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Inclusive language in health policy – a timely case (study) of cervical screening in Australia

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ABSTRACT
Language is important in health policy development. Policy changes in Australia to increase cervical screening offers a timely case example to explore the function of inclusive language in health policy. Gender and sexuality diverse people with a cervix have been largely invisible within health promotion programs, which has led to reduced awareness of, and access to, cervical screening. Twenty-eight semi-structured interviews were conducted with 29 key informants between April and October 2022 about the role of inclusive language in cervical screening policy, promotion, and delivery in the context of a national program to promote cervical screening. Three themes were identified from what key informants believed to be the role of inclusive language: (1) the common goal of inclusive language as policy advocacy for broader inclusivity; (2) the inevitable partiality of inclusive language in policy as an opportunity to start conversation; and (3) policy as a bridge between essential but diffuse components of the health sector with multidirectional influences. Inclusive language was seen to operationalise equity in health policy within the broader aim of eliminating cervical cancer among under-screened populations.

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Introduction

The language used in policy is of concern to policymakers (Erdocia, 2022; Østergaard Møller & Sommer Harrits, 2013). Notable contributions to inclusive language in policy are how to represent women equally through changes in lexicon (e.g. flight attendant, firefighter, etc.) and syntax (e.g. he and she, they etc.) (Lakoff, 1973); also known as non-sexist language (Alvanoudi, 2020; Doyle, 1998). Over time, the contexts of language use have multiplied, reflecting ongoing social, political, and ideological change in the

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recognition of minority inclusion. Inclusive language for gender diverse people is a continuation of efforts to ensure equal representation between people of all genders, whereby linguistic reforms can be seen as tributary of earlier feminist critiques of sexist language – and in doing so, extending the range of language beyond the gender binary. Such efforts are now evident in recommendations to changes in language used to describe practices related to, for example, menstruation and pregnancy, birthing, and lactation (Botelle et al., 2021; Dahlen, 2021; Gribble et al., 2022; MacDonald, 2019; Miyagi et al., 2021; Moseson et al., 2020; Stroumsa & Wu, 2018), all of which have historically fallen under the domain of 'women's health' (Doyal, 1996). At the same time, policy also names those people for whom a policy is intended to serve and so language has a central function of including (and excluding) specific population groups (see, for example, the historical absence of Aboriginal and Torres Strait Islander people in the Australian context in Fforde et al., 2013). The exclusion of language has intention and meaning, as does its inclusion.

Underpinning these linguistic changes is the recognition that barriers to access and provision are of vital concern in the promotion of equity within the healthcare sector (Baum et al., 2009) – and these concerns extend to policies aiming to reduce health inequities among different communities (Braveman et al., 2011). The drive towards inclusive language in cervical screening policy reflects that certain cancers may be more endemic in some communities of gender and/or sexuality diverse people (Boehmer et al., 2011; Moore & Meads, 2013; Quinn et al., 2015). There is a need for effective interventions to reduce the burden and impact of cancer among these diverse populations (Drysdale et al., 2021), including training in cultural competency and explicit inclusion of gender and sexuality diverse people in materials and resources (Pratt-Chapman et al., 2022; Ussher et al., 2023). This article contributes to these efforts by considering what inclusive language looks like in health policy, using the timely case (study) of new health policies in the context of cervical screening in Australia.

Inclusive language in health policy

Inclusive language is defined by the American Psychological Association as 'language that is free of bias and avoid[s] perpetuating prejudicial beliefs or demeaning attitudes' (Bias-Free Language, n.d.). Inclusive guidelines now exist for international organisations such as the United Nations (United Nations, n.d.). This drive is mirrored in Australian guidelines for inclusive language for gender and sexuality diverse people; for example, those developed by community health organisations (ACON, 2019) and for use within the public sector (LGBTIQA + Inclusive Language Guide, 2023), as well as attempts to standardise national data collection to meaningfully include gender and sexuality data (Australian Bureau of Statistics, 2023).

