

8 October 2026

Select Committee on Women's Health
PO Box 6100
Parliament House
Canberra ACT 2600

RE: Select Committee on Women's Health

Dear Committee

Thank you for the opportunity to provide feedback on the draft third edition of the National Safety and Quality Health Service Standards.

I am writing on behalf of Women's Health NSW and our membership. Women's Health NSW (WHNSW) is the peak body for 21 non-government community-based women's health centres (WHCs) in New South Wales (NSW). The Women's Health Network in NSW has been delivering high-quality health services to the women of NSW for over fifty years. We are proactive on priority issues relevant to women's health, advocating for improved health outcomes so that women and girls can reach their potential within a gender and culturally safe and healthy environment.

We are funded by a Ministerial Approved Grant called the Women's Health Program. Women's Health Centres offer a unique, integrated primary health care model that addresses a wide range of physical and mental health needs that women present with, as well as the social determinants of health and the health impacts of violence against women. Key components of WHC's service model include individual and group counselling, chronic disease prevention and management, integrated care and referral support for domestic, family and sexual violence (DFSV), women's health clinics providing sexual and reproductive health services, and health education and health promotion to equip women to participate in their own healthcare and wellbeing.

WHNSW appreciates the opportunity to provide input into the Select Senate Committee into Women's Health. We will be speaking to Terms of Reference I through to K, and N drawing from the literature, practice experience and the lived experience of women who we support through the WHCs, including case study examples.

I appreciate the Senate Committee's consideration of these recommendations and the opportunity to contribute to the growing evidence base and recognition of women's pain and chronic health conditions.

Should you require additional information please reach out to Sarah Lambert, Sector Capacity Manager on 0404 466 890 or scc@whnsw.asn.au

Regards,



Denele Crozier AM
Chief Executive Officer

Women's Health NSW provides the following responses to Terms of Reference I through to K, and N and supports this with case study examples, and recommendations.

1. Response to the Terms of Reference

TOR I - The ways in which women and girls experience recurrent, severe, or long-lasting pain conditions;

Women account for a large proportion of those affected by chronic pain and are more likely to encounter prolonged symptoms, delayed referral and unsuitable treatment pathways that may provide ineffective. (1) Over 50% of chronic pain conditions are more prevalent in women, whereas approximately 20% of these conditions are more prevalent in men. Overall women present with greater disability and loss of function due to pain. (2) This disparity is sometimes referred to as the 'gender pain gap', a form of health inequality linked to implicit bias in clinical responses to women's pain. (3)

It is recognised that multiple factors contribute to the gender pain gap including biological and hormonal differences between the sexes. Hormonal fluctuations are known to influence pain thresholds and sensitivity in women. A study in the US found that more women than men developed chronic pain after an emergency department visit for acute pain (15.5% versus 8.7%). (2) This may suggest that women are more vulnerable to the transition to chronic pain with the immune system, central nervous system and endocrine system all playing a role in the sex differences after an acute stressor or injury. (2)

The 2025 National Pain Report found that women were more likely to suffer from widespread pain (25.6% of female respondents). (4) The literature and the Victorian Inquiry into Women's Pain identified common conditions where women experience recurrent, severe or long-lasting pain conditions women uniquely experience or do at higher prevalence; menstrual and hormonal conditions, endometriosis, pelvic pain, musculoskeletal pain, migraines, Fibromyalgia, bladder pain syndrome, and Rheumatoid Arthritis. (5)

Research and medical attention of women's health and wellbeing is often focused on reproductive health. As a result, many conditions and issues experienced by women are not well understood, routinely studied, recognised or addressed. This can lead to a 'one size fits all' approach based on data collected predominantly by men and about men. This results in conditions experienced by women differently being poorly understood and overlooked, for example cardiovascular disease (6) where women with chest pain often experience other symptoms that are seen as atypical, and face longer delays in ECGs and are more frequently transported to hospitals lacking advanced cardiac intervention capabilities. (2) In examining the gender-pain-gap it is important not to overlook the psychological and sociological factors that play a substantial role in how individuals' express pain and their symptoms are perceived by health workers.

Stereotypes portray women's pain as exacerbated or emotionally driven. This first starts when accessing health services not with the pain itself, but with the doubt. Women report commonly describing their symptoms which they have often struggled with for weeks, maybe months. The response by health professionals that downplay, dismiss symptoms, or distort women's experience of pain and messages from society reinforces that she must be overstating or blowing her experience out of proportions. Clients of WHCs report being told 'it's part of being a woman' and 'they need to learn to cope with the pain.' This can then discourage people from seeking care, reduce trust and honest disclosure, undermine engagement with treatment, and make people less likely to return for future care.

