

Breaking Boundaries: Toward Consistent Gender-Sensitive Language in Sexual and Reproductive Health Guidelines

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Abstract

This review assesses gender-sensitive language in sexual and reproductive health (SRH) guidelines, including a guideline for polycystic ovary syndrome. We conducted a systematic search across databases like Medline, EMBASE, and Cochrane until July 31, 2023, using terms related to gender-inclusivity, SRH, and guideline protocols. Criteria for inclusion were gender-sensitive language, SRH focus, and guideline relevance, excluding non-English articles or those without policy considerations. Our search yielded 25 studies, with 6 included for qualitative synthesis. Results showed significant gaps in using gender-sensitive language in SRH guidelines. The debate on this language mirrors broader societal discourse. Recognizing gender diversity is essential for research, clinical practices, and societal norms. While promoting inclusion, drawbacks like unintended erasure or miscommunication should also be addressed. A gender-additive approach balances inclusivity and biological accuracy. Precise and inclusive discourse is crucial. Future research should focus on systemic approaches in the SRH sector.

Keywords

- ▶ gender
- ▶ gender-sensitive language
- ▶ sexual and reproductive health
- ▶ guidelines
- ▶ sex
- ▶ health

The current robust discourse on sex and gender has catalyzed societal shifts, underscoring the power of language to shape societal norms, reveal hidden inequities, and redefine visibility. Central to this discourse is the dyad of sex and gender—the former representing a biological construct, while the latter, increasingly recognized for its complexity and diversity, represents a social construct. This discourse is particularly germane to the sexual and reproductive health (SRH) sector, situated within both the biological and societal spheres. However, despite the nascent and growing literature on the needs and preferences of gender diverse groups

regarding SRH care, the research sector has been slow to adopt consistent approaches to using gender-sensitive language (see ▶ **Table 1**).

Clinical guidelines play a vital role in bridging the gap between research and practice. By consolidating and interpreting the latest scientific evidence, these guidelines offer healthcare providers clear, evidence-based recommendations for patient care.¹ Setting a standard of care, they promote the uniform application of research findings across diverse settings, thereby advancing evidence-based practice. As such they are an essential resource for education and

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Table 1 Gender terminology

<p>Cisgender/cis: Individuals whose gender match their birth-assigned gender.</p> <p>Cisnormativity: The assumption that everyone is cisgender, thus marginalizing trans individuals.</p> <p>Dead name: A person's previous name which they've discarded due to gender or identity changes. Its use can cause distress.</p> <p>Gender-additive: Use of a range of gender identities in addition to traditional norms.</p> <p>Gender affirmation: A trans person's journey to embody and be acknowledged as their genuine gender. Medical or legal steps are not obligatory for validation.</p> <p>Gender binary: Viewing gender solely as male or female. Nonbinary does not fit within this strict categorization.</p> <p>Gender fluid: Someone with a changing or shifting gender identity.</p> <p>Gender/gender identity: One's internal sense of being male, female, nonbinary, etc., whether binary or not.</p> <p>Gender pronouns: Pronouns like "he," "she," or "they" that express one's gender.</p> <p>Gender queer: An identity that does not fit traditional male/female norms strictly.</p> <p>Gender-sensitive: Policies, language, and other social and institutional practices that intentionally include people of all gender identities.</p> <p>Heteronormativity: The perspective that heterosexuality is the only "natural" or "normal" relationship or orientation.</p> <p>Nonbinary: A gender identity that is not strictly male or female.</p> <p>Sex: A classification that is often made at birth as either male or female based on a person's external anatomical characteristics. However, sex is not always straightforward, as some people may be born with an intersex variation, and anatomical and hormonal characteristics can change over a life span.</p> <p>Trans (transgender/trans): People whose gender identity differs from their birth-assigned gender, encompassing various identities.</p> <p>Reference: CFCA Resource Sheet—February 2022. Australian Institute of Family Studies. Accessed September 2023. Available at: https://aifs.gov.au/resources/resource-sheets/lgbtiqa-glossary-common-terms. List is not exhaustive</p>