Moves towards greater inclusivity in health are evident where gender-marked terms are replaced by gender-indefinite nouns, a strategy referred to as 'gender neutralisation' (Sczesny et al., 2016) (e.g. replacing 'woman' with 'person' or 'mother' with 'birthing parent') or where more than one term is used combined with 'and', a strategy commonly referred to as 'additive language' (Pendleton, 2022) (e.g. rather than referring to women alone, using 'women and pregnant people'). A further option is to avoid gendered terms where possible, circumventing the need to indicate which gendered person may experience these states (Stout & Dasgupta, 2011) (e.g. referring to 'pregnancies' or 'births') or person-centred language (e.g. when you are pregnant/give birth). Yet, concerns have been voiced regarding the relevance and consequence of inclusive language in reproductive healthcare, especially where gender-neutral terms are deployed (Dahlen, 2021), including the unintended erasure of 'women' as a distintive biomedical field. For example, Gribble and colleagues (2022) argue that inclusive language may work to alienate cisgender women by reducing their identity to mere anatomical parts. Conversely, proponents of gender-neutral language argue that the additive approach risks 'othering' or minimising those who do not identify with the primary (or hierarchically ordered or first placed) term (i.e. women), which relegates them to a secondary position (Davis, 2022; Silver, 2019; Zimman, 2017). A recent narrative review found that gender-additive approach 'balances inclusivity and biological accuracy' (Garad et al., 2023).

Nevertheless, inclusive language is more socially accepted when it is backed by official guidelines and protocols (Cooper, 1989). As such, the relationship between policy-making and social change is interrelated and unidirectional (Alvanoudi, 2020). On the one hand, inclusion and equality – and associated demands for advocacy – find their way into public policy as a way to legitimate and formalise such principles (Brookfield, 2023; Erdocia, 2022; Zampini, 2018). On the other hand, official regulations may either stipulate social change by facilitating new norms or, conversely, by maintaining the status quo, both through the authority of 'black letter formalisation' of state-crafted policy (Brookfield, 2023; Lea, 2020). Drives towards inclusivity are evident in widespread policy changes to previously gendered health concerns to promote health equity more broadly.

A case (study) of inclusive language in cervical screening policy

Cervical cancer is a disease of inequity, affecting mostly women and people with a cervix who do not have access to the human papillomavirus (HPV) vaccination and cervical screening (mostly within resource limited settings but also evident in some high-income countries). In recognition of the importance to alleviate undue and preventable suffering and mortality, the World Health Organization (WHO) released a global strategy to accelerate the elimination of cervical cancer as a public health concern, calling on all countries to achieve the elimination threshold of four or less cases per 100,000 'women' (to use their wording; World Health Organization, 2020). Ongoing commitment to cervical screening is a fundamental part of this strategy.

In Australia, cervical cancer's incidence rate is relatively low (6.5 cases per 100,000 people with a cervix) (NHMRC Centre of Research Excellence in Cervical Cancer Control, 2022), which is, in part, due to the implementation of a National Cervical Screening Program (NCSP) since 1991 (Hall et al., 2019). While Australia could reach the WHO elimination targets if current screening rates continue, populations who experience the greatest barriers to healthcare will not benefit from Australia's elimination efforts, including gender and sexuality diverse people, Aboriginal and Torres Strait Islander peoples, some culturally and linguistically diverse people, people living in rural and remote areas, people with disability/ies, and people of low socioeconomic status – as well as their intersections (that is, how gender and/or sexuality intersects with other aspect of a person's identity, such as race, class, ethnicity, etc.), which are often less visible in health research in general (Curmi et al., 2016; Kerr et al., 2022; Yu et al., 2022). In particular, gender and sexuality diverse people with a cervix have been historically invisible with health promotion centring the audience of concern for cervical screening as ‘women’, leading to reduced awareness of, and access to, screening compared to heterosexual cisgender women (Gibson et al., 2021; Newman et al., 2021; Peitzmeier et al., 2014; Potter et al., 2015). Trans men, in particular, have reported notably lower cervical cancer screening rates than other populations who are eligible for this screening (Dutton et al., 2020; Peitzmeier et al., 2014). Furthermore, the idea that lesbian women are at lower risk of cervical cancer persists among some healthcare providers (Mooney-Somers et al., 2019) despite their identification as women.

