GENVIC

GENDER EQUITY VICTORIA

INQUIRY INTO WOMEN'S PAIN

GEN VIC SUBMISSION

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About GEN VIC

Gender Equity Victoria (GEN VIC) is an independent member organisation representing organisations and individuals across Victoria who are dedicated to achieving intersectional gender equality. We are the only peak body of this kind across Australia.

GEN VIC evolved from the Women's Health Association of Victoria (WHAV), which was formed in 1994 as a peak body for the women's health sector and expanded in 2018 to provide coordinated action to support a growing gender equity movement across industries, communities and sectors.

Our member organisations include Victoria's leaders on gender equity, women's health, sexual assault services, the justice system, employment support and the prevention of violence against women, reaching every region in Victoria.

Our vision is for a gender-equal society where all people can thrive.

Throughout this submission we refer to two (2) key terms – gender equity and intersectionality. Provided below are definitions that explain what these mean:

What is gender equity?

This report follows the definitions of gender equity and gender equality as outlined in Our Equal State.[1] While gender equality and gender equity are used interchangeably in the Victorian Strategy, it acknowledges they are distinct terms. Gender *equity* recognises that differences in gender-related needs and power should be identified and addressed in a manner that fixes any imbalances. Gender *equality* is when people of all genders have equal rights, responsibilities, and opportunities. Equality does not mean that women, men, people with intersex variations, and trans and gender diverse people will become the same. Rather, their rights, responsibilities and opportunities will not depend on their gender.

Phrasing can be important. While gender *in*equity acts as a barrier to the health and well-being of women and is a key driver of gendered violence, gender equity enables the physical, mental, emotional and economic health and well-being, of all Victorians, including women and gender-diverse people.

Championing gender equity supports women and gender-diverse people and in turn, the wealth and productivity of women and the State of Victoria.

What is intersectionality?

Intersectionality refers to the interconnected nature of social categorisations such as race, class, and other aspects of identity and the overlapping discrimination that creates unique experiences for individuals from marginalised groups.

Kimberlé Crenshaw coined the term in the late 1980s to describe the way multiple forms of social inequality or disadvantage can intersect with each other. [2]

Intersectionality highlights how social categorisations like race, gender, and class are interconnected and intersect to create complex and varied experiences of discrimination or advantage. This concept is essential for understanding and addressing inequalities more comprehensively, as it reveals how various forms of discrimination can compound and manifest differently based on an individual's multiple social identities.

Recommendations

The following summarises all recommendations included in GEN VIC's submission:

1. Build a **robust research** base to address gaps in understanding and treating pain, particularly concerning conditions more prevalent in women and conditions that affect women differently from men.
2. Provide **training** to healthcare professionals on recognising and addressing pain in women, including **early detection, diagnosis, and treatment** of pain and common chronic conditions.
3. Enhance **communication and pain assessment tools** to promote effective communication strategies between patients and healthcare professionals.
4. Expand **access to pain-specific services** including primary care, specialists, and public multidisciplinary clinics across Victoria, including in regional and rural areas.
5. Develop and implement **gender-responsive and trauma-informed pain management protocols** that address biases related to women's pain experiences and promote supportive experiences in services.
6. Investigate **intersectional experiences of women's pain** and encourage intersectional approaches in pain research, service delivery and policy development.
7. Enhance **cultural responsiveness** in pain care, including pain management programs and training for healthcare professionals.
8. Address **socioeconomic barriers** in pain healthcare, including affordability and availability.
9. Support public health education campaigns to **raise awareness** about pain, common pain conditions affecting women, such as endometriosis and migraine, and sexual and reproductive health.
10. **Monitor, evaluate and respond** to women's pain experiences in healthcare settings.

Introduction

Pain is a complex but common health problem, with one in five Australian adults estimated to be living in pain.[3] This submission follows the International Association of the Study of Pain definition of pain as an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.[4] While there are different ways to understand or categorise pain, this submission refers to three primary patterns of pain:

- **Acute**: sudden and intense pain that usually disappears when the underlying cause is treated e.g. broken bones, burns, childbirth.
- **Episodic**: pain that occurs periodically or irregularly and may be associated with a long-term condition, have triggers, or be unknown e.g. painful periods, migraine.
- **Chronic**: pain that has persisted beyond three months and may be associated with complex or unknown causes e.g. fibromyalgia, cancer pain.[5]

Pain is understood as a personal experience that is influenced in complex ways by biological, psychosocial, and social factors.[4] GEN VIC also acknowledges that pain remains a developing area of health, and much remains unclear about its complex nature and experiences and, in turn, its available data and evidence.

