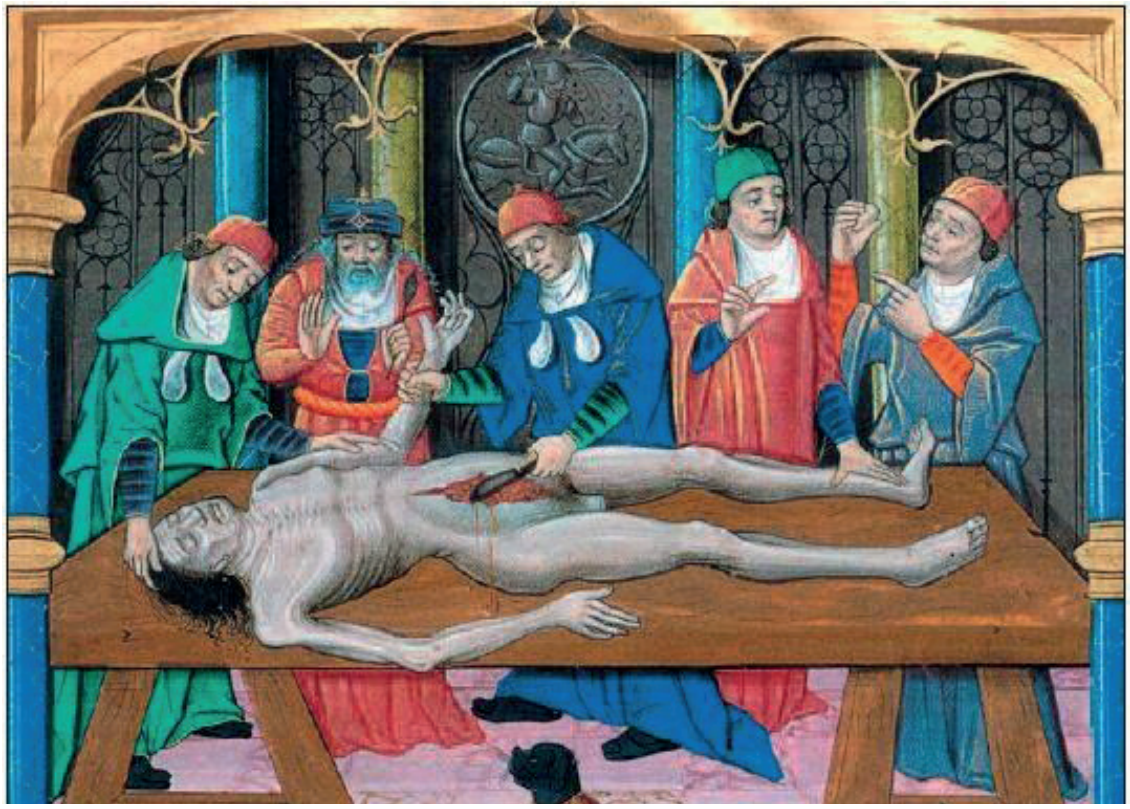
Science itself was affected by the prejudice that kept women out of the sphere of science. For centuries, research was influenced by social beliefs that the woman was an inferior being. Darwin (XIX century) and his followers argued that women could never aspire to be equal to men on an intellectual level. This conviction, which was proven when it was written in the discourse of scientific authorities, does not differ much from what many centuries before led Aristotle to argue that women were a kind of deviation from a more perfect type: the man. Men would be the measure of humanity and woman a fault, an incomplete man or even mutilated.

In the biological sciences, where there is more than one sexual form of a species, the male is considered the standard specimen; similarly, the representation of a male body tends to be the illustration of the human species. The representation of the female figure, when there is one, is mostly associated with specific themes: reproductive organs and pregnancy.

> "The exclusion of women's bodies from anatomical textbooks, except the specifically obstetrical, reveals the phallocentricity of the anatomical discourse, even in the 20th century. The male body is understood to be the 'universal' anatomical model, and homologies with the male body are physical as well as visual."
>
> Petherbridge & Jordanova, 1997

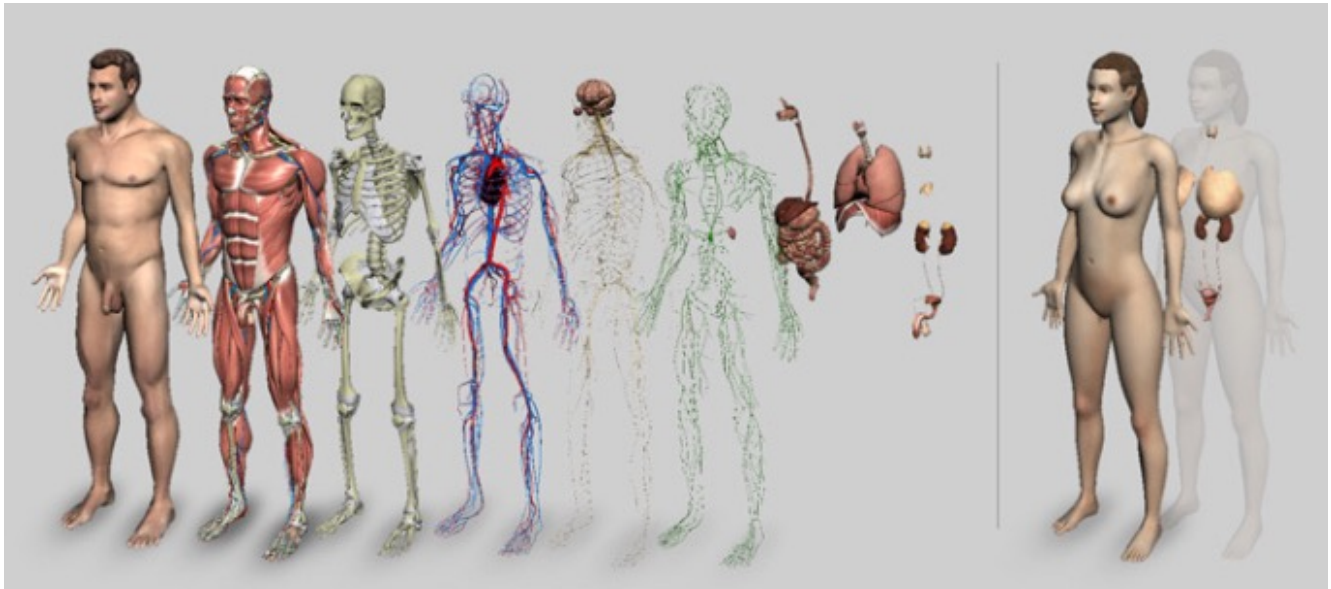
'The female is, as it were, a mutilated male.'

Aristóteles
(384-322 a.c.)



Dissection of a corpse, painting from the 15th century.

During the Renaissance, dissections became a central practice in medical education and research. Until 1800, they were carried out in public, since their value was considered not to be confined to the medical community, but to the whole of society.



Top image: illustration from The Human Body book What It Is and How It Works (1959). Golden Press.
Bottom image: Biosphera, Software image Introduction to Human Anatomy 3D (2012)

In a study[1] that focuses on the historical representation of the female body within scientific illustration, it is explained how, in addition to the anatomical characteristics of each sex, gender representations are usually used. Although sex alone does not determine a female or male identity at birth, and cultural aspects are unnecessary for understanding the biology of the body, anatomical illustrations are far from neutral, importing sociocultural messages, ideas, and values.

Scientific images are imbued with characteristics that are considered 'appropriate' to each sex and the very ideal of beauty and health in effect, whether by body language, dress, posture, hair or silhouette. In fact, scientific research has not only failed to move away from gender stereotypes but has also helped to perpetuate gender discrimination problems. At each stage of its long history, and far beyond figurative representation, medicine absorbed and strengthened socially constructed gender divisions.

"One is not born, but rather becomes, a woman. No biological, psychological, or economic destiny defines the figure that the human female acquires in society."

Simone de Beauvoir

For centuries, medicine persisted in the belief that, except for reproductive organs, all other organs and functions functioned equally in men and women, so there was no need to study them. Knowledge about female biology was centred on women's reproductive capacities. This defined and restricted the meaning of being a woman.

Even during the twentieth century, many studies prove the under-representation of women in research. Up until the 1990s, it was argued that the variation in hormones associated with the menstrual cycle would introduce too many variables, and affect the consistency of the results, meaning that the exclusive participation of men in clinical trials was common.

On the other hand, the possibility of pregnancy could not be ruled out, so males (rodents) would be chosen instead of both fertile females and females in general, particularly when testing medicines, in the laboratory.

Nevertheless, it is illogical to consider that gender difference justifies the exclusion of women in these studies but not the extrapolation to women of the results of tests done only on men.

[1] The female body in scientific illustration: a visual reflection around conventions and standards of representation, Marta Jerónimo Miranda Afonso, Masters

Historical devaluation is still present

There is undoubtedly still a lack of knowledge about women. The inclusion of gender as a variable to be considered during research is relatively recent in medicine and, although more and more funding requires the inclusion of women in clinical trials, it cannot be said that they are currently represented sufficiently.

It is not known how taking medication can affect the menstrual cycle. It is not known how the symptomatology of some diseases differs between men and women. It has become evident that there is an under-diagnosis of heart disease among women because they have different complaints compared to men, and because their physical symptoms are more likely to be associated with mental disorders.[1]

The Portuguese Society of Cardiology states that 80% of deaths from coronary heart disease—the main cause of death among Portuguese women—can be prevented with lifestyle changes and education, but adds that 'the coronary disease in women is under-diagnosed and there is a recognised level of under-treatment'.

The general consensus is that the gender bias still exists — in research, in clinical practice, and in patients themselves —which leads to the misdiagnosis of diseases because they present themselves differently in women. Other diseases that affect mainly women remain partly a mystery, with consequences for the medical practice and women's health.

> "The 'nature' and capacities of women were vigorously investigated by a scientific community from which women (and the feminine) were almost entirely absent. Consequently, women had little opportunity to employ the methods of science in order to revise or refute the emerging claims about the nature of women. (...) Thus emerged a paradox central to the history of modern science: women (and what women value) have been largely excluded from science, and the results of science often have been used to justify their continued exclusion."
>
> Schienbinger, 1987

[1] Statements by Cristina Gavina, Vice-President of SPC (Portuguese Society of Cardiology), 2021

Gender bias in medicine

Gender blindness

Under-representation of women in clinical trials, linearly extrapolating results from male to female tests—that persists. A study that analysed 20,020 clinical trials in the US between 2000-2020 revealed that women are under-represented in cardiology, oncology, neurology, immunology, and haematology clinical trials[1]. According to Yale School of Medicine, out of the 25 participants in a 2015 study on 'female Viagra', 23 were men[2]. This bias explains why symptoms are not always related to diseases in women or why there is a greater incidence in women of serious adverse effects of medicinal products (clinical practice is conducted by weight-only adjustments, while other aspects, such as gastrointestinal transit, may be important in drug absorption).

Male bias

A male-dominated research perspective is reflected in the choices of the problems studied. According to a PubMed survey, there is five times more research on erectile dysfunction, which affects one in five men, than on premenstrual syndrome, which affects the overwhelming majority of women[3]. It is also responsible for the lack of awareness surrounding the causes of certain female diseases, such as endometriosis, which affects one in 10 women [in the UK, for example, an average of seven and a half years is estimated between the first time a woman sees a doctor about their symptoms and the final endometriosis diagnosis [4]].

Gender role ideology

The doctor and patient's attitudes stem from stereotypes built around men and women. When it comes from the patient, it can influence the way symptoms are expressed or even if medical attention is sought. When it comes from healthcare professionals, it means that diagnoses are made is differently according to gender. A 2018 study found that doctors often consider men with chronic pain as 'courageous' or 'stoic' and women with the same symptomatology as 'emotional' or 'hysterical'[5]. These representations can also be harmful to men; for example, in situations of depression or osteoporosis, diseases that are more common in women.

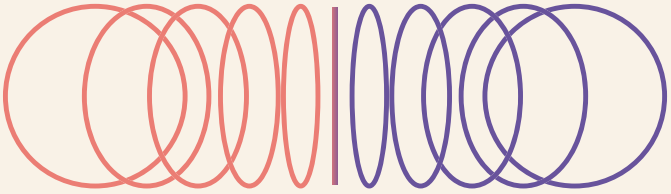
[1] Northwestern Medicine, Analysis of Female Enrollment and Participant Sex by Burden of Disease in US Clinical Trials Between 2000 and 2020, published on 18th June 2021 at JAMA Network Open
[2] A Drug for Women, Tested on Men, Yale School of Medicine, 2016.
[3] The female price of male pleasure, The Week, 2018.
[4] Endometriosis in the UK: Time for Change - APPG on Endometriosis Inquiry Report 2020, based on a survey answered by 2890 women with endometriosis
[5] 'Brave Men' and 'Emotional Women': A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain, 2018.

Female fragility: a cultural conception to be deconstructed?

The gender bias, which has been relevant regarding the advance of medicine, naturally crosses in the way each gender manifests its discomfort. This would suggest that women, culturally associated with frailty, would give in more easily to this role. However, in reports from the women we interviewed, we found precisely the opposite; women attempt to escape from this place of fragility, even when the malaise was evident.

Among Portuguese women, especially older women, there is the legacy of a certain type of woman who was able to resist stoically in a country that for a long time did not know how to protect her from profound gender inequality and, so often, from poverty and disease. These women were mothers and grandmothers of the Portuguese women we interviewed, and their essence still interferes with their identity construction and in the assumption of female virtues.
If we consider the fact that most women (naturally) suffer more in comparison to men, is it even correct to say that they are more fragile? On this matter, the sample's opinion is divided. Even if 'frailty' is subject to various interpretations, research suggests that around half of women tend to distance themselves from this association, even (or mainly) in comparison to men. Among the women surveyed, 53% do not find themselves in a place of greater fragility than men, a number that rises slightly among women between 45 and 54 years old; 39% report feeling generally more fragile than men around them, although it is difficult to generalise; only 8% report that men are stronger, and women should not counteract their fragility.

Although acknowledging of frailty may mean that women become more defensive in relation to events that disturb their well-being (assuming that they are more susceptible to disturbances than men), the escape from this condition remains present in most Portuguese women, who (culturally) have always placed themselves in a role of inferiority.

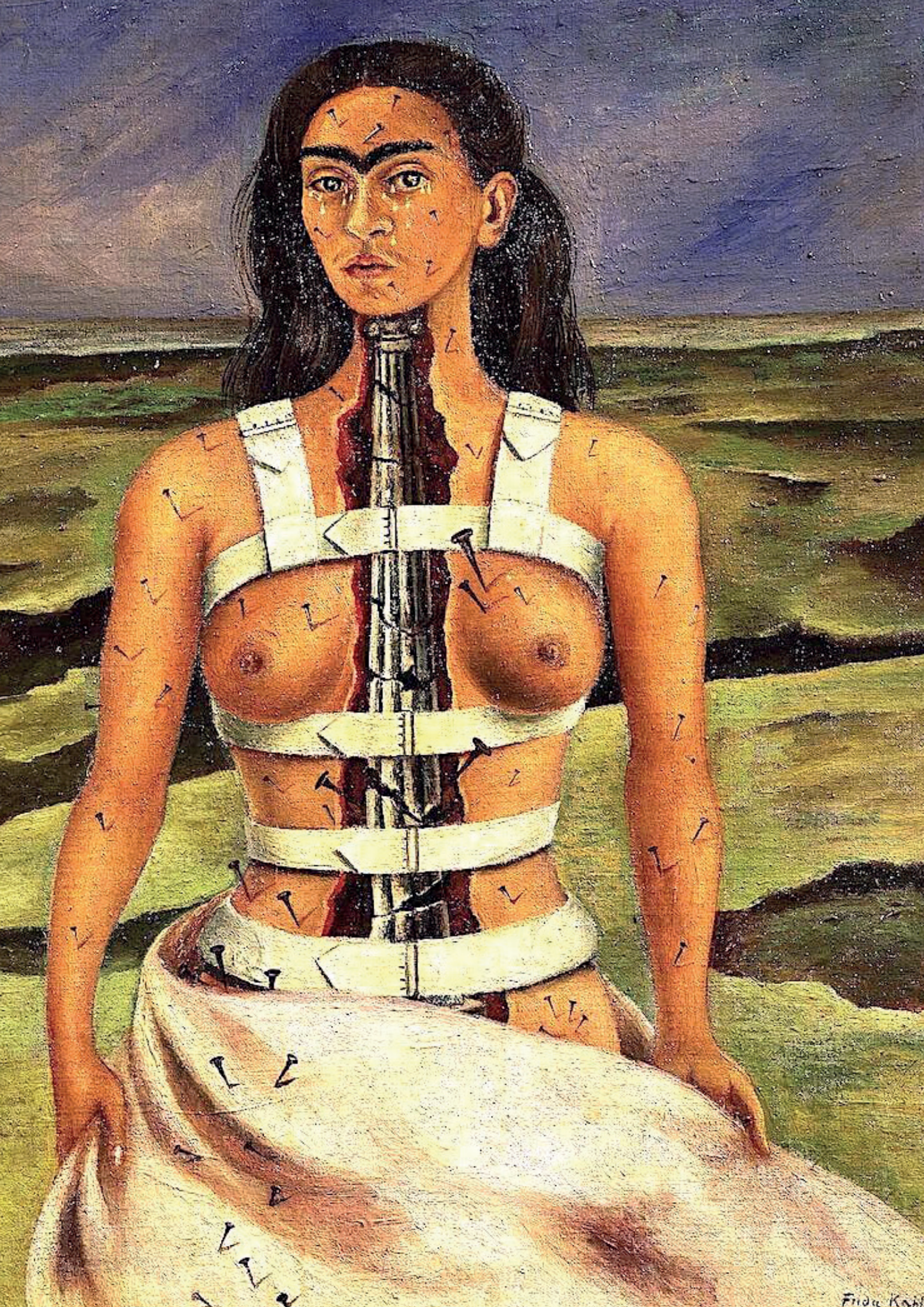


"Recently, a cousin of mine had a stroke and was paralysed on the right side. People have thrombosis or a stroke and stay. And I'm like, 'Oh my God, can this ever happen to me?' And will I, with just one arm, be able to pull the other? I think like this ... if anything happens to him [to the husband] I'll be able to help him ... massages, exercises back and forth, I think I'll be able to help him. If that happens to me, I don't know ... I don't think so. He will cry and cry but won't go there. I'll have to pull my arm or, if I'm capable, I'll have to tell him: 'Husband, pull my arm!'."

W, 72 years old, married, two children, in-depth interview

"My mother was also [strong], not as much as I am, but she was a fighter. This posture of being strong is also wrong, it is not always good (...) We have more blemishes. I normally say that we have more blemishes on the belly than they do on the whole body. We have all the hormonal part, all the fertile part of the woman is much more complex than the man's ... have you seen what they have? A urinary tract infection, that's a joke to us! ... they have much more strength than we do, one must admit, but we are much more perseverant, we are more resilient."

W, 56 years old, divorced, three children, in-depth interview

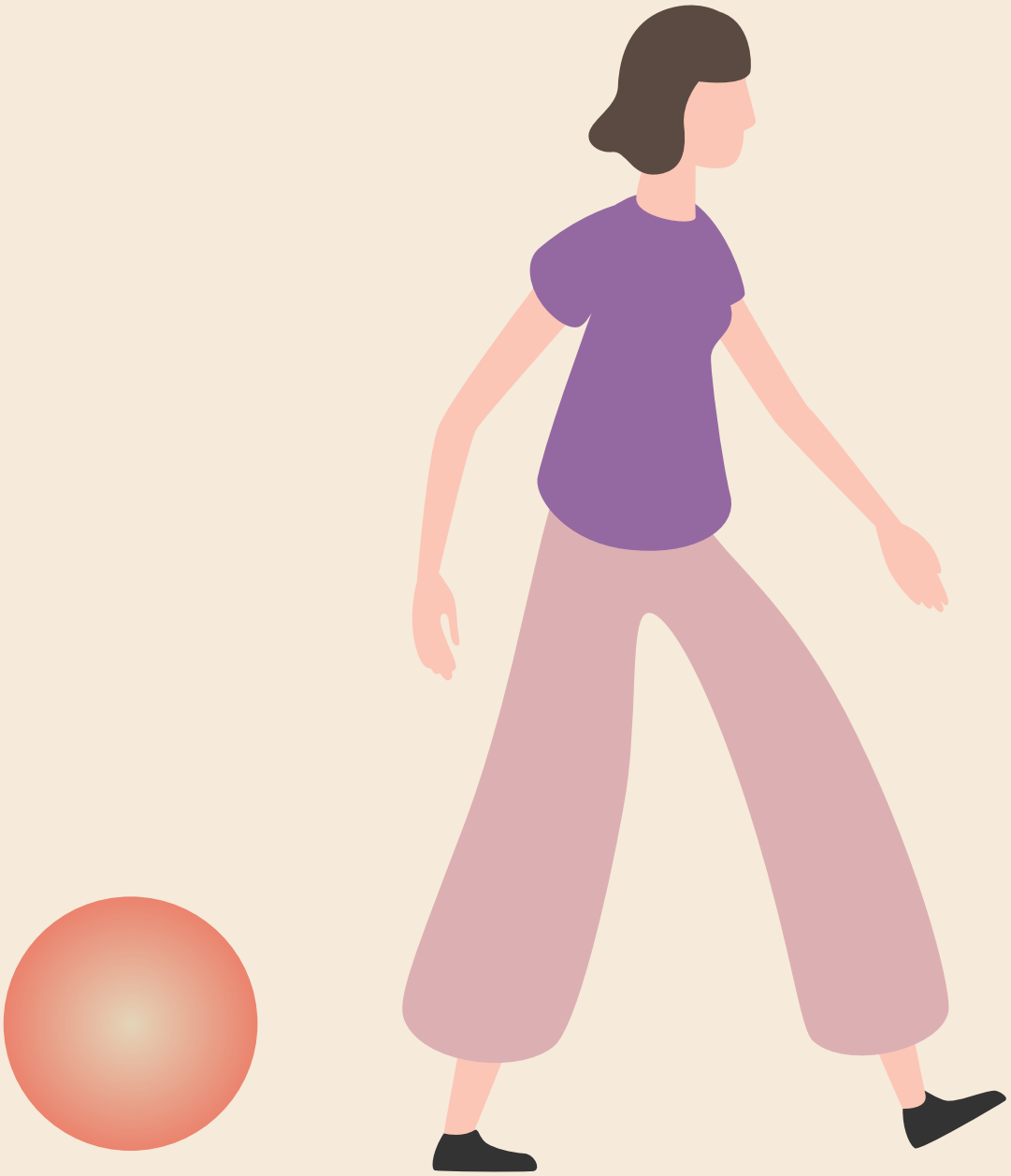

Frida Kahlo

Frida Kahlo:
On the one hand, the documentation of her fragility, and on the other, her strong spirit, depicted by a male image.

Frida Kahlo's whole life was marked by the physical pain she suffered following a childhood accident and from the surgeries to which she was consequently submitted. The honesty and coldness in the representation of human pain are hallmarks of her work, but while it is true that she exposed her fragility, Frida also seems to have renounced the female gender— when she depicted herself wearing male clothes with short hair—representing her strength when facing adversities.

There is a clear gap between men's and women's reports on their health and well-being. One could say, as they visit the doctor more often, they would have more diseases diagnosed. Or that it's culturally easier to assign the role of patient to women, as some experts suggest. Or even that we have not yet fully defeated the historical devaluation regarding women's bodies and health.

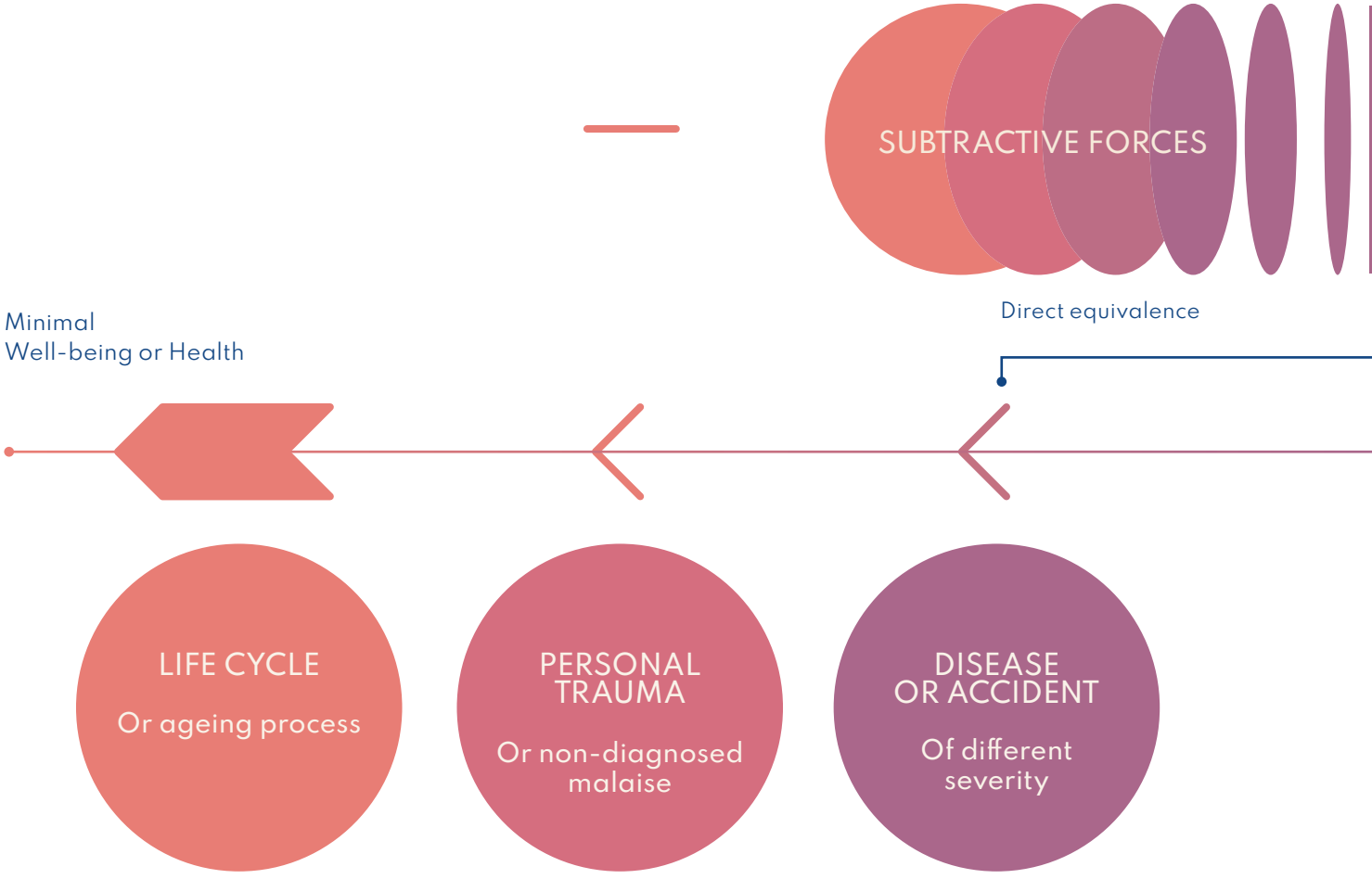
It is not the intention of this research to deny or confirm these hypotheses; instead, we aim to focus on trying to better understand well-being subjective variables that can explain these differences and, in particular, prove the existence of health and well-being areas that women do not achieve because they lack information or awareness or because they normalise the malaise associated with their reproductive health.



How can they be explained?