Another contributing factor is the cultural expectations where women in Australia have been typically encouraged to manage pain by simply enduring it and expectations of coping without complaint. (1) Longstanding ideals of stoicism and self-management where women's pain is frequently depicted as ongoing and difficult to resolve, connected to expectations concerning emotional labour and bodily regulation. Pain for women is positioned as an ongoing condition to be managed individually in everyday life. Women from marginalised backgrounds including First Nations women, culturally and linguistically diverse including refugee women and women with disabilities tend to encounter higher levels of dismissal and reduced access to care encountering additional biases of racism and ableism. (1)

Then there are systemic factors. A large body of medical research shows that female pain is more commonly questioned and described as generalised, leading to health care interactions where women must assert their own physical experiences with considerable effort to achieve recognition. (7) Women's pain is often interpreted within psychosomatic frameworks, creating expectations of substantiated evidence of emotional or mental health causes in clinical settings. Pain associated with men however is regularly situated in diagnostic explicit or externally caused scenarios including injury. These contrasting portrayals adhere to deep-rooted gendered stereotypes, assumptions and norms that question the credibility and evidence of pain of women. (1) Samulowitz et al. (2018) describe how gender bias in healthcare can result in women being perceived as overly dramatic or less credible, a perception deeply rooted in societal gender norms that expect women to be more emotionally expressive and men to be stoic. (8,9)

The experience of delayed diagnosis, being left without a diagnosis or misdiagnosis, inadequate pain management, treatment access and increased suffering for women can impact all facets of the woman's life including her relationships, work, financial security and quality of life. (10)

Chronic pain takes a significant emotional toll on many women, affecting their mood, relationships, and overall quality of life. Women suffering from persistent pain often experience feelings of frustration, sadness, and social isolation, which can worsen their physical symptoms and create a vicious cycle of suffering. According to recent research, chronic pain notably disrupts emotional wellbeing, with many women reporting negative impacts on mood, sleep, and social connections (11) Women who repeatedly feel invalidated may be reluctant to seek future care, potentially delaying diagnoses and worsening health outcomes. This emotional burden highlights the importance of a holistic approach to pain management, one that addresses not only physical symptoms but also the psychological and social factors affecting a woman's health. (10)

The National Pain Report (2025) found that in a cost-of-living crisis, healthcare costs for people living with chronic pain are significant. Respondents reported having to do without essential household items to afford medications and to manage their chronic pain, especially when the ability to do paid work is impacted. One in four reports cutting back on food costs and many households were deprioritising dental (45%) and optical (30%) care and reducing transport, utility, phone and internet usage. (4)

Pain is a leading presenting issue at women's health centres. A representative sample of WHC's in 2025-2026 provides a picture of the work WHC's do supporting women in their communities experiencing pain.

- Data from 2025-26 found women presented to 13 women's health centres for chronic pain on 2,745 occasions. Chronic pain made up 9% (n=2,745 of 29,778) of presenting

issues for medical and physical health for these 13 centres. A further 1710 Occasions of Service (OOS) were recorded for Gynaecological/urogenital (pelvic conditions).

- Women in rural and regional areas are more likely to present with chronic pain, with data from four regional and rural centres showing 14% (n=577 of 4,243) of medical and physical health presentations are for chronic pain.
- Data from eight women's health centres shows 482 women (or 60 women per centre) reported having chronic pain, this is 23% of all clients who come to the centre for medical and physical health support. This suggests chronic pain may contribute to or be the cause of other presentations.
- 674 women from eight WHC's presented with Gynaecological/urogenital- Pelvic conditions (pelvic pain, endometriosis, polycystic ovarian syndrome, pelvic inflammatory disease, cysts, fibroids, polyps, pelvic floor dysfunction)

The case studies we provide at the end of the submission provide a picture of the lived experience of women accessing WHCs.

TOR K - Barriers to effective pain management, including the range and affordability of available treatments;

Cost and availability of specialist health services

The complexity of these chronic pain conditions can make it difficult to identify which practitioner, or service has the appropriate expertise. Specialist services may also be limited in number and geographically concentrated, resulting in long waiting periods and significant financial costs. People may require multiple appointments across different providers. People may therefore have to navigate multiple providers before accessing care that appropriately recognises the complexity of their presentation and meets their financial and individual needs. Health services are predominantly offered during standard business hours. For people who are working, caring for children or have other responsibilities, attending repeated daytime appointments can require taking significant amounts of leave, arranging childcare and incurring additional travel and other indirect costs. Consequently, the practical cost of treatment extends well beyond the consultation fee.