About this submission

In this submission, GEN VIC outlines the impact of pain on women in Victoria, extending beyond the medical model of health to consider the complex and intersecting social factors that contribute to understanding the burden of pain. It considers the barriers and enablers to addressing women's pain management, including medical knowledge, service access, and personal skills. It then offers ten recommendations for systematic improvements.

While the scope of this inquiry focuses on the experience of pain for women and girls 12 years of age and over, GEN VIC acknowledges the burden of pain in other population groups, including trans and gender-diverse populations and children under 12.

This report was collated by reviewing the available evidence on women's pain and intersectionality in Victoria and engaging with members of GEN VIC. A member forum was held on 5 June 2024, where 16 GEN VIC members, including representatives from women's health services, contributed their expertise to help inform this submission.

The following outlines the findings and recommendations from this process.

Overview of women's pain

Women disproportionately carry the burden of pain in Australia.[3] This is particularly well acknowledged regarding chronic pain, with women more likely than men to be living in chronic pain across all life stages.[3,6]

It is not clear why the pain gap is so stark, but clinical research suggests sex and gender can play a role in susceptibility to develop chronic pain, the way individuals contextualise and cope with pain, and how pain is perceived and treated clinically.[7]

While there is a lack of data available to explain the overarching burden or other primary patterns of pain for women in Australia, there is a very clear picture of the pain burden and inequities when and listening to the experiences of women and examining common pain conditions.[6]

Common conditions

The following outlines chronic conditions or groups of conditions that are unique to or more common in women and contribute significantly to the disproportionate pain burden. While there are conditions commonly linked to pain, it is important to note that many women live with unexplained pain and may not be diagnosed with an underlying condition.

The following is not an exhaustive list of conditions and only highlights some of the more common pain conditions in women with current available research and data.

Musculoskeletal conditions: Musculoskeletal conditions includes conditions that affect the bones, muscles, joints, and connective tissues.[8] They are typically painful conditions and are the leading contributor to non-fatal burden of disease in Australia.[4] Women are 20% more likely to live with a musculoskeletal condition than men.[4]

In addition, many specific musculoskeletal conditions are significantly more common in women, including, fibromyalgia (80-96%)[9], osteoarthritis (73%)[10], and rheumatoid arthritis (70%).[11]

Musculoskeletal conditions were significantly the leading principal diagnosis in chronic pain hospitalisations in 2017-2018, making up almost 45% of chronic pain hospitalisations in women.[3]

Endometriosis: Endometriosis is a painful inflammatory condition in which tissue normally found in the uterus is found in other parts of the body.[12] Nearly one million Australian women are diagnosed with endometriosis, and one in seven (14%) of women are diagnosed with endometriosis by the age of 49.[13]

There were approximately 32,000 of endometriosis-related hospitalisations in 2016-17 alone, with nearly 79% of those among women aged 15-44.

Pelvic pain: Pelvic pain, including acute and chronic pain in the abdomen, affects up to one in five women and one in 12 men. [14] Other research points to even higher prevalence, with almost half of Australian women surveyed in 2023 reporting experiences of pelvic pain.[15]

While pelvic pain may be a result of endometriosis or other reproductive conditions, it is also commonly linked to other conditions, including irritable bowel syndrome, bladder pain, and migraine.[14,16]

Migraine: Migraine is a common neurological disorder, with symptoms including head pain, aura, motor weakness and nausea.[17,18] There are different types of migraines, which may be episodic, chronic, or linked to women's menstrual cycles.[17]

Migraine is almost three times more common in women, and 86% of people in Australia with migraine are of working age.[18] In addition to the burden of disease, the total economic cost of migraine in Australia is estimated to be $35.7 billion.[18]

Historically, pain research has exclusively focused on male subjects.[7] There continues to be gaps in our understanding of women's pain and why some common painful conditions affect women so starkly.

