# Experiences of Pain in Sexual & Reproductive Health Procedures

## Policy Brief

Carrie Purcell
Mari Greenfield

The Open University
PolicyWISE

# Introduction

Physical pain is a common experience across many sexual and reproductive health (SRH) encounters, in particular during procedures, for women and other people with a uterus* in the United Kingdom and beyond (Women and Equalities Committee 2024; Nurofen 2024).

Recent research, including our own, has highlighted pain in relation to procedures such as abortion, hysteroscopy and IUD insertion, among many others. These experiences cut across all contexts of healthcare provision from general practice, to community sexual and reproductive health, to hospital-based gynaecology services.

The normalisation of women's SRH-related pain – whether from chronic conditions or procedures – means it arguably receives inadequate recognition or prioritisation in healthcare. Since this normalisation is based on assumptions about female bodies, this inequity can be framed as a 'gender pain gap'.

National guidance on pain management in some types of procedure has been provided by the Royal College of Obstetricians and Gynaecologists and the Faculty of Sexual and Reproductive Health. And yet, as a recent report highlighted, unnecessarily painful procedures continue to be a problem in frontline practice.

# Four Nations Policy Overview

Looking across procedures and contexts of care has the potential to highlight that this is not just an issue in one area of policy, practice or provision, but an endemic issue in SRH care across the UK.

SRH procedure pain requires attention at strategic and practical levels, including its explicit prioritisation in the 'women's health' plans of each UK administration. Momentum in this policy area has been growing in recent years but there are examples across the four nations where better understanding and recognition of procedure pain could be embedded into strategic initiatives to improve SRH and gynaecology care. As a primarily devolved issue, strategies to address procedure-related pain must be adopted by each UK nation, as well as learning and evidence shared across these contexts.

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*Terminology note: We use 'other people with a uterus' throughout this report to refer to trans and non-binary people who may require SRH procedures. At the time of writing, we viewed this as the most appropriate language to capture this group, since the procedures do not relate to current gender presentation or sex assignment at birth.

Scotland's first Women's Health Plan: A Plan for 2021-2024 had the ambition to ensure 'equitable health outcomes', provide inclusive and respectful healthcare, and improve care for women. Although the plan acknowledged women's pain in relation to certain conditions such as endometriosis, it did not explicitly address SRH procedure pain. An updated plan is currently in development.

The first Women's Health Plan for Wales was published by NHS Wales in December 2024. With a vision to improve healthcare services for women whom, it acknowledges, 'wait longer for pain relief and report having their symptoms dismissed'. While improvements to abortion care is a clear priority, the issue of SRH procedure pain is not explicitly addressed.

The Women's Health Strategy for England was published in August 2022. Pain related to procedures such as IUD fitting or hysteroscopy is noted as part of the evidence and priorities of the strategy, although it is acknowledged that there remain disparities in women's individual experiences of procedures, especially for certain demographics.

Northern Ireland is currently the only UK nation without a dedicated women's health strategy. In 2024, the Health Minister outlined a Women's Action Plan which would 'pave the way' for a longer-term strategy, and a Women's Health Survey ran between November 2024-January 2025 as part of a wider public listening exercise.

# Findings

In phase 1 of The Gender Pain Gap in Sexual and Reproductive Health project, we conducted discussion groups with 22 participants with lived experience of painful SRH procedures to centre lived experience and inform improvements in care. Our interim report highlighted four key findings identified in the analysis of these discussion groups:

### 1. Negative and judgemental attitudes were as big a problem as the pain itself

Participants reported highly negative experiences relating to attitudes expressed by health professionals, and a 'sense' that their pain was viewed as unexpected or wrong. They felt their pain was dismissed or ignored, and were made to feel it was their fault rather than an issue with the procedure. Anxiety emerged where health professionals were seen as withholding information on pain, particularly for some neurodivergent individuals.

### 2. Gender norms and power dynamics can have a silencing effect

The assumption that female bodies are expected to tolerate pain was commonly referenced, as was the norm of 'not making a fuss', which led to self-silencing. Feelings of vulnerability prevented participants from voicing their pain.

### 3. Negative perceptions of health professionals followed from painful experiences

Pain was seen as being minimised or ignored in verbal and written information and trivialised in the language used. This in part set the terms of participants' experiences and what they then felt able to say about them. It also shaped whether they felt able to ask to stop procedures partway through, with notable implications for informed consent.

### 4. Self-advocacy is challenging and should not be necessary

Self-advocacy in SRH procedures was seen as challenging, and as involving internal negotiations which went unseen by health professionals. The suggestion of offering pain relief as standard, rather than requiring individuals to request it, could signal that women and other people with a uterus are not expected to endure pain in routine healthcare.

# Recommendations

Based on these *interim findings*, we make two key recommendations:

## 1. Recognition of procedure-related pain in government strategies in all UK nations

Policy and decision makers should ensure that the significance of procedure pain is articulated in future women's health plans. Government strategies in each of the four nations should explicitly recognise the issue of SRH procedure pain, in order to prioritise it as an area for improvement in women's healthcare. Sharing of approaches, experience and evidence across the nations could further strengthen improvements.

## 2. Improved clinical guidance and professional development for healthcare professionals

In order to support the embedding of future strategic priorities into frontline practice, support should be provided to improve not only the provision of pain relief, but also communication around pain. Doing so would avoid the dismissal of pain experiences and remove the need for self-advocacy in challenging situations. This should be implemented across all contexts of provision and procedure type.

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**Dr Carrie Purcell** is a researcher at The Open University in Scotland, with extensive experience of applied and policy-oriented sexual and reproductive health research.

**Dr Mari Greenfield** is a researcher at the Open University who specialises in working with marginalised groups on reproductive health issues.

If you'd like to know more about the progress of the Gender Pain Gap in Sexual and Reproductive Health project, or any of the Open University's Reproduction, Sexualities and Sexual Health Research Group's work, please contact carrie.purcell@open.ac.uk.

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**policywise@open.ac.uk**

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