Physiognomy of the life cycles

Health status: an itinerant condition (recovering the concept)



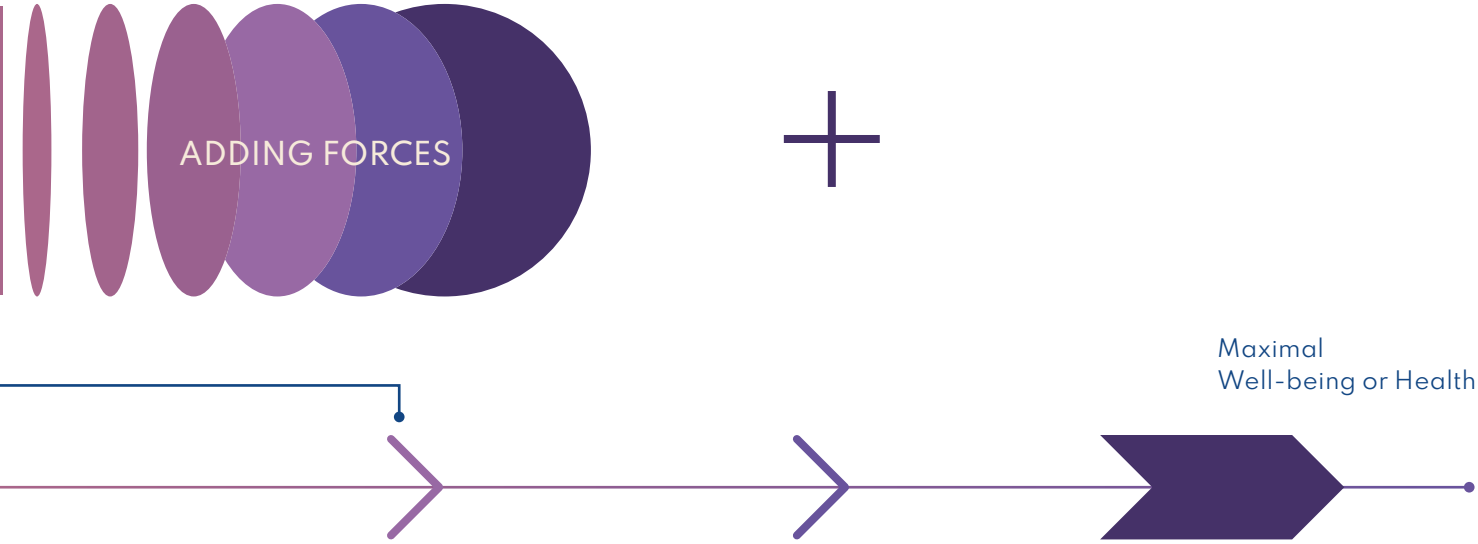
Forces that result not only from the specific requirements of each stage of the life cycle, but also from ageing—a process of degeneration of the organism, which results from the natural passage of time and, in an advanced stage, brings about dysfunctions, limitations and weaknesses.

Subjective diverse forces. They may have symptomatology (despite the absence of diagnosis) or simply impulses arising from traumas related to disease episodes; awareness of genetic heritage—conscientious or not—is in this sphere of fear of a pathology.

Diagnosed diseases or accidents of different nature and severity that require a direct response. These are unpredictable forces, unlike those stemming from the natural ageing process or those related to specific life cycle stages.

In the 2021 study, The Health of the Portuguese: an ID, health was represented as a continuous axis that is established between two ends: maximum health (without objective limit), and minimum health, which culminates in death. All people stand somewhere between these two ends, and that position is not fixed in time. As exuberant as health is, everyone experiences displacements along the health or well-being axis throughout life.

Generally, one slides along the axis as one ages. This model—a simplification of a subjective and extremely complex equation—seeks to highlight opposite forces that unchain movements along the well-being or health axis. On the left side, the factors that can remove well-being, on the right side, the action of the person, more or less induced by health professionals.



RESPONSE TO DISEASE OR ACCIDENT

Adherence to cure processes

Response actions to a diagnosed disease, self-conducted and/or by healthcare professionals. Theoretically, they have a beginning and end (the cure), except for chronic diseases, where the healing process is replaced with an effort to defend the health condition.

PROTECTING FROM THE CONDITION

Protect health and prevent disease

Actions performed with the purpose of protecting health and preventing disease. It includes managing well-being on a daily basis, preventing the onset of illness (due to an unhealthy lifestyle), detecting diseases (e.g. by screening) or minimising the sequelae of an already diagnosed disease.

ENHANCING HEALTH

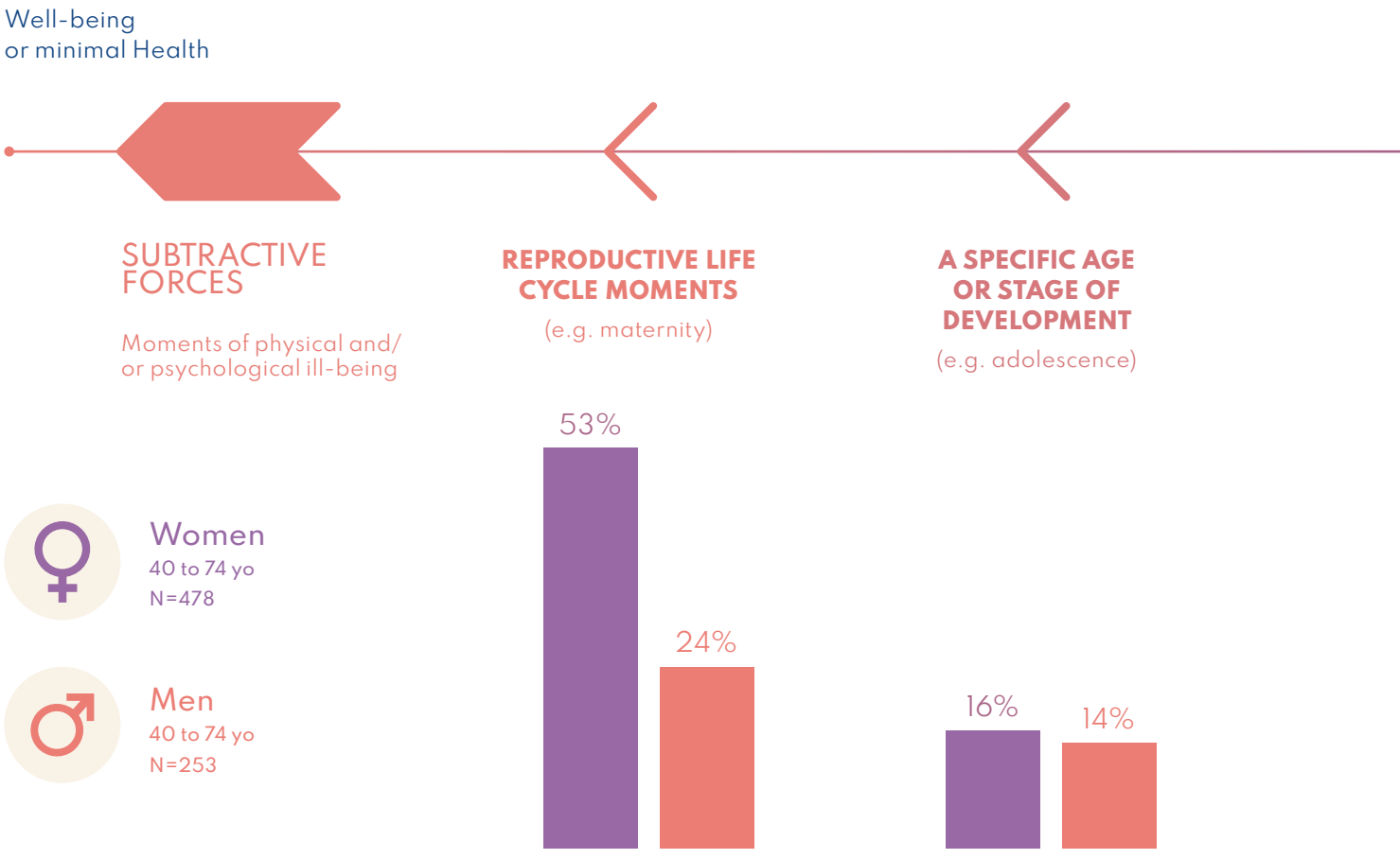
Well-being maximization

Own-initiative actions regarding healthy lifestyles, with the aim of improving the overall health level. People seek more vitality, self-esteem, well-being, etc. It can be long-term or more oriented to the achievement of longevity (with quality of life).

Female malaise with no male equivalent

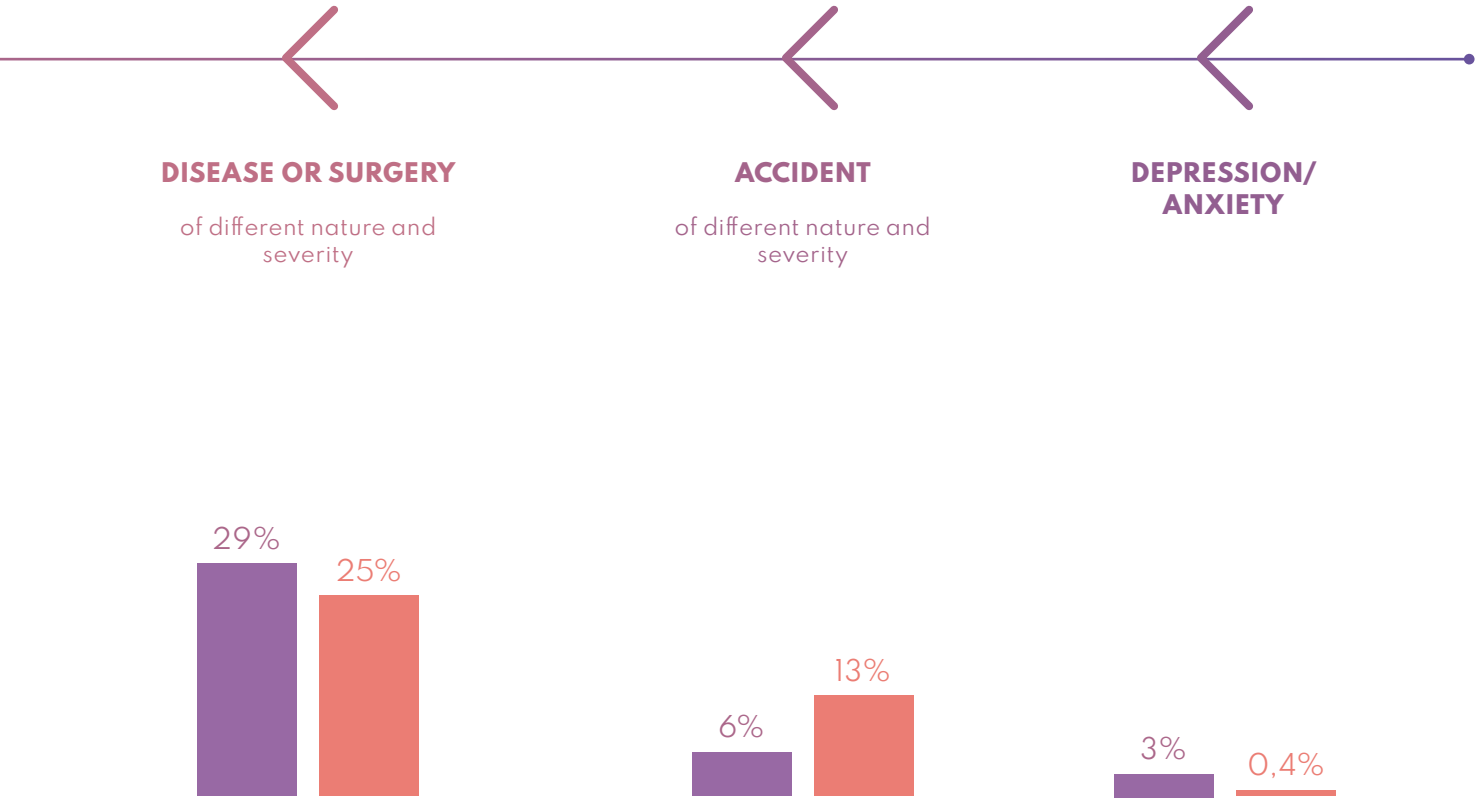
There are conditions and experiences within the life cycle that are unique to women. Pregnancy and childbirth are not diseases, but they are processes that can have negative health implications. Issues related to menstruation, contraception, unwanted pregnancy, abortion or fertility problems have repercussions only on the woman's body. As much as it is recognised that men are involved and sensitive to some of these processes, there is an insurmountable gender dichotomy in everything that involves women's reproductive health.

If we remove illness, surgeries, and accidents from the list of events that were at the genesis of a moment of profound physical or psychological ill-being, we see that there are subtractive health or well-being forces throughout women's life cycles, such as pregnancy, that have no male equivalent. Even those where equivalence is possible, such as the post-birth of a child, depression in women's well-being is much more profound, and the recovery process much more demanding.



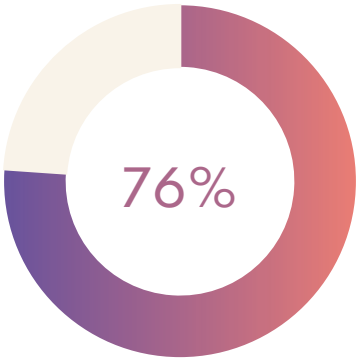
The extent of those differences between the sexes in terms of well-being is reported by the weight of those who report at least one time that they faced malaise during their lives: 72% of women vs 48% of men between the ages of 40 and 74. The difference is significant and increases when we look at details of the events that brought forth the malaise. Women not only report, on average, more events, but more events with harmful physical and/or psychological consequences. 16% of women who have experienced malaise say that they have been left with serious damage (in the body or mind) and that they are currently dealing with that, in opposition to 8% of men.

The fact that women are naturally subject not only to more subtractive forces, but also to more powerful subtractive forces, can explain why the extra effort they make to stay healthy is not reflected in their health condition (and perception). The counterforces they embrace (for example, showing more restraint in food or in alcohol and tobacco consumption) is not sufficient to compensate for the additional loss of well-being they are subject to.



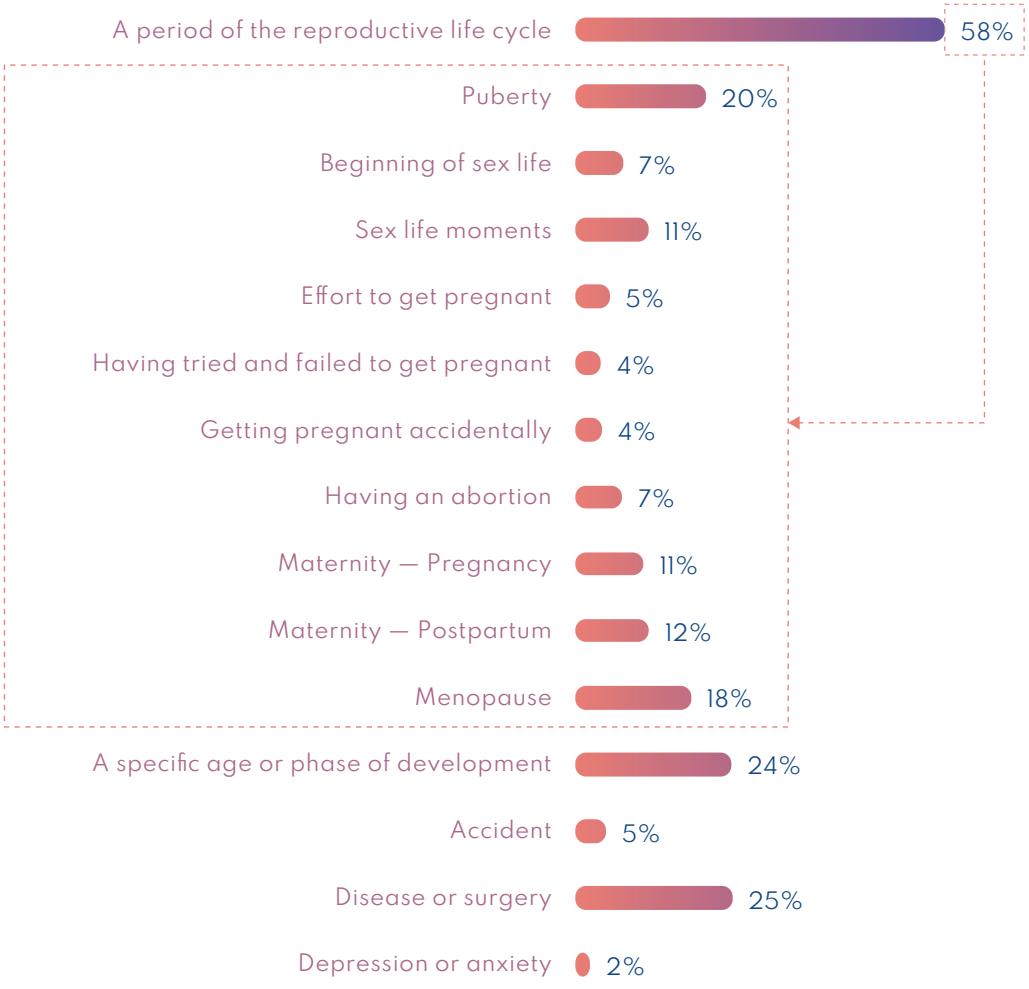
Report ill-being that was related to significant body changes or some other physical or psychological aspects

N=707



Moments of physical and/or psychological ill-being

N=707



Although this data is important in identifying the moments women may feel more fragile, it does not give us a reliable scale of the number of women who have experienced ill-being nor its intensity.

The fact that these women are at different stages of their life cycle changes the relative weight of each event. Many women have not yet experienced motherhood, and most are far from the menopausal age. On the other hand, 30 years later, it is difficult to recover from what happened at puberty. It is in the approach of age to the moment when events occur that one can (better) perceive the scale of the disturbance. Puberty, for example, is referred to as a moment of malaise by 62% of women between 20 and 24 years of age; menopause is indicated by 48% of women between 55 and 64 years of age.

This exercise also relies on memory, and memory is not loyal to the real facts, or it has too many elements, because the experiences were reinterpreted, or have fewer elements because facts are selected and if they don't matter for the story they're deleted, for a sense of continuity. It is unlikely that in a sample in which 66% of women have children, only 12% felt unwell during the postpartum period. The memory they want to create about an event that was deeply striking in their life stories—having a child—prevents an objective appreciation of the impact that motherhood had on their physical or mental state of health. It is no coincidence that reports of the puerperium were more dramatic among women who had unplanned pregnancies, who were unwelcomed by their families or who had been abandoned by their companions.

Finally, although hormonal changes cyclically experienced by women have several physical, psychological, and emotional effects, research suggests that women are not always able to relate the symptoms of malaise with events in their reproductive life cycle.

'Women have two X chromosomes and men have one X and one Y, which makes a great difference.' This causes women to have a different somatic configuration and different somatic needs compared to men. This means they cannot work the same way. They work similarly, but they're not exactly the same.

While men go through puberty and then senescence and do not have periodic cycles of hormonal changes, this is quite different for women. After puberty, menstrual cycles begin, which bring about menstruation and ovulation; there is pregnancy, childbirth, postbirth, and menopause.

Most sleep disorders in women are related to these periods because some experience insomnia with menstruation, others have hypersomnia or insomnia during pregnancy, and many women start experiencing insomnia after the birth of a child (often the first). When they reach menopause, they go back to experiencing insomnia related to hormonal disturbances because they stop producing oestrogen. All of this causes women to be more vulnerable to sleep disturbances than men in hormonal terms.'

Teresa Paiva, neurologist professor and physician specialised in sleep medicine

Lisbon Sleep Summit, 2018

A cycle more conducive to emotional instability

Emotional well-being was difficult or very difficult to manage

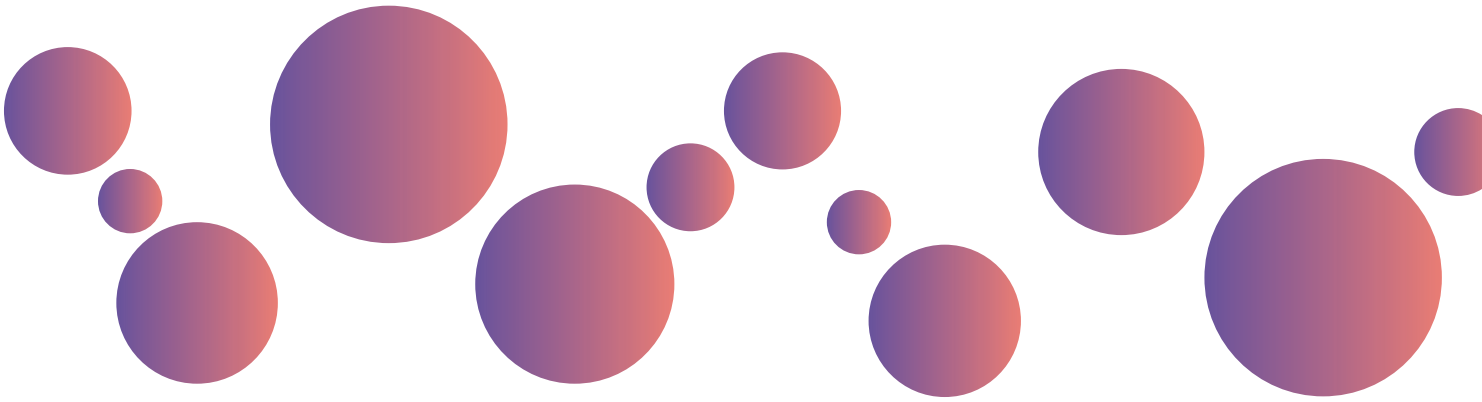
30%
during pregnancy
[If you are or were pregnant]

N=217

52%
during postpartum
[If you had children]

N=212

PUBERTY **CONTRACEPTION** **PREGNANCY** **MATERNITY** postpartum



"I have no idea why I started taking the pill. When I was 16 or 17 years old, my mother decided that I had to go to a gynaecologist, although I was not sexually active. I didn't get along with the pill, and after three months I was super depressed. I went there and she gave me another pill and I became less depressed. I thought this was normal, but last year I realised it wasn't … but I took all these years to realise this! They never explained anything to me and they never gave me any other alternatives.'

W, 25 years old, single, no children

"The baby blues, all those postpartum difficulties, knocked me to the ground. The fact that I didn't sleep, that breastfeeding wasn't working, that my daughter didn't sleep and had cramps … I felt truly lonely. I thought that people hadn't realised how much I was suffering … those first six months felt like six years. Time wouldn't pass. (…) I thought to myself: either I am overreacting, or I am incompetent! Maybe I'm being a drama queen. I handled it, until I couldn't anymore … then I went to the psychiatrist"

W, 35 years old, married, one child

Women of reproductive age go through a series of events that cause mood swings. Whether these are negative or not, they involve hormonal variations that can affect the emotional response to these events, often causing anxiety or sadness.

Although they are not diseases, unless they are too intense or long-lasting, these symptoms affect the well-being and require major adaptation effort.

37%
during menopause
[If you are or were going through menopause]

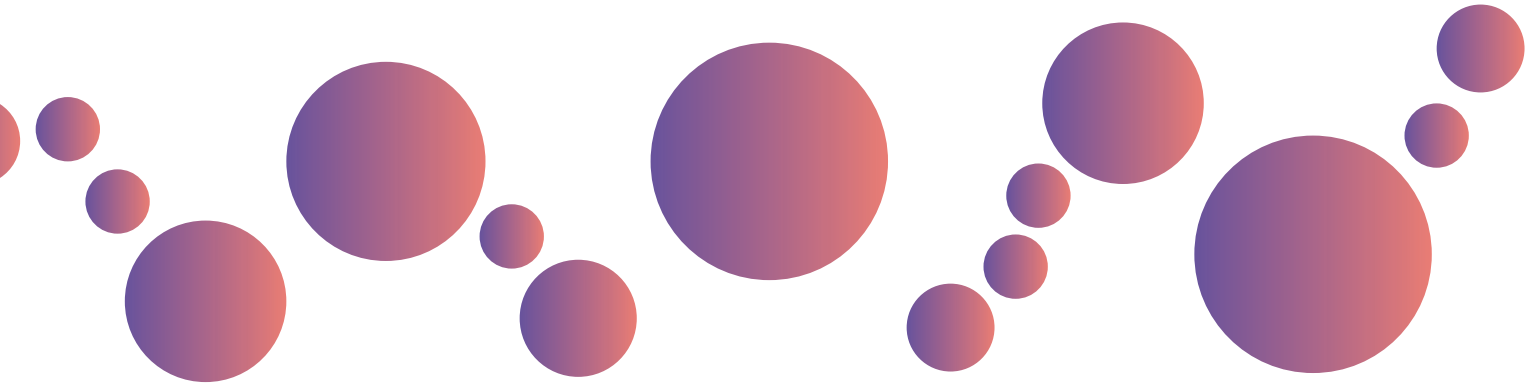
N=298

INFERTILITY
Not being able to get pregnant

UNWANTED PREGNANCY

ABORTION

MENOPAUSE



"I got married at 35 and had never had that 'wanting to be a mother' thing, I never imagined myself that way, it wasn't natural, it wasn't my ambition. He wanted ... very, very, very much to have a child ... [The fertility process] is something that I don't want to remember much, because it was horrible (...) It is so physically, emotionally demanding ... I had this friend who did the treatments, and every time she lost [the baby], it was devastating. I don't think it's fair for any woman to go through that."

W, 48 years old, divorced, no children

"I did tubal ligation at Beatriz Ângelo Hospital. It was the last time I went there, three years ago. I got pregnant and had to have an abortion. I'm taking medication that can cause malformation. I thought that I didn't want to take that risk ... and I made that decision. The doctor advised me, I was having a lot of second thoughts ... 'It's the best thing to do. But I don't do it because I am part of the hospital's conscientious objectors.' ... It was truly sad."

W, 49 years old, married, two children

"I have anxiety. The sweating part doesn't bother me so much, it's not pleasant, but considering everything I've been through, it doesn't bother me too much ... one moment we're hot, then we take off the coat, then we put it again ... that's secondary. For me, the emotional part is more complicated, as it is altered. I'm even taking medication for that ... I almost reached the limit and really had to take medication."

W, 59 years old, married, three children

A cycle more conducive to depressive disorders

There is a clear relationship between women's reproductive health events and mood disorders. Sex hormones are important regulators of neural activity, therefore changes that result from events such as puberty, pregnancy, postpartum, menopause, abortion, or simply the menstrual cycle, can lead to variations in brain function, causing women to be more likely to develop depressive or anxious disorders.

Although the causes have not been fully established and these disorders result from a combination of different factors, it is in adolescence that gender differences regarding depressive symptoms emerge—the tendency towards psychological depression is significantly higher in girls—and this greater vulnerability is something that follows women throughout their lives.

Whether maternity itself is a risk factor for the psychological state of women's health is a theme that has generated heated debate; there are no studies that prove, for example, that postpartum depression is only related to biological aspects. Nonetheless, research points to postpartum as the woman's life stage with a higher risk for onset or resurgence of a mental disorder, estimating that postpartum depression may affect between 10% and 20% of pregnant women (the number varies depending on the methodology and diagnostic tools of each study).

Besides biology, women's own health biography can be a risk factor for depression. Previous problems related to pregnancy such as infertility or abortion result in a higher risk for post-partum depression. The profound changes that take place in the body during the maternity period, and the subsequent dissatisfaction with personal image, may be related to depressive symptoms during pregnancy and postpartum.

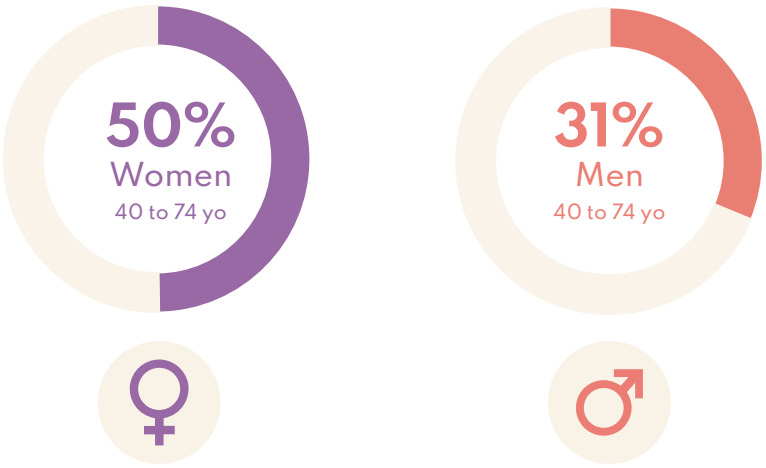
Menopause will also be another critical moment for women's mental health. In addition to the hormonal aspect, loss of reproductive capacity or changes in the body can cause anxiety and depression.