What GEN VIC Members would like to see change:

" Requiring government funded health research to include an adequate number of women, and data to be disaggregated by sex and gender, or demonstrate why this is not required."

Recommendation

1. Build a **robust research** base to address gaps in understanding and treating pain, particularly concerning conditions more prevalent in women and conditions that affect women differently from men.

Diagnosis and treatment delay

Pain Australia estimates that up to 80% of Australians living with chronic pain are missing out on treatment that could improve their health due to a shortage of services.[19] In addition, women face significant delays in diagnosis and appropriate treatment for pain.

One study showed that women wait longer to receive pain relief medication when presenting with acute abdominal pain in hospitals, while another showed that women were half as likely to be prescribed painkillers than men after the same surgery.[20,21]

Women are also more likely to be prescribed sedatives rather than pain medication for their pain.[21] For chronic conditions, many conditions more common in women have long diagnostic periods, including an average of 6.5 years for endometriosis[13] and 2-4 years for fibromyalgia.[22]

While these gaps are acknowledged, the whole experience of women living with undiagnosed and untreated pain in Australia is not clear.

What GEN VIC Members would like to see change:

"[Women] are believed about what they need - based on knowledge of their own experiences and body."

"All health professionals are more knowledgeable so that regional/rural don't have to travel so far to get answers."

Factors that contribute to the diagnosis and treatment delay include:

- There is low awareness of contemporary evidence of pain and treatment options among health practitioners.[23]
- There is a shortage of pain-specific services, including access to multi-disciplinary pain services in public hospitals.[19]
- Communicating pain is inherently challenging between patients and healthcare professionals.[24] This can be compounded by inadequate pain measurement tools (like the numeric rating system).[25]
- Investment in pain research has not kept pace with the growing prevalence of pain and conditions that cause pain.[26]
- There is limited data collection on pain, and measures of distinct types of pain (e.g. neuropathic and musculoskeletal pain).
- Common vague pain symptoms are difficult for healthcare professionals to interpret. Possible diagnoses are broad and overlap with different areas of medicine.[27]
- People from regional, rural and remote areas have less access to services and face long wait times and travel to pain services.[19]

Inequitable pain treatment and delays in diagnosis for underlying causes of pain leave women living with preventable pain and the associated impacts on their lives for longer.

What GEN VIC Members would like to see change:

"Additional funding for comprehensive sexual and reproductive health education; mandatory gender equity training and trauma-informed practice training for healthcare professionals."

Recommendations

1. Provide **training** to healthcare professionals on recognising and addressing pain in women, including **early detection, diagnosis, and treatment** of pain and common chronic conditions.
2. Enhance **communication and pain assessment tools** to promote effective communication strategies between patients and healthcare professionals.
3. Expand **access to pain-specific services** including primary care, specialists, and public multidisciplinary clinics across Victoria, including in regional and rural areas.

Gender-based violence, gendered discrimination and bias

There is significant evidence that shows a link between gender-based violence and chronic pain conditions.[28] This includes intimate partner violence, violence perpetrated by a family member or stranger, and childhood abuse.

Gender-based violence is both considered to be a risk factor for chronic pain, and a consequence of chronic pain. It is associated with conditions including pelvic pain, fibromyalgia, migraine, and back pain. The impact of this can be further compounded by healthcare that is not trauma-informed or gender-responsive. Healthcare workers may not be aware of the strong link between chronic pain and gender-based violence, and this can result in incomplete and ineffective treatment for women in pain.[28]

In addition, women's experiences in healthcare continue to point to gender inequity in pain management. Gender bias can impact the way pain is perceived and treated. This includes that women's pain is often underestimated and linked to false gender stereotypes like being oversensitive to pain or exaggerating pain.[29,30]

A recent study showed that even when men and women present with the same amount of pain in their facial expressions, their pain was perceived to be lower in women by observers.[29] Clinicians' perception of patient trustworthiness can also be impacted if the patient they have a history with depression.

When women are perceived to be untrustworthy about their pain, they face further disadvantage in their treatment. Women are more likely to be judged as appropriate for psychotherapy, while men are more likely to be given pain medicine, even when the presenting pain is the same.[31]

Concerning issues like discrimination, downplaying, gaslighting and dismissal of pain are well-documented in women's experiences of pain. The recent #EndGenderBias survey by the National Women's Health Advisory Council showed that almost 40% of women experienced gender bias in chronic pain healthcare.32 Almost 70% of women surveyed felt they were not believed and heard about their health issues.