training of healthcare professionals. Consequently, clinical guidelines significantly influence health outcomes by minimizing care variability, enhancing patient safety, and encouraging a patient-centered approach (e.g., shared decision-making). As indispensable tools, they facilitate the transformation of research discoveries into tangible health benefits for the population. This includes research on patient preferences and care experience. Indeed, accessible clinical guidelines support and empower people to learn about recommended care pathways and stimulate informed decision-making about these with healthcare teams.

The application of gender-sensitive language in clinical guidelines in the SRH sector should be a vital component of addressing patient preference and experience of care. Yet currently this application is inconsistent and lacks precision in the gender-specific terminology deployed.² Guidelines often resort to narrow, biologically determined expressions of sex, failing to acknowledge the complex and diverse landscape of gender inclusivity. While this omission can foster and perpetuate confusion, miscommunication, and a disregard for individual identities, it needs to be balanced with the imperative for biological accuracy and the differentiation of the biological term "sex" with the sociologically framed term "gender" (see ►Table 1). The SRH sector is at a critical juncture for timely action on use of inclusive language, with a responsibility to take an evidence-based approach that would optimize patient experience and care and advance respect, inclusivity, and accurate representation of all individuals engaging with the SRH sector.

This review aims to inform an evidence-based, respectful, and inclusive application of gender-sensitive language and related considerations in SRH guidelines. It was generated in the context of need for consistency in guidelines generally, and specifically international guidelines in polycystic ovary syndrome (PCOS) and premature ovarian insufficiency. A

narrative review with a systematic search was chosen as the most appropriate format, as this review method is anchored in plausible truth, and offers authoritative insights by synthesizing and evaluating a broad spectrum of literature. Such analyses rigorously incorporate both foundational stances and antithetical viewpoints, concurrently emphasizing the contemporaneity of evidence, culminating in conclusions that resonate with expert-resonant conclusions and inform policy directives.^{3,4}

A systematic search was conducted from inception to the 31st July 2023 through Medline, Medline in-process, and other non-indexed citations, EMBASE, and all EBM reviews including Cochrane Database of Systematic Reviews, Cochrane Clinical Answers, Cochrane Central Register of Controlled Trials, American College of Physicians Journal Club, Cochrane Methodology Register, Health Technology Assessments, the Database of Abstracts of Reviews of Effectiveness, and the National Health Service Economic Evaluation Database. The search terms are shown in ►Supplementary Table S1 (available in the online version only). Bibliographies of the relevant publications were searched for any additional publications.

Selection Criteria

Inclusion criteria encompassed any article type containing guidance about gender-sensitive language for guidelines and/or policy considerations for SRH research or healthcare settings.

Articles in languages other than English were excluded. Key exclusion criteria were no gender-sensitive language considerations, not focusing on SRH, and no guidelines or policy guidance and/or considerations in healthcare setting.

A single reviewer (R.M.G) assessed titles, abstracts, and then full-text articles against inclusion criteria.

Review

From an initial pool of 25 studies, editorial, opinion pieces, and narrative reviews identified through systematic search, 19 were excluded, resulting in 6 studies for qualitative synthesis (see ►Fig. 1). The included studies comprised one literature review,⁵ one systematic review,⁶ one qualitative study,⁷ one quantitative study,⁸ an editorial,⁹ and an opinion piece.¹⁰

Results and Analysis

Societal and Language Shifts

The biological origins of sex were firmly established in the early 19th century as a binary classification¹¹ setting the stage for the fervent debates and discussions around gender and societal roles that continue today. During this time, the concept of “gender,” distinct from biological sex and referring to social and cultural roles, was largely unrecognized. The widespread use of gender did not emerge until the mid-20th century, spearheaded by sexologist John Money.¹² This shift in terminology mirrored changing societal perspectives. During the societal upheavals and cultural shifts of the 1960s, traditional gender constructs were critically examined due to their role in perpetuating hierarchical power structures tied to societal and economic disparities.