People living with chronic pain confront the same challenges as the rest of the population in seeing a GP however they often require more frequent and longer appointments. The National Pain Report shows GP access is a challenge, and some GPs are turning away patients with chronic pain 18% had encountered GPs who had their books closed or were not accepting new patients. (4) 54% of respondents reported they could not make an appointment with a GP within two weeks over the last six months. Worryingly, 8% of respondents said the GP they contacted "did not want to see people with chronic pain or people using opioids", putting up a considerable barrier to care for that portion of people living with chronic pain. (4)

Management of chronic pain remains within primary care. However, research shows for those with complex needs this is suboptimal, requiring a more biopsychosocial model with multidisciplinary teams (MDTs) attending to multidimensional nature of chronic pain. (12) Australian literature and lived experience of women accessing WHCs report that many women feel the medical system is not equipped to manage chronic and complex conditions with limited options for those who do not fit the known diagnostic criteria. (13,14,15) As an example, WHCs report a significant barrier to effective pelvic pain and endometriosis care is the cumulative cost

and time required to access multiple services including specialists. Care frequently involves gynaecology, pelvic health physiotherapy and other allied health or pain management services, often over an extended period. It is also not uncommon for WHCs to report women not having been referred for investigations and specialist consults. The Pain Report shows that those living with chronic pain are not being linked to specialised services with 18% of respondents in 2025 having received a referral to multidisciplinary pain management from their GP, down from 19% in 2024. Another 17% had received a referral to a private pain specialist, down from 20% in 2024. 16% had received both (down from 19% in 2024), but 40% had received neither. (4) The literature supports an integrated approach enhancing communication across various health providers is essential to ensure women receive optimal care that addresses their complex biopsychosocial needs as opposed to focusing exclusively on surgery and medication for pain. Better access to specialists, allied health providers including physiotherapists, psychologists, alternative/complementary therapists to implement holistic care plans. (16)

The time burden of accessing care is also an important and often overlooked barrier. Research shows that it is not uncommon for people living with chronic pain to have as much time as a part-time job dedicated to their health management needs. (15) The 2025 Pain report found 4% of respondents spending over 21 hours a week getting to, waiting on, and attending appointments. 43% of respondents visit the GP about their chronic pain monthly, 17% fortnightly, and 4% weekly. (4)

The wait for an appointment is long, and some respondents get lost in the system. Once referred it takes a long time to be able to secure an appointment. The 2025 Pain report had no respondent being able to secure a specialist appointment within 12 months. For 47%, obtaining an appointment took 1-2 years, for 12% 2-3 years, and for 11% more than 3 years. The report found 30% of respondents got lost in the system and never received an appointment.

Even where services are available, the out-of-pocket costs associated with repeated specialist and allied health appointments can make comprehensive care inaccessible, particularly for people requiring ongoing treatment. In addition, pain and chronic conditions cause increased absenteeism and increased financial burden due to loss of salary. It is not uncommon for women to suffer through symptoms to save their leave for extreme pain, avoiding taking leave for fear of losing their job. (14)

Regional WHCs report the availability of bulk billing GPs is particularly challenging, and women often need to travel long distances, even interstate to access specialists. Improving access therefore requires consideration of both financial and time affordability. Greater availability of bulk billing GPs, affordable or subsidised allied health and specialist gynaecology services, alongside more flexible models of care such as extended-hours appointments, coordinated multidisciplinary services and appropriate use of telehealth, would reduce the burden on patients. (25)

Lack of investment in research

Women's health is historically underfunded. Research has seen women excluded from clinical trials because hormones were seen as 'too complex.' This has seen the male body treated as the default and generalised to all people in clinical protocols and guidelines which fail to account for sex and gender physiological differences such as medication responses. (3) Women's experiences are often viewed as deviations from the norm where symptoms do not fit into the masculine experiences, hereby making many conditions invisible and labelled 'pain the absence of diagnostic evidence' or 'pain without organic pathology'. (17)

Diagnosis

Pain plays an important protective role alerting the body to potential or actual harm, however unlike other medical metrics such as blood pressure or heart rate, there is no test that objectively measures pain. Instead, people are asked to rank their pain on a scale. The interpretation of this is then impacted by clinician bias, with lived experience not honoured as it perhaps should be, reflecting the historically paternalistic approach of medicine. (8)

Then there is the need to locate the origin and cause of the pain. Physicians are trained to find a problem and fix it, but if they cannot find something wrong with clinical tests available then they tend to think it is a psychological or emotional problem and dismiss it. (8) Women's pain is often interpreted within psychosomatic frameworks, creating expectations of substantiated evidence. Where pain associated with men is diagnostically explicit or external caused scenarios including injury and other physiological causes.