The report also pointed to treatment and diagnosis as the most problematic stages of healthcare, with over 70% of respondents reporting gender bias during these stages. In other research, women in Australia have reported trauma due to their medical experiences and fear to seek medical support for their chronic conditions.[33]

Dismissing and undertreating pain contributes to the diagnosis and treatment delay and gender pain gap, leaving women in preventable pain for longer.

Recommendation

1. Develop and implement **gender-responsive and trauma-informed pain management protocols** that address biases related to women's pain experiences and promote supportive experiences in services.

Intersectionality

Further understanding of the complexity of pain, health disparities, bias in healthcare, barriers to accessibility and social and cultural experiences can be uncovered by considering intersectionality and pain – or how different factors can influence how women and girls experience pain based on compounding factors.

While there is limited evidence available of different experiences of intersectionality in pain, the following apply an intersectional lens by outlining some sub-population groups and social categorisations that can experience discrimination and compounding disadvantage in pain. While these are presented separately, the experiences of people with intersecting identities and experiences should be considered.

Aboriginal and Torres Strait Islander peoples

There is limited research and data to reflect Aboriginal and Torres Strait Islander peoples experience of chronic pain, including no national surveys that include a question about chronic or long-term pain.[34]

However, research suggests that the Western medical understanding and measurements of pain do not fully depict Aboriginal and Torres Strait Islander peoples understanding and experiences of pain. Their perspectives of pain are more deeply rooted in bio-psycho-social-spiritual contexts, which have not been adapted in pain medicine.

Aboriginal and Torres Strait Islander peoples also face negative attitudes, harmful stereotypes and inaccessible language in healthcare settings that further limit their access to pain healthcare.[35,36] Negative experiences can deter Aboriginal and Torres Strait Islander peoples from seeking further help unless absolutely necessary, compounding the negative experience of pain.

Culturally and linguistically diverse (CALD) communities, including migrants and refugees

Pain is understood and experienced in diverse ways in different cultural and migrant communities.[37] It can be understood in different frameworks, including biomedical, biopsychosocial, and traditional medicine.

Experiences more common in CALD communities such as migration and war or violence can be understood to shape the development and relationship with pain. For example, some research shows that people from Vietnamese, Assyrian and Mandaean communities who faced conflict or displacement had increased challenges with pain and accessing support for pain in Australia.[37]

Spiritual identity can also be an important part of people's pain narratives, including their coping strategies like spiritual relationship rituals, praying and hoping, and seeking social and community support.

Again, similarly to Aboriginal and Torres Strait Islander communities, the impact of pain on CALD communities is unclear due to limited data collection and availability. [38]

What GEN VIC Members would like to see change:

"Culturally competent service provision and resources."

"Invest in First Nations specific care - establishing trust is such a critical aspect in medical interventions."

Socioeconomic status

Socioeconomic status (SES) includes an individual's income, education, employment, and financial security. The link between low socioeconomic status and poor health is clearly established in Australia, including the compounding disadvantage of the poverty cycle, which includes lost opportunities for employment or education and less access to healthcare.[39] Socioeconomic disadvantage is associated with an increased risk of chronic pain.[3]

People from the lowest SES areas are 1.7 times more likely to be hospitalised with chronic pain than those from the highest SES areas.[3] People from low SES backgrounds face higher prevalence of conditions that cause chronic pain, including musculoskeletal conditions.[8]

Pain healthcare can carry high financial costs to access, including private and specialised healthcare. There is a lack of accessible public healthcare for pain, including multidisciplinary pain clinics.[19] People from low SES backgrounds face further delays in accessing pain healthcare due to the affordability of services.

Age

The experience of being an older or younger adult can significantly impact experiences of pain and treatment in healthcare settings. The prevalence of chronic pain including pain related hospitalisation increases with age, and almost 30% of people aged over 85 experiencing moderate or severe pain for over 6 months.[3]

One study referred to the high rate of chronic pain in older adults aged over 65 as a 'silent epidemic'.[40] Older adults report experiencing negative age stereotypes, including blaming health problems and chronic pain on aging instead of further investigation.[41] In addition, age discrimination can be considered a predictor of further pain.