Consequently, trans- and nonbinary individuals frequently found themselves challenging these constructs, particularly in relation to their identities and physical bodies. This period also ushered in the influential queer theory, which proposed sex and gender as socially constructed entities, with gender assuming greater significance over biological sex.¹³ As a result, the traditional dichotomy of male/female sex started to broaden, fostering the emergence of “gender identity.” Gender identity is a comprehensive term encompassing a person’s inner sense of gender,¹⁴ as opposed to being externally conferred through societal orthodoxies.

As a medium for mapping power structures, language can both emphasize and suppress societal components. The shift in gender language, propelled by the ambition for diversity and equity, initially emerged in the context of inclusion and equality.

The Phenomena of Erasure

The trend to decoupling biological sex from associated genders can risk marginalizing those who identify with cis-genders (cis-[Latin] “on this side”), including those who identify as women, triggering substantial backlash due to a phenomenon known as “erasure.” The term erasure holds significance for both proponents and critics of gender-sensitive language in SRH. Supporters such as Morrison et al¹⁵ contend that the predominant emphasis on heteronormative and cis-gender experiences in health research leads to a systemic erasure of gender and sex minority experiences. Such an oversight results in patients facing stigma, bias, refusal of care, and even the use of “dead names” in the healthcare system, problems made worse by a lack of professional knowledge on determinants of gender and sex minority health. Consequently, conditions like PCOS, which can have masculinizing effects, are often labeled as “gendered illnesses” with treatments aimed at restoring traditional femininity.

Another area highlighting the implications of these constructs of sex and gender is health, particularly in conditions like PCOS provided by Wugalter et al¹⁶ who delved into the experiences of gender-diverse individuals with PCOS, which is a condition marked by elevated androgen levels. Their findings highlighted how cis-heteronormative interpretations of PCOS can intensify difficulties for these individuals, even though certain symptoms, such as increased body hair, might resonate with and affirm their gender identities. Participants in the study expressed feelings of alienation due to the exclusive gendered perspective of PCOS in both social and medical settings. These findings were validated by Schweisberger et al¹⁷ in a study that investigated the prevalence of gender diversity among adolescents with PCOS. The study found a higher prevalence of gender diverse identity among youth with PCOS (7.6%) compared to youth without PCOS (1.8%). While gender diverse youth with PCOS did not show elevated androgen levels compared to youth without PCOS, they exhibited increased hirsutism scores and a notably higher incidence of depression and anxiety. Those with PCOS have been shown to have a comparatively high prevalence of mental health challenges and this risk may be exacerbated by societal