Women's pain is frequently depicted as ongoing and difficult to resolve. (1) Women can wait an average of 4 years for a definitive diagnosis and almost half are re-diagnosed at least once with 32% originally given a psychological diagnosis or medically unexplained symptoms before later being re-diagnosed with an organic condition. (13) Women are frequently told there is nothing that can be done and that their symptoms are either medically unexplained or attributed to psychological conditions, 'all in her head' or labelled as malingerers, often without thorough investigation. (8)

Women report in the research a perceived lack of interest, feeling that as chronic pain was not a life-threatening disease, such as cancer, then health professionals were not as interested in identifying the cause of the pain. (16)

Fatigue was also identified in the literature as a common but poorly understood symptom of many chronic conditions. Conditions such as myalgia encephalomyelitis (ME) /chronic fatigue syndrome (CFS) and postural orthostatic tachycardia syndrome (POTS) are more commonly experienced by women, and yet research shows GPs do not readily accept ME/CFS as a condition at all. (13)

Research and practice experience shows that women value obtaining a diagnostic label as this not only validated their symptoms and the impact on their lives (16) a diagnosis was more associated with having a condition that can be treated and taken more seriously by doctors, assisting their navigation of health services. (13)

Research points to the need for clinical protocols that attend to sex and gender differences and, particularly for procedures where undertreatment is common. (3). An example is the World Health Organisation adopting new guidelines for pelvic pain at 3 months where previously it was only considered chronic once it had last for 6 months. For many women pelvic pain is cyclical or associated with functions that may not occur every day or not be continuous during the day e.g. defecation, urination, sexual intercourse, making it harder to make a case for chronic pain versus constant daily pain. (18)

Treatment

Literature raised that the response to opioid receptor antagonists may generate a difference between men's and women's experiences of pain. However more research is needed to fully understand the biological mechanisms for pain experienced by women and the effectiveness of medications which are typically only clinically tested on men. (9) It is also important that the

impact on reproductive health and the ability to conceive is considered with some pain medications inhibiting ovulation. There is also little evidence on the use of analgesics in chronic pelvic pain and use in women as opposed to men. (18)

Studies show that women are less likely to be prescribed pain relief when presenting at emergency departments, both opioid and non-opioid even when reporting equivalent pain scores. Additionally, research has shown that postoperative pain in women was often managed with sedatives rather than appropriate analgesics, whereas men received more consistent pain medication. (3) Women living with pain are also more likely to be prescribed antidepressants and get more mental health referrals. (9)

Systemically, there is a lack of standardised, gender-sensitive clinical guidelines for pain management, especially in routine yet invasive gynaecological procedures. Certain routine medical procedures disproportionately affect women and are associated with poor pain management practices e.g. intrauterine device (IUD) insertions and hysteroscopies are frequently conducted without adequate analgesia despite consistent reports from women of significant pain during these procedures. We are starting to see advocacy for appropriate analgesia or sedation for cervical biopsies and pelvic examinations in response to women reporting moderate to severe pain. Even where effective pain relief protocols exist, they are inconsistently applied across clinical setting contributing to avoidable discomfort and distress. For example, in the case of IUDs only 30% of physicians offer anaesthesia, despite approximately 70% of women reporting moderate to severe pain. (3)

There is a need for new conceptual frameworks to replace the traditional biomedical ‘reduce and resolve’ approaches to healthcare given the rate of symptom reoccurrence and the psychosocial impact of chronic pain. (13,14) An example is Rovito (2026) who suggests endometriosis be viewed through a feminist disability lens, which recognises the other parts of the body outside the gynaecological areas affected such as the bladder, gastrointestinal system and neurology, as well as the chronic pain that endometriosis can cause. (19)

GPs are the healthcare professionals most likely to provide or refer patients to a pharmacist for a medication review. A third of respondents in the 2025 Pain Report did not have a Medicine Management Plan. Forty-two percent of respondents received a review from their GP, 5% directly from a pharmacist, and 18% from both a GP and pharmacist. Alarmingly, 31% reported never receiving a medication review at all (4)

Accessibility of medical appointments would be bolstered by increased telehealth support options, particularly in regional areas for those who have mobility challenges. The 2025 National Pain Report found 1 in 6 find a lack of telehealth options. 88.5% liked telehealth appointments with pain preventing attending in-person appointments and 14.2% struggle to get time off work to attend appointments. (4)

There is substantial evidence that people with chronic pain have a high prevalence of psychological distress and impairment functioning in daily activities is common. Therefore, consideration of co-morbid mental health issues and the management of pain should be offered alongside medical interventions. It is important to note the standard psychological approaches for managing pain such as fear and associated behavioural avoidance or catastrophising may not be appropriate for all pain conditions women experience and may in fact reinforce gender biases. There is however some evidence for CBT and ACT as a way for a therapist and client to work collaboratively to understand and address unhelpful patterns, mindfulness-based

strategies and treating associated depression, feelings of hopelessness, isolation, associated shame and a culture of secrecy. (16)