Age is also a notable factor that contributes to the experiences of young people and pain. The two age groups with the highest reported impact on personal life from pain are people aged 20-24 and 55-59, with the younger 20-24 age group with the highest impact.[19] Several conditions that cause episodic and chronic pain are more common or increasing in young people, including endometriosis, migraine, fibromyalgia and some auto-immune conditions.[9,13,17,42]

Studies that have looked at adolescents' and young adults' experiences of pain point to high proportions of disadvantage, including self-reported depression, poor well-being, low school engagement and low access to healthcare.[43] Other studies of young women have highlighted common experiences of feeling as though their symptoms are not taken seriously and that they are wrongly perceived as healthy or exaggerating.[33]

There are many more sub-population groups, social categorisations and experiences of intersectionality to consider that are not explored deeply in this submission. They include, but are not limited to, gender identity, ability, religion, sexuality, mental health, education, and body size.

Recommendations

1. Investigate **intersectional experiences of women's pain** and encourage intersectional approaches in pain research, service delivery and policy development.
2. Enhance **cultural responsiveness** in pain care, including pain management programs and training for healthcare professionals.
3. Address **socioeconomic barriers** in pain healthcare, including affordability and availability.

Implications

The impacts of pain on women are broad and far-reaching. The preventable human suffering from pain alone is devastating for many women in Victoria. In addition, pain has further implications in society including social and economic consequences. The following outlines the negative implications of pain on women and Victorian society. Most data referenced focuses on pain across genders, noting that the impact on women is likely to be greater.

Social

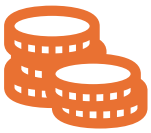
Pain can have devastating impacts on the personal lives and social health of individuals, including loss of sleep, relationships, exercise, and routine.[19] For most people living with chronic pain, pain restricts their ability to access many activities, including self-care, hobbies, caring, and mobility.[5,44] Nationally, chronic pain resulted in the loss of approximately 340,384 Disability-Adjusted Life Years (DALYs) in 2018. In Victoria, the well-being from lost DALYs equated to $16.8 billion in 2018.[44]

Mental health

Rates of mental ill-health, including anxiety and depression, are higher among people living with chronic pain.19,45 Mental ill health is linked to both the outcome of chronic pain and the cause of chronic pain, often feeding into one another and worsening over the course of time. Mental health can be greatly affected by other factors associated with pain, like isolation, social exclusion and lost employment.

Employment

With 68% of Australians living in chronic pain being of working age (15-64), the impact on individual employment and the productivity of workplaces is profound.44 Pain costs an estimated $48.3 billion a year on productivity costs, including absenteeism and reduced employment. Back problems and arthritis account for 40% of forced early retirements.19 While organisations and the government carry some of the associated costs, Individuals are the ones that carry the biggest share of the employment cost.[44]



Economic

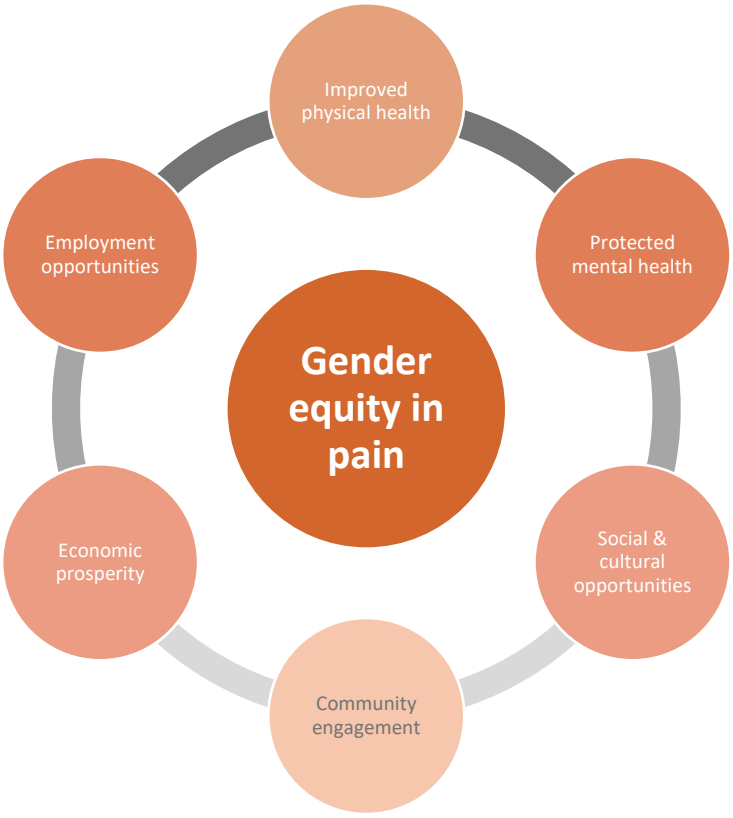
Pain, and specifically chronic pain, is one of Australia's most costly health issues. While the specific costs for women is unclear, Deloitte estimated that total financial costs of chronic pain in Victoria was $18.6 million in 2018.44 The leading healthcare cost for pain was in hospital care, estimated at 41% of the total healthcare cost, totalling $5.1 billion.44 Pain Australia estimates that half of the economic cost of chronic pain could be saved by timely effective treatment.[19]