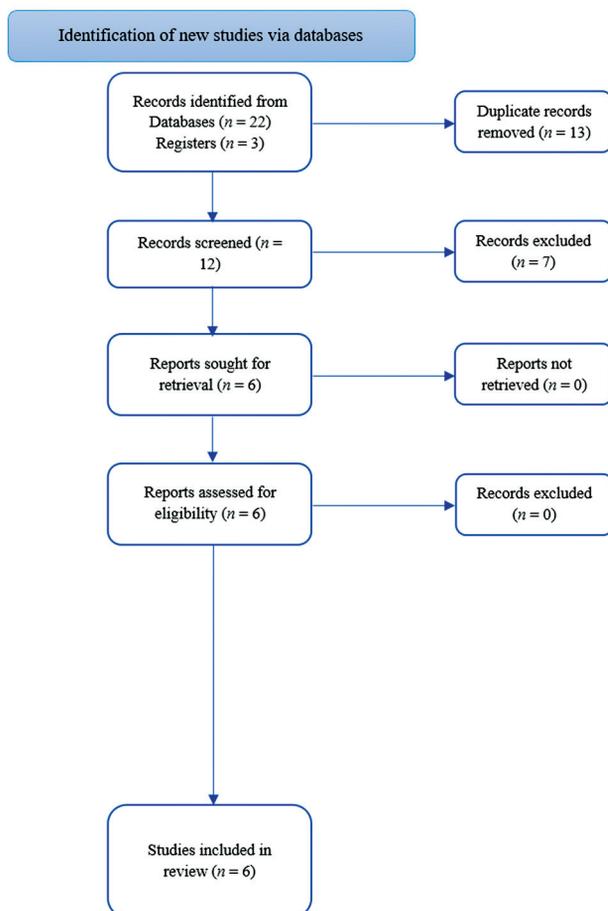


Fig. 1 PRISMA diagram of study selection.

stigmatization related to cis-gender expectation,¹⁸ perpetuated within a clinical setting (e.g., physical appearance). The findings underscore the potential iatrogenic risks of a cis-normative clinical approach, emphasizing the importance of gender identity eliciting gender preferences within adolescent PCOS programs and the need for tailored treatment strategies to support diverse gender identities.

Backlash

However, not all attempts at inclusivity have been universally embraced. Dinour's¹⁹ proposal to replace "breastfeeding" with "chest feeding" sparked intense debate, with detractors perceiving it as an erasure of women and taking issue with its anatomical inaccuracy. Other terms that have been introduced as replacements for sex-based language include "bodies with vaginas," "cervix havers," and "vulva owners." Critics, such as Gribble et al,¹⁰ argued that while these terms aim for inclusivity, they could unintentionally result in exclusion of those with medical conditions, like those with congenital abnormalities or who have had specific surgeries. They further caution that such terminology could alienate cis-gender women by reducing their identity to mere anatomical parts. Gribble et al¹⁰ postulated that eliminating sex-based language might have unintended repercussions, potentially leading to imprecision and misinformation. The debate underscores concern about erasing women as a valid gender identity and raises questions about the implications of linguistic shifts in research of erasure and risks to access of appropriate medical care.

Inconsistent Approach with the SRH Sector

In the search for appropriate broadly inclusive terms, the linguistic shift toward gender inclusivity, while broadly acknowledged as important within the SRH sector, has yet to land on an acceptable compromise. Controversy persists. Various platforms and institutions have grappled with these changes in different ways. For instance, *The Journal of Midwifery & Women's Health*⁹ adopted a policy of "intentional inconsistency" with regard to gender-neutral language, offering authors the autonomy to select the gender-related language they deemed most appropriate for their manuscripts, albeit expressing a preference for the terms "women" or "woman." This approach is consistent with the findings of a small study conducted by Kinney et al,²⁰ which sought to assess the understanding and acceptance of gender-sensitive language revisions in the Breastfeeding Attrition Prediction Tool (BAPT). It uncovered that while a significant portion of the revised, inclusive terminologies were understood and accepted, some alternatives for breastfeeding, such as "chestfeeding" or "body-feeding," posed comprehension difficulties and were met with resistance. Since breast tissue is not unique to any specific sex or gender, breastfeeding is inherently an inclusive term. However, objections likely stem from societal implications surrounding human lactation and the associated language, which impact the term's perceived inclusivity. Resistance and difficulties also underline the importance of testing the specific inclusive terminologies with all key stakeholders, given the varying levels of understanding and acceptance they may invoke. It is evident that the road to linguistic inclusivity is complex, with various

facets to consider. As such, further research is imperative in this field to explore acceptable, clear, consistent approaches to inclusive language and to avoid further destructive polarizing views around inclusive language.