In Australia’s national program, there have been significant policy and guidelines changes: the first was the transition from two-yearly Papanicolaou testing (commonly referred to as the Pap Smear) to five-yearly HPV testing in December 2017; and the second was the transition from restricted to universal access for self-collection cervical screening in July 2022. Self-collection is highly acceptable in a diverse range of settings for different populations and is expected to increase screening participation in Australia (Camara et al., 2021; Creagh et al., 2021; Saville et al., 2018).

Key shifts in language within the broader policy context in which the national program operates demonstrate that language in cervical screening health policy is not universal. For example, the terms ‘women’ and ‘girls’ were predominantly used throughout the WHO global strategy (World Health Organization, 2021). Australia’s policy announcement about increasing access to self-collection for screening referred to ‘women’, ‘people eligible for a cervical screening’ and ‘people with a cervix’ interchangeably (Australian Government Department of Health, 2021), while the national program and affiliated websites refer to the policy change towards universal access to self-collection using an array of terminology such as ‘women’, ‘people’, ‘patients’, and ‘women and people with a cervix’ (Australian Government Department of Health and Aged Care, 2019; ‘Landmark Changes Improving Access to Life Saving Cervical Screenings,’ 2021). In contrast, the National Strategy for the Elimination of Cervical Cancer in Australia uses ‘eligible people’ and ‘women and people with a cervix’ almost exclusively (Australian Centre for the Prevention of Cervical Cancer, 2023). The clear lack of consistency in the terminology used across these key policy documents and domains, may reflect different jurisdictions’ linguistic preferences including using language that resonates most with the target audience for policies.

This moment of change in cervical screening policy in Australia presents a timely opportunity to explore the contemporary shift towards inclusive language in health policy. In this article, we ask: what do key stakeholders variously involved in cervical screening perceive the role of inclusive language to be in health policy?

Methods

We conducted a targeted qualitative study of the role and impact of, and decision-making processes for, inclusive language in cervical screening policy, promotion, and delivery in the context of the NCSP in Australia. Potential key informants were identified through the research team’s professional networks, as well as participant snowball sampling, which enabled recruitment of a wide range of professional experts who could speak to the changes in health policy and promotion in cervical screening in Australia, and the delivery of cervical screening to various eligible and/or currently underscreening populations. Purposive sampling processes were employed to invite key stakeholders across all but one Australian States and Territories, including a mix of metropolitan, regional, rural and remote locations, in professional roles such as generalist clinicians (nurses and doctors) in women's health (including obstetrics/gynaecology), cancer prevention (both government and non-government organisations), as well within organisations serving specific populations (Aboriginal and Torres Strait Islander peoples, gender and/or sexuality diverse people, people with a disability, rurally-based or geographically isolated women, and some culturally and linguistically diverse communities). Potential participants were emailed an invitation to an interview, with a Participant Information Statement and Consent Form containing details about the study attached, which detailed who was conducting and funding the study, and what participation in the study entailed (interview, anticipated length of time, etc.). Written or verbal consent was collected at the outset of each interview. No incentive was offered for participation in an interview. Recruitment was ceased once 'incoming data points (interviews) produce little or no new useful information relative to the study objectives' (Guest et al., 2020) which was retrospectively determined through consideration of sampling, data collection and analysis processes (Saunders et al., 2018), with most locations, domains and specialities represented.

Interviews were conducted by the first two authors, and the interview schedule covered topics such as key informants' previous involvement in the national program, their views on the role of language across community, clinical and policy domains, their experience in considering or implementing inclusive language in their work, and recommendations for future policy development. Interviews were recorded and transcribed verbatim. Transcripts were thematically coded using qualitative software (QSR NVivo version 12) using inductive thematic analysis (Terry et al., 2017). Specifically, analysis of the interviews was conducted by the first two authors, who met regularly throughout data collection to discuss emerging themes. A coding framework was then developed by the first author, which included both descriptive and discursive (that is, underlying meanings that informed descriptive accounts), which was reviewed by the research team and further insight incorporated. Provisional themes were refined through a process of open thematic mapping and repeated re-examination of the data and subsequently refined themes retested against the data. Data used for this article were primarily taken from coding nodes on the role of language in policy domains and the implications of inclusive language for future policy development to respond to the question of what inclusive language in policy looks like and what is its function. To protect the anonymity of key informants, broad categories are used to describe the domain of expertise in the sample (cancer policy, health promotion, healthcare delivery, and population group advocacy). Ethical approval was provided by the UNSW Human Research Ethics Committee (UNSW HC220031).