Inversely, the positive implications of reducing the prevalence and impact of women's pain would have positive flow-on effects throughout society.

Addressing women's pain and promoting gender equity opens social, community, and economic opportunities for women.

The infographic pictured illustrates the potential positive impacts promoting gender equity in pain could achieve.

This model reverses the cycle of compounding disadvantage for women living with pain, showing how positive effects from gender equity and improved physical health can impact other areas of health and wellbeing.



Barriers and enablers

Barriers and enablers are factors that negatively or positively influence experiences and outcomes.

These barriers and enablers were collected from GEN VIC members during an engagement forum for the Inquiry into Women's Pain. The forum was designed to allow members to contribute their insights and suggestions for improvements.

The following table outlines some key barriers and enablers for addressing women's pain as identified by GEN VIC members and reinforced by the available literature. It is followed by some final key quotes from members outlining what they would like to see change.

Medical knowledge and clinician skills to manage pain and underlying conditions

Barrier

- **Limited research and evidence:** Insufficient research on women's pain limits the ability to address pain, including in underserviced areas like underlying conditions in women.
- **Lack of awareness of comprehensive pain management**: Low professional knowledge of pain medicine and referral pathways in primary care, acute care, and allied health can delay treatment or cause harm.
- **Normalisation and downplaying of pain:** Women's pain experiences are frequently normalised and dismissed, leading to a lack of serious consideration and appropriate treatment options.
- **Psychological issues blamed for pain:** Pain is often attributed to psychological problems in women, resulting in mismanagement and neglect of underlying conditions.

Enabler

- **Greater research into women's pain and underlying conditions:** Investing in research can allow a better understanding of pain and conditions that commonly cause pain in women.
- **Training for clinicians about pain**: Training will improve knowledge of the current evidence base for pain, underlying conditions, available referral pathways, and understanding when referral is appropriate.
- **Training for clinicians about gender-responsive healthcare**: Increased awareness of conditions prevalent in women, gender bias, and gender equity can build capacity to provide care for women in pain.
- **Holistic treatment models**: Implementing holistic treatment models can provide wraparound support that considers physical, mental, social and cultural aspects of managing pain.

Service availability and access

Barrier

- **High costs and financial barriers**: The rising cost of primary healthcare, allied health and specialist services combined with unhelpful consultations, misdiagnosis, and long wait times creates a significant financial burden for women seeking help with pain.
- **Lack of specialised women's pain services and geographic disparities:** There are not enough affordable healthcare services that can treat women's pain, especially in regional and rural areas.
- **Low availability of culturally appropriate models of care**: There is less access to support for women from CALD and Aboriginal and Torres Strait Islander backgrounds.

Enabler

- **Greater investment into women's health and pain management services**: Reducing costs and increasing availability of services, including in regional and rural areas, allows better access when and where it's needed.
- **Services specific to women's pain**: Health services specific to women's needs ensure women feel understood and are provided the most appropriate care for pain.
- **Trauma-informed and culturally safe care:** Implementing trauma-informed and culturally safe care across all healthcare services increases safe and appropriate access.
- **Continuity of care models**: Implementing continuity of care models allows consistent and ongoing support for women managing pain and complex chronic conditions.