Risks of Noninclusive Research

Rioux et al⁵ and Moseson et al⁸ highlighted the urgent need for gender-sensitive language in the context of SRH. They argue that current academic language is largely (cis) woman-centric, excluding a diverse group of transgender and gender nonbinary people who also have SRH needs and experiences. In a review of 500 recent articles across health research fields, Rioux et al found that only 1.2% of articles used gender-sensitive language, emphasizing the pervasive erasure of gender diversity.⁵ Such exclusion contributes to inaccurate scientific communication and negative societal impacts, including the perpetuation of exclusionary language by various stakeholders. Moseson et al⁸ identified unique challenges that individuals with marginalized gender identities face when seeking SRH care and participating in research, especially abortion services. These challenges include but are not limited to discrimination based on gender identity within clinical settings, limited provider expertise, refusal of care, lower levels of insurance coverage compared to the general U.S. population, and frequent incongruities between gender presentation/identity and the sex/gender listed on administrative documents. These barriers can lead to delays in seeking abortion services and unmet preferences for specific abortion options, ultimately compromising the overall quality of abortion care for transgender individuals.

Furthermore, clinicians and researchers are obliged through codes of practice to ensure that all points of SRH access, research, information, and care delivery are comprehensive, inclusive, and accessible to people of all genders. This premise, Moseson et al⁸ argued, is likely to be broadly supported by healthcare treatment providers and should not only foster respectful care and research environments but also advance the quality of healthcare and research. Both Rioux et al⁵ and Moseson et al⁸ underscored the immediate need to adopt gender-sensitive language as a crucial first step toward inclusivity, not just in epidemiological research but across all health research fields.

Similar findings were reported from a systematic review on LGBTQ+ cultural competence in fertility care encompassing 25 studies which unveiled significant barriers such as heteronormativity, cisnormativity, stigmatization, and psychological distress.⁶ Additionally, a glaring lack of tailored information for the LGBTQ+ community was evident. Fertility providers recognized these gaps, showing a willingness to bolster their cultural competence. Recommendations included the adoption of gender-neutral language, the use of preferred pronouns, and inclusive intake forms. Additionally, a strong emphasis on cultural awareness, especially during potentially triggering examinations for transgender patients, and dedicated LGBTQ+-specific resources are paramount. Addressing cisnormativity in ART-related resources through targeted materials for the LGBTQ+ community and integrating welcoming LGBTQ+ symbols like the Pride flag can make a positive difference.

Taking a stance against discrimination with robust policies and fostering a culture of continuous learning, anchored in the principles of “...cultural humility which encourages lifelong learning and listening, rather than listing assumptions” and reflective practice, can further enhance fertility care for the LGBTQ+ community.

Given the tension between polarizing approaches that fail to consider all stakeholders and the urgent need for gender-additive language²¹ that respects all gender identities, we argue that language should remain broadly inclusive of all groups. We also contend that research is imperative to avoid damaging and polarizing opposition, leaving vulnerable and marginalized groups with compromised care.

Reports conclusively show, while the imperative for linguistic inclusivity remains paramount, it is equally crucial to understand its roots and impacts. The authors of this article suggest that language evolution is not created in a vacuum but hinges on time, context, and a shared cultural foundation. While some studies probe artificial language constructs, it is vital to not reduce individuals to basic bodily functions, as terms like “menstruator” may insinuate. It is likely that semantic bleaching,²² the process where words fade or dilute their original meanings over time, may assist the evolution of a new lexicon of terms that resonate. History indicates that language flourishes best within its cultural milieu, as the limited adoption of constructed languages like Esperanto that lack a cultural anchor demonstrates.

Typically, linguistic comfort and acceptance are tied to a mutual understanding of the need for change. Forced rapid shifts can elicit resistance, especially when such adaptations challenge core identities and risk creating unwanted divisions. When a community adopts specific terminology, the scientific community should collaborate on terminology development with the community. It is crucial to prioritize the inclusion of marginalized groups in scientific discussions. Moreover, there is a need for discretion, avoiding language that could polarize or offend, ensuring smoother linguistic adaptations across diverse cultures.