Even if the genetic tendency for depression may be the same between sexes, the reproductive cycle attributes an additional risk factor to women. The present study not only supports the higher prevalence of depression in women, but also proves that, in its genesis, there are often themes related to these events.

Have you ever had a breakdown or depressive episode?

Answers: 'Yes, currently'; 'Yes, I had'; 'It wasn't diagnosed, but I think so'

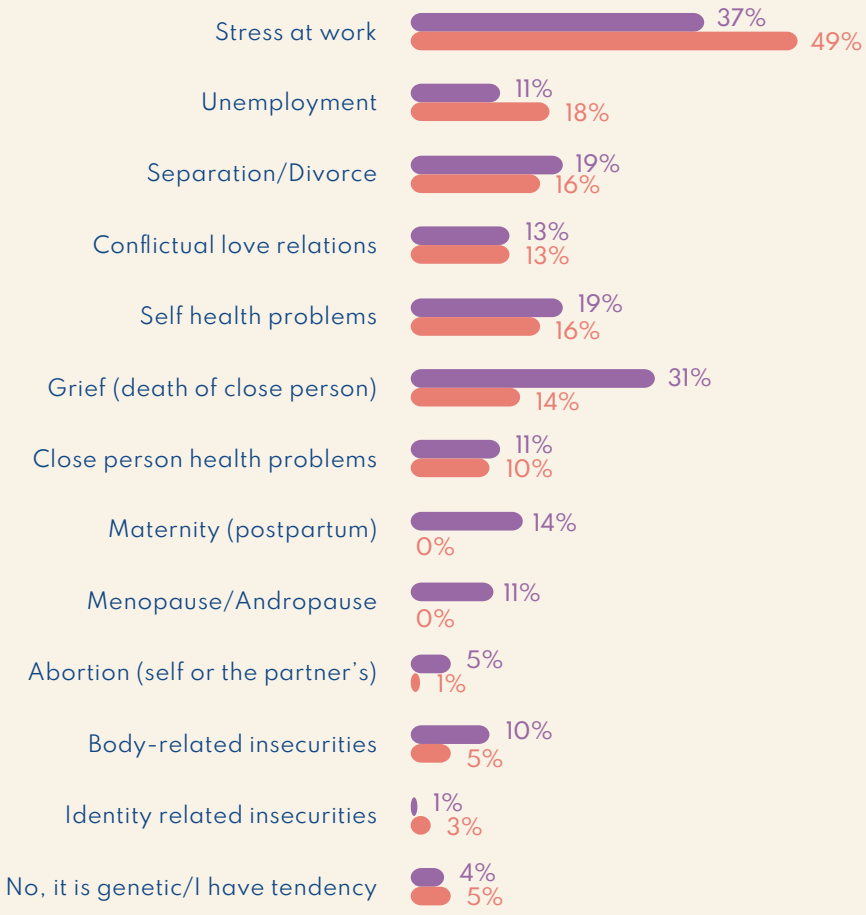
N=731



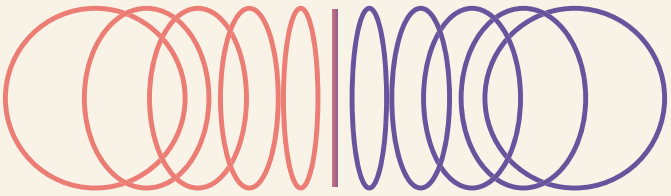
Did that episode is or was related with any specific event?

(If nervous breakdown or depression is reported)

N=317



Dorothea Tanning
Maternity, 1946-47



"Nobody told me about postpartum depression, people just told me to get ready because I could get a little sad. But crying compulsively because my whole body was a mess (...). To others, I was great one month after giving birth, I also didn't gain much weight during pregnancy. 'But I'm not great! I'm thin because I throw up almost everything that I eat. At night my body starts vomiting everything, in shock ... I'm not great!' I don't think anyone gets it. And when I said that, people were shocked. 'But aren't you glad to be a mother?' I like my daughter very much and no, I'm not happy being a mother, I'm not being able to deal with this (...) My mother spent her life saying: 'You feel overwhelming love for your daughter, while she's still in your belly, and when she's born, you look at her and that's immediate!' But I have never been a person of immediate emotions ... I process, I have to rationalise everything that happens, and I have always liked my daughter, but I did not have that overwhelming will (...) It all went so wrong... I had burn scabs and I thought: 'But who's capable of liking this? I must have a problem because it's not natural for me to cry so much because my body is all burned! It's all natural, my own mother makes it seem all natural.

I think we're raised to be superwomen and we can get everything done, and I was always very strong. My friends used to say that I was Madonna because I had everything under control. But it's not supposed to be like that."

W, 34 years old, married, pregnant and a two-year-old daughter.
Postpartum depression diagnosis

How to realise it?


REFRAMING
REVOLUTION

Although the underdeveloped world has endemic problems regarding women—and there is some regression on progress in developed countries (such as the decriminalisation of abortion in the US)—there have been major developments in women's health in recent years.

The inclusion of women in scientific activity and research (without prejudice to the contribution of some male researchers) has made gender bias in research and medical practice visible. Books, journals, and non-scientific documentaries have brought the problem into the public sphere, turning this into a mainstream discussion. As a result, gender mainstreaming as a study variable has become a requirement for many of the agencies that sponsor them.

What science says about women impacts how they are seen socially; to recognise that, throughout history, science has been partly partial indicates that things are already becoming fairer. On the other hand, the presence of women in research brings aspects of female life into view, such as menstruation or menopause, generally taking some of the interest away in men.

In addition to science, other developments have taken place and have contributed to a change in attitudes towards women's health. To add to these developments in medicine, the technology industry has woken up to the potential of women-directed tools and femtechs—applications, wearable devices, and software oriented to women's health are gaining more devotees (and investment). In our sample, 29% of women currently use at least one application or technology related to the management of their menstrual cycle (47% between 20 and 24 years), either to manage the effects of the menstrual cycle or because they do not want to become pregnant. What began with fertility and menstruation monitoring products and services promises to expand into health fields that go far beyond female reproductive health.

In addition to the promise of improving the quality of life of women, the good news is that these technological innovations can serve data collection at an unprecedented scale and with reliability in scientific research (assuming that ethics prevail in how this data is managed). As well as giving space to the female perspective, these changes foretell improvement in the quality of science for all.

Finally, awareness about aspects related to women's health is growing within society. Far beyond traditional media, there's the contribution of social media such as Instagram or TikTok, which are very popular nowadays. Whether by sharing intimacy, by the type of language—more visual or humorous—or by giving place and voice to anonymous suffering, networks are playing a crucial role in the normalisation of issues still covered by stigmas and taboos.

Reframing Revolution

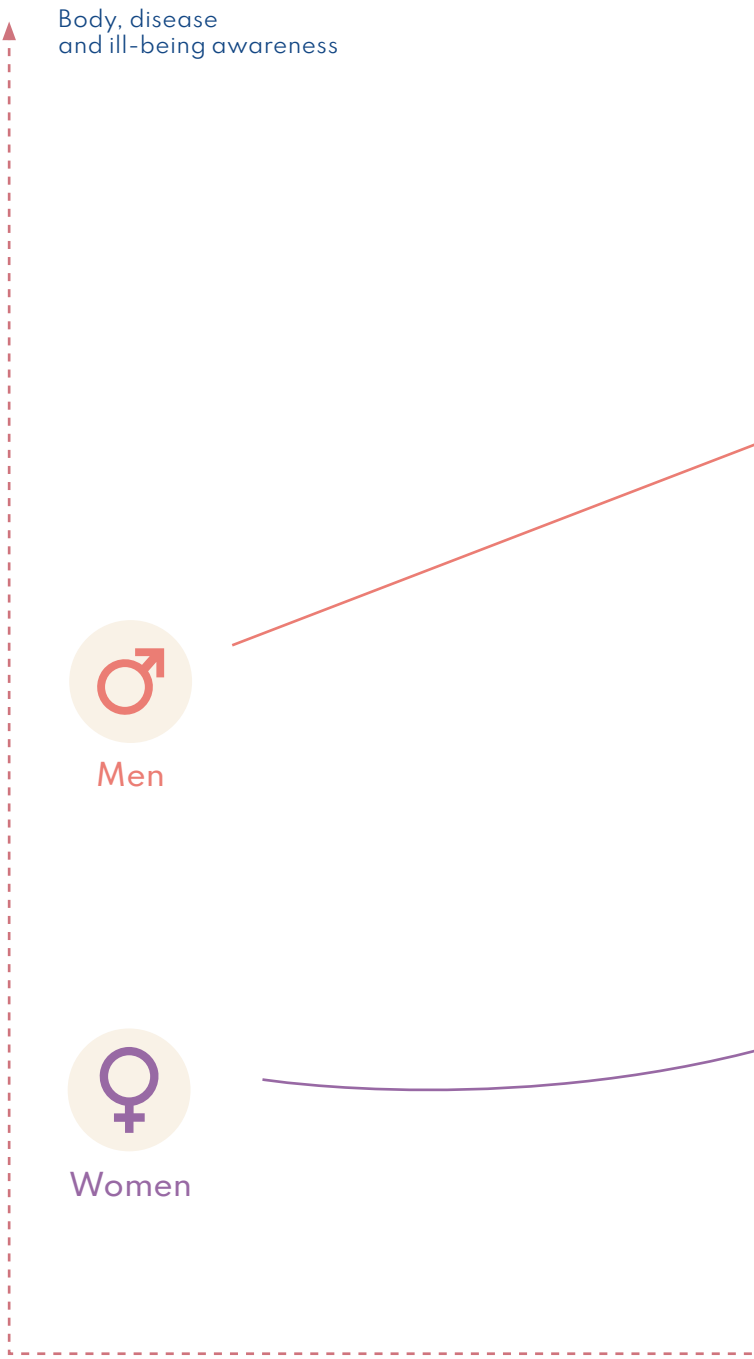
Launched by Peanut, an online community targeting women in the U.S., the initiative involves a digital gallery with dozens of illustrations of female bodies, made in collaboration with doctors. Behind it there's the conviction that 'the misrepresentation of what a body can look like when it suffers from a certain condition can lead to errors in health conditions' diagnosis and poor treatment. Moreover, the assumption that there is a normal body type is false and harmful.' It is addressed to health experts and women.

Narrowing the knowledge gap: a work in progress

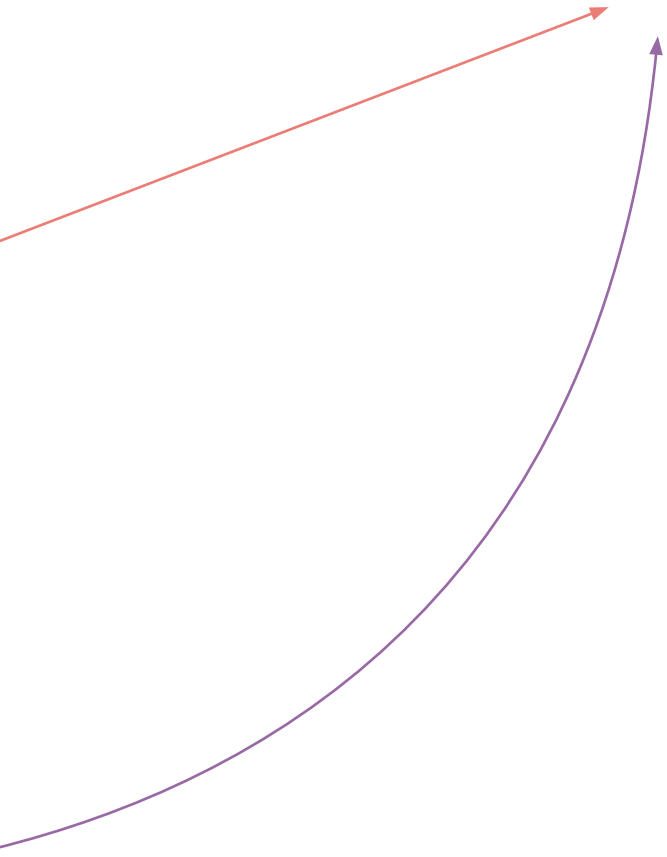
In terms of knowledge about the body and diseases (and the impact of diseases), strictly speaking it is not yet possible to speak of gender equality, but there are a set of driving forces that are countering systemic prejudices in society and contributing to approximate the level of knowledge of one sex and another, alongside medicine committed to improving practices and protocols.

More profoundly is the ambition that women can reach a new paradigm of relationship with their body; a better understanding of the mechanisms that affect their well-being.

More than claiming gender equality, the intention is that knowledge is translated into a new ambition and possibility of well-being for women, recognising that, for biological reasons, this well-being goal will always differ from the men's one.



Renewed woman's relation with body paradigm [and renewed aimed well-being]



Driving forces for change
[narrowing the gap]

Social Awareness

Media actions demand (other) attention and consideration from society considering women's health issues (far beyond legal claims) - recognition of malaise as the first aspect to change.

Products and Content

Products' or services' brands targeting women, media brands and sub-brands, groups in social networks and other that treat issues with a new approach (and new languages).

Technology

New technologies allow women to monitor symptoms over time and to be more knowledgeable about their bodies. They add up to other medical developments that offer new solutions for comfort, treatment or diagnosis.

Research

Major brand initiatives promise, through big databases, a major and pioneer development on women's health research particularly on issues that haven't been researched).

Time

To acknowledge and dispute the normalisation of ill-being

Research leads to four areas of ill-being that women do not oppose or seek to minimise because of lack of information, lack of awareness about the collateral effects of this malaise and, above all, normalisation of 'not being well'.

The first three result from the sex. Due to biology, women go through periods of life that are major well-being destabilisers—menstruation, maternity and menopause—because of the physical, psychological, and emotional transformations that are involved. Everything suggests that the suffering they experience is normalised (namely by women themselves), which contributes to the neglect of a potential area of well-being. Even with medicine, there doesn't seem to be a systematic approach in preventing women's suffering, although it is known from the start that these are the moments conducive to physical and mental health disorders.

The fourth area of ill-being is a result of gender, which establishes that women pursue beauty ideals that are largely difficult to attain. The discomfort that begins by not reaching an ideal weight (not necessarily the healthy weight) is spreading to other spheres as life experiences and age are diverting the body from a concept of beauty that fights against ageing.

In the following pages, the aim is to work out the undervaluation scale regarding each of these areas and to inspire new approaches to women's well-being (through references to initiatives that should be read as merely illustrative of possible courses of action).

Discomfort metrics
(malaise proxys related to
the reproductive life cycle)

Menstruation

Around 1.8 million women menstruate and 39% of them find it difficult. According to the calculations, there are 1,375 difficult days in the lives of over 700,000 women. This means approximately 3,7 years of their lives.

Maternity

About 85,000 women experience a maternity process every year. 48% consider the postpartum phase difficult or very difficult. In the final analysis, there are more than 140 difficult days in the lives of 40,000 women every year.

Menopause

Approximately one million women between the ages of 45 and 64 will be at the menopause stage. 32% find it difficult or very difficult. According to the calculations, there are 1,213 days of discomfort in the lives of over 265,000 women. This means approximately three years of their lives.

Relationship with the body

About one million women are uncomfortable with their weight, although their BMI suggests 'normal weight'. 27% recognize that dissatisfaction with their weight interferes greatly with their psychological well-being. That's almost 259,000 women suffering unnecessarily.

The forementioned data results from an analysis by Return On Ideas, based on surveyed answers and on extrapolation to a national universe (Pordata data): resident population, women by age group (2021) and life births of mothers resident in Portugal (2017 to 2021)

Realising the full potential of well-being

Menstruation

Talking about menstruation is akin to talking about a woman's history. Since (at least) antiquity there have been myths and theories that try to explain a phenomenon that, in certain religions and cultures, still refers women to a place of isolation and exclusion.

The way menstruation is viewed is closely related to the social status of women, and it has progressed (almost) worldwide, albeit at different rates. This progression happens as new menstrual collection products and hormonal contraceptives are created, both fundamental for the affirmation and consolidation of the role of women in the public sphere.

In Portugal, the implementation of democracy has brought unequivocal achievements. The country was one of the first in Europe to offer the contraceptive pill and, during the 1980s, it even granted women with incapacitating menstrual pains unpaid leave for up to two days. A benefit that was revoked in 2009, returning to public discussion this year.

Although many of the misconceptions about menstruation, which historically penalised women, have been mitigated in western societies, several studies show that embarrassment and shame persist, as well as a 'social etiquette' that keeps the topic invisible.

In a study developed in 2016[1] with women from 190 countries, there are more than 5,000 euphemisms for 'menstruation'.

Another study from 2020[2] reveals that women are as likely as men to perpetuate the stigma and taboo around menstruation, stating that 54% believe they should not have sex while menstruating because it is unhygienic (vs 52% of men).

Experts who view menstruation as a social phenomenon speak of a 'menstrual paradox', an issue apparently so natural that it does not need to be addressed, so banal that everyone knows what it is and therefore does not need to be discussed openly. As Patrícia Lemos, a menstrual health educator, suggests, despite its centrality in the daily life of women, 'most of them never thought about what this means for themselves beyond the superficial and dichotomous layer of 'it bothers me'/'it does not bother me'.

Menstruation is now known to be a far more complex experience than the simple act of releasing blood every month. It is known to be brought on by something greater—a menstrual cycle, which impacts the psycho-emotional dynamics such as sexuality or the way women see and live their own body—and, in this sense, it is possible for women to better understand the functioning of their body and their emotional states.

If it is true that taboos and misinformation persist, it is important to recognise the latest shift in importance surrounding the awareness of it.

[1] Study by Clue, a partnership with The International Women's Health Coalition
[2] Global V Taboo Tracker, created by Essity

Menstruation, a new perspective under construction

Brief chronology

2015

✓ 'Period' is considered one of the words of the year following a comment by Donald Trump about a journalist: 'You could see the blood coming out of her eyes. Blood coming out of her … from everywhere.' #periodsarenotaninsult became a hashtag on Twitter, with several women announcing their menstruation to Trump for months.

✓ The marathon runner Kiran Gandhi, runs the London marathon while having her period and does not use menstrual collection products to raise awareness: 'I ran with blood running down my legs for people who have no access to tampons and who, despite cramps and pain, hide and pretend they don't exist.'

✓ Thinx produces the first reusable menstrual underwear that eliminates the need for tampons and sanitary towels.

2016

✓ At the Olympic Games, Chinese swimmer Fu Yuanhui wins the bronze medal in the 100-metre competition and gains fans by mentioning in interviews that she had menstruated the night before.

✓ Portugal reduces VAT on menstrual cups.

2017

✓ Libresse/Bodyform (an Essity brand) makes headlines with Blood Normal, the first menstrual product advert to show red-coloured liquid.

2019

✓ The short film Period. End Of Sentence wins an Oscar. The documentary set in India follows a group of women who learn how to operate a low-cost sanitary towel-making machine for sale at affordable prices.

✓ An emoji is created for menstruation. 🩸

✓ The American women's soccer team wins the World Cup with coaches citing the importance of adjusting practices to the menstrual cycle.

✓ The United Nations views menstrual health and hygiene (MHH) as a human rights issue.

2020

✓ Scotland and New Zealand pass laws to provide free menstrual products in schools.

✓ In the United Kingdom, a state menstrual support program is set up involving the free distribution of menstrual collection products up to the age of 19.

✓ The Zomato company creates paid leave for menstruation days.

2022

✓ Supermarket chains Asda and Aldi change the name of the product corridor for menstrual collection from 'feminine hygiene' to 'period products'.

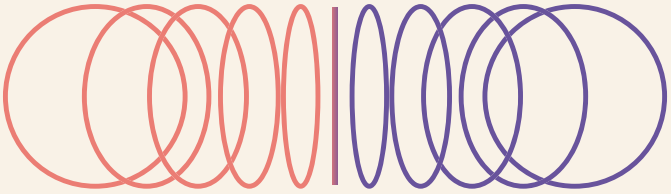
✓ The Spanish government approves a menstrual license for women suffering from disabling pain.

✓ At the Roland-Garros tennis tournament, tennis player Zheng Qinwen explains in an interview that she felt severe abdominal pain. 'That's a girls' thing. The first day is always so hard. On the field, I wish I was a man.' Referring to a leg injury that forced her to stop halfway through match, she declares that the pain 'incomparable' to the one caused by menstruation.

‘PERIOD’, Rupi Kaur (2015)

Rupi Kaur, a Canadian artist, has photographed images of moments experienced by her sister for a university project to combat stigma around menstruation. The photograph was later removed more than once from her Instagram account for allegedly violating EU rules, without the platform explaining those rules. Kaur decided to report what she called censorship in a social media post: 'I will not apologise for not feeding the ego and pride of a misogynistic society that accepts my body in underwear but is not comfortable with a small loss of blood,' she wrote. The public protestation prompted Instagram to reinstate the photographs on Rupi Kaur's profile.

The discomfort of menstruation
in direct speech



"At the age of 14, I would faint. As I menstruated many times a month, or ovulated several times a month, even with the pill I would menstruate twice a month ... it was all because I had anaemia. I felt very strong pain, like those cramps you have when having a baby, of course it wasn't as strong, but that's what I felt! I had cramps ... it was, like, sharp cramps ... it was a contraction, and it was really disabling. Even so, I had to go to school, but to do physical education or to do competitive swimming was really complicated, it was impossible.

Nowadays, it's not like that, but I still feel pain on the first and second day. I think that eventually the person gets used to the pain. Ok, I know already what I'm going to go through on the first and second day, but it's nothing like how it used to be. But I remember when I wanted to get pregnant, for a year I didn't take the pill and it all came back. What I know is; if I don't take the pill, I'll go back to the same. I stopped taking the pill six or seven years ago, and as soon as I stopped, I automatically felt the same pain."

W, 38 years old, married, two children, talks about menstruation

43%

of women aged between 20 and 74 menstruate

N=707

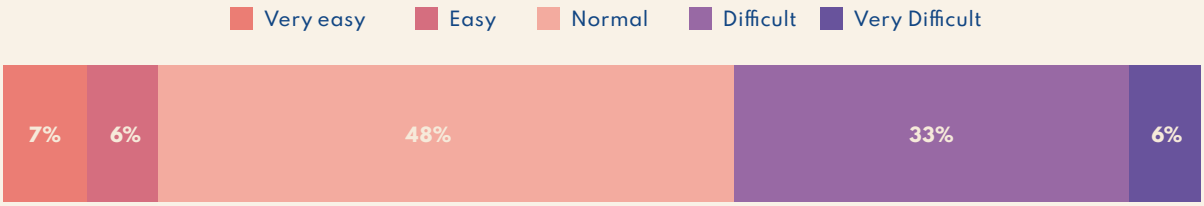
38% regularly

6% not every month

Malaise measures

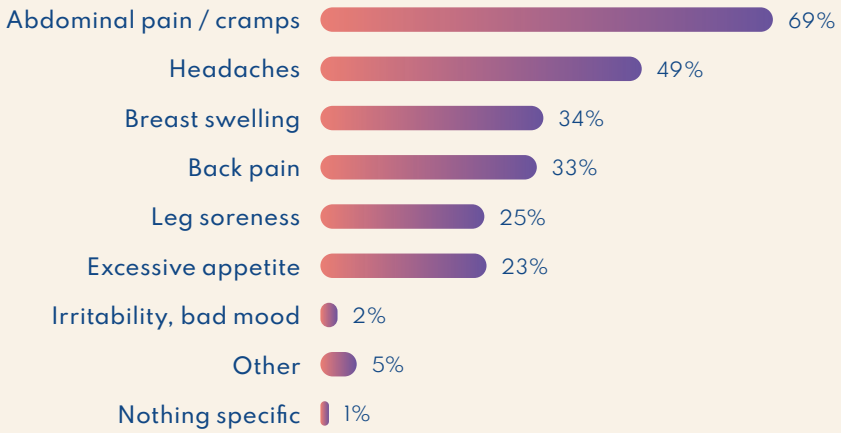
Concerning menstruation, how would you describe what you feel?

N=307



What do you feel?

N=268



42%

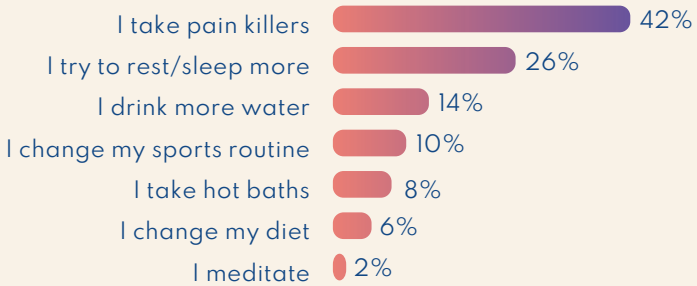
feel three or more symptoms

17%

Cumulates abdominal pain, headache and back pain

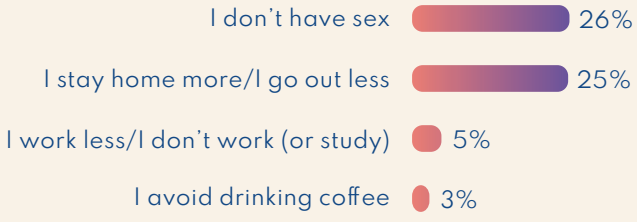
63%
N=307

change their routines when they menstruate



58%

has compensation behaviours



42%

has retraction behaviours

Acknowledging spaces that promote well-being

THE (EXCESSIVE) NORMALISATION OF ILL-BEING

International studies[1] suggest that 10 to 12% of women suffer from severe pain when menstruating. In the current research, 6% of women who menstruate refer to menstruation as 'very difficult' and 33% 'difficult'; among those who consider it difficult or 'normal', 17% accumulate abdominal pain, headaches, and back pain.

In talks about menstruation, it became clear that for the majority, 'normal' pain means pain that can be tolerated with painkillers. Does the fact that many women do not describe this level of pain as 'very difficult' mean that the pain is not intense enough, or is it the first sign of the normalisation of discomfort?

In order to determine the misunderstanding and consequent inaction, a classification of 'normal' was introduced into the scale of evaluation of discomfort, to which 48% of women interviewed for menstruation adhered. Clearly confirming the hypothesis, 27% of women who classify what they feel when they menstruate as 'normal' have three or more symptoms of discomfort and 7% cumulare the three types of pain mentioned above.

27%

of women who rate what they feel when they menstruate as 'normal' have three or more symptoms of discomfort

N=148

7%

of women who rate what they feel when they menstruate as 'normal' cumulate abdominal pain, headaches, and backpain

N=148

"In my case, it was natural; my body only ovulates when it wants to, but I see menstruation as a good thing because it is normal for a woman's body to have three or five days to clean the uterus so that she can become pregnant again. For those who have that as a goal. For those who don't, it's still cleaning. That's how I see my period."

W, 35 years old, one child, married, talks about menstruation

[1] Dawood, Y, Glob. libr. women's med.,(ISSN: 1756-2228) 2008; DOI 10.3843/GLOWM.10009.

MISUNDERSTANDING OF THE 'MONTHLY CYCLE'

Several studies show that women do not know what is going on in their body to justify the monthly 'blood loss' [e.g. in a UK study[1], 14% failed a multiple-choice questionnaire, with 7% indicating that 'old blood was removed from the uterus to be replaced with new blood']. It is therefore expected that an understanding of all the phases of the menstrual cycle—follicular, proliferative, ovulation, menstruation—is not grasped by the vast majority, and even more when it comes to perceiving that—by the knowledge of the 'particular biology' of each body—that there is the possibility not only of minimising malaise but also of boosting productivity and results.

Experts argue that if the effects of the main menstrual hormones—oestrogen and progesterone—are understood in neurochemistry, both its damage and its potential benefits can be emphasised. The focus of the study was historically oriented towards the negative effects of imbalances caused by these hormones, resulting in a pattern of action in medicine that tends to suppress the female natural cycle at the first sign of imbalance, using synthetic hormones.