Findings

A total of 28 semi-structured interviews were conducted with 29 people (one interview was conducted with two key informants from the same organisation) between April and October 2022, each interview lasting between 31 and 56 minutes in length (median 46 minutes). Key informants provided diverse professional perspectives on the role of language in health policy, promotion and education, and healthcare delivery with respect to cervical screening. In particular, key informants were asked their views on the varied phrasing of ‘women’, ‘women and people with a cervix’, and ‘people with a cervix’ (Table 1).

Three themes were identified that captured what key informants believed to be the function of inclusive language in cervical screening policy.

The common goal of inclusive language as advocacy for broader inclusivity

When asked which phrase (‘women’, ‘women and people with a cervix’, and ‘people with a cervix’) is more accurate and acceptable, the majority of key informants preferred the

Table 1. Key informants.

Characteristic	Total ($n = 29$)
Domain of professional expertise	
Cancer policy	8 (28%)
Health promotion	5 (17%)
Healthcare delivery, incl cervical screening	9 (31%)
Population group advocacy	7 (24%)
Age	
20–29 years	3 (10%)
30–39 years	4 (14%)
40–49 years	6 (21%)
50–59 years	6 (21%)
60+ years	10 (34%)
Gender	
Woman (cis and trans)	25 (86%)
Man (cis and trans)	2 (7%)
Non-binary	2 (7%)
Sexuality	
Heterosexual	15 (52%)
Gay/Lesbian	8 (28%)
Bisexual	0 (0%)
Queer/Pansexual	4 (14%)
Not specified/preferred not to say	2 (7%)
Indigenous status	
Aboriginal and/or Torres Strait Islander	3 (10%)
Not Aboriginal or Torres Strait Islander	26 (90%)
Country of birth	
Australia	21 (72%)
Other	7 (24%)
Not specified/preferred not to say	1 (3%)
State of residence	
New South Wales	10 (34%)
Victoria	10 (34%)
Tasmania	3 (10%)
Western Australia	2 (7%)
Northern Territory	2 (7%)
Australian Capital Territory	1 (3%)
Queensland	1 (3%)
South Australia	0 (0%)
Rurality of residence	
Metropolitan	18 (62%)
Regional	5 (17%)
Rural	3 (10%)
Remote	3 (10%)

phrase ‘women and people with a cervix’. Yet, in further exploring the reason for this preference, there was clear recognition that differences in language used in diverse policy, medical/clinical and community health domains associated with cervical screening meant that language could never be used uniformly or universally in all contexts. For instance, of the key informants who explicitly voiced opposition to the phrasing ‘people with a cervix’ (i.e. gender-neutralisation) to identify the key population for cervical screening, their concerns centred on the difficulty in translating ‘cervix’ to lay publics:

> People with a cervix is not plain English, it just isn’t, it won’t translate very well so my personal view is we shouldn’t use it on its own, we should use ‘women and people with a cervix’ in order to get the best balance as we can, as clunky as that sounds. (Interview 2 – cancer policy)

The phrase ‘women and people with a cervix’, however, was seen to resolve those concerns. Despite those specific concerns over phrasing, inclusive language was recognised as an important principle to be upheld in health policy. Specifically, language was seen to matter significantly in policy development, health promotion and advocacy, and healthcare delivery, with policy, especially, needing to reflect contemporary language usage:

> Yeah, so, like, language is important, absolutely, because language tells a story of where the policy […] is currently sitting. (Interview 12 - population group advocacy)

For some working in healthcare delivery and population group advocacy, the aim of inclusive health policy was to be responsive to broader conversations around gender diversity that were taking place in community at the same time. These key informants perceived that inclusive language is ‘becoming an urgent conversation for the sector, and I think that people are realising that, yeah, that if they haven’t had this conversation internally that they kind of have to and it’s overdue’ (Interview 17 – healthcare delivery). For others working in cancer prevention policy and promotion, the need for inclusive language reflected a longer process of organisational change as part of its long-standing commitment to inclusivity:

> It seems to have dripped in, in a fairly sort of slow drip way, over quite a long period of time and that it’s just being something that’s being talked about within the organisation, you know, with the obvious need and want to be inclusive, and how best we can do that. (Interview 2 - cancer policy)

However, the specifics of what inclusive language entails was subject to ongoing discussion, which is indicative of the complexity of the issue and the continued need for negotiation. This negotiation continually took place despite attempts to standardise protocols for inclusive language:

> But the discussion about whether it should be people with the cervix or whether it should be women, [it] doesn’t matter how many times you lock it in, it [the conversation] keeps coming up. (Interview 1 - cancer policy)

At the same time, for those tasked with developing health policy, there was a recognised need for concerted, deliberate efforts to ensure that policy development processes accurately and responsibly reflect inclusivity:

> Then, you know, we thought about it and then we thought we really should change the wording and we started to look for opportunities to do that. (Interview 2 - cancer policy)

But, as this key informant continued, these efforts should be collectively realised and implemented ‘in parallel with other organisations and other individuals’.

Whether the need for inclusive language was in response to current debates or reflecting the longstanding values of organisations, there was broad agreement that inclusive language was a positive change in health policy. One such representative quote of this agreement saw this recognition as a ‘common goal’ of the sector in the wider commitment to effective health promotion in which inclusive language was just one strategy amid others to achieve this aim:

> And that is using appropriate language, using appropriate spokespeople and trusted sources of information and really taking a strength-based approach for engagement and also, you know, hopefully driving the desired health behaviour. (Interview 13 - healthcare promotion)

Leadership by policy domains was underpinned by the recognition that this moment represents a timely opportunity to embed inclusive language as a general function of good health policy:

> We should go for gold. We need to go from the top from guidelines/policy downwards. We need to keep doing this until it is everybody’s business that we are inclusive. (Interview 1 - cancer policy)

As such, inclusive health policy in the context of cervical screening was recognised as an awareness of, and responsiveness to, all under screened populations:

> I see no reason why that [inclusive language] framework wouldn’t also be worked if one of the goals is to end up with guidelines that are inclusive and meet the needs of various groups and in particular priority populations for our program and priority populations. (Interview 5 - healthcare delivery)

Health policy as advocacy for people historically excluded from such documents, then, was seen as the proper function of inclusive language in health, framed in terms of health equity:

> I would remind policymakers that including minoritized vulnerable people really doesn’t impact on anyone else’s capacity or ability to access health care and that our services are made only ever stronger by being inclusive and affirming. That’s all that people need to remember. (Interview 12 - population group advocacy)

This form of policy advocacy was described as borne from the need to expand language to reflect the diverse needs of under screened populations that may not be currently reflected in the national cervical screening program. The principles of diversity should form part of the rationale for expanding language, which was ‘not the need to remove anything language wise, but to add’ (Interview 12 – population group advocacy). Additive language included terminology that reflected other under-screened populations, rather than simply remove the historical primacy of cisgender women as the intended targets of cervical screening (e.g. ‘women and people with a cervix’). At the same time, an ever-expanding additive approach risks being ‘its political correctness gone mad’ (interview 2 – cancer policy) and points to the difficulty of implementation, translation, and interpretation.

Despite these concerns, key informants perceived policy as well positioned to enact this change in language ahead of the wider sector, especially given the elevated role of health policy as guiding social change:

> I just think with the change of language, it takes a long time, a long time for people to get used to and I think the more we say it, the more we talk about it, the better that is going to be for us to get used to the language, but also it will become normal and such an everyday thing, and half the time we won't realize the influence we are having on people that we are actually making them comfortable and included in our services. (Interview 7 - healthcare delivery)

In taking a principled position to promote inclusivity, policy makers were seen to be positioned to advocate for changes in language to reflect the addition of otherwise invisible or under screened populations, at the same time as retaining 'women' as one primary population group of cervical screening services. As such, 'women and people with a cervix' was seen to balance those competing demands for inclusion to mitigate against the inadvertent erasure of women.