Stigma

Alongside the frustration of diagnostic difficulties and being dismissed, women report a strong sense of trauma, including stigma, prejudice, shame and blame received by health services. The greatest level of stigma respondents report comes from health professionals, with nearly half (48%) of those surveyed feeling stigmatised from this quarter, a figure that rose to two-thirds (63%) for non-binary respondents. (4) In an Australian survey of women living with chronic conditions conducted in 2021 almost all participants described traumatic adverse events in their experience of healthcare, including bullying and intimidating behaviour from healthcare staff, and some reported being overtly accused of faking their illness. This is particularly seen in pain related to reproductive and sexual health where communicating about bodily functions, pleasure, pain and behaviours is stigmatised and can be culturally taboo. Most women recall a negative tone during period talks with their mothers and this continues to message that its part of being a woman and we must grin a bear menstrual pain. Additionally sexual and reproductive issues often cause anxiety about fertility, identities as women and the ability to fulfil sexual desires. (20) These negative experiences and fear of stigma when accessing services leads to some women feeling unsafe in hospital and medical settings owing to professionals misunderstanding of their complex conditions. (13)

It is also suggested that women with chronic pain have been socialised to prioritise their duties, and those women who fail to manage their pains and demands from the outside world blame themselves for their pain and health issues. This can lead to a vicious cycle of self-shame and not accessing healthcare. (9)

Expertise

It is challenging for non-specialist health professionals to remain current in a rapidly evolving field alongside the broad range of other conditions they manage. Education at entry to practice, ongoing professional development and accessible clinical guidance are therefore important mechanisms for ensuring that current and evolving evidence is translated into routine care. (6)

The Victorian Government's Women's Health and Wellbeing inquiry found that many clinicians feel underprepared when it comes to women's pain. Of health professionals consulted 70% reported limited knowledge or skills in managing pain and chronic health conditions and many pointed to gaps in training and evidence to support their work. (21)

Research shows that staff training on implicit bias and patient-centred communication in addition to the development of gender adapted treatment protocols suggest improvements in women's satisfaction and trust toward medical professionals. (3) Patient satisfaction is closely associated with having healthcare professionals who are compassionate and listen. In an Australian study participants were asked what 'better' would look like. The responses were; greater community and health professional awareness of women's pain, access to high quality, affordable and gender responsive healthcare for all women, and the inclusion of lived experience in research, and the design and implementation of programs. (14)

Lastly, it is important to recognise workforce shortages that particularly impact regional and remote areas. The National Women's Health Strategy Baseline report identified shortages of sexual and reproductive health workers and the impact of annual contracts on care continuity.

It is the experience of WHCs that GPs are also extremely hard to recruit. WHCs have a long history of utilising nursing staff, however the current Medicare arrangements are extremely limited and do not adequately meet the needs of longer consultations commonly required by women living with pain and chronic conditions. (22)

Self-empowerment (self-educate and advocate)

An important part of living with pain and chronic health conditions is learning to manage symptoms through becoming educated and developing resilience in the face of ongoing symptoms. (16) In the literature and the practice of WHCs we see women feel empowered through self-education and emphasise the importance of ‘taking charge’, considering alternate/complimentary therapies’, finding other treatments that work and establishing peer support avenues. (14) Indeed it is found that self-efficacy has been associated with a reduced likelihood of using prescription pain medication, and improved physical and mental quality of life. (18) It is therefore important to invest in public health initiatives that give women access to evidence-based information and resources. (16)

Self-management includes attending to the psychological distress living with pain and chronic conditions can cause. Literature and practice experience shows it is common for women to experience hopelessness, depression, suicidal ideation and low self-efficacy. The 2025 National Pain report found that one in five respondents sought help via a helpline, with Lifeline the most used. However, 61.3% of those who used a helpline felt that the service provider did not understand chronic pain and therefore did not feel their needs were met. (4) It is therefore important that training on pain and chronic conditions is available to all health professionals, including the mental health workforce, recognising the co-morbidities experienced.

TOR J - Women’s experience in seeking appropriate healthcare responses to pain, including experiences of medical misogyny;

As was raised (in TOR I) there are systemic sex differences in the clinical management of pain through assessment and treatment models and guidelines. This leads to women’s pain being interpreted within psychosomatic frameworks, lower likelihood of effective pain medication being prescribed and timely access to other treatments. (1) This results in women having to assert their own physical experiences and advocate for medication investigation, requiring considerable achievement to achieve recognition. We have heard women taking a male to medical appointments and emergency departments as a strategy to improving the likelihood they will be heard and their needs addressed.

For women, gender bias and medical misogyny underlies their experience of healthcare and treatment of forementioned conditions. Gender bias in healthcare is widespread, and women, doctors, researchers and administrators can all hold biased views about gender impacting the healthcare experience of women. This is further heightened where people have intersecting minority experiences such as ethnicity, visa status and socio-economic disadvantages.