On the contrary, a medical school currently recommends educating women about 'the importance of diet, exercise and stress management to help promote a better hormonal balance (...), which will allow them to take advantage of the different forces they will experience as their natural cycle progresses'[2]. Alisa Vitti, menstrual health expert, is the creator of the concept 'cycle-syncing', based on the thesis that each phase of the cycle provides women with brain super-powers and, this way, it can and should be a guide for the launch, execution, and finalisation of projects of all kinds. Knowing what these superpowers are and when they can arise will be a valuable matrix of life planning that most women are unaware of.

'It is important that women of all ages better understand their body. Knowing how different hormones can affect their energy levels, mood, creativity, etc can place them in a position of control, rather than turn them into victims of their bodies.'

Danielle Duboise and Whitney Tingle
Sakara Life brand co-founders
[vide following pages]

26%

of women feel a lack of energy/ tiredness, mood changes and sleep changes 'almost every month' or 'every month'

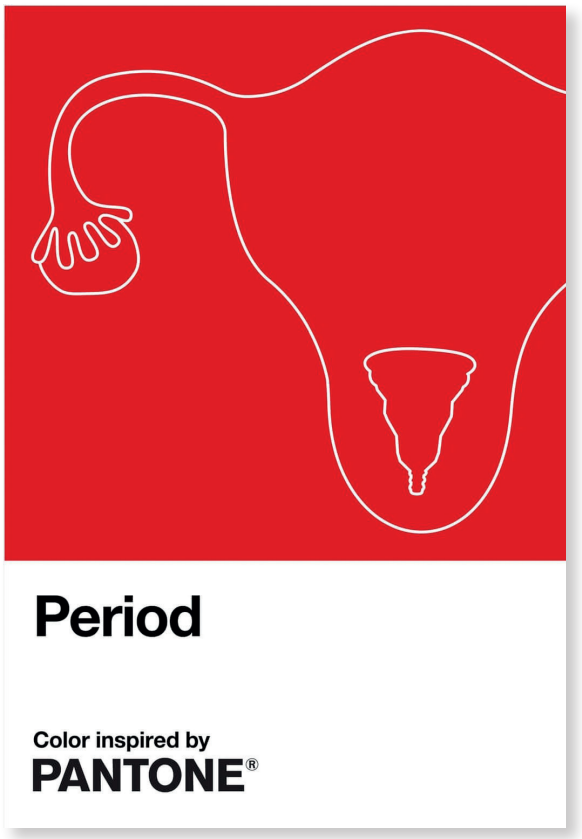
N=307

of those, just 49%

associate those symptoms with the menstrual cycle

[1] YouGov, UK, 2019
[2] According to Allison Devine, Board Certified Ob/Gyn at Austin Diagnostic Clinic and at Faculty at Texas A&M Medical school

Social Awareness



INTIMINA + PANTONE

New 'pantone' wants to break taboos around menstruation

To break the stigma around menstruation, Intimina—in partnership with Pantone Color Institute—launched the Seen + Heard campaign in 2020, from which the colour Period was born.

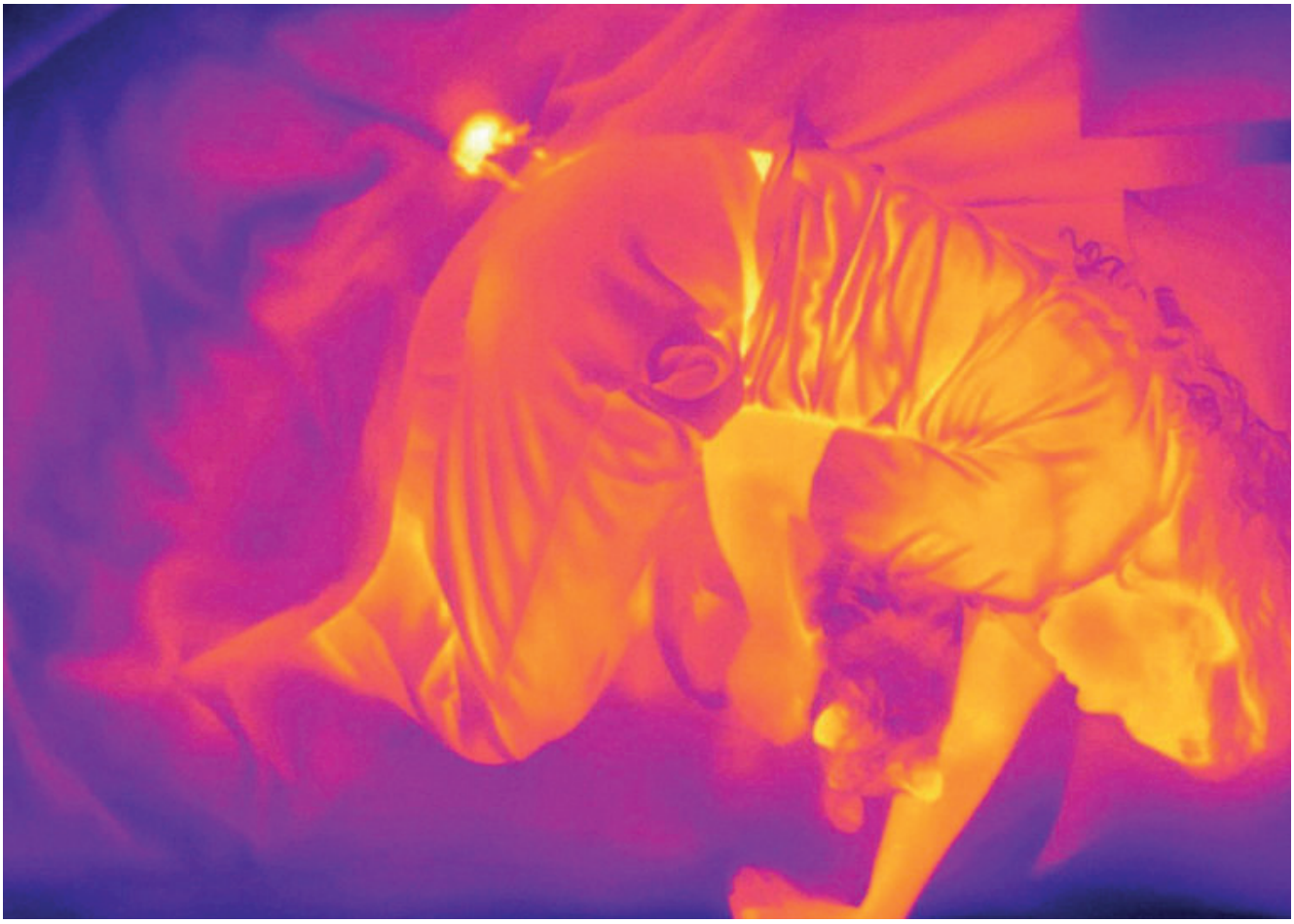
'Although billions of people experience menstruation, it is a topic historically treated as something that should not be seen or spoken about publicly. And if we look at popular culture, the depictions of the period vary from extremely inaccurate and insensitive, or as the target of jokes and derision. That's enough, it's 2020. Isn't it about time for periods to stop being regarded as a private matter or a negative experience? Isn't it about time we draw attention to the people who are trying to perpetuate the stigma around the period? Or to those who make jokes about it? Isn't it about time we come together to create a positive view of the period, ensuring that it is seen and heard?', said Danela Žagar, global brand manager at Intimina, about this initiative.

THINX

Sliding package challenges the norm of menstrual product packaging

Advertising and menstrual collection product packaging doesn't traditionally illustrate its function and method of use well (flowers, abstract lines, etc). The American start-up Thinx, which has gained notoriety for creating absorbent underwear that replaces sanitary dressings and tampons, challenged that tradition by developing a sliding packaging that illustrates exactly where to put the tampon. Over the years, the company has created various products and even sub-brands that help women manage topics such as menstruation or sexuality.

Social Awareness



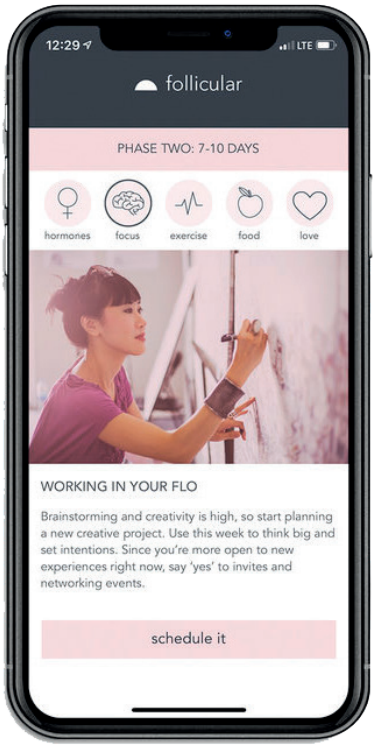
BODYFORM

Campaign highlights the malaise associated with sleep deprivation caused by menstruation

A recent study by Bodyform (Essity group) estimates that women lose five months of sleep during their lifetime, on average, due to the discomfort and anxiety caused by menstruation. The survey, which gathered more than 10,000 women in 11 countries, further revealed: 62% of women have the slightest sleep during the period; 33% have difficulty sleeping for fear that menstrual products do not sustain the flow and dirty the sheets or pyjamas; 62% do not like sleeping in other people's homes or going on vacation during the menstrual period; 18% prefer to reject a date rather than face the possibility that this person might see a spot on the pyjamas or sheets.

Based on this research, the brand launched the #Periodsomnia campaign, a film that combines action, animation, and thermographic imagery to illustrate that 'periods don't sleep', even when women are desperate for a night's sleep. At the same time, the brand launched a menstrual collection product with an adaptive technology designed to provide greater protection and comfort during the night.

Products and Contents



MYFLO TRACKER
The only menstrual monitoring app that uses the Cycle-Syncing® Method

The term 'cycle-syncing' was introduced by Alisa Vitti in 2014. Diagnosed with polycystic ovary syndrome, she spent 15 years studying the menstrual cycle, which culminated in the creation of a 'synchronisation with the cycle' method. The concept proposes the adjustment of day-to-day activities, such as diet, physical exercise, social life or sexual activity, based on the four stages of the menstrual cycle.

The aim is to help correct imbalances and mitigate the symptoms caused by the hormonal changes specific to each menstrual phase, serving as a 'guide' to the most suitable moments for performing certain activities or tasks. The concept has been transferred to a menstrual monitoring and fertility application, My-FLO.

SAKARA LIFE
Food alchemy to cope with hormonal fluctuations

Sakara Life is a herbal and fresh meal delivery service that integrates the Cycle-Syncing® Method in its offers. The service includes doctor advisory support, by medical professionals, including Aviva Romm who is the author of the book 'Hormone Intelligence', where she explores the world impact on women's hormonal health.

Romm collaborated on the development of meal packs, which includes one designed for 'hormonal cure'. 'Our hormones, though we're told they're totally unpredictable, are in fact very predictable—both monthly and over life. Despite what we've been taught, our cycles aren't supposed to make us miserable—and if they are (think: period pain, pain during sex, intense mood swings, wildly irregular cycles, breasts that are too tender to touch, overwhelming fatigue, uncontrollable cravings, menstrual migraines)—something's out of sync and these are 'hormone alarms', states the author.

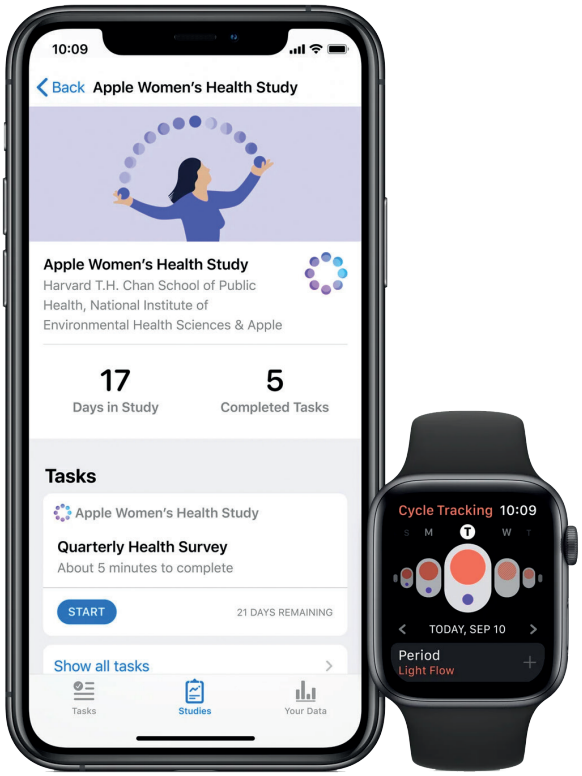
Research

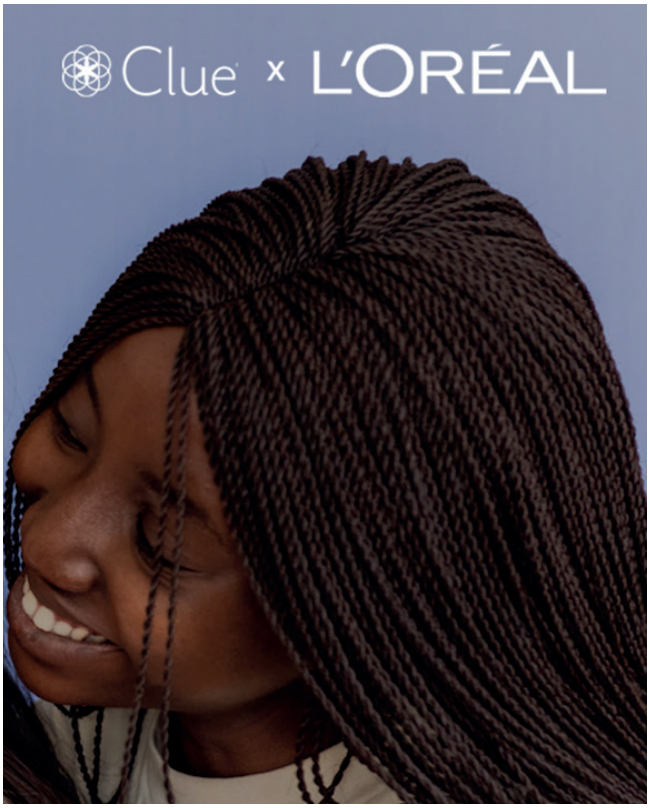
APPLE + HARVARD RESEARCH

A study that research developments in science around women's health

In 2019, Apple launched the Apple Women's Health Study, a longitudinal study that seeks to deepen the understanding of women's menstrual cycles, assessing, among other aspects, the impact of demographics and lifestyle factors. The research resulted from a partnership between Apple and Harvard T.H. Chan School of Public Health, and used data from iOS users' who installed the Apple Research app.

With a representative sample and an unprecedented methodology, the study represents progress regarding the understanding of women's menstrual and reproductive health, which will allow for the best care, diagnostic ability, and treatment of gynaecological diseases.





L'ORÉAL + CLUE

Brands come together to research the impact of menstruation on the skin

L'Oréal and Clue, a menstruation monitoring application, have teamed up to investigate how the skin is impacted by the menstrual cycle. Through application data (obtained through surveys), they intend to create content related to skin problems that result from the hormonal changes that occur during menstruation: acne, dry skin, dermatitis or susceptibility to UV rays. According to Clue, skin changes are among the categories most monitored in the application.

L'Oréal will contribute with personalised advice, based on the week of the menstrual cycle, supported by dermatologists, endocrinologists and gynecologists.

‘Saúdes’ Test

New products use pulse therapy to relieve menstrual cramps. Ovira and Livia are examples of devices based on TENS technology (transcutaneous electrical nerve stimulation); through a small electric current that passes through two compression pads placed on the hips, these devices block pain to reach the brain, relaxing the muscles of the uterine zone and relieving pain. With another technology, Oovi alleviates pain by sending pulsations through a wireless device, connected to a gel pad that is placed in the pelvic area.

Imagine that you could have access to a menstrual pain relief device that uses pulse therapy for pain relief (cramps). This technology could replace painkillers. In your case, how useful would you consider such a service?

32%
Very useful

[36% useful]

N=307

In Portugal, around one million and eight hundred thousand women menstruate and 39% of them find it difficult. According to our calculations, that amounts to 1,375 difficult days in these women's lives. Approximately 3.7 years of their lives.

Despite being universally present in women's lives, the topic is still invisible and, because it is so normal (i.e. natural to female biology), it is considered as a necessary ill-being and therefore undervalued, under-discussed and not understood.

In addition to highlighting the level of ill-being and its consequences among Portuguese women lives, this research suggests not only for enhancing the well-being that can come from the mitigation of normalisation but, above all, from educating women about the whole cycle and its neurochemical influence. There is, after all, a positive side to undiscovered hormonal fluctuations.

This is a new approach to life that medicine, nutrition, and neuroscience are proposing; the use of a different calendar to indicate the days on which certain superpowers emerge and on which days one should condescend, in addition to taking a more informed approach to physical exercise, nutrition or stress management, lack of energy, and willingness to meet higher demands.

Advances in science and technology, as well as being of interest to brands and businesses, are crucial for creating a different future, a future that is apparently already available.

Realising the full potential of well-being

Maternity

Maternity is a social construct that goes far beyond the possibilities of biology. As a concept, it changes significantly according to age or culture but tends (because it is contaminated by gender roles and the historical undervaluation of women's complaints) to establish an ideal of a 'perfect mother', based on myths of spontaneous unconditional love and maternal instinct. These myths—which are so not because they cannot be real, but because they coexist with some fantasy—sustain the discourses that romanticise and idealise the process of motherhood.

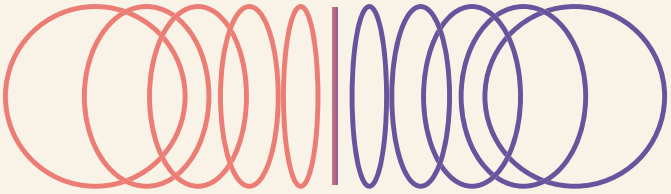
Even today, most mother-oriented messages and campaigns portray images of women who are happy and naturally able to cope with the demands of a baby, while showing states of joy or tranquillity. There is a widely publicised social discourse that not only idealises motherhood, but suggests that, in this role, women will find personal fulfilment and fullness. Even the desire for being a mother, and being happy in that role, is still somehow charged by society.

Idealisation around motherhood establishes models to which women feel (if only subconsciously) they must correspond. In this framework, the other side of motherhood does not fit. Infertility and other physical impediments also don't fit it. The same goes for doubts, pain, and anguish. Differences between women and between each experience of maternity have no place. Disliking motherhood also doesn't fit in.

By normalising the maternal instinct, women are required to learn to how to be a mother without an instruction manual, ignoring the uniqueness of each woman, baby, and family. The mother is responsible for the permanent care of a totally dependent being, whose needs override self-care, in a phase of great physical and psychological weakness due to childbirth, aggravated by tiredness and sleep deprivation. Many are isolated and without a support network; many accumulate work in the domestic sphere. These maternity experiences are socially absorbed as natural, and the resulting discomfort is normalised by women themselves.

Some studies maintain that the distance between the social construct and the reality of motherhood can have an impact on women's mental health. Likewise, in this research, conversations with women suggest that confronting difficulties throughout the process—such as breastfeeding—can trigger a series of negative feelings of frustration, insecurity, or even guilt.

It is increasingly argued that grasping the causes and speaking uninhibited about the anguish of motherhood can help women achieve balance. Indeed, due to a growing number of awareness-raising initiatives and mother support solutions in one of the most demanding stages of a woman's life cycle, the paradigm has gradually shifted. It is time to give new formulations to the concept of motherhood, which dismantle ideas and certainties wrongly constructed around the theme.



"I felt totally cheated, that was the feeling I felt inside. I felt cheated about what it means to be a mother and what it means to have a baby, and I think that as women, we should explain to other women that it is normal to feel fear, that it is normal to look at the child and not want to have it, that it is normal to cry, that it is normal to want to run away ... all of this is normal, but no one speaks about it!

For me, the most difficult part was not even the physical, it was really the emotional, because up until that moment I had an idea what it meant to be a mother... but, suddenly, there was a child there and I was with her 24 hours a day and I panicked. There was a day or two when she cried from morning to night and I was under stress, she wouldn't shut up ... First, I tried to understand why that was happening, (...) and realised that all those feelings were also normal, because I was going back to normal, and my hormones were still crazy.

Those four months I stayed home on maternity leave were the worst of my life. It's only after I started working, having a routine, and time for myself ... then yes, I started enjoying motherhood. But until then I couldn't because we were always together. My brain wouldn't shut down, it wouldn't rest!"

W, 41 years old, single mother, talks about maternity

As much as there has been a profound evolution regarding the aftercare of mothers, the focus certainly remains on the baby's health and well-being. In 2020, the maternal mortality rate reached 20.1 deaths per 100,000 births. There has been no record of such a high number in Portugal for 38 years. Out of those deaths, eight occurred during pregnancy, one during childbirth and eight during the puerperium (up to 42 days after delivery)[1]. And while it is recognised that the recovery period for women extends far beyond the first weeks after the birth of the baby—the so-called 'fourth trimester', in which women have unique biological, hormonal and emotional needs—many do not have the support they need.

Studies reveal that even in areas such as psychiatry, there is a historical disregard for the impact that pregnancy can have on women's development.[2] Not to be confused with postpartum depression, postpartum dysphoria or baby blues is a transient but extremely common condition, affecting 50% to 85% of women, revealing how demanding the puerperium is. This period is still seen through dichotomous lenses in which, at one extreme, there is pathology and depression, and, at the other, a romantic image of the passage to motherhood.

In 1973, anthropologist Dana Raphael, coined the term 'matrescence' to create awareness for the identity crisis women suffer when they become mothers, seeking to normalise, rather than pathologise, the 'mixed feelings' that women experience during motherhood. Over the last decade, Aurélie Athan, a reproductive psychologist at the University of Columbia, has been conducting efforts to reintroduce the term into public consciousness, highlighting the extent of changes that occur during motherhood and that they can be compared to the transformations experienced in the transition from adolescence to adulthood.

During motherhood, women are pushed to the limit, undergoing physical, psychological, emotional, and identity changes. In addition to expanding the research on how the process of motherhood affects women's brains, the transition to motherhood calls for a new model that, instead of assuming that difficulties in motherhood indicate a psychological problem, women should be supported during a period in which they have to confront, beyond all physical aspects, feelings of ambivalence in relation to motherhood, so often a source of shame or stigma.

> "The birth of a baby brings with it a series of dramatic changes in the mother's physical well-being, in her emotional life, in her social status, and even in her identity as a woman. I distinguish this transitional period from others by calling it 'matrescence', in order to amplify the mother and focus on her new lifestyle."
>
> Dana Raphael, The Tender GIFT: Breastfeeding (1973)

[1] DGS data (2022)
[2] BALSAM, Rosemary H., Freud, The Birthing Body, and Modern Life, published at Journal of the American Psychoanalytic Association (2017)

'BEHIND GLASS' by Lisa Sorgini (2020)

There was a period in history when postpartum was known as the 'confinement' of women. The idea was picked up by photographer Lisa Sorgini, during to the COVID-19 pandemic. The photographs captured in Behind Glass, arose not only from the context of pandemic restrictions, but from the desire to explore the process during which women become mothers. In this photo essay, Sorgini captured mothers and children through the windows of their homes on the Australian coast.

'Adolescence is so celebrated; matrescence not so much. It's impressive because the changes are usually greater. It's a kind of initiation that society doesn't seem to embrace. While informing about a particular period, 'Behind Glass' speaks more broadly to the experience of motherhood … where women are at the centre of an intense inner world while continuing to reluctantly remain separated from the outside.'

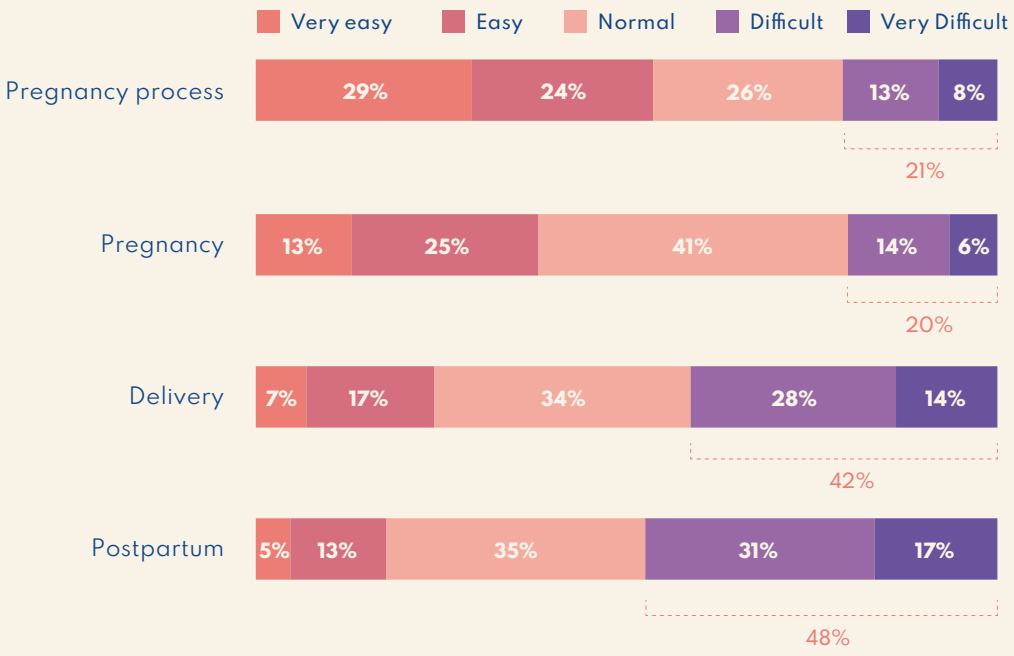
52%

of women in the fertile window have at least one biological child

N=409

The process view

N=212



69%

of mothers report at least one of the stages of maternity—pregnancy, childbirth or postpartum—as having been difficult or very difficult

56%

of mothers with more than one child report that the procedures were different or very different from each other

Realising the full potential of well-being

LACK OF KNOWLEDGE AND PREPARATION

In spite of all the information available today, significant information deficits among women can be observed, especially in the first pregnancy. Generally speaking, there seems to be little pedagogy about what each phase of the experience involves, ignoring that predictability can be a safety factor.

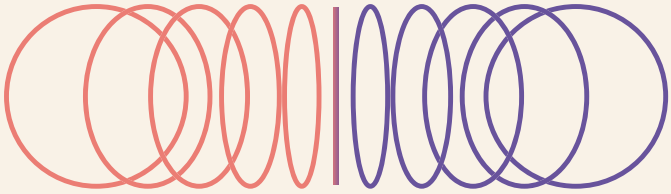
From the conversations with women, it is clear that—even for those who attend preparatory courses—there isn't a lack of superficial information, but it rarely delves into issues that actually create anxiety in women, such as nursing or labour-related decisions [in our sample, an aspect women recognised as being non-prepared]. When there's no professional information, the perceptions that women create from reading discussions on social networks prevail, often inaccurate or incomplete with regards to understanding the benefits or risks that can result from certain choices for the woman or the baby.

The gap between expectations in relation to the process (as mentioned, highly idealised) and what happens in practice is a factor that interferes with women's satisfaction and the experience of having a child. In a national study based on the experience of 7555 women who were mothers between 2015 and 20191, it was concluded that control perception is decisive in the quality of a labour experience. Having no control is one of the aspects that explains why women who started labour and had to be referred for a caesarean are less satisfied with the experience, after those who did a caesarean without labour (i.e. those who knew in advance that this would be the delivery method). They also consider the moment of contact with the baby after birth to be less satisfactory.

The support and communication established between mothers and medical staff is inherently crucial both for the confirmation of choices and women's trust. Several studies support the notion that when professionals meet their needs, women usually have a positive delivery experience, even if the delivery is prolonged or involves medical complications. In the above-mentioned study, it was also found that, although women who have vaginal deliveries acknowledge that they are more satisfied, their responses point more often to having had a more disturbing experience.