The inevitable partiality of inclusive language health policy as opportunity

There was also broad recognition that policy was a slow instrument to change. Despite the 'cumbersome' nature of policy that has 'lagged behind social change pretty much in all cases for a long time' (Interview 9 – healthcare delivery), there was a clear imperative to ensure language was always a consideration in policy instruments:

> So, I actually think that the pressure will continue to be on policymakers and then the policy makers need to be able to decide at what level implementation is going to look like and where the priority is going to be, but I think that it needs to be, you know … steps that keep happening. (Interview 12 - population group advocacy)

Indeed, as this key informant continued, policy offered a more 'expansive' domain that was less constrained by the politics of the time:

> I would say that for policy settings being expansive, particularly for things like this, means that implementation will be more related to the policy than the politics. (Interview 12 - population group advocacy)

Accordingly, key informants asserted policy should lead the debate, 'but if we wait for that before we do anything it will be 20 years, so I think we would need that representation [now]' (Interview 5 – healthcare delivery).

The perceived imperative for policy to act on this issue promoted the need for policy 'agility', as one key informant termed it (Interview 1 – cancer policy), in responding to opportunities to reflect on language as the need arises:

> I mean language changes so quickly, it's hard to keep up, but it's not impossible. (Interview 9 - healthcare delivery)

However well-intentioned policy advocacy was in response to community-led change, there was also broad recognition of health policy's partiality in ever capturing social change at the community level:

> You know you're always creating materials and then when about two years, there's change, and you go 'oh we've got to change it all over again'. (Interview 1 - cancer policy)

As such, part of policy's agility means having to revisit decisions made at the organisational level, which presents challenges to the ongoing relevance and timeliness of its implementation.

According to key informants, fast-faced changes in community contexts meant that policy requires constant revision and new policy developed to replace those out of date, and so there was the perception that policy could only ever be partial in reflecting change accurately and in a timely manner. However, its partiality was also seen as an inherent aspect of policy development itself:

> But, you know, this organisation knows as well as any that no organisational strategy is set in stone. Like you are not beholden to nothing, like just because you have written it down you can change it. So, they know that because they do it all the time. (Interview 17 - population group advocacy)

Rather than avoiding or mitigating the partiality of policy, key informants were clear that this partiality represented opportunities for continuous change so long as the principles underpinning inclusive healthcare design and provision remain. It is these principles that ensure that policy change is beneficial even if 'mistakes' are made at the time:

> I think the challenges are that we are going to make mistakes and we don't have the appetite to do that. I think, broadly, we are at the stage where people are so worried about getting things right that they are not prepared to try things and potentially get them wrong. But my perspective is that if you have well-planned and well-researched initiatives that then don't go to plan, it's actually worth learning that lesson. And in the principles of doing no harm, I think if it's well planned and well researched, you are unlikely to do harm. (Interview 12 - cancer policy)

Accordingly, the inherent partiality of health policy itself was seen as valuable in the way it can prompt 'conversations' (Interview 15 – population group) within the sector. Indeed, the inevitable partiality of health policy was entangled within broader social change, and progress in the policy domain offered a way forward for the entire health sector:

> Well, I think the guidelines are foundational guidelines and I think we can push the envelope a bit further faster in the guidelines and expect the medical community and the nursing community and all the health professionals to get their heads around it, right. It's not a big ask. (Interview 5 - healthcare delivery)

Key informants in this study recognised that language was changing continuously, and that policy could only ever reflect what inclusive language is acceptable in particular times or places. However, policy's elevated position as advocate for inclusivity meant that it had to grapple with the inevitable partiality. Rather than see this as a constraint, key informants generally saw this drive towards inclusivity (and the difficulty of its implementation) as an opportunity to drive widespread change.

Policy as a bridge between essential but diffuse components of the health sector

There was less consensus among key informants as to the extent to which health policy drives greater inclusivity in non-health related domains. Opportunities for change were largely framed in terms of a community-led groundswell, where policy change was guided by change experienced downstream:

> So, I think policy should be guided by what's happening on the ground, you know, what patients are telling us here and now about their needs about the language in the community at the moment. (Interview 9 - healthcare delivery)

At the same time, there was also recognition of the influence that policy has in guiding political change upstream:

> Whereas I think if we can have influence [on] our leaders and influence the policymakers and influence the environment that is the leadership. (Interview 1 - cancer policy)

Moreover, key informants positioned health policy as a bridge between community advocacy around inclusion and medical professionals who were tasked with carrying out policy imperatives because 'leading that professional practice is going to be critical just as it is increasing community visibility in that space as well as policy connections between them' (Interview 14 – health promotion).