Guidance for SRH Guidelines

In the rapidly evolving field of healthcare, the use of language plays a pivotal role in ensuring inclusivity and clarity. However, the use of gender-sensitive language in guidelines is inconsistent, and there is little guidance on best-practice approaches. In response to the inconsistent use of gender-sensitive language in preventive healthcare guidelines, the U.S. Preventive Services Task Force (USPSTF)² released a report and position statement outlining a future approach to guideline development. Contrary to serving as a set of finalized guidelines, this document aims to set the groundwork for a more gender-inclusive approach in future guideline formulation. The USPSTF advocates for a collaborative research plan that actively considers gender-diverse populations. They propose conducting systematic reviews that clearly indicate the gender of participants, with the subsequent evidence to be reviewed by gender-diverse groups for input.

Recognizing a broad spectrum of gender identities, including those who identify as men, women, gender nonbi-

nary, gender nonconforming, or transgender, the USPSTF aims to rectify imprecision and inconsistency in language and approach.² The Task Force begins this effort by identifying issues related to sex and gender at the onset of the guideline development process. A rigorous and systematic review of the existing scientific literature’s applicability, variability, and quality is carried out to ensure the proposed guidelines would be universally relevant.

To mitigate ambiguity and potential misinterpretation, the Task Force is committed to using clear, specific, and inclusive language, often preferring gender-neutral terms. Part of this initiative includes identifying gaps in evidence concerning sex and gender in preventive care, thus highlighting areas requiring additional research. Although this work is still in progress, the anticipated outcome is a set of universally understood, inclusive, and comprehensive clinical preventive service recommendations. This endeavor not only establishes a new standard for the USPSTF’s future guidelines but also provides a blueprint for other health organizations aiming to enhance inclusivity and diversity in healthcare provision. Importantly, when gender-neutral language is not feasible, the USPSTF ensures clarity by explicitly stating that their recommendations are rooted in biological sex, not gender identity, advising individuals to consider their sex at birth when determining the applicability of these recommendations.

The USPSTF position statement which provides guidance can be located at *USPSTF Methods for Considering Sex and Gender in Recommendations*. Through this transparent approach, the USPSTF aims to lay a foundation for inclusive guideline development, rather than presenting a finalized set of guidelines.

While the USPSTF made significant strides, they are not the only body aiming for this delicate balance. A second example of striking an equilibrium between gender inclusivity and biological precision is the international guidelines on PCOS¹⁸ which serves as an exemplar in this regard. Systemically formulated to resonate with a diverse global audience, this guideline acknowledges an evolving landscape and integrates insights from the literature, stakeholder input, and lived experience experts. It integrates insights from a spectrum of ethnicities, geographies, cultures, and gender identities. In considering inclusive approaches, the authors evaluated three options: (1) making no changes, (2) using gender-neutral language where applicable, and (3) adopting a gender-additive approach. Ultimately, they chose to implement options 2 and 3. The guideline employs gender-neutral terms such as “individuals” or “those with PCOS” when sex and gender specification is nonessential. Concurrently, it underscores the significance of biologically accurate terminology, opting for terms like “female” when delineating biological nuances. Importantly, while embracing a broader gender discourse, the guideline retains the use of “woman/women,” ensuring it holistically encompasses all who identify with this term. This informed linguistic approach offers a template for guideline developers, illustrating a way forward in blending gender inclusivity with biological exactness in SRH guidelines (see ► **Table 2**). This evolution in healthcare language was influenced by overarching discussions in the field.

Table 2 Harmonizing gender inclusivity with biological precision in healthcare language.

<p>The international guideline on the assessment and management of polycystic ovary syndrome (PCOS) 2023 provides an approach for harmonizing gender inclusivity with biological precision in healthcare language.</p> <ol style="list-style-type: none"> 1. Neutral terms like “individuals” or “those with PCOS” were used when sex or gender specifics were nonessential 2. For biological clarity, terms like “female” were utilized 3. Maintain the use of “woman/women” to include everyone identifying as such
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This approach mirrors a “gender-additive” approach first raised by Silver²³ advocating for an additive and expansive approach rather than replacing or erasing the word woman. Following this, the Brighton and Sussex University Hospitals NHS Trust introduced guidelines in the United Kingdom regarding gender-sensitive language in perinatal services, as detailed by Green and Riddington.²⁴ Their guidelines emphasize a gender-additive approach to language to “ensure that everyone is represented and included.”²⁴ This approach, though forward-thinking, was not without its critiques.