Despite the difficulty of labour, it is in relation to the postpartum period that preparation seems to fail the most. This stage proves to be the most difficult out of the whole process, and yet it is often the most romanticised. Satisfaction with this experience is also significantly related to women's self-perception, regarding how close or distant she feels from socially constructed expectations.

[1] Experiências de parto em Portugal, Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto

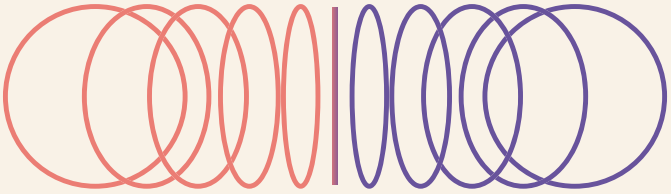


"We decided to stay in the private hospital because we had someone who would explain it to us. That's what I feel when one has insurance. We have the power of choice, we can choose a doctor who, in the first pregnancy, explained everything to us in every ultrasound of my daughter. It happened to be the person who explained everything from one end to the other, everything that was going on. He spent 40 minutes with me on every ultrasound explaining, measuring, and seeing if everything was OK, and giving me the assurance that I hadn't been receiving during other processes at the public hospital ... I think knowledge is power and I felt much more confident throughout the pregnancy by getting this information from a doctor who saw all the details and calmed us."

W, 38 years old, two children, married, talks about maternity

"The first team I had at Santa Maria explained things to me, they assured me that I was not going to have pain, everything was very controlled, and they kept asking if I was OK. But the team that checked up on me the next day treated me super badly! I said I was in pain: 'It's normal, you're in labour' ... after five hours, I had to say: 'Look, I had no pain until eight in the morning and now I have pain since the doctor came in. Something's not right! I've been here for 28 hours, I'm in pain, nobody tells me anything, nobody does anything. Do something! (...)'. I think there is a great lack of information, and it may even be a lot of 'the doctor knows best', we may not even contest ... but if they explain it to us, that's all we need! But they don't bother."

W, 34 years old, one child, married, talks about maternity



"I didn't like the delivery and there were several things that happened where I didn't feel comfortable. [After the first daughter] I read a lot, I did a lot of research, and I changed doctors for my second child. I found an amazing doctor and I felt a huge difference ... [with the first] you don't know anything and for the time being, as she is the doctor, we don't question her, and then the pre-birth course is only at the sixth or seventh month. At that point, it is difficult to raise questions, it is not clear what the obstetrician philosophy is, until D-Day ... and then nobody wants to get into conflict and put the follow-up that has been done at risk. It's difficult ... for example, I had a caesarean in my first pregnancy that was completely unnecessary (...). The doctor was known for doing a lot of caesarean sections ... and nowadays I feel totally misled because I hadn't asked for it and, there it is, I feel that it was the doctor's job to help my body to do that [labour] and it was not up to her to decide that my body wasn't going to do it."

W, 32 years, two children, married, talks about maternity

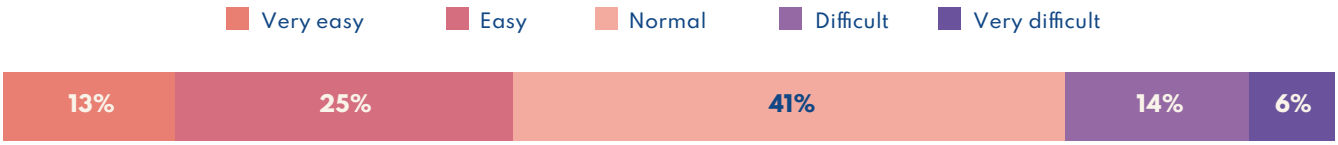
"[During the fertility process] I was looking for information on blogs, it filled the void. In the consultations it was the 'don't think about it'... I felt that the opinion was not technical. I searched the blog 'De Mãe para Mãe', that follows women in the various stages. For me this was important, I didn't want to talk to mothers who got pregnant right away, I wanted to figure out how I could mentally prepare myself for the results. And on this blog, there are female nurses who share studies."

W, 35 years old, married, one child, in-depth interview

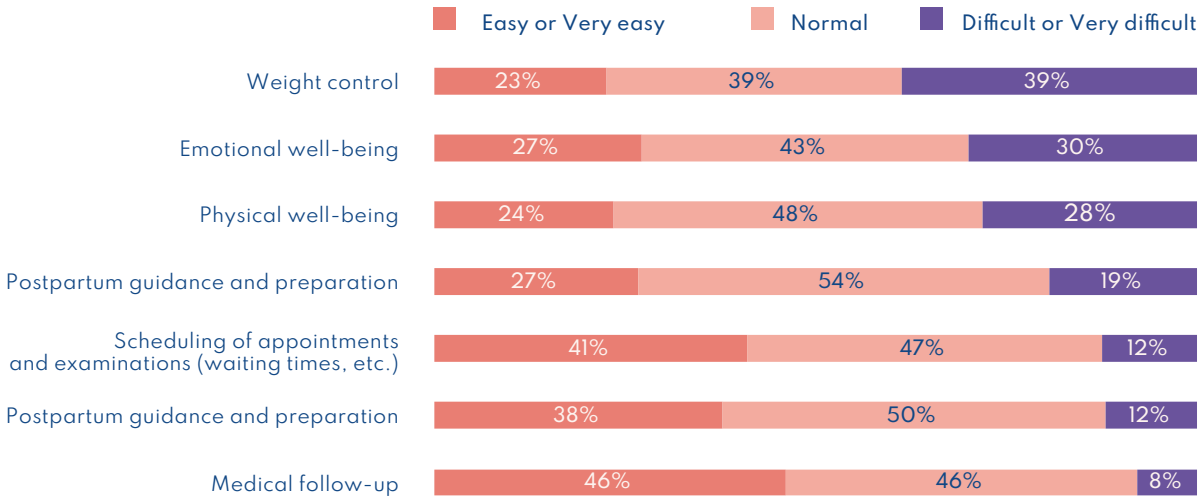
Pregnancy

How would you describe pregnancy?

N=217

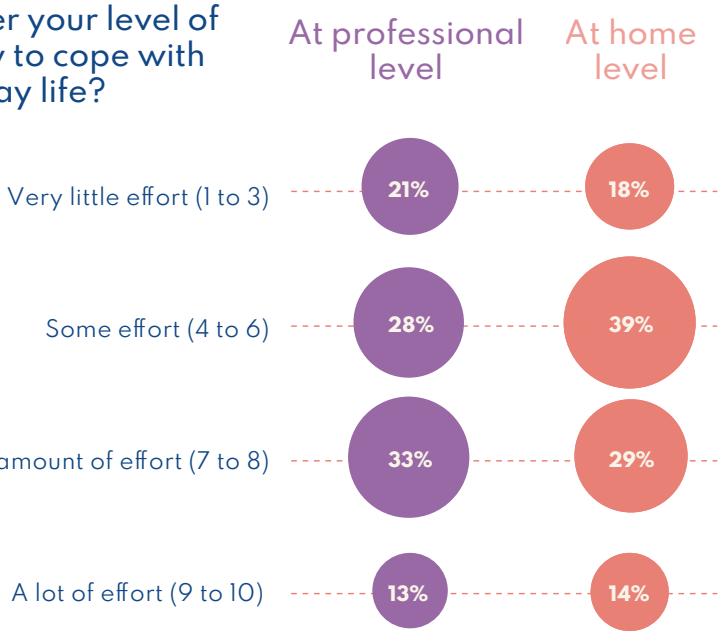


More difficult or easier aspects that you identify during this period?



How would you consider your level of effort during pregnancy to cope with the demands of everyday life?

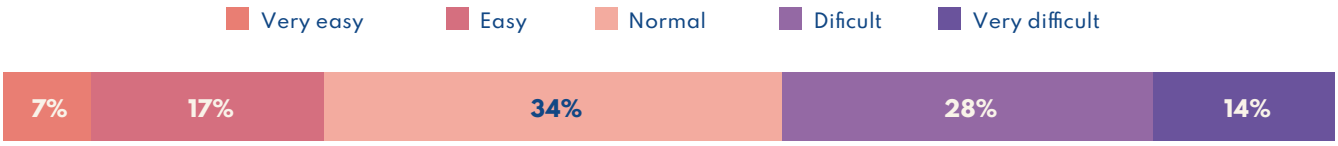
N=217



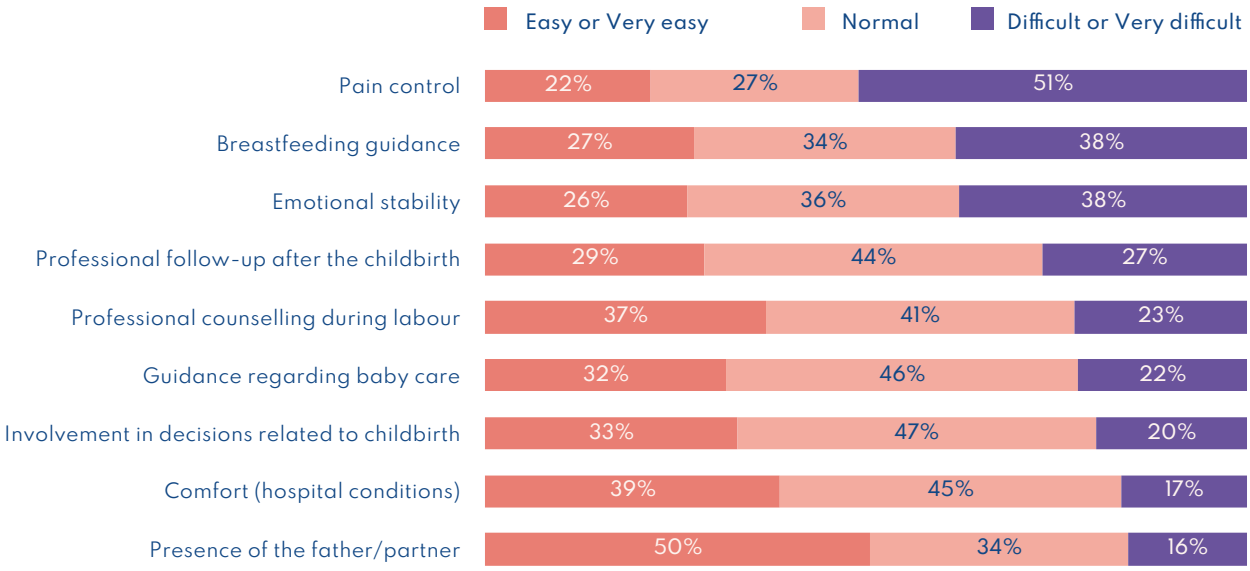
Childbirth

How would you describe childbirth?

N=212

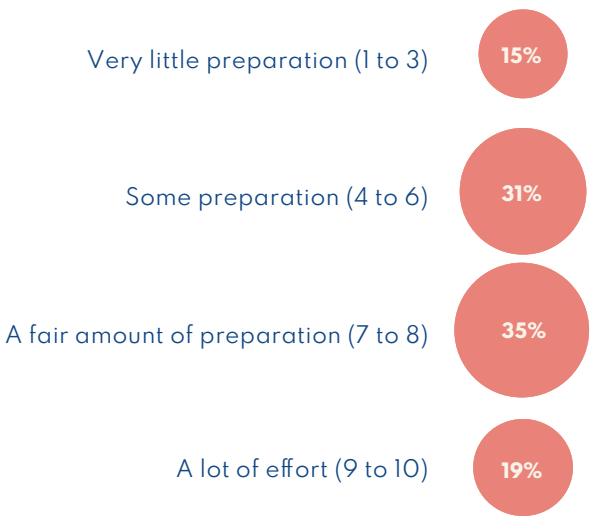


More difficult or easier aspects that you identify during this period?



Do you feel that you went to the (first) birth knowing what to expect or less prepared than you should be?

N=212



33%

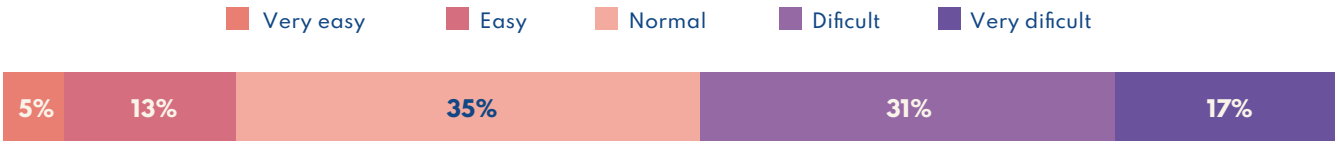
reports having felt in some medical or nursing act carelessness or aggressiveness that seemed unnecessary [during childbirth(s)]

N=212

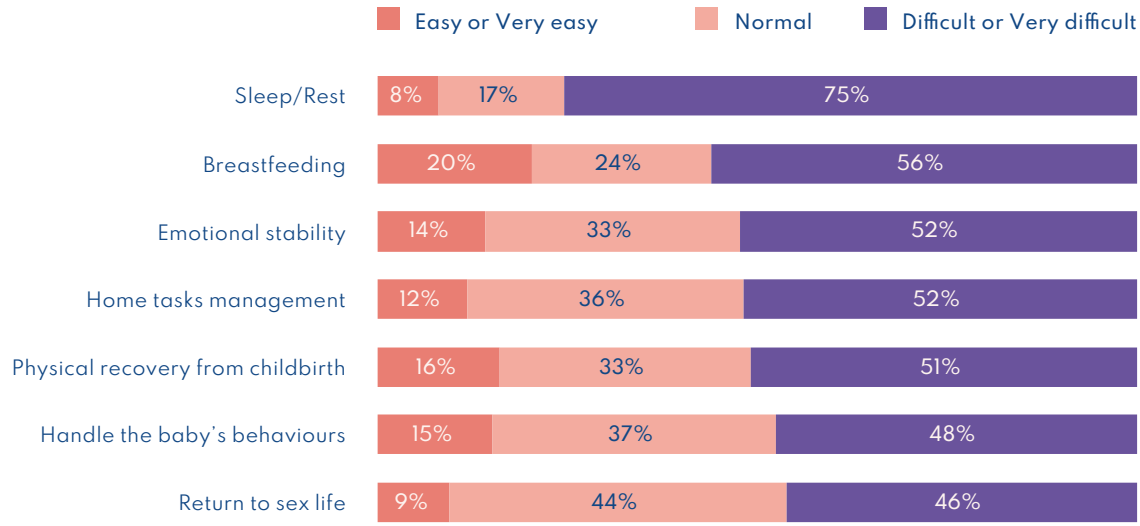
Postpartum

How would you describe postpartum?

N=212

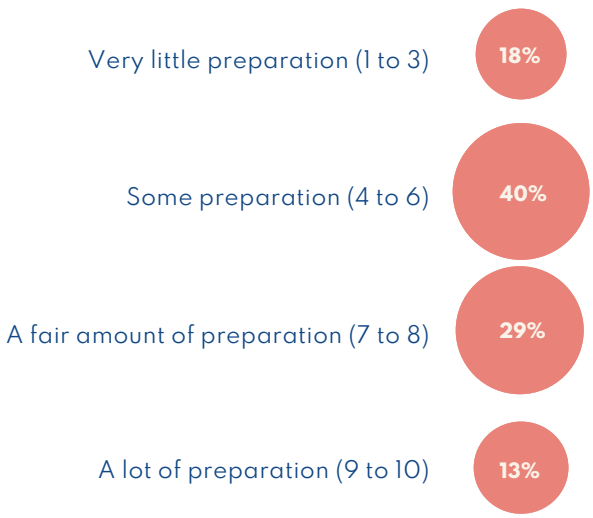


More difficult or easier aspects that you identify during this period?



Do you feel that you knew what to expect or do you think you were less prepared that you should be?

N=212



Acknowledging spaces that promote well-being

THE (EXCESSIVE) NORMALISATION OF ILL-BEING

As to be expected, the postpartum period is the most difficult part of the maternity process. Even in cases where women do not show psychological or emotional instability, it involves physical recovery from childbirth, which tends to be more difficult among women who have had a caesarean section [62% of those who had a caesarean section report that physical recovery was difficult or very difficult vs 46% of those who had vaginal deliveries].

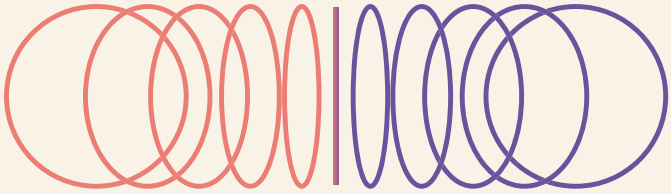
Although at all stages of the maternity process there is some tendency towards normalisation of discomfort, it is at this stage that there seems to be more inconsistency between what is asked of women and the support offered to them. During this period, women's care is secondary to baby care, either because the woman herself sticks to the child and has no time for self-care, or because society (possibly including some health professionals) not only naturalises the puerperium malaise but tends to reduce the period of malaise to those 42 days.

The psychological and physical consequences of childbirth, however, extend far beyond this date. International studies note that about half of the women who give birth still feel pain weeks later. According to a survey[1] that questioned 2400 women, more than 40% of women with vaginal deliveries reported perineal pain and almost 60% of those who had a caesarean section felt pain in the incision two months after the birth. Nearly 80% of respondents stated that pain interfered with their daily activities. And one in three reported urinary or intestinal problems.

The psychological impact will last even longer, not least because the accumulation of tiredness and anxiety around taking care of the newborn does not disappear within days. After sleep and rest, breastfeeding is the issue that emerges as the most critical of the postpartum phase. Concerning this, 56% of women report it as being difficult, some referred to breastfeeding as being physically demanding (and it's not possible to share this responsibility), others referred not being able to breastfeed. In these cases, the malaise greatly impacts the psychological as there is a non-correspondence with the ideal of motherhood, which generates feelings of guilt or frustration.

As with menstruation, also with regards to motherhood, an attempt was made to ascertain the undervaluation of the malaise. Once again, it is proved that, within the 'normal' situation, there is a great deal of discomfort: from the women who indicate as 'normal' what they lived during the postpartum period, 65% admit problems with sleep or rest, 45% difficulties with breastfeeding, 38% difficulties with physical recovery or with their sex life, and 34% emotional instability.

[1] Listening to Mothers: Pregnancy and Birth. New York: Childbirth Connection, May 2013

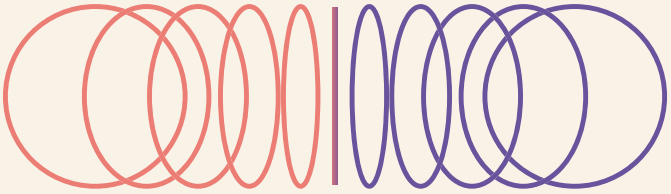


"I hated breastfeeding because it's all very violent. (...) The fact that she must wake up every three hours, then she doesn't fall asleep right away and when she falls asleep, she is already waking up again ... There were times that I would wake up crying because I had to breastfeed her. I think, because it's such a violent period, that I only breastfed for two months. And if I'll have the third, I don't think I'm ready to breastfeed every three hours and for so many months."

W, 38 years old, two children, married, talking about maternity

"I had no idea it was so debilitating ... I thought it was 24 hours and that's it, we had a sore body. I had no idea I was going to bleed. But the worst for me was constipation, I thought I was going to die! I didn't realise the urgency of that one time it came; I started crying, I thought I was going to die! No one explained this to me ... they told me, 'There's some stuff here for you to take' ... but they didn't explain. I had everything at home, because I bought it, and then I remembered that they had given me something ... I read it to see how often. It's every meal ... I didn't know I was going to get to that point. It hadn't clicked. Just like there's Ben-u-ron for the pain, I wouldn't take it because I could handle it ... I think that part is misinformation. They don't tell us much. In the first pregnancy, as I got stitches, I could hardly sit down. In the second, this constipation, from the massive haemorrhages..."

W, 32 years, two children, married, talking about maternity



"During postpartum, it felt like all the difficulties, the baby blues, hit me right in the face. I felt like I was truly alone. (...). Everyone would tell me, 'It will pass!' And it did but, at the time, that didn't help! I didn't want to worry my mother, so I didn't tell her anything ... the psychological aspect is what first comes to my mind. I felt this pressure to feel happy. When we say we're sad, they try to argue against ... I disconnected from social media because I was comparing myself to strangers and I thought: 'I'm going to give up on these patterns of happiness.'

'I feel like I have to be functional especially because of A. [daughter]. I've put on 20 kilos, and I still have 15 to lose. Going back to my regular weight would affect the psychological problems, making me feel good and healthy. I feel like if I go back to my weight, everything will get better: self-esteem, performance. I get frustrated with jogging now, so I don't do it.

'How can I improve my health?' I've been looking for that answer since A was born. It is particularly difficult after this stage, it is a reconstruction process that I have not yet managed to do; to go back to healthy life routines, diet, stress management. Putting on weight was not inevitable, but the fact that I was locked up at home closed me up and I didn't react as usual. Outside of meals, I eat what I shouldn't, almost unconsciously."

W, 35 years old, one 20 months old child, married, in-depth interview

Social Awareness

PUBLIC FIGURES RAISING AWARENESS ABOUT MATERNITY CHALLENGES

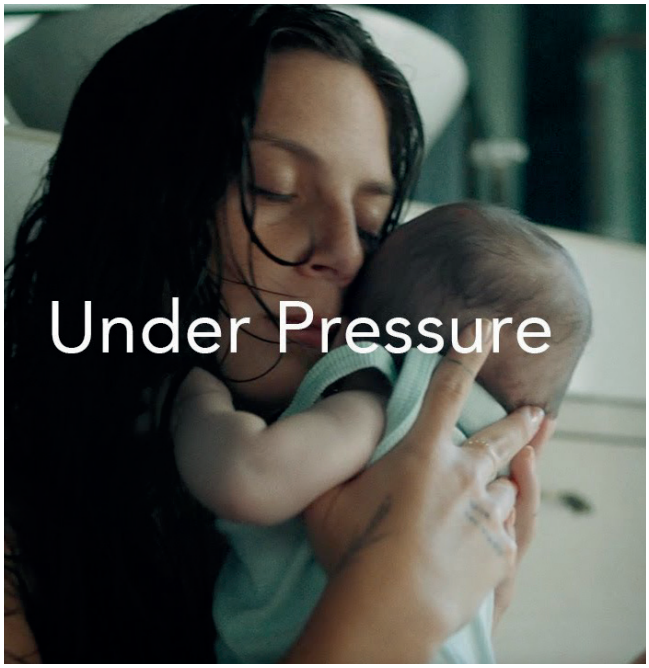
In recent years, an increased number of public figures have used their social media platforms to raise awareness about motherhood challenges. Personalities such as Adele, Gwyneth Paltrow or Chrissy Teigen have spoken openly about postpartum depression, which affects between 10% to 15% mothers. In Portugal, figures such as Marta Bateira (Beatriz Gosta) or Mariana Cabral (Bumba na Fofinha) have also contributed to the process of demystifying postpartum with their Instagram posts. Themes such as sleep deprivation, difficulties with breastfeeding or identity disorientation have been explored without beating around the bush.

MOTHERCARE
Celebrate the real postpartum

A new campaign by retailer Mothercare has been tested at 30 London Underground stations to call for a more honest representation of motherhood. Composed of ten portraits of new mothers in underwear posing with their children, the Body Proud Mums campaign aims to represent 'a part of motherhood rarely seen in the media'. Without digital touches, the photographs reveal body transformations that occur with motherhood, such as scars and stretch marks. Each portrait is also accompanied by the phrase: 'Beautiful, isn't she?'.

The campaign was launched along with a study that reveals that more than half of new mothers are unable to feel pride in their body during the postpartum period and more than half use filters when they publish photographs of their bodies on social media.

Products and Contents



DOVE + POSTPARTUM SUPPORT INTERNATIONAL

Campaign that aims to change the narrative around postpartum

Baby Dove partnered with Postpartum Support International to break the stigma around postpartum. Proprietary research has shown that the majority (59%) of American mothers feel that society does not allow them to share their experiences of how difficult the first year of maternity can be. In an advertising video to the sound of 'Under Pressure' the brand reveals the hidden side of the postpartum, period with a woman crying while looking at her caesarean scar and another sleeping next to the washing machine. Knowing that 85% of mothers agree that the first year of maternity is nothing like what they see on social media, Dove encourages women to share images under the hashtag #OneRealPressure to help change the narrative around it.

PERELEL

Supplements adapted to the different maternity stages

Perelel offers five varieties of supplements, and it is the 'first and only vitamin created by obstetricians-gynecologists'. Formulated by healthcare professionals with knowledge of nutrition and the needs of pregnant women, it covers the stages of preconception, first, second, and third trimesters of pregnancy, up to the first five months of the postpartum period.

The goal was to create a Mom Multi Support Pack that would help control stress and anxiety, sleep, and energy while covering nutritional needs. The ingredients used include ginger and vitamin B6, added to relieve first-trimester nausea and the so-called post-birth Beauty Blend to strengthen hair, skin and nails.

Research

4TH TRIMESTER PROJECT
Hub for sharing content
on postpartum

A free, expert-written, postpartum health information centre, NewMomHealth, designed to help the four million women who every year become mothers in the United States. The website aims to build a community for women to share information and learn together.

During the so-called '4th Trimester', many mothers and their families face considerable challenges without the support of employers and society at large. 'The baby is the candy; the mother is the wrapping. Once the candy is out of the package, the packaging is put aside,' argues the NewMomHealth.com team.

MAVEN CLINIC
Virtual clinic for supporting
mothers and families

The Maven Clinic is a telemedicine network focused on women's health, which supports employees of companies such as L'Oréal. Maven connects people with gynaecologists, nutritionists, lactation consultants, and other experts via video chat or messaging for a fraction of the cost of a personal appointment. It was founded on the premise that access to better health care before, during, and after pregnancy benefits both employers and workers (requiring fewer days off and ultimately preventing employee turnover). In addition to coordinating pregnancy care and services that help women get back to work, the Maven Clinic also offers fertility-related benefits such as egg freezing, in vitro fertilisation or genetic counselling.

Technology

ELVIE + WILLOW INNOVATIONS

Wireless breast milk extractors
covered by health insurers

Wireless breast milk extractors facilitate the daily life of mothers, but prices restrict widespread use. The British brand Elvie developed a new device, the Stride, which is covered by health insurers in the US, because it is cheaper. The milk extractor, silent and wireless, is powered by a light motor that can be placed on the back or in a pocket and has tubes that connect the two glasses to discreetly collect the milk. The American brand Willow also sought to launch a more affordable bomb, Willow Go.

PELVITAL

Technology for treating lesions
on the pelvic floor

Pelvital was created with the aim of significantly improving the lives of women suffering from pelvic floor problems. The brand is focused on expanding traditional treatment options, inspiring women to treat conditions rather than just manage symptoms. Their first product, Flyte, is a device for the treatment of stress urinary incontinence, designed to treat the weakened muscles of the pelvic floor, reducing losses of urine and restoring the normal functioning of the bladder.

‘Saúdes’ test

Imagine that you could have had access while giving birth to a therapist to help you manage anxiety and pain. This therapist would use techniques (e.g. breathing and control exercises) that favour psychological and physical relaxation (helping the muscles working the right way during delivery). In your case, how useful would you consider such a service?

39%
very useful

[36% useful]
N=212

Imagine that you could have had access to a confidential and free line, 24 x 7 days a week, providing specific support for mothers.in your case, how useful would you consider such service?

IN PREGNANCY

26%
very useful

[47% useful]
N=217

IN POST-PARTUM

31%
very useful

[42% useful]
N=212

Considering the average number of births in Portugal over the past five years, about 85,000 women experience maternity every year. 69% of these women consider at least one of the stages of maternity — the process of becoming pregnant, pregnancy, childbirth or postpartum — difficult or very difficult. Taking stock, there are 58,650 women who go through a difficult period every year.