Policy's function is a careful balance of responding to community needs and instigating changes over time. However, the difficulty was getting the strength of advocacy right:

> So that's a difficult thing, but I really think that we keep plugging it in, so there is some change overall, we start to see it in written press; we start to get those conversations started, but not to the point where people just go 'oh shut up, it represents such a small … ', you know? Not everybody needs that language to change and they might come on board if we're not a thorn in their side and just irritating. (Interview 1 - cancer policy)

This required key informants to see the value of their contribution in the wider health promotion landscape. But these opportunities also require careful rationale for change because there was clear acknowledgement that the process of translating community needs into evidence-based policy change must be done with expertise. As one key informant explained, policy functioned as a bridge between multiple forms of 'subject matter expertise':

> So, we have multicultural advisors in [policy organisation], and we have, you know, we have a big contract with [LGBTQ + community health organisation] on a place-based sort of funding agreement with them. We have an Aboriginal team and Equity team, so we kind of gather all of them to help us and then we insert that at a national level. (Interview 1 - cancer policy)

For policy to function as advocate for the broad principles of inclusive language, policy processes need to recognise the value that policy makers themselves bring to the 'cycle' of policy development, implementation and evaluation:

> A lot of the kind of policy directive and advocacy from us, and the different sorts of submissions we've made at different times, probably come from three places. Our interpretation of the evidence, our experience with community and community's participation in our kind of consultation mechanisms, so, and then also our own kind of lived expertise and lived experience. (Interview 12 - population group advocacy).

As just one case study of health promotion policy, cervical screening policy development within the context of the national program offered opportunities to reflect on other domains, in some ways functioning as the vanguard for further systematic change in wider cancer prevention and treatment:

> I don't think we can just change it at the cervical screening level and then have the non-inclusive language everywhere else. Do you know what I mean? Like I think if it's going to be used, it should be an all or nothing. (Interview 11 - population group advocacy)

Far from seeing policy as a stand-alone instrument to advocate for inclusivity key informants were acutely aware of the challenges in its implementation across diverse domains, such as clinical encounters and community health initiatives, with translation a key aspect of what key informants recognised as part of the 'policy cycle'. This meant being receptive and responses to other ways of articulating inclusivity in diffuse contexts – in effecting, being cognisant of both up- and down-stream opportunities for change.

Discussion

As findings demonstrate, inclusive language warrants consideration of the diverse settings and priorities between policy development, clinical engagement and community cultural specificity. Despite differences between the function of these settings, a principled commitment towards inclusivity drove many health policy deliberations, which served to bridge these domains – allowing top-down and bottom-up influences to be captured and disseminated. As described, the function of health policy was to advocate for greater inclusivity of all under-screened populations, of which gender diverse people were only one, albeit an intersectional, group. If policy is recognised as a form of advocacy for those historically excluded from health promotion targets (Brookfield, 2023), then policy is well positioned to enact change ahead of the wider sector, especially given the elevated role of health policy as responding to entrenched inequities. At the same time, there was clear recognition that inclusive language could only ever be partial given the fast-paced change within specific communities and social progress more generally. The partiality of policy was seen as inevitable, but it enabled broader, more far-reaching conversations on inclusivity to be had. And so while policy is not a static instrument, its 'black letter' formalisation (Lea, 2020) represents a written form of language that ultimately has a flow on to other modalities. As such, inclusive language within health policy developed in the context of cervical screening in Australia is simultaneously advocacy, partial and bridging – all of which served to operationalise equity in health policy with the aim of equitably eliminating cervical cancer in the Australian population. This, then, means that language matters greatly as a fundamental step in making visible the health needs and preferences of all people with a cervix.