Restrictive gender norms and biases reinforced within health care systems frequently result in experiences of stigma and gendered health discrimination. Gender bias in health care is responsible for a range of disparities between men and women, across diagnosis, treatment and access to care. In the 2025 National Pain Report nearly half of all women reported stigma from health professionals and almost 40% felt stigmatised by their GPs. (4)

Restrictive gender norms and biases reinforced within health care systems frequently result in experiences of stigma and gendered health discrimination. Gender bias in health care is responsible for a range of disparities between men and women, across diagnosis, treatment and access to care. The National Women's Health Strategy 2020-2030 (NWHS) identifies stigma experienced by women in accessing healthcare as a core component of eliminating gendered stigma and health discrimination. (23) The Australian Women's Health Alliance in their Eliminating Gendered Health Discrimination policy brief outlined the following ways gender-based stigma and discrimination can have a profound impact on all aspects of health and wellbeing for women. (24)

- Women experience dismissal of their pain and symptoms, physical and verbal abuse or violence, involuntary treatment, institutionalisation, breaches of bodily autonomy, breaches of confidentiality and/or denial of autonomous decision-making, and lack of free and informed consent. For example, women are consistently provided with less support for pain management than men, despite reporting higher levels of it, due to a perception that they are "more sensitive", are "overly emotional" or that they 'overreact.'
- Medical misogyny also encompasses gendered structural barriers to accessing healthcare leading to delayed or misdiagnoses and access to treatment. Endometriosis, for example, affects one in ten women, but can take up to ten years to diagnose. The causes of this wait include long waiting lists for diagnostic surgery and high out-of-pocket expenses. Similarly, inconsistencies in the availability of abortion sometimes force Australian women to travel outside their local area or pay significant out-of-pocket expenses. (15)
- Medical misogyny is linked to poorer mental health outcomes and experiences of medical trauma. Medical trauma, discrimination and stigma can significantly impact women's future interactions with services and dissuade future health seeking behaviour.
- Women's greater life expectancy, together with lifetime differences in earnings and workforce participation, means that many older women experience economic vulnerability.
- Institutionally it results in chronic underfunding of women's health services and items under Medicare, gender hierarchies that see men secure a greater share of medical-research funding than women, undervaluing feminised health workforces and underrepresentation in leadership positions.

A recurrent finding in the literature was how women handle pain and the multiple demands from their surroundings e.g. family, work, household management, found that an overload of responsibility that traditionally falls on women is an obstacle for recovery. (9) The 2025 National Pain Report shows that women access practical community support at higher rates than men. This shows the societal impact of gender bias that permeates outside medical settings, on women's ability to manage pain and chronic health conditions. (4)

TOR N - The regulation of medical devices used in women's healthcare treatments, including risk assessments, monitoring and reporting;

The regulation of GP's, nurse practitioners and midwives, providing and offering safe and effective medical devices, such as IUDs, Implanon's and oral contraception to help with pelvic

pain, is not being initiated in primary health care as well as what it should. While we welcome the increase in Medicare rebates for long-acting-reversible contraception introduced in November 2025 which included nurse practitioners and midwives, and we are excited for the LARC centres of excellence being rolled out, nationally we identify two areas for improvement.

We urge greater incentives for completing LARC training to ensure GPs, nurses and midwives are up to date and current on best practice including the use of pain management otherwise, we are concerned care may be guided by limited expertise, outdated information and potential bias.

We also ask that the cost of LARC devices is addressed, recognising the cost is prohibitive for some women. While the new centres of excellence are welcomed in covering the consultation and procedural costs, not covering the cost of the device poses a barrier for women without financial resources, especially those non-Medicare eligible. Copped IUDs are also registered as devices and therefore do not come under the PBS making it a more costly option. The potential impact of not having access is not only preventing pelvic pain from being managed but also unplanned pregnancies and women having to return to country of origin when on work visas. Funding is therefore needed to cover the cost of all LARC devices for women who require financial assistance.

2. Case Study Examples

We provide three case study examples from women's health centres to illustrate the impact of women's experience of pain, in seeking appropriate healthcare responses and barriers to care including medical misogyny, the range and affordability of treatments to name a few forementioned.

Client A- prolapse bladder, bowel and uterus and, sexual assault

Client A resides in a regional area. She attended ED after a sexual assault. Client A has history of mental health, suicidal ideation/attempts, self-harm, and intravenous drug use – was in a recovery phase at time of event.

Client A has a history of childhood abuse, neglect, poor parenting etc, that impacted her ability to parent and remain well whilst trying to navigate community. She was in rehab as a teenager where she was groomed by a worker who later fathered two of her children, who he sexually assaulted. He is now in prison, and she has been compensated under the redress scheme after demonstrating her eligibility.