Despite the significant changes regarding maternal health, there are still aspects that cause serious discomfort for women, both physically and psychologically. Research confirms that ill-being is viewed as a necessary part of the process. Pain, breastfeeding issues, sleep deprivation, body changes, anxiety, negative feelings of guilt or frustration are all maternity-related issues that have been normalised.

Women are not pre-prepared for what awaits them. There is a lack of information and pedagogy regarding the factors that women face in childbirth and postpartum. Even if a great deal of this is out of their control, predictability can be a safety factor.

After delivery, the woman is given the entire responsibility for caring for a baby, without an ‘instruction manual’, while trying to fit into a socially constructed ideal of motherhood. Women are victims of a society that insists on romanticising a phase involving overwhelming challenges, giving them little support and little opportunity to talk about it.

'Not feeling bad' does not mean 'feeling good'. The effort to restore a good level of health and well-being is closely linked to healthy routines, and this is one of the aspects that takes the longest time to re-establish. The examples listed here are proof of how far we still have to go, not only in alleviating ill-being, but also in providing help for women recovering from a delivery, whose consequences far exceed 42 days of the puerperium.

Realising the full potential of well-being

Menopause

Menopause does not happen instantaneously and represents much more than the end of the menstrual cycle. It is a transitional process that generally takes place between the ages of 40 and 58, although in some cases it happens very early, around the age of 30, and in others later, around the age of 60. Natural menopause occurs in 3 phases—perimenopause (or pre-menopause), menopause and post-menopause—and the intensity and duration of symptoms differ greatly from woman to woman.

Scientific development and the exponential increase in average life expectancy would suggest that there is in-depth knowledge on the subject. The truth is that the understanding about this stage of a woman's life cycle remains largely sub-par. Little is known, for example, about the impact on well-being, productivity, and social relations associated with a condition that, according to the President of the Portuguese Menopause Section of the GSP, affects 2.5 million women in Portugal.

While menopause poses increased health risks, it should be 'embraced and managed, rather than treated as a disease'[1]. Lifestyle can greatly lessen its effects, which leads experts to argue that, although the average age of menopause is 51 years, prevention should start much earlier, around the age of 35.

The symptoms of pre-menopause represent millions in health expenses and loss of productivity and reflect a clear well-being deficit. In 2019, Jornal de Notícias reported that Portuguese women spent €2.78 million per year in medication to treat menopausal symptoms. In the same year, the Portuguese Society of Gynaecology (SPG) revealed that menopausal symptomatology interfered with the professional activity of almost one in every four women and obliged 5% to be absent from work.[2]

Like other milestones in the women's life cycle (adolescence, matrescence), at menopause the social role of women is redefined. A recent study[3] shows that more than ¾ of women (76%) pre-menopausal or menopausal change their lifestyle as a result of its effects and 67% consider it a 'new chapter of life'. It is, however, the stage that most stigma and taboo ends.

According to the president of the Portuguese Menopause Section of the GSP, Fernanda Geraldes, menopause 'is most often associated with a phase of decline of women—aging, weight gain, less attractive, end of reproductive capacity and sexuality,' when in fact the '50-year-old woman is active on a personal, professional and sexual level, with dependent children and parents,' so it is essential to enhance her physical and psychological well-being and break myths.[4]

Most women going through the menopause do not feel well served or represented in health speeches and campaigns or even by consumer brands. A Female Founders Fund report on the global menopause market[2] (which includes femtechs) alerts: 'women at this stage of life continue to be seriously under-served.[5]'

[1] According to Irene Aninye, director of scientific programs at the Society for Women's Health Research
[2] Data released by the GSP in Oct 2019
[3] Over The Bloody Moon, 'Redefining the Menopause;' survey conducted by Kantar UK & Ireland, of 1000 pre-menopausal or menopausal women aged 30 to 65 years old, between 2 and 7 March 2022
[4] In statements to Lusa regarding the 'Women Without a Break' Conference, Oct 2019
[5] Only 5% of femtech start-ups address menopause

Menopause, a new perspective under construction

Brief chronology

2015

✓ In an interview with The Daily Telegraph, American actress Angelina Jolie, then 40, speaks openly about her early entry into menopause, after being subject to preventive removal of the ovaries and Fallopian tubes.

2017

✓ Actress Gillian Anderson is interviewed on Lena Dunham's Lenny Letter blog, where she discusses topics such as shame around menopause and the (almost-total) ignorance women have about pre-menopause.

2018

✓ On Instagram, actress Gwyneth Paltrow comes across a promotional video of her brand (Goop) to talk in the first person about the symptoms of pre-menopause, stating that 'menopause needs a rebrand.'

2019

✓ Creation of the Movimento Menopausa Divertida Portugal (MMDP), a Facebook group for information, sharing and support directed to women, which today has about 27 thousand members.

✓ Vichy organizes a conference in Portugal called 'Women without a Pause', giving voice to specialists from various areas of health—dermatology, cardiology, nutrition, sexology, and pharmacy—to talk about menopause.

2020

✓ Former U.S. First Lady Michelle Obama speaks openly about hot flushes on The Michelle Obama Podcast 'I was dressed, I needed to go out to an event and literally it was like someone put me in an oven and turned it on at the maximum, and everything started to melt.'

2021

✓ In the work sphere, the multinational Diageo introduces the global initiative 'Thriving Through Menopause', which ensures access to support sessions and mindfulness, as well as increased flexibility for women going through menopause (e.g. changing work patterns or access to sickness benefits to cope with symptoms); Edelman UK & Ireland also announced 10 paid leave days to alleviate the impacts of menopause.

✓ Launch of VIDAs—Associação Portuguesa de Menopausa—the first non-clinical Portuguese organisation totally dedicated to menopause.

2022

✓ The Mayor of London, Sadiq Khan, announces the implementation of pioneering worldwide legislation to help women live the menopausal transition better.

✓ Scottish Prime Minister Nicola Sturgeon, 52, says on menopause: 'I am very conscious of being a woman with a profile and a platform, a reasonable degree of influence. I feel responsibility to talk about this. And yet, I'm way outside my comfort zone, in terms of the intensely personal nature of the subject. That tells me that no matter how far we've come, we still have a long way to go if someone in my position still feels uncomfortable with this.'

42%

of women aged between 20 and 74 are menopausal

N=707

2%
Pre menopause
(still menstruating but already feels menopause symptoms)

3%
Menopause
(sporadic menstruation)

38%
Post menopause
(no menstruation for more than 12 months)

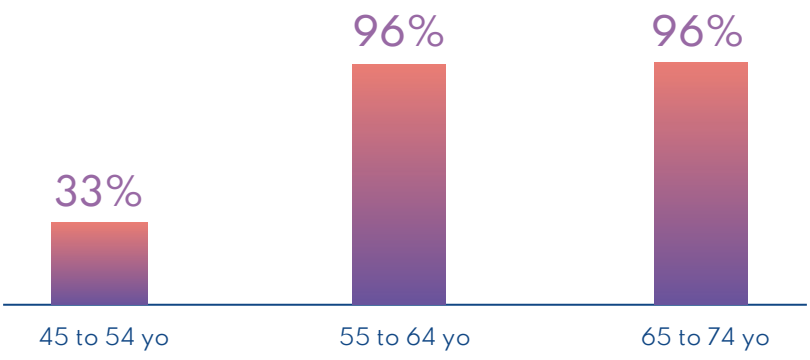
29%
It was natural, a normal ageing decline

2%
It was before, had an emotional shock

7%
It wasn't natural, it came from an intervention

Premenopausal, menopausal or postmenopausal women

N=707



Among women aged between 35 and 44, 6% menstruates but is irregular, and 20% does not menstruate due to the contraceptive (therefore, it is not possible to assess how regular the menstrual period is)

Women Living Better (WLB)—a research and awareness-raising platform focusing mainly on the pre-menopause and hormonal changes women experience from the age of 40—has conducted two major studies, with the support of gynaecologists and researchers, in the area of women's health, in order to better understand different pre-menopausal experiences.

The latest survey, conducted in 2020, was presented at the annual meeting of the North American Menopause Society and won the award The NAMS Media Award 2021, which recognises professionals whose work contributes to expanding knowledge on menopause. Four key ideas stand out from this study, which interviewed 2400 women.

1. Pre-menopausal symptoms begin before menstruation becomes irregular, which usually happens in the early 40s.

2. Most women expect the changes associated with menopause to begin at age 50 or later, creating a difference between the expectation and the actual experience.

3. Similar symptoms occur before and after menstruation becomes irregular.

4. Symptoms experienced go far beyond hot flushes (the most commonly addressed symptom).

"It was never a conversation I had. We don't know what's going to happen. We have an idea based on what we hear and read (...). In my case, since there was nothing very serious that made me go to the doctor, when the matter came up, we talked about it. It all took place as it was happening. There was not a previous conversation about how to prepare for it. (...) I think that it is always important to have a conversation in advance, to prepare us for this new phase that will happen in our lives. Because, if something comes up, I may have read or heard about it from a friend, but this technical conversation is key for alerting us, so that we are aware of the signs. Then, if it doesn't happen, it didn't happen."

W, 56 years old, married, two children, in-depth interview

Menopause discomfort

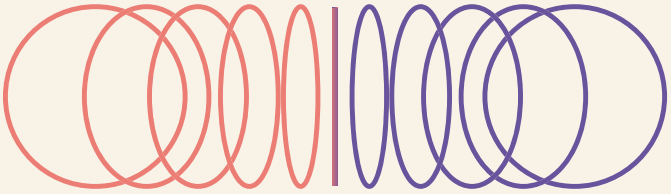
In direct speech

"Before the menopause, I was a nine [on a scale of 1 to 10 in well-being], but during the menopause I was a five. It was mainly due to the hot flushes. After the menopause, I would say a six because I think I've gotten used to living with this ... I'm already 59 years old, on my way to 60, from time to time I still have hot flushes. I stopped taking the pill five years ago, but I took it for almost 10 years. Now I take some natural things and I can live with it. But I started very early, I suffered a lot..."

W, 59 years old, married, three children

"Two years after not having a period, I have exactly the same symptoms and they are always frequent: sweats, tachycardia ... I would go to bed, fall asleep and after five minutes I would wake up as if I had run a marathon. As if I ran a sprint. My heart would start beating and beating. I even thought that I was having a heart attack for no reason! (...) They were hormonal changes; the body was suffering, and I had two solutions: either I lived with it or I should start the therapy women usually do. As I can't do hormonal treatment, the options I had were much more limited. In these situations, I think medicine leaves us few or no options. So, I live with ... bring it on ... sweats and quasi heart attacks! I'm learning to live with this. As long as it's benign, we adapt and accept."

W, 54 years old, married, two children



"I was already menopausal at the age of 47. Before that, the changes I felt when I had my period were those critical days when we get angry and nervous, and in physical pain. When I reached menopause, I started to experience this daily. I didn't have my period, but I had the symptoms, the irritability. This was for me very complicated because I had a small child and being a mother of a small child at this age is difficult.

That was the hardest for me. That and insomnia. Spending sleepless nights, it's hard. For the hot flushes I started taking soy isoflavones because otherwise it was unbearable and impossible. I couldn't deal with it; it was really bad … I did this for about ten years, but the first years were very, very complicated. Then acceptance comes in and one begins to live as if it was normal.

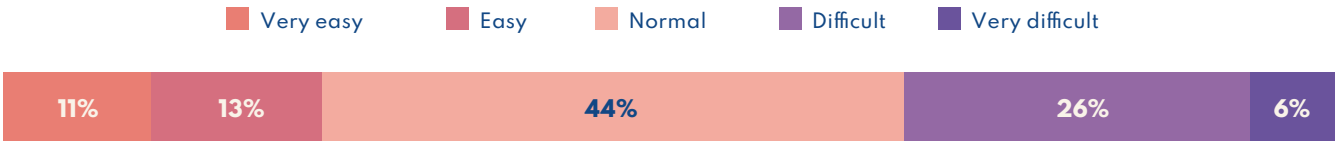
I'm more in control of the moody part, but I still have insomnia. That means being awake 24 hours a day because I'm awake at any moment. I have moments during the day when I feel very sleepy and I don't sleep because I'm working and when I lie down, I sleep deeply for an hour and then I'm able to have three or four hours without any desire to sleep. This part is very complicated and difficult to solve because it brings physical and emotional tiredness."

W, 60 years old, divorced, one child
— Conversation between women in post-menopause, talks about menopause

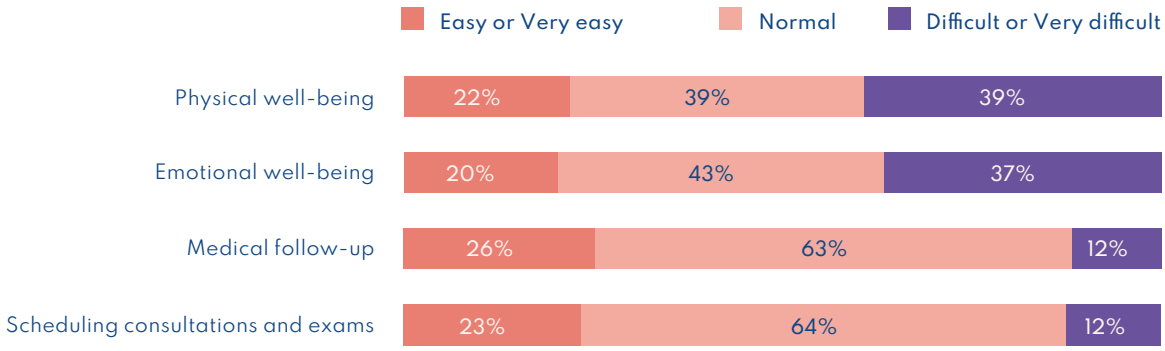
Menopause

How would you describe menopause?

N=298

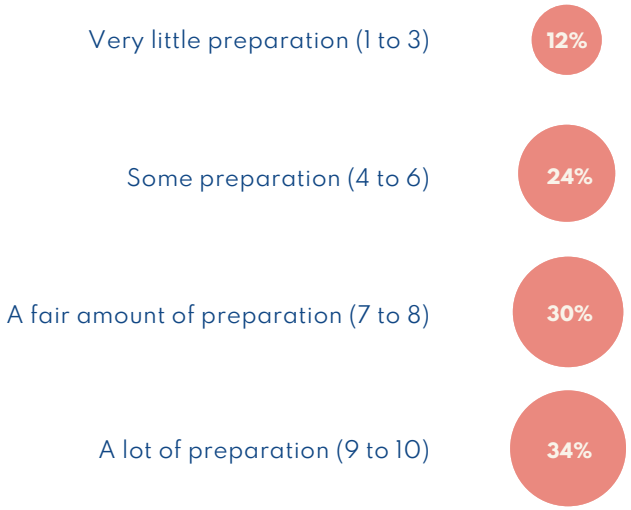


More difficult or easier aspects that you identify during this period?



Do you feel that you knew what to expect or do you think you went less prepared than you should be?

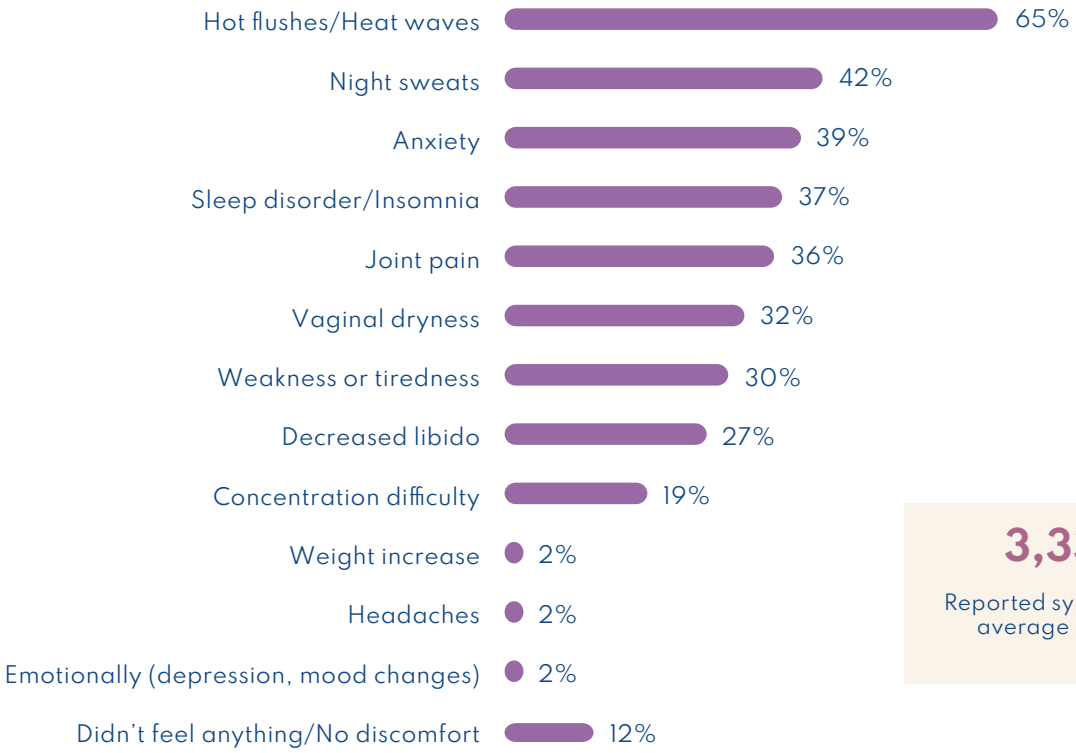
N=298



The measures of malaise

What symptoms or discomfort do you or did you feel during menopause?

N=298

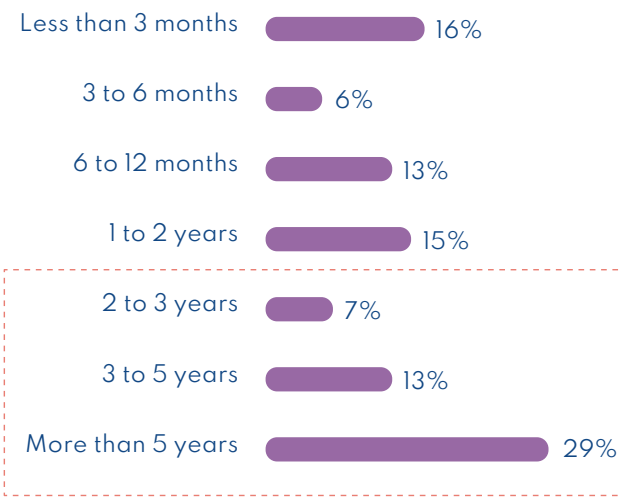


3,33

Reported symptoms average num.

How long did the symptoms last or for how long have you been feeling them?

N=298



49%

feel discomfort for more than 2 years

Acknowledging spaces that promote well-being

THE (EXCESSIVE) NORMALISATION OF ILL-BEING

International studies show that eight out of 10 women experience menopausal symptoms such as night sweats, sleep disturbances, reduced libido, and anxiety. In our study, only 11% report not having any symptoms, and 53% accumulate three or more symptoms on a list headed up by hot flushes/heatwaves.

In conversations with women who had or who are going through menopause, it is clear that women resign themselves to living with a discomfort that, in 29% of cases, lasts more than five years.

If it is true that menopause does not impact all women the same way, that its effects may be related to pre-existing health problems and some women have few or no complications. It is also noticeable that there are a number of women who qualify as 'normal' a phase that, judging by the level and duration of the symptoms they state, should actually be classed as 'difficult'.

As in previous chapters, in order to ascertain the scale of malaise undervaluation and the inaction it leads to—in which 44% of women had or are experiencing menopause—a comparison of 'normal' was introduced into the process evaluation scale. Confirming the hypothesis in an obvious way, 49% of these women who classify what they feel at menopause as 'normal', have three or more symptoms of discomfort; 43% feel these symptoms for more than two years, and 7% accumulate 4 symptoms of malaise: hot flushes, night sweats, insomnia, and joint pains.

Of the women who described menopause as 'normal'

N=130

49%

reports more than two symptoms of discomfort

43%

feels discomfort symptoms for more than two years

7%

accumulates hot flushes, night sweats, insomnia and joint pain

ASSOCIATING MENOPAUSE WITH OLD AGE

The pathological conception of menopause creates a negative picture of female ageing. This picture, also because women's bodies have always been associated with fertility and good physical appearance, translates, in some women, into a feeling of loss of social value.

The lack of knowledge of what menopause involves and means, coupled with a self-image deterioration, leads one to perceive menopause as a rite of passage into old age and, in some cases, into sexual abstinence.

Developments in women's studies have shown positive aspects of menopause. In cases where women feel little effects, menopause is felt as a liberation. In other cases, once symptoms are controlled or overcome, women feel better and feel more in control over their lives. 'Menopause is the best thing that happens. We should have everything backwards ... we should have been menopausal all our lives! Now I'm much better, I've gained quality of life', commented a 53-year-old woman about the hysterectomy she was submitted to years before.

Disinformation is another major problem. Perimenopause is difficult to diagnose. Due to a lack of information, many women act upon the specific symptom—such as hair loss—without being able to relate what they feel to with menopause. Some will be treated with anxiolytics because neither they nor the doctors know the physiological changes that cause their anxieties. One of the study's participants commented in an interview how strange it was that when she was menopausal, this was not included in her family doctor's clinical records. This sheds light on the need for education of women (not to mention doctors) about menopause and its effects.

"It's about giving voice to the celebration. 'Ageing without remorse', it's our mantra. Instead of looking at ageing as a problem that needs to be fixed, we wanted to build on the idea of a new and exciting phase of life. We look at women our age and we see them full of energy, starting businesses or running marathons ... that is, instead of calling this category anti-aging products and services, we should call it pro-ageing."

Helen Normoyle, co-founder da plataforma 'My Menopause Centre'

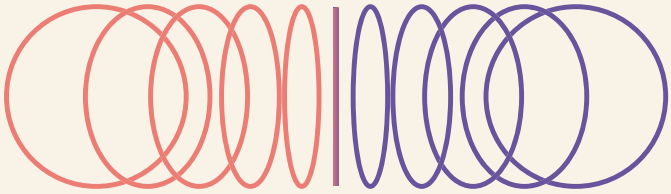
74%

of postmenopausal women feel that what they do in life is valuable and rewarding vs 62% of the total sample

N=268

A phase that can be positive in women's lives

In direct speech



—'I've always seen menopause as a moment like every other moment in my life, but not every woman thinks like that! There are women who think that menopause is a step towards the end of their lives, that they stop being women, but right now I even feel more woman. I don't know why, I don't know if it's because of that, but I didn't gain weight, I didn't lose weight, maybe I lost muscle tone, I never had breasts and now I also don't...
—Mine has diminished, but it's not because of these factors that are associated with femininity, that I've somehow lost, that I feel more, or less, feminine. On the contrary. But I do have friends who think that because they no longer have periods, they no longer feel like women ... and, even more dangerous, that they think that others, namely husbands, no longer see them as women...
—They even think that the period ends and sexual intercourse ends.
—No more female factor.
—It's over.
—It's also because of our partners, not our bad relationship with ourselves. We don't change a thing. We actually change for the better. Age does not worsen sexuality because we have more time, we are not afraid to become pregnant, the body is more available, now if there isn't the other side...
—I don't have a partner, but if I did, I'm sure I'd be at the best of my life! Because I know everything I feel and everything I experienced after menopause. And I've never felt so good with my sexuality, with my body, with my emotions as now. And so, I am absolutely sure that if I had a partner, I would be much happier than I have been in the past.'

Dialogue between participants, talks about menopause

Fleabag, Phoebe Waller-Bridge (2019)

Although it's not represented frequently in popular culture, narratives about menopause usually revolve around the hyperbolisation both of the psychological state of the woman, and the symptomatology associated with the transition to menopause. Only recently, have writers and directors like Phoebe Waller-Bridge come forward, who in the Fleabag TV show gives a more positive portrayal of post-menopausal life. In one line from the show, actress Kristin Scott Thomas, who acts as a 58-year-old woman who has just received a career award, states:

> —'I've been longing to say this out loud: women are born with pain built in, it's our physical destiny. Period pain, sore boobs, childbirth. We carry it with ourselves throughout our lives. We have pain on a cycle for years and years and years and just when you feel you are making peace with it all, what happens? The menopause comes, it is the most wonderful f....g thing in the world. And yes, your entire pelvic floor crumbles, and you get f....g hot, and no-one cares, but then, you're free! No longer a slave, no longer a machine with parts, you are just a person.
> —I was told, it was horrendous?
> —It is horrendous, but then it's magnificent.'

Social Awareness

GENM
Brands united around menopause

GenM is a non-profit organisation created to make menopause into a more positive experience. In 2021, it presented an open letter, signed by 31 brands, which, in addition to committing to creating and marketing products that meet the needs of women in menopause, they promise to use of their platform to normalise the discourse around the theme. Although GenM focuses mainly on the UK market, it anticipates that many of these companies will implement measures on a global scale. 'Our ultimate goal is to work with our partners to create the world's first menopause label, which will be side by side with other labels, such as vegan and cruelty free,' said Heather Jackson, the project's co-founder.

Published in 2021, its latest research, Invisibility Report[1], reveals, for example, that 87 percent of menopausal women feel ignored by society and brands; 97 percent think brands should better meet the needs and desires of menopausal people; and 91 percent have never seen specific advertising or marketing for menopausal products.

[1] Online survey conducted in 2020 on a representative panel of the British population, on a sample of 2010 women

Social Awareness

TENA
Campaign promotes intergenerational discussion on menopause

Tena's recent campaign stemmed from a study that found that more than 80% of women talk very rarely to their mothers about menopause. Centred on the relationship between mother and daughter, while the former goes through menopause, history suggests that this stage of a woman's life is a sort of reverse of puberty or a second entry into adulthood.

If puberty is a period of beginnings, society continues to treat menopause as an end. 'We know from the statistics that women will suffer less from symptoms and feel better if they are better prepared. We wanted to establish an intergenerational discussion with which women could identify. Also, it was important not to portray the menopause as an end. The idea of liberation is something that we heard a lot in the focus groups— women felt great when it was over. We wanted to portray the ups and downs.'

Under the hashtag #LastLoneleyMenopause, the film humorously reports menopausal symptoms. 'Humour helps make it easier to talk. [But] we didn't want to make fun of women—there is a balance. But we thought; what if women could aspire to this moment in their lives, and not just regret it? Because there are a lot of good things that come out of menopause, like becoming a much more confident woman.

Note: The ad is the winner of Channel 4's Diversity in Advertising Award. An 'Infrequently Asked Questions' guide with real testimonies that encourages readers to ask more and better questions about menopause, is also available on Tena Women website

Products and Contents

P.VOLVE
A fitness program
for menopause

The health platform P.Volve launched the fitness programme, Moving with Menopause, to help women live this phase better. Although pre-menopause can start in the 30s, the company found that most women (83%) are unable to find an appropriate exercise plan to manage the transition. The Moving with Menopause regimen comprises 16 videos, focused on the four main symptoms women face during menopause, including mental health problems and muscle mass loss. Exercises to relieve stress are also included, using meditation techniques. P. Volve believes that in the future, spaces such as gyms and spas may have specialists focused on relieving menopausal symptoms.

RORY BY RO

Rory is a brand targeting women between the ages of 45 and 65 in search of more knowledge about menopause. The platform offers prescription and over-the-counter products for hot flushes, vaginal dryness, sleeplessness, and eyelash loss—symptoms often ignored by women, according to the brand. Women are encouraged to fill in their data online so that a healthcare professional is then able to determine the appropriate treatment. It is also possible to have a teleconsultation with a doctor for about 13€. 'Menopause and puberty are the only things all women will go through at some point in their lives, but there are still very few online resources,' says Rory's founder.

Products and Contents

KINDRA (PROCTER & GAMBLE)
New offers in a historically neglected market

Procter & Gamble has launched a new brand targeting menopause. The oestrogen-free products were formulated to relieve hot flushes, mood swings, and vaginal dryness, among other symptoms. They include three food supplements and a vaginal lotion, available without a prescription. The products are currently on sale on the brand's website, designed as a community space to support menopausal women.

Kindra [brand] has the mission to market its products at more affordable prices than prescription drugs. According to P&G, the menopause treatment market 'has long been forgotten.'