While well-intentioned the drive towards greater inclusivity, complexity remains in its implementation (which remains outside the scope of this article). For example, key informants generally favoured the phrasing 'women and people with a cervix' (that is, as an additive strategy to achieve inclusivity), but also recognised that this may not be appropriate in all domains and represent all underscreening communities' cervical screening needs. Key informants widely recognised that this may indeed be a temporary language marker, which may shift over time as new needs and preferences are identified and implemented. In particular, those involved in health service delivery were adamant that ongoing training and translation were fundamental in the implementation of inclusive language practice (which then leads to questions about how to implement inclusive language policy into practice). Regardless of complexities of implementation and practice, key informants were clear that policy was in the best position to advocate and model the principle of inclusivity to effect both up- and down-stream change.

Cervical cancer screening has been identified as a domain in need of intervention (World Health Organization, 2020), and the new policy announcement of self-collection is only one response to increase screening participation. At the same time, applying interventions developed for general populations to increase cancer screening without any modification for gender and/or sexuality diverse people has been proven both ineffective and inappropriate (Berger & Mooney-Somers, 2017). The existing evidence base on cancer screening interventions suggest that gender diverse communities prefer targeted interventions, however, targeting can mean either recruitment or adaptation of interventions to diverse communities, and there was considerable variety in these approaches (Drysdale et al., 2021). As such, inclusive language strategies can be seen in terms of targeting hereto now under screened populations by expanding the targeted audience from ‘women’ to ‘women *and* people with a cervix’ to better include gender diverse people. In this respect, key informants in this study saw that effective targeting needs to be accommodated in policy as its high-level role as advocacy for underscreening populations, else the ongoing exclusion of gender and sexuality diverse people will continue in practice.

Conclusion

Renewed efforts in cervical cancer elimination are a timely opportunity to chart discernible shifts in language, most evident in the use of gendered, gender-neutral and gender inclusive language in health policy. The continued explicit or implicit exclusion of gender and sexuality diverse people from public life has long reaching implications, given the way that language shapes policy in ways that normatively position certain people as included (and indeed worthy) of public citizenship (while their ongoing invisibility in policy works to exclude them from the domain of policy intervention). This in turn, filters into other domains, such as the access to and provision of healthcare. The policy announcement on self-collection for cervical screening can be seen as an indicative case study that is underpinned by the principles of inclusivity, which is, in part, responsive to the needs and preferences of gender and sexuality diverse people. It is important to note, however, that a crucial step in developing inclusive health policy is ensuring that language used reflects the preferences of people for whom policy is intended to serve.

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References

ACON. (2019). *A Language Guide: Trans and Gender Diverse Inclusion*. ACON: Sydney. Retrieved January 9, 2024, from https://www.acon.org.au/wp-content/uploads/2019/07/TGD_Language-Guide.pdf

Alvanoudi, A. (2020). Indexing gender, culture, and cognition: An introduction. *Journal of Language and Discrimination*, *4*(1), 1–15. https://doi.org/10.1558/jld.40948

Australian Centre for the Prevention of Cervical Cancer. (2023). *National Strategy for the Elimination of Cervical Cancer in Australia*. Australian Centre for the Prevention of Cervical Cancer.

Austrlian Bureau of Statistics. (2023). *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020 | Australian Bureau of Statistics*. (2023, September 21). Retrieved January 9, 2024, from https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release

Australian Government Department of Health. (2021, November 8). *Landmark changes improving access to life saving cervical screenings* [Text]. Australian Government Department of Health; Australian Government Department of Health. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/landmark-changes-improving-access-to-life-saving-cervical-screenings.

Australian Government Department of Health and Aged Care. (2019, September 5). *Who should get a Cervical Screening Test* [Text]. Australian Government Department of Health and Aged Care; Australian Government Department of Health and Aged Care. https://www.health.gov.au/initiatives-and-programs/national-cervical-screening-program/getting-a-cervical-screening-test/who-should-get-a-cervical-screening-test.

Baum, F. E., Bégin, M., Houweling, T. A., & Taylor, S. (2009). Changes not for the fainthearted: Reorienting health care systems toward health equity through action on the social determinants of health. *American Journal of Public Health*, *99*(11), 1967–1974. https://doi.org/10.2105/AJPH.2