Late 2025 she engaged in consensual sex, that then became nonconsensual and she was sexually assaulted. At this point in time, she had very limited relapses with her drug use. She presented as ED haemorrhaging vaginally from the injuries inflicting upon her and discussion was had as to whether she may need a transfusion and/or surgery. The doctor at ED when she presented had read her medical history, which outlined some of the history above and on presentation for the initial consult with him he stated, 'a bit of fun gone wrong'. Additionally, she reported her examination was cruel and painful.

As a result of this stigmatising experience, she has relapsed and is using a significant amount of methamphetamines (injecting), has increased her use of online gambling, shoplifting, struggles with her activities of daily living, has come to the attention again of DCJ regarding her 8 year old

son, and is experiencing increased suicidal ideation and self-harm. She is working with sexual assault, alcohol and other drugs and local women's health centre teams.

When the Women's Health Centre does safety and wellbeing check ins, what is discussed more than anything is not the actual sexual assault but the flashback of the doctor and his comments. The WHC has also worked to find a bulk-billing doctor she is comfortable seeing for her severe prolapse of the bladder, bowel and uterus which was severely impacted by this assault and her substance use.

Client A has attempted to make a complaint to the hospital and gain a copy of her discharge notes which were never provided in the first instance.

This presentation illustrates stigma experienced because of multiple lived experiences including illicit substance use and dependence, dependence, mental health conditions including suicidal ideation and self-harm, childhood abuse and sexual assault. Additionally living in a regional area, with limited finances and presenting reproductive and pelvic region all contributed to biases and negative beliefs expressed by health professionals in their interactions and treatment, and her subsequent health and recovery. It also highlights the importance of listening to women's descriptions of their pain and functional limitations, recognising invisible disability, providing trauma-informed care, and ensuring women with persistent pelvic or other chronic pain have access to appropriate investigation, referral and ongoing multidisciplinary support.

Client B- chronic pain (pelvic, spinal and head injuries)

Client B sought GP care from an inner-city women's health centre. She was living with longstanding chronic pain following a serious motor vehicle accident involving significant pelvic, spinal and head injuries. Her history was further complicated by prolonged domestic and family violence and associated legal stress. She felt her DFV trauma had not been considered in her healthcare prior to accessing the WHC, where she felt safe to discuss her experiences, the emotional impacts and linked to recovery services.

The client required longer appointments and trauma-informed care that took into account her trauma and stress of active DFV legal matters for continuity of care. Her presentation illustrates the intersection between chronic physical pain, trauma, psychological wellbeing and experiences of violence and how negative experiences with health services in the past and internalised stigma and delayed help-seeking.

Client C- Ehlers-Danlos syndrome (EDS) and Postural Orthostatic Tachycardia Syndrome (POTS)

A woman living with Ehlers-Danlos syndrome (EDS) and Postural Orthostatic Tachycardia Syndrome (POTS) presented to a women's health centre with widespread joint and musculoskeletal pain, fatigue, dizziness, heavy legs, significant exercise intolerance and low mood.

Ehlers-Danlos Syndrome (EDS) is a group of connective tissue disorders that affects the skin, joints, and blood vessel walls. Despite being relatively rare, its impact on patients' lives can be profound. However, due to its often-invisible symptoms, EDS is frequently misunderstood and stigmatized. She reported feeling her symptoms had worsened following COVID-19 but had been met with doubt with one health professional saying 'you don't look sick' leading her to

question her experience and if she was exaggerating her condition or asking too much of health services. One concern in caring for women with complex presentations is the risk that physical symptoms may be attributed too readily to anxiety, stress or psychological distress. Mental and physical health can coexist and interact, and women still require appropriate assessment of their physical symptoms.

Her experience highlights the challenges of living with conditions where disability and functional limitations may not be immediately visible. Listening to her account of her symptoms and limitations was therefore extremely important and highlights what a woman is able to demonstrate during a short medical consultation may not reflect the impact her condition has on everyday functioning and support needs. Living with multiple chronic conditions, disability, financial disadvantage or other social pressures, access to safe, affordable and ongoing care can be challenging.

Client D- chronic pelvic pain

A woman aged 28 years came to see the WHC clinic for a second opinion for chronic pelvic pain onset of periods. She had a history of painful periods commencing at age 11, increasingly getting worse over the years.

Her male GP referred her to a gynaecologist (female). Client D felt she was dismissed when following a pelvic ultrasound no endometriosis was shown. She was offered a laparoscopic exploratory procedure and was advised if no endometriosis was detected there would be 'nothing we can do to help.' The specialist did insert a Kyleena IUD to 'help with pain and bleeding'. Client D had a bad experience with the insertion and never returned to the specialist. After the WHC nurse spent time listening and provided information on possible causes for pain and a referral to the WHC GP she reported feeling heard and a sense of validation that her pain was being taken seriously, and they were going to take steps to identify the underlying cause. The GP provided a referral for a deeper endometrial scan which showed mild or superficial disease and also the Kyleena was embedded slightly into the wall of the uterus. The IUD was removed and the client started oral contraception and was referred to a reputable specialist for a second opinion.