WOMANESS
Personal care for menopause in the 'mass market'

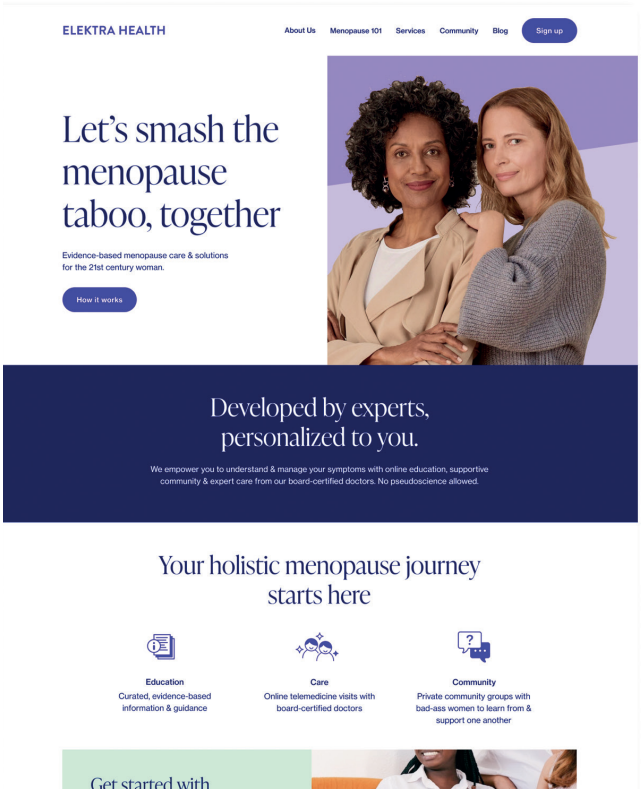
The American brand Womaness was created to support women with symptoms of pre-menopause, menopause, and post-menopause, such as vaginal dryness, hyper-pigmentation, loss of skin elasticity or incontinence. Since 2021, Womaness has been on sale at Target and Ulta Beauty, retailers in the USA. 'Supermarkets and pharmacies offer a variety of feminine care products for menstruating women, but when it comes to menopause, the offer remains scarce. There is still no brand that really offers a full and affordable solution for menopause', says the company's CEO.

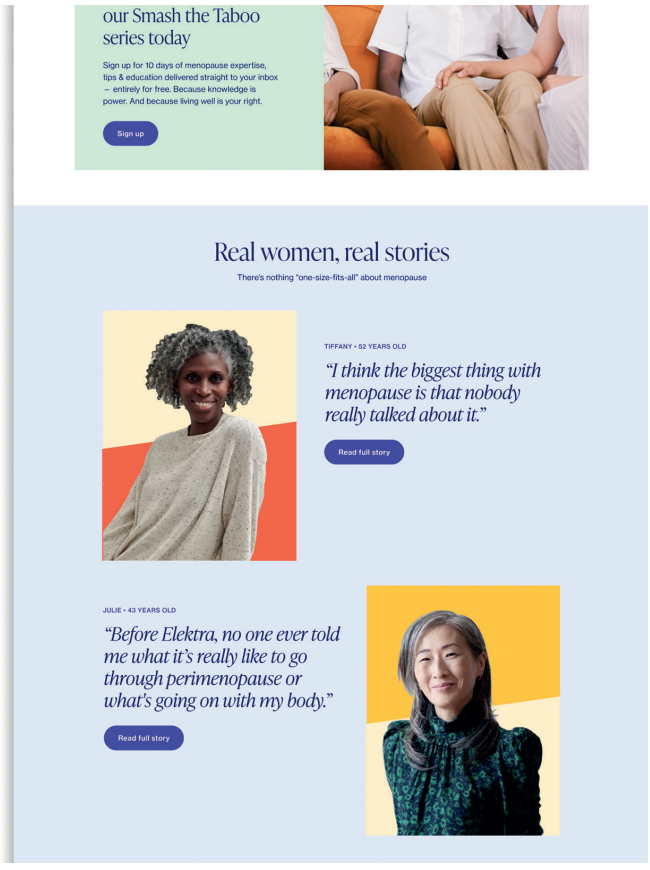
Research

ELEKTRA HEALTH
Telemenopause

Elektra Health is a specialised menopausal telemedicine platform that offers unlimited virtual medical support, personalised content, and access to a private community of women living at this stage of their life cycle. The process begins with an evaluation and the formulation of a wellness plan personalised to the objectives of each woman. There is also an option available for organisations and companies to support women in the workplace.

A recent study conducted by Elektra Health[1] found, for example, that ⅓ of women consider that menopause negatively affects their performance at work; 44% feel that they do not receive sufficient support from their employer about managing the menopause; 20% considered abandoning (or quitting) the job due to malaise caused by menopause and 73% would like support to manage menopause from their health insurance.





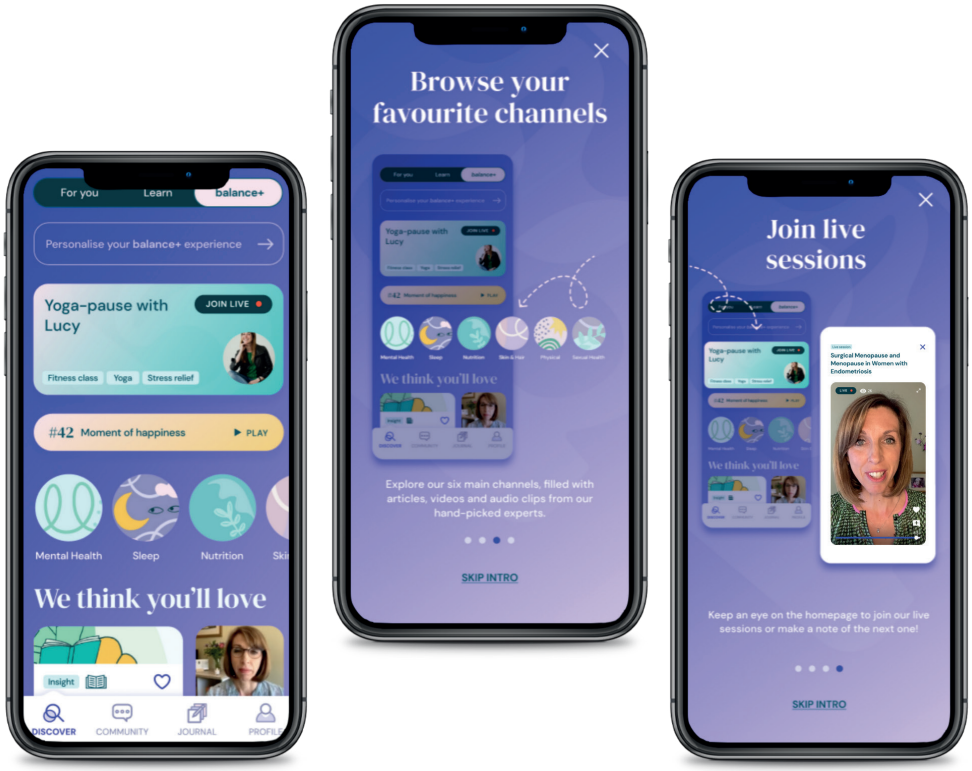
[1] Menopause in the workplace report, on a sample of 2000 women aged 40-55 working in the US, July 2022

Technology

BALANCE + DIAGEO
Partnership to support menopausal transition in the workplace

Balance is the world's first medically approved application for women going through menopause and pre-menopause. The app provides a safe space for women to catch and monitor menopausal symptoms in order to fill the educational gap in this area. Created by the medical specialist of menopause Dr. Louise New-son, the application's content explores the importance of holistic health and well-being in the management of this stage of the life cycle.

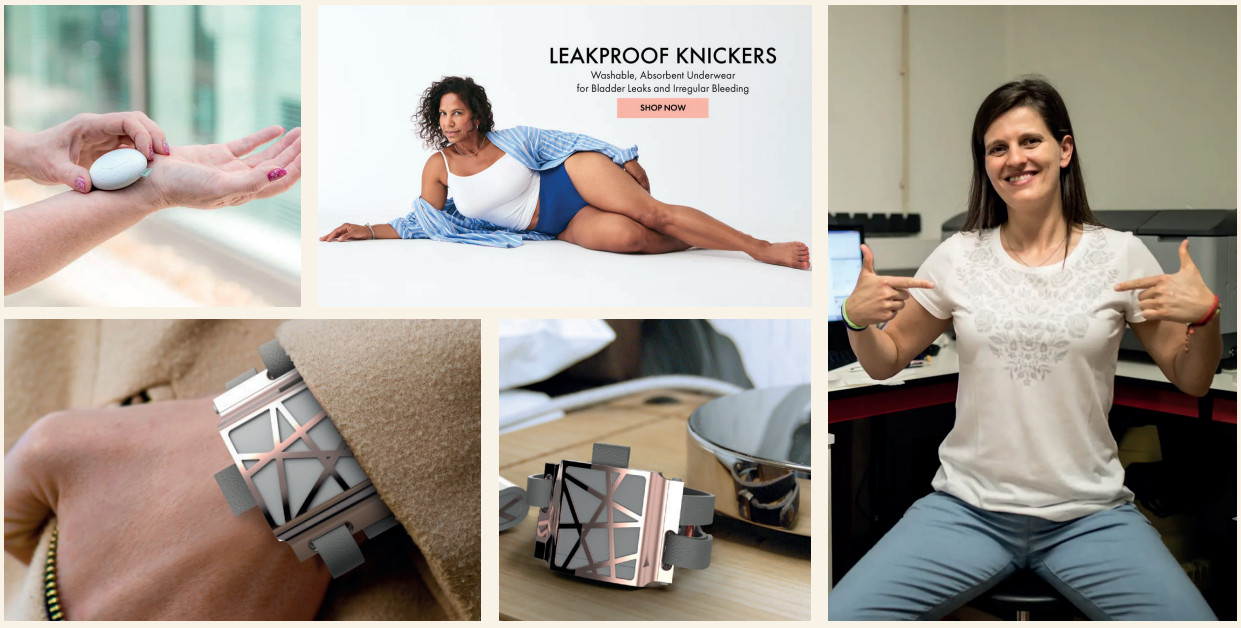
Diageo, a multinational beverage brand, became the first company to make the balance+ application available to all its employees worldwide. Workers will have access to specialised content to help optimise physical and mental health, nutrition, sleep, sexual health, skin, and hair. The partnership comes under Diageo's Thriving Through Menopause Guidelines initiative.



‘Saúdes’ test

To mitigate one of the main symptoms of menopause–hot flushes—innovative technologies have been created. Pebal is an easy to transport device that cools between 10° to 15°C and can be used on the body to relieve hot flushes. Grace is a bracelet that detects the start of an hot flush, it generates a cool sensation around the wrist and by doing so activates the natural body temperature regulation system.

The bracelet is connected to an app on the mobile phone, which allows to monitor and manage the symptoms of menopause. Become is a clothing brand that uses technological fabrics that help controlling hot flushes and night sweats. The Portuguese Ooze Nanotech created Intimae, a T-shirt with a medicinal silicone coating, that regulates the body temperature.



Clockwise: Pebel, Become, Intimae by Ooze Nanotech, Grace

‘SAÚDES’ TEST

Imagine that you could have access to a bracelet that detects the onset of hot flushes and generates a feeling of cold in your wrist that activates the body's natural temperature regulation system. In your case, how useful would you consider this device?

26%
very useful

[36% useful]

N=298

In Portugal, around one million women aged between 45 and 64 will be at one of the stages of menopause. The 'pause' is not fleeting; half of women will experience symptoms for longer than two years and 29% for more than five years. Some symptoms may last more than a decade.

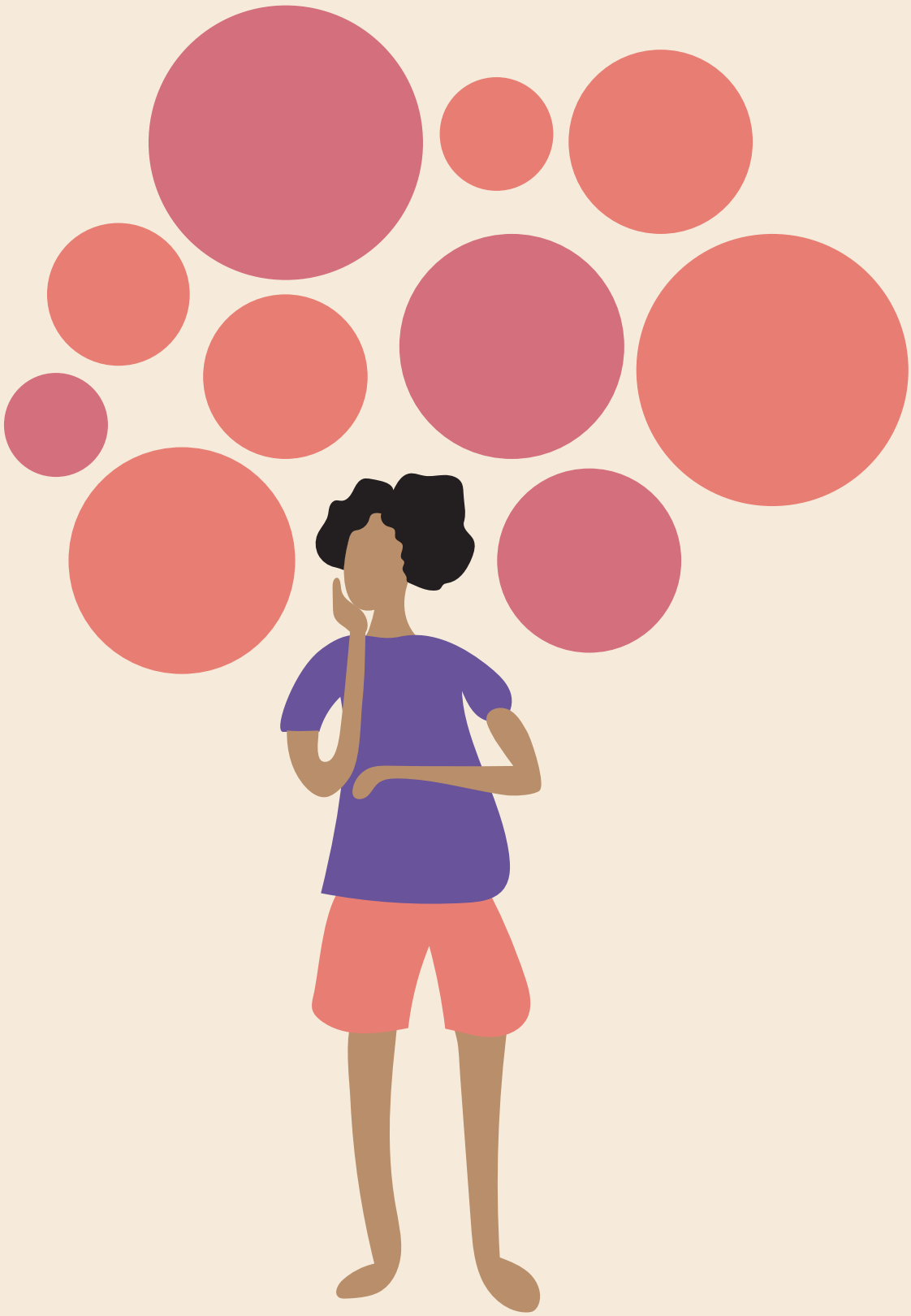
Out of the women who had or are going through the menopause, 32% find it difficult or very difficult, but the majority (44%) consider their discomfort 'normal'. Symptoms (such as hot flushes or insomnia) may be present within the 'normal' range for more than two years.

Although attitudes towards menopause are changing, the specific needs of this group are still far from being met, whether in the field of medicine or consumerism. Helping women is not giving them the right to absence or abstinence but directing them towards solutions.

The first help they need is education. Due to lack of interest or paternalism, many women are still denied the prior information they need to navigate menopause. Menopause may come older than 40; some women will be over 30 years old with deficits in hormone production. Not all of them will have symptoms, but all of them will face health risks. After menopause, one in two may develop osteoporosis; the likelihood of having a heart disease is five times greater; dementia becomes much more common than among men.

Learning to monitor the body early during menstruation—something that the new technologies make easy—may help to perceive the changes that will be indicative at the start of menopause and may allow for earlier action on the symptoms. Lifestyle behaviours can lessen the symptoms themselves.

Finally, the experience of menopause is not only physiological. It is also social. Menopause must no longer be seen as a rite of passage into old age but celebrated as the entry into a new phase in the life of women, often more positive.



Realising the full potential of well-being

Relationship with the body

'How can one justify this spiral of aesthetic constraints, whose epicentre is being slim? What is the meaning of this 'tyranny' of beauty, precisely at a time when women are massively rejecting the role of decorative object?'

La Troisième femme, Gilles Lipovetsky (1997)

The woman's conflict with her body has historical roots. It was mostly during the European Renaissance (15th century) where, through body beauty, the woman reached a new social status, which may have contributed to extreme gender stereotypes. Already in the 20 th century, press, advertising, cinema, and fashion were determinant for the propagation of aesthetic canons that democratised and fuelled the female 'beauty industry'.

This portrait of women has been so remarkable in the construction of feminine self-image that not even the social advances achieved in past decades have pushed back the demanding aesthetic standards of society.

In recent years, we have tried to exalt a new culture of beauty, centred on self-confidence and on valuing the difference and uniqueness of each woman [see Body Neutrality, in the box next to it], but we cannot fully state that we are living in the decline of aesthetic norms. On the contrary, the more freedom women are given in terms of appearance, the more evident is their submission to an ideal of beauty that refuses ageing and weight gain.

The importance placed on appearance is currently inflated by the culture of well-being and health (which requires self-control), which is why obesity or being overweight is disapproved overall.

As Gilles Lipovetsky, a French philosopher, suggests, 'it is no longer enough not to be plump, now one has to have a firm, muscular and toned body, free from any sign of loosening or flaccidity.[1]'

According to a study sponsored by Dove[2], two out of three women have already been the target of pejorative comments or insults regarding their bodies. These observations, made by family members or close allies, in person or on social networks, focus especially on weight. Among these women, 66% recognise that these negative comments have negative effects on their self-esteem.

Susie Orbach, a British psychotherapist, says in an interview that having an unhealthy relationship with the body 'constitutes a hidden public health emergency, appearing obliquely in the statistics on self-harm, obesity and anorexia; the most visible and obvious signs of a broader body malaise[3]'.

[1] LIPOVETSKY, Gilles. The Third Woman (1997)
[2] Based on a January 2022 survey with 316 women (>18 years), of which 201 suffered from body shaming
[3] Ditching the diet - how I learned to accept the body I have, The Guardian (2022)

Body Neutrality

a new paradigm in the relationship with the body

The term 'body neutrality' was popularised in 2015 by the image coach, Anne Poirier, to help people build a healthier relationship with food and exercise. Body neutrality gives priority to the function of the body and to what the body can do, instead of appearance', she explains.

Anuschka Rees, a German psychologist and author of Beyond Beautiful, argues that 'the goal is not to feel neutral about our appearance. 'We will always like some parts of our body more than others… the goal is to neutralise the impact that appearance has on life, well-being and decisions.'

For Rees, the concept goes beyond the body-positivity movement, as it is not only contrary to the ideals of beauty of our time, but to all aspects of society that promote beauty as an objective and appearance as an indicative factor of a person's value.

Created in the US in the 1960s, the body positivity movement has played an important role in raising awareness of the diversity of bodies and physiognomies, but in recent years has been losing followers. On the critics' side, one of the arguments is that the movement ignores the health risks associated with being overweight, focusing too much on redefining the concept of beauty and not so much on changing the value physical appearance has in society.

Body neutrality is based on principles secondary to the aesthetic dimension, such as, the recognition of our bodies' potentialities - the ability to resist and to keep us functional; the predisposition to avoid conversations about food, weight and ideal bodies, and the performance in physical activities that promote, in the first instance, well-being.

In a study conducted in 2018[1], more than 200 female university students were asked to take part in a gym class and were divided into two groups: one was led by an instructor who worked on motivation focussing on appearance (e.g. 'end this cellulite!') and the other highlighted the functional aspects (e.g. 'think about how strong you're getting!'). Although satisfaction levels increased in both groups, after the training, the second group experienced a significantly greater increase in well-being than the first.

The distinction between qualitative appreciation and functional is central to what Kelly McGonigal, a health psychologist, professor at Stanford University and author of The Joy of Movement, teaches in her classes. 'One of the greatest principles of body neutrality is to experience exercise or movement as a way of engaging with the body, not as a way of changing it[2]'.

[1] Study 'Tone it Down: How Fitness Instructors' Motivational Comments Shape Women's Body Satisfaction, published in Journal of Clinical Sport Psychology Volume 12 (2018)

[2] Can 'Body Neutrality' Change the Way You Work Out?, New York Times (2022).

The search for fitting Aesthetic Standards

The pressure placed on women's appearance is not limited to weight. Society instils in women the need to escape old age, whether by dyeing their hair, toning the body, stretching the skin or returning to body forms that have changed over the time and experiences of motherhood.

In fact, the relationship between women and their appearance is wrapped in a great paradox; if, on the one hand, more and more protests are made against the dictatorship of beauty and more eclectic references of beauty are sought on the other, women's bodies have never been submitted to so many homogeneous standards at all stages of life.

Among our respondents, 31% have already had or manifest a desire to have at least one form of cosmetic surgery (i.e. plastic surgery that is not clinically necessary). Of these, 27% recognise that the objective is to delay the effects of ageing. Most (52%) say they want to fix something they don't like in their body. This desire to correct or transform the body is not exclusive to mature women; 32% of women between 20 and 24 would like to have cosmetic surgery.

Anuschka Rees, a German psychologist who spoke to more than 600 women to publish the book 'Beyond Beautiful', argues that women still struggle much more with their appearance than men, with consequences that translate into gender inequalities. According to her research, women really believe that their lives could be better if they were more beautiful. Is it true? And how much well-being could one gain if women did not live so attached to this ideal of beauty?

"I would describe my relationship with my body as appreciative and healthy, but I would never say that I 'love' certain parts of my body—in fact, I'm very much against the belief that a healthy body image means 'loving' our appearance. I don't 'love' my thighs or my boobs more than my lungs or my sense of balance. The idea that we should strive to 'love' our appearance is just another product of how we overvalue beauty as a society."

Anuschka Rees,'Beyond Beautiful' author: 'A Practical Guide to Being Happy, Confident, and You in a Looks-Obsessed World' (2019)

Have you ever done or plan to undergo cosmetic surgery (I.e. a plastic surgery procedure that is not clinically necessary)?

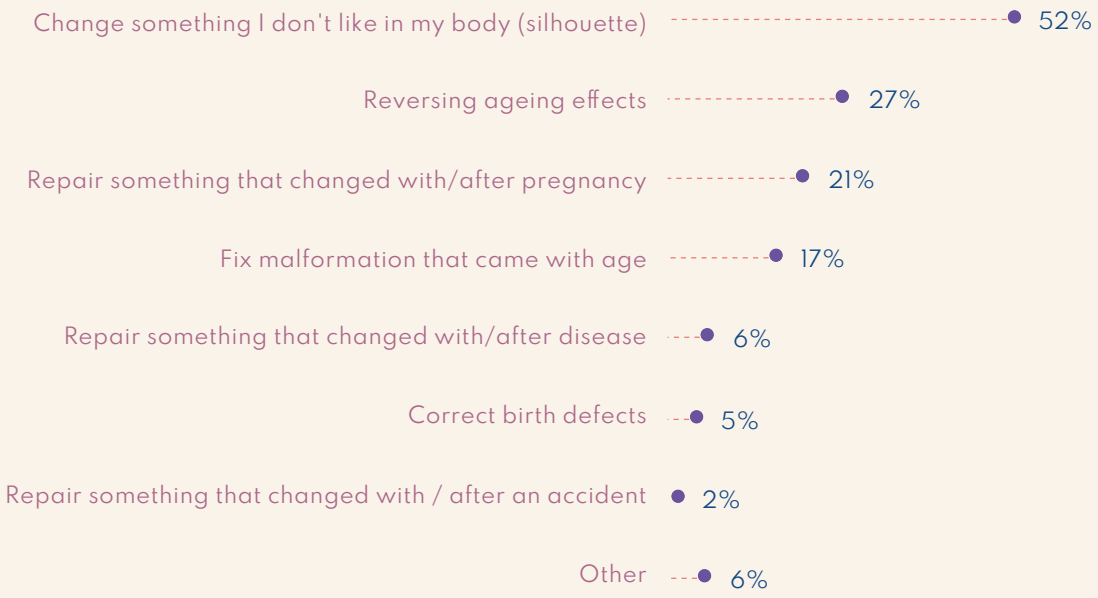
N=707

8%
has done or plans to do

23%
Would like to do

What drives you to undergo surgery(ies)?

N=218



Women's relationship with weight

55%

followed a weight-loss program, that is, a regular and relatively long diet

N=707

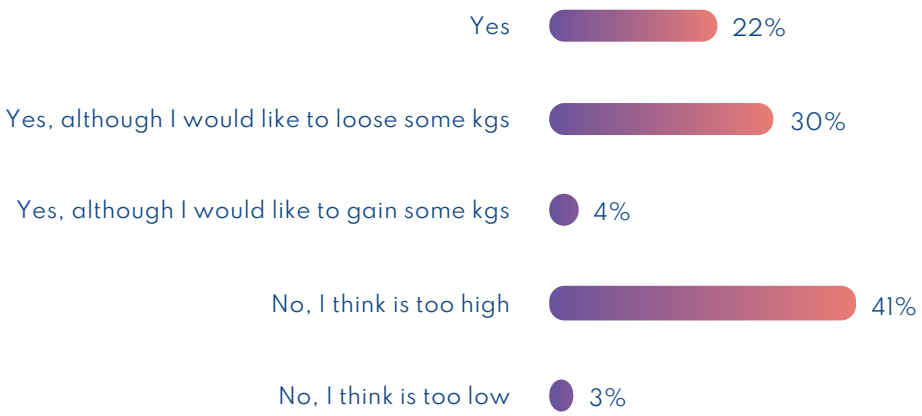
14%

of the women between 34 and 44 years old, went on more than 20 diets or can't tell because they 'live from a diet to another diet'

N=139

Are you comfortable with your weight?

N=707



71%

Of the women consider their weight too high or would like to loose some kgs

N=707

37%

Of the women who are uncomfortable with their weight recognise that this dissatisfaction impacts their psychological well-being

N=550 I Answers TOP 3

Women's Biology and Weight

Guilt cannot live here

When they're young, women have about 10 times more oestrogen than men. When oestrogen levels are high, excessive fat displacement occurs mainly in the hips and thighs, leading to the typical pear-shaped body type, known as female-type obesity.

Normally, healthy men have very little oestrogen and subcutaneous fat. When they begin to gain weight, it tends to be more on the belly, intestinal space, what is known as 'visceral fat' or 'central weight gain'. This results in the characteristic apple-shaped body type, more of the male type, when weight gain becomes excessive. However, this is also the most metabolically active type of fat and therefore easier to lose, which is why men generally lose weight more easily than women.

Menstruation: out of control once a month

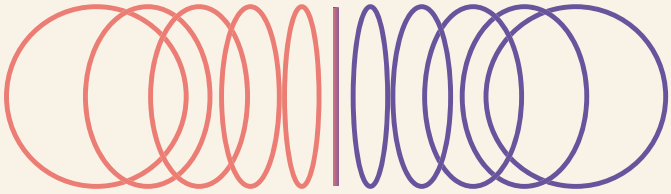
Among women, deregulated eating may partly explain the effects of the menstrual cycle. A few days before menstruation, the physical changes and mood changes some women report—fluid retention, depression, irritability, and uncontrollable sugar cravings—may be related to oestrogen depletion and an increase in progesterone, which leads to a serotonin decrease. Low levels of serotonin are, in themselves, associated with depression, anxiety and compulsive behaviour, also translated into the desire to ingest carbohydrates and sweets.

Menopause: the change of shape

When oestrogen levels decrease with menopause, while maintaining levels of testosterone, the ratio of oestrogen/testosterone changes in favour of testosterone. The presence of testosterone that is not oestrogen-neutralised tends to promote the distribution of male-type body fat, and women who gain weight during and after menopause tend to see their waist thicken, with their silhouette becoming closer to the apple shape. The same effect is seen in women with polycystic ovary syndrome, who produce excess androgens.

The interference of weight in health perception

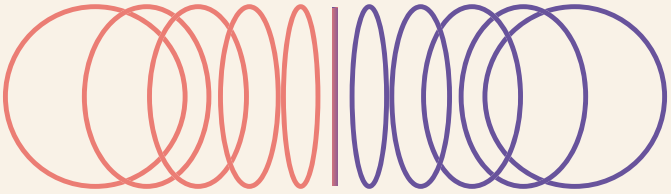
In direct speech



"Moderator: I'd like you to think about how we feel. For example, do you feel healthy in general? Let's start there.

— I don't feel particularly healthy, I never did, but then that goes to the mental part ... physically I've never felt healthy and after being a mother I feel even less healthy. And when I was healthier than I am now, I realise that my problem was not a matter of physical health, but psychological. (...) Because of stereotypes ... more on that sense. I used to be thin, and I didn't see myself as skinny, and now I see old pictures and I don't know how I didn't see myself as skinny. And that affects me psychologically, but in me there is no psychological problem that affects my physical side, that is, it's all from outside to inside and not from inside to outside.

—The exact opposite is true with me. When I'm mentally more stressed, that reflects on my body. Seven years ago, I was fatter, and I was going through a lot of stressful situations ... I tried diets several times because, in terms of aesthetics, it was not good, and not only ... but diets never worked. From the moment I started focussing on other aspects, I improved a lot psychologically... and I started doing more sport and naturally lost weight. I started working five months ago, it was a super stressful experience and I've changed a lot. I feel like it's happening again, so for me the question is the other way around; it's from the inside out.



— I feel healthy now, but if you ask me next month, I may not feel. I often say that obesity is my chronic disease because I've always had ups and downs and I can't eat like a normal person because I have tendency to get fat and I have to be careful about exercising. (...) I run to lose weight, to stay healthy, I'm very careful about what I eat, and I stress enough about what I've eaten and calorie management....

— I was listening and finding it curious because the question was more general, in terms of health, and I believe today what most people think about, especially women, is weight ... and it's funny because weight ends up being linked to health, but if men were here, they wouldn't think the same way, it's not the first thing that comes to their mind. Health and weight. I think that a woman is too brain-washed to think; I'm only healthy if I achieve the weight I idealised. I'm saying this, but I also think this way."

Conversation between participants, start of talks about menstruation (women aged 25-40)

Acknowledging spaces that promote well-being

OBSESSION WITH IDEAL WEIGHT

If there is an obvious conclusion to draw from this research, it's the relationship women establish between their weight and their health. When faced with the question, 'Do you feel healthy?', weight emerges as a spontaneous and persistent argument. Throughout the interviews, words and phrases such as 'dilemma', 'ups and downs', and 'falling' have demonstrated the feeling of lack of control and instability that variation in weight causes. The relationship between weight and psychological well-being also very clearly comes up in the testimonies.

Among the women in the sample, 41% are not comfortable with their weight because they consider it excessive, and 30% recognise that they would like to lose a few kilos. Is that justified? According to the calculation of Body Mass Index, 49% of women are effectively overweight. In Portugal, obesity has been recognised as a chronic disease since 2004. About 53% of the adult population is overweight and 1.5 million Portuguese are obese.[1]. Obesity also affects women (17.4%) more than men (16.4%) and affects mainly the population from 55 to 74 years of age, over 20%[2].

No one is contesting the fact that being overweight is a public health issue. However, it is debatable whether this is an area of health and well-being that needs to be improved, but everything suggests another well-being issue, which is also important here; the fact that women who, despite their normal weight, experience the psychological discomfort of not being able to meet a standard of beauty that is excessively anchored in thinness.

Taking BMI into account, 48% of women surveyed are at a normal weight; out of these, more than half report some discomfort regarding their weight and 27% strongly agree with the idea that dissatisfaction with their weight greatly interferes with their psychological well-being. Is this not a potential for wellbeing to be fulfilled? How can this focus on the perfect body be neutralised, especially during phases of life (such as maternity) during which women experience weight changes, due, mainly, to biological factors and unrelated to their will?

48%

of women have normal weight (by BMI calculation)

N=707

54%

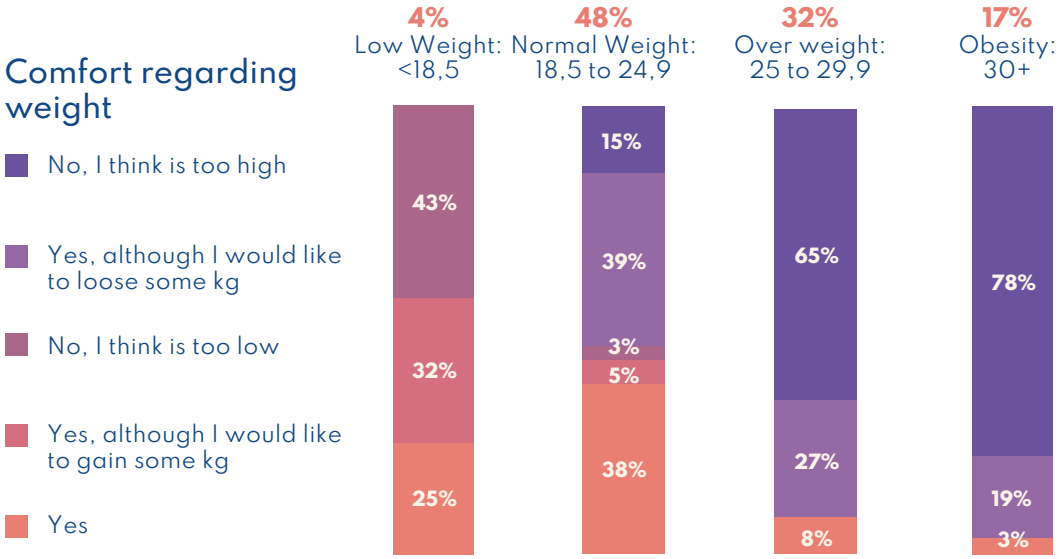
of these consider themselves above the ideal weight

27%

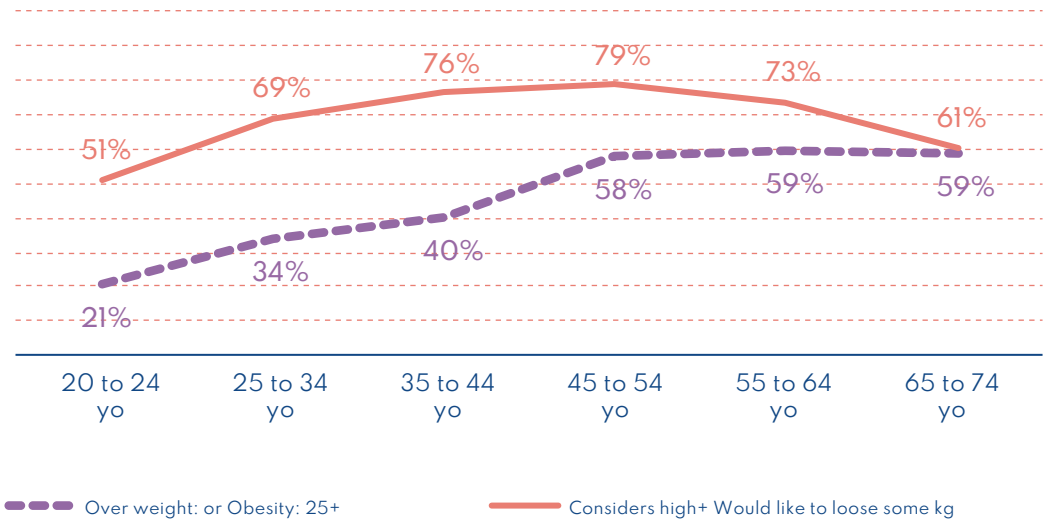
strongly agrees with the idea 'dissatisfaction with my weight impacts greatly my psychological well-being'

[1] 'O Custo e Carga do Excesso de Peso e da Obesidade em Portugal', Centro de Estudos de Medicina Baseada na Evidência (CEMBE) from Faculdade de Medicina da Universidade de Lisboa and by the consultant Evigrade-IQVIA (2021)
[2] Data from Inquérito Nacional de Saúde, INE (2020)

PERCEPTION VS REALITY
BY CALCULATING THE BODY MASS INDEX



Comfort with own weight and BMI by Age



Social Awareness

Social Awareness

DOVE, Study on Body Shaming in Portugal (N=316 Women over 18, 2022)

A study shows that most of the depreciating comments end up being about weight (68%), way of dressing (23%), 'big butt' (19%), big breasts (15%), and face (15%). As a consequence, 19% of women wear larger, darker clothing to cover or disguise the body. In the course of the study, the brand invited 13 women to share the insults made to their appearance, resulting in an exhibition held in May at the Colombo Shopping Center (in the images).

Products and Contents

THE SHAPA

Scale with no screen or metrics wants to change the paradigm of the relationship with the body

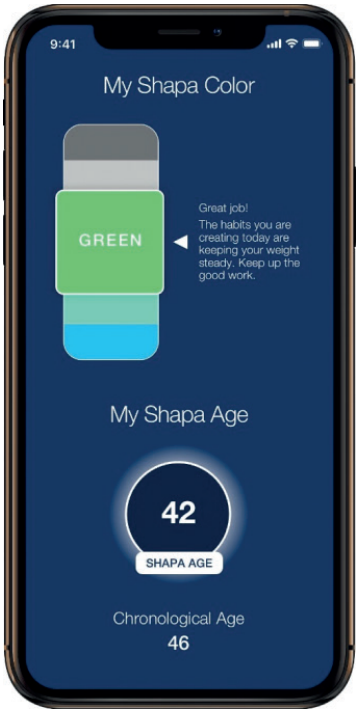
The Shapa is a subscription service that features a round, screen-less scale designed to remove the anxiety and frustration associated with weighing and promote the adoption of healthy habits. Its co-founder, Duke University's professor of psychology and behavioural economics, Dan Ariely, relied on the 'aversion to loss' principle to design the product. This originates in the tendency of individuals to be more affected by weight losses than gains. As far as weight is concerned, this means that the negative feelings triggered by gaining few kilos is actually more striking than the positive feelings associated with a possible loss of weight.

The Shapa places the emphasis on individual health and choices, focusing mainly on a system of incentives and not on metrics. According to Ariely, real health is often misrepresented by how the data is read. In the case of weight, this can vary by about 3kg per day, so it will tell us very little about the general well-being. 'By giving people more granularity, we are making information less useful', Ariely says.

Like other smart scales, the Shapa is connected to an app and can capture information such as bone density, muscle mass or overall weight through a small electric current. The main difference? Under no circumstances does it reveal the weight, opting for a simpler language; a five-colour scale, which indicates whether we are a little better, a little worse, a lot better, a lot worse, or the same. This five-colour system takes into consideration how people actually gain and lose weight. A few extra kilos or less means nothing, especially if they are not sustained over time. The app creates an average of the last three weeks' weight and uses them to give constructive feedback. According to Ariely, this type of approach will help people to better understand how their choices affect overall health, removing unnecessary frustration and demotivation.

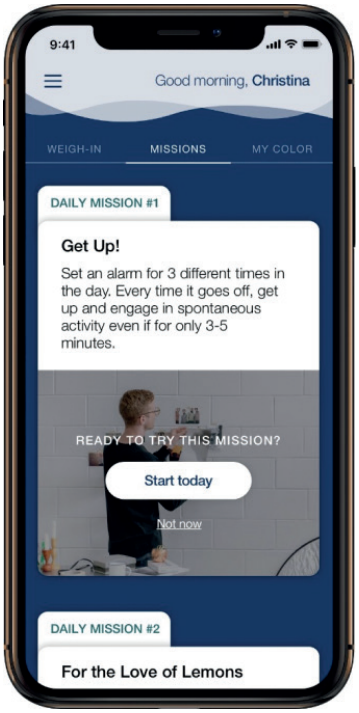
The Shapa Scale

Subscription service that includes a screenless scale and metrics



My Shapa Color

Simplification of natural body weight fluctuations in a five-colour feedback system

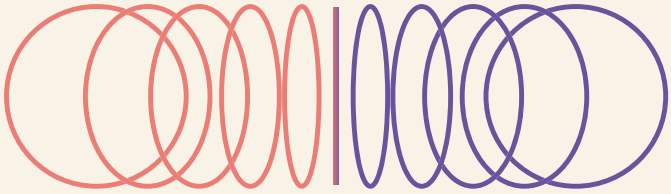


Customised Missions

Suggestion of healthy habits easy to integrate into daily routine

Shapa Badges

Use of behavioural science for system design of incentives, allowing the collection of badges that reflect the achievement of healthy habits



"I am always very focused on my weight, on keeping my weight within the average. This influences the mental aspect.
I don't think I've ever been in the sweet spot, but I was better [before pregnancy].'

'[Doctors] explain things in a simplistic way. 'Try to exercise.' What kind? 'A good diet'. Which one?'

'I needed multi-disciplinarity to be able to know what I have to do. During pregnancy we are monitored by several doctors. I go to the family doctor, and he says I'm overweight and tells me what I should do. That I already know, but I can't! Nutritionist: this is your BMI. You are overweight, you have to stick with this... I need help from a mind point of view, help me stick to the plan. The psychiatrist doesn't help either; his focus is to listen as little as possible and prescribe as much as possible. The work that should be done, from the psychological point of view, does not exist."

W, 35 years old, married, one child (15 Kg above recommended weight)

According to our calculations, about one million Portuguese women between the ages of 20 and 74 are uncomfortable with their weight, although their BMI is within what is conventionally called 'normal weight'.

Excessive weight gain can be counterproductive in terms of health, not least because it can lead to eating disorders. Recent studies have argued that there are various types of eating disorders and that these disorders can occur not only at all ages, but also at any body mass index spectrum.

Research shows that women tend to measure their health in kilograms, and their self-image (and health perception) is affected by how far their weight is from what they consider to be the ideal weight (not necessarily, healthy weight). 27% of those with a normal BMI recognise that dissatisfaction with their weight interferes greatly with their psychological well-being. There are almost 259,000 women who could feel better in their daily lives if they were not subjugated to an ideal where the cult of thinness rules.

Obesity concerns are legitimate and tackling them is urgent, but everything indicates that its prevention should be handled with care so as not to affect the self-confidence of women when often they are not even overweight. For those who are, there is a lack of tools that help them navigate the world of healthy diets, recognising that there is no single recipe for losing weight and that self-sabotage can only be prevented by working on intrinsic motivation (i.e. the psychological side).

Women's judgments about their bodies are polluted by images that determine aesthetic standards that—for most, and from a certain age—are unattainable. Rather than resigning themselves to ugliness or obesity, body and mind health should be promoted as the focus of self-esteem, from adolescence to old age.

The measure of the dream

In the founding research, The Health of the Portuguese: an ID, we declared our wish to improve health by calling it ‘the measure of the dream’. That’s where the work that ends here began. It’s where we began to question the gaps in women's health and well-being when compared with men's, in which we confirm and seek to explain here.

Without any pretension of providing final answers or solutions, it is a fact that women's well-being is far from what it could be at different stages of their reproductive life cycle—menstruation, maternity, menopause — and regarding their relationship with the body. To these aspects we could add others such as contraception, of which the responsibility and side effects are still almost entirely attributed to women.

It is also evident that one of the reasons women feel less well-being lies in the difficultly they have in recognising their discomfort, because it has been historically normalised or because they have been silenced.

In one of his books, Gonçalo M. Tavares writes: 'What matters is not just that the individual survives, but that the individual's happiness survives and lasts. Health seen as a synonym of well-being, of well-existing, I would say: of not dying.'

How many women say: 'If they’re feeling well they won't die' in Portugal? How many say they're OK when, they ARE really in pain or discomfort? How can you calibrate the measure of your dream?

This is the question we leave to each woman who’ll read this work, as well as to all decision-makers, media, health professionals, and other caregivers who may have a role in this process of information, awareness and paradigm shift in relation to women's well-being.

Annexes

Field Work

QUALITATIVE STUDY

Total sample: A) 12 in-depth interviews [8 women and 4 men] and B) 3 focus groups [24 women].

Field work: carried out between February 21 and April 28, 2022.

Universe A): Individuals with a different life cycle and health/disease profile, and men health problems and issues equivalent to those of women, both aged 25 years and older, part of the IPSOS-APEME Global Panel.

Universe B): Women with underlying sexual and reproductive health conditions able to address the topic of menstruation (between 25-40 years old, with and without children), maternity (between 30-50 years old, with children) and menopause (between 50-65 years old, without menstruating for at least 1 year), part of the IPSOS-APEME Global Panel.

Methodology: In-depth interviews online and face to face, and workshops held at IPSOS-APEME headquarters

QUANTITATIVE STUDY

Total sample: 960 individuals [707 women + 253 men].

Field work: carried out between May 20 and June 15, 2022.

Universe: Women living in mainland Portugal, aged 20 to 74 years, by proximity to reproductive health events. Men living in Mainland Portugal between 40 and 74 years old to ensure natural incidence of diseases [Control Group], part of the IPSOS-APEME Global Panel.

Methodology: 587 women and 203 men interviewed online, by the Ipsos APEME Online Questionnaire Panel, to which 120 women and 50 men interviewed by phone were added to reach older and/or less qualified targets.

Note: Out ff the 707 female respondents, 2 (0.28%) do not identify as cisgender (i.e. female). As they also experience biological constraints, their responses to this survey were considered in the analysis.

Characterization of the total sample

AGE	W	M
20 to 24 yo	8%	0%
25 to 34 yo	15%	0%
35 to 44 yo	20%	16%
45 to 54 yo	22%	33%
55 to 64 yo	20%	28%
65 to 74 yo	16%	23%

REGION	W	M
North	33%	32%
Centre	23%	22%
Lisbon	29%	30%
Alentejo	7%	7%
Algarve	5%	4%
Islands	5%	5%

Characterization of the women sample

FORMAL EDUCATION	
Primary	6%
Basic Education: 5th to 9th Grade Current	9%
Secondary Education: 10th to 12th Grade Current	38%
Technical Courses/Teacher Training	4%
Higher Education: Degrees / PHDs	42%

HOUSEHOLD	
1 person	14%
2 persons	32%
3 persons	30%
4 or more persons	24%

AVERAGE HOUSEHOLD NET INCOME	
Under 500€	4%
From 501 to 750€	8%
From 751€ to 1000€	15%
From 1001€ to 1200€	10%
From 1201€ to 1500€	14%
From 1501€ to 2000€	17%
From 2001€ to 3000€	14%
Above 3000€	5%
DK/DA	13%

NUMBER OF CHILDREN	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
0	34%	83%	68%	39%	20%	13%	17%
1	31%	6%	21%	36%	42%	35%	24%
2	30%	11%	7%	22%	36%	47%	40%
3	4%	0%	2%	4%	3%	3%	10%
4 or more	2%	0%	2%	0%	0%	3%	10%

CARER OF ILL, DISABLED OR FRAGILE PERSONS	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
Yes	10%	8%	2%	8%	10%	20%	11%

Menstruation

Currently, do you menstruate regularly, every month?

BASE: WOMEN'S TOTAL (707)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
No, I'm menopausal	42%	0%	0%	0%	33%	96%	96%
Yes	38%	83%	65%	68%	37%	1%	1%
Yes, but not every month/ irregular	6%	8%	11%	6%	7%	3%	2%
No, I use a contraceptive that stops it	11%	6%	15%	20%	21%	0%	1%
No, I have a health condition that is affecting my cycle	2%	4%	5%	4%	1%	0%	0%
No, I'm pregnant	1%	0%	4%	1%	0%	0%	0%

Do you usually use any application or technology related to managing your menstrual cycle?

BASE: WOMEN THAT ARE NOT MENOPAUSAL (409)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
Yes	29%	47%	37%	22%	19%	-	-
No	71%	53%	63%	78%	81%	-	-

[If yes] Why do you use it?

BASE: WOMEN USING APP/CYCLE-RELATED TECHNOLOGY (120)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
Manage/anticipate effects of my menstrual cycle	59%	76%	68%	42%	40%	-	-
I don't want to get pregnant	27%	16%	16%	42%	40%	-	-
I want to get pregnant	5%	0%	5%	13%	0%	-	-
Pregnancy follow-up	1%	0%	3%	0%	0%	-	-
None / I don't care much	8%	8%	8%	3%	20%	-	-

Sexuality

Currently, how would you describe your sex life?

BASE: WOMEN TOTAL (707)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
Totally satisfying	32%	42%	33%	27%	38%	31%	24%
Mostly satisfying	28%	15%	41%	38%	30%	22%	15%
Mostly unsatisfying	7%	8%	6%	9%	7%	10%	4%
Missing or almost non-existent	33%	36%	20%	27%	25%	37%	57%

What makes you feel unsatisfied or less satisfied?

BASE: SUBSEGMENT OF WOMEN WHO ARE MENOPAUSAL OR HAVE NO CHILDREN, AND REPORT NOT HAVING A TOTALY SATISFYING SEX LIFE (356)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
I have no partner	39%	58%	31%	30%	26%	35%	54%
Low libido	26%	23%	37%	28%	32%	32%	8%
I feel pain during sex	15%	32%	20%	7%	17%	17%	7%
Difficulty to reach orgasm	15%	19%	24%	23%	23%	9%	5%
My partner's sexual dysfunction	10%	6%	2%	5%	15%	13%	14%
My sexual dysfunction	9%	0%	6%	5%	15%	9%	12%
I don't feel emotionally close to my partner	7%	13%	8%	9%	9%	4%	5%
Problems in the marital relationship	7%	3%	4%	16%	4%	9%	4%
I don't feel attracted to my partner	6%	3%	0%	2%	11%	9%	6%
Other	4%	0%	6%	12%	8%	1%	1%
None/Dk	2%	0%	4%	2%	4%	0%	1%

Contraception

What contraception method do you currently use? (multiple)

BASE: WOMEN IN THE 'FERTILE WINDOW', EXCEPT PREGNANT WOMEN (403)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
Pill	43%	53%	52%	36%	40%	-	-
Male condom	16%	32%	12%	18%	10%	-	-
IUD or SUI (any type)	11%	0%	4%	13%	21%	-	-
Subcutaneous implant	4%	2%	3%	5%	3%	-	-
Coitus interruptus	3%	0%	5%	4%	3%	-	-
Natural methods	2%	0%	0%	4%	2%	-	-
Vaginal ring	1%	0%	3%	1%	0%	-	-
Patch	1%	0%	0%	1%	1%	-	-
Tubal ligation	1%	0%	0%	1%	1%	-	-
Injection	1%	0%	1%	1%	0%	-	-
Female condom	0,25%	0%	0%	1%	0%	-	-
None	24%	28%	27%	22%	21%	-	-

Do you feel you were involved in that choice?

BASE: SUBSEGMENT OF WOMEN WHO DON'T HAVE BIOLOGICAL CHILDREN AND USE HORMONAL METHODS OR INTRAUTERINE CONTRACEPTIVES (106)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
Yes, it was my informed choice	76%	79%	69%	92%	67%	-	-
Yes, although I feel I wasn't given much information	18%	21%	24%	0%	17%	-	-
No, it was mainly a doctor's decision	5%	0%	4%	8%	17%	-	-
No, I don't even know why I'm using this contraceptive	1%	0%	2%	0%	0%	-	-

Do you find that a contraceptive method that allows men to control contraception (e.g. male pill) is missing?

BASE: SUBSEGMENT OF WOMEN WHO DON'T HAVE BIOLOGICAL CHILDREN AND USE A CONTRACEPTIVE METHOD (192)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
Yes	60%	63%	69%	58%	33%	-	-
No	38%	37%	30%	38%	67%	-	-
No, I believe women must be accountable for it	2%	0%	1%	4%	0%	-	-

Do you feel or ever felt, side effects related to any contraceptive?

BASE: SUBSEGMENT OF WOMEN WHO DON'T HAVE BIOLOGICAL CHILDREN AND USE A CONTRACEPTIVE (192)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
Yes, very severe	3%	2%	1%	4%	6%	-	-
Yes, severe	9%	10%	10%	6%	11%	-	-
Yes, mild	41%	35%	50%	31%	44%	-	-
No	48%	53%	39%	60%	39%	-	-

[If yes] What kind of side effects?

BASE: WOMEN WHO REPORTED SIDE EFFECTS (100)	TOTAL	20 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 YO 54 YO	55 TO 64 YO	65 YO 74 YO
Weight gain	42%	33%	44%	52%	36%	-	-
Breast swelling or increased tenderness	36%	29%	30%	52%	45%	-	-
Low libido	34%	54%	35%	14%	27%	-	-
Mood swings	30%	54%	26%	19%	18%	-	-
Headache	26%	33%	28%	24%	9%	-	-
Poor circulation	23%	13%	26%	33%	9%	-	-
Abdominal pain	21%	38%	12%	24%	18%	-	-
Nausea	19%	25%	19%	14%	9%	-	-
Vaginal dryness	19%	13%	26%	10%	27%	-	-
Depression	13%	25%	9%	10%	9%	-	-
Acne, oiliness/less acne	4%	0%	7%	0%	9%	-	-
No menstruation/irregular	2%	0%	5%	0%	0%	-	-
Spider veins	2%	0%	2%	0%	9%	-	-
Liver disorders	1%	0%	0%	5%	0%	-	-
Fluid retention / abdominal swelling	1%	0%	0%	5%	0%	-	-
None	1%	0%	2%	0%	0%	-	-

Subjective Well-Being

Note on the indicator construction

There are different ways to define and measure subjective well-being, and there is no consensus on which should be used by academia or politics. In this research, we used the formula developed in a study[1] with a representative sample of 43,000 Europeans who participated in the European Social Survey. This analysis, which included respondents from 23 countries, allowed us to calculate subjective well-being in the different countries, ranking, at the time of the study, Denmark with the highest (40.6%) and Portugal with the lowest (9.3%) 'flourishing rate'.

Although these values might be outdated, the study remains critical in its definition and conclusions, mainly because it identifies cultural differences about how well-being self-perception is constructed, and because it reveals (by proving that the indicator is multidimensional) that valuable information is lost in case well-being is only measured regarding the one-dimensional item of "general satisfaction with life".

In this study, the definition of subjective well-being is constructed as an exact opposite of a spectrum of more common mental disorders: depression and anxiety. Beyond the absence of a mental disorder, it measures the presence of characteristics such as learning, productivity, creativity, good relations, among others that promote individuals' "flourishing".

By analysing the worldwide accepted symptoms of depression and anxiety, and by defining the exact opposite of each symptom, we were able to identify subjective well-being characteristics: ability, engagement, purpose, optimism, positive relationships, self-esteem, resilience, emotional stability, vitality and positive emotion. Specifically, in this formula, two new variables were introduced to allow a more in-depth gender comparison: the time domain and stimulus.

[1] Flourishing Across Europe: Application of a New Conceptual Framework for Defining Well-Being Dez 2011

Ability	Most days, I feel that I accomplish what I do
Engagement	I love learning new things
Purpose	I usually feel that what I do in my life is valuable and rewarding
Optimism	I'm always optimistic about my future
Positive relations	There are people in my life who really care about me
Self-esteem	Overall, I have a very positive opinion of myself
Resilience	When things go wrong in my life, it usually takes me a long time to get back to normal
Time Control	I can manage well my time and the tasks I have to do on a daily basis
Emotional Stability	(Last week) I felt calm and relaxed
Vitality	(Last week) I felt very energetic
Stimulus	(Last week) my day-to-day was full of interesting things
Positive Emotion	Overall, all things considered, how happy would you say you are?

New variables introduced in the study for gender comparison purposes

Diagnostic criteria for depression and anxiety are DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) and ICD-10 (International Classification of Diseases)..

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