Women's knowledge and skills to identify and manage pain	
Barrier	**Enabler**
• **Lack of awareness that pain can be treated:** Many women are unaware that their pain can be effectively treated, leading to prolonged suffering. • **Low levels of health literacy:** Limited knowledge and skills needed to manage pain effectively and understand when and where to seek medical help. • **Prolonged time undiagnosed when there is an underlying issue:** Women often endure significant periods of undiagnosed or unmanaged pain without proper support. • **Communication barriers:** Communication issues can prevent women from effectively conveying their pain and needs, particularly if English is not their first language.	• **Accessible information**: Evidence-based information about pain and chronic conditions can build knowledge and skills. • **Empowering and educating people in pain**: Pain education, including evidence-based knowledge of pain and pain management techniques, can reduce pain.[46] • **Supporting navigation of health systems**: Helping people navigate health services and systems can help them find the right care for them. • **Increased health promotion and community education**: Promoting broader community education and awareness can support knowledge and positive attitudes towards key issues like women's health, pain management, and sexual and reproductive health

"Best practice in information and access to services is normalised, made easy to access, not the exception."

"Mandatory professional development for healthcare professionals; gender equity training for healthcare professionals."

"Increased health promotion and awareness among the public and physicians around endometriosis."

What GEN VIC Members would like to see change:

"Greater collaboration between women and clinicians to ensure referral, diagnosis and treatments actively promote alleviation of pain and its psychological impacts, models responsive for the needs of indigenous, migrant and refugee women and women with disabilities, more nuanced research on gendered experience of pain and responsive diagnostic and treatment models."

"Accountability relating to women's experiences of pain - monitoring of pain experiences, with monitoring of responses to pain from healthcare providers."

Recommendations

1. Support public health education campaigns to **raise awareness** about pain, common pain conditions affecting women, such as endometriosis and migraine, and sexual and reproductive health.
2. **Monitor, evaluate and respond** to women's pain experiences in healthcare settings.

Conclusion

This submission considered the impact of pain on women living in Victoria. It outlined how pain disproportionately impacts women, including higher rates of common conditions that cause pain, including migraine, reproductive and pelvic pain conditions like endometriosis, migraine and musculoskeletal conditions like osteoarthritis. Factors including historic research inequities, gender-based violence, discrimination, service shortages and a lack of awareness and evidence-based knowledge were highlighted as core factors contributing the gender pain gap.

This submission also considered the intersectional experiences of women and called for greater consideration of women from diverse backgrounds and communities to ensure improvements in pain services and treatment are available to all. This submission was informed by the expertise and insights of members who shaped the findings and recommendations, and GEN VIC acknowledges their valuable contribution.

GEN VIC offers 10 recommendations to address women's pain in Victoria and make positive changes for all. The recommendations are summarised again on the following page.

Recommendations

The following outlines all recommendations based on GEN VIC's submission:

1. Build a **robust research** base to address gaps in understanding and treating pain, particularly concerning conditions more prevalent in women and conditions that affect women differently from men.
2. Provide **training** to healthcare professionals on recognising and addressing pain in women, including **early detection, diagnosis, and treatment** of pain and common chronic conditions.
3. Enhance **communication and pain assessment tools** to promote effective communication strategies between patients and healthcare professionals.
4. Expand **access to pain-specific services** including primary care, specialists, and public multidisciplinary clinics across Victoria, including in regional and rural areas.
5. Develop and implement **gender-responsive and trauma-informed pain management protocols** that address biases related to women's pain experiences and promote supportive experiences in services.
6. Investigate **intersectional experiences of women's pain** and encourage intersectional approaches in pain research, service delivery and policy development.
7. Enhance **cultural responsiveness** in pain care, including pain management programs and training for healthcare professionals.
8. Address **socioeconomic barriers** in pain healthcare, including affordability and availability.
9. Support public health education campaigns to **raise awareness** about pain, common pain conditions affecting women, such as endometriosis and migraine, and sexual and reproductive health.
10. **Monitor, evaluate and respond** to women's pain experiences in healthcare settings.

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