This presentation highlights the importance of a multidisciplinary approach, listening to a woman's experience of pain, appropriate referrals and the importance of GPs having education and knowledge of the management for endometriosis and/or pelvic pain.

Client E- endometriosis

Client E is a 36-year-old Aboriginal woman and single mother of three who has surgically confirmed endometriosis. She experiences chronic pelvic pain with severe exacerbations during menstruation, when her pain reaches 10/10 it can leave her unable to move from the floor for 24–48 hours. This affects her ability to care for her children and work as a registered nurse.

Despite the severity of her pain, Client E avoids presenting to emergency departments because of a previous traumatic experience where she reports being accused of drug-seeking and experiencing racial discrimination. She is also extremely reluctant to take any analgesia because of fears of dependency. She relates this to childhood and intergenerational trauma and the stigma she experiences as an Aboriginal single mother living in social housing. This is despite her professional understanding of analgesia as a registered nurse.

Client E is now receiving multidisciplinary support through a women's health service, including nursing, GP, physiotherapy, dietetics and counselling. An important part of her care is addressing her pain while also recognising the trauma and stigma that influence how safe she feels accessing healthcare and using pain medication.

Her experience demonstrates how previous experiences of racism and being labelled as drug-seeking have contributed to avoiding emergency care even when experiencing severe pain. It highlights the importance of culturally safe, trauma-informed care and of listening to and believing women experiencing endometriosis and persistent pelvic pain.

Client F- pelvic pain and endometriosis in regional area

28-year-old female found the regional WHC service as the volunteer Pelvic Floor Physio (PFP) suggested it to the Gynaecologist whilst on clinical placement at the hospital. Client has had multiple admissions to ED over the years with pelvic pain and has been dismissed and treated for pelvic inflammatory disease, despite tests coming back negative. She has a background of endo and pelvic pain and the PFP has been treating her over approx. 18 months. Client is now doing very well – however as she does not work so, without the WHC they would not be able to afford private services. The client had been accepted to the local Pelvic Pain and Endo Clinic - they waived the \$100 sign-up fee for her but could only offer 1 x 30-minute session of physio then she would have to pay for it after that.

Her experience highlights the impact of limited services in regional areas and what a difference no-low-cost service options make for women who have financial barriers to accessing vital treatment for their pain.

3. Recommendations:

We provide the following recommendations based on presented literature and practice experience of delivering women's health services via community women's health centres for fifty years in NSW.

1. Greater investment in women's medical research and pain management approaches and implementation of the National Women's Health Strategy 2022-2032, ensuring inclusion of diverse populations and adopting sex sensitive methodologies to address current evidence gaps and promote equitable pain care.
2. Strengthen Medicare support for multidisciplinary, integrated rural, regional and remote care by valuing nursing, midwifery and allied health roles appropriately, supporting coordinated team-based models, and enabling flexible outreach so visiting specialists can operate effectively.
3. Funding to cover the cost of all long-acting-reversible- contraception devices for women who require financial assistance.
4. Create Medicare bulk billing items that recognise the provision of complex, trauma-informed care for the full range of healthcare service providers.
5. Ensure all women and girls are able to access high quality, timely, affordable, and gender-responsive health and social care by providing targeted approaches to meet the needs of culturally and linguistically diverse women including refugees, Aboriginal and Torres Strait Islander women, those living in regional and remote areas, living with disability and LGBTIQ+ women. Approaches include supporting specialist access via telehealth, fly-in-fly out arrangements, use of interpreters and bilingual workers and access to no-low-cost pain management multidisciplinary teams.

6. Increase access to multidisciplinary teams for pain management. Embed pain coordination into women's health clinics to ensure women receive trauma informed, culturally safe and gender sensitive approaches.
7. Standardised evidence-based, gender sensitive pain management protocols should be developed and implemented, particularly for procedures where undertreatment is common.
8. Policy frameworks and health programs should support the integration of lived experience, including the development of pain assessment and care standards. Lived experience cannot be an afterthought, it needs to be included from the start of any program development with diverse experiences, populations and women genuinely represented
9. Greater incentivised education and information for GPs including best practice pain management, tried and tested referral pathways and LARC. Continuous education and sector wide training requirements for HPs on women's health and pain issues should include content on gender bias and medical misogyny for more optimal use of diagnostic tools and treatment options.
10. Training made available on the impact pain and chronic health conditions on psychosocial health and wellbeing for all health workers including the mental health workforce and support helplines.
11. Greater availability of low-now cost alternative and complimentary therapies including physiotherapy, naturopathy, dietician and Chinese Medicine.

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