Specifically, Brighton and Sussex University Hospitals’ guide was not welcomed by all quarters. Dahlen²⁵ pointed out that the potential ambiguity and lack of clarity in gender-neutral terms, especially when communicated to a broader audience, remains a point of contention. She cites Lord Hunt in the UK House of Lords, who asked: “do we really want to see demeaning terms such as ‘menstruators,’ ‘individuals with a cervix,’ ‘birthing bodies,’ or even ‘chest feeders,’” Dahlen²⁵ then posits that: “It is not unreasonable to expect that some women may feel debased by a term like ‘menstruators,’ and clinicians have the same obligations to them (women) not to use language that deeply offends.” It is evident that while there is a push toward inclusivity, there are sensitive intricacies to be considered.

A broader observation in this trend raises further nuanced concerns. The overwhelming focus on modifying female-specific language without a parallel shift in male-associated terminology suggests a potential imbalance in representation and policy. Clinicians are now confronted with the intricate task of navigating this linguistic landscape, striving to balance inclusivity with scientific accuracy and clarity. As healthcare continues to adapt to the diverse needs of the population, the challenges posed by linguistic shifts underline the importance of constant reflection, review, and adaptation.

Way Forward

The lexicon of healthcare, especially in SRH, is undergoing a pivotal transformation focusing on the need for inclusivity. In addressing the imperative need for inclusivity, Moseson et al⁸ emphasized the need for the SRH sector to adopt gender-sensitive practices. This would serve as a significant step toward dismantling the barriers faced by transgender and nonbinary individuals in the realm of SRH care. This is not an isolated sentiment. Similarly, Rioux et al⁵ voiced concerns over the persistent use of woman-centric (cis) language prevalent in academic discourses regarding pregnancy. They underscored the urgent necessity to include gender-diverse individuals in research studies and to shift

toward using gender-sensitive language. Some scholars propose a blended approach, whereas others emphasize the need to retain gender-sensitive terms such as women and include other terms that are inclusive.

Navigating the nuances of gendered language is undeniably complex. In the quest for balance, it may be appropriate to adopt broad and inclusive language when discussing women and mothers, contingent upon the context and intended purpose. Irrespective of the chosen approach, clarity in terminology and avoiding the merging of terms is important. For instance, Gribble et al¹⁰ proffered that when the biological dichotomy is intended, the term “sex” should be used. If the discussion refers to societally constructed roles and expectations based on sex, “gender” should be applied, with a clear definition accompanying the term. Finally, in situations where “gender identity” is the focus, it is crucial to ensure that this phrase is distinctly differentiated from both “sex” and “gender.” Such nuanced suggestions, while helpful, emphasize the intricacy of the matter at hand.

Conclusion

Amid these conversations, the broader implications become evident. The ongoing debate surrounding gender-sensitive language in SRH guidelines reflects the broader societal discourse on gender identity. The recognition of gender diversity and the subsequent shift in language usage have profound implications for research, clinical practices, and societal norms. Gender-sensitive language can contribute to diversity and inclusion, but it is equally important to consider potential drawbacks, such as unintended erasure or miscommunication. Using an expansive and gender-additive approach may help strike the right balance between acknowledging biological sex and respecting gender identities.

The SRH sector has the opportunity to lead this effort by implementing guidelines that harmonize gender inclusivity with biological precision in healthcare language. As the field continues to evolve, fostering a discourse that is both inclusive and precise will remain an essential endeavor.

Conflict of Interest

None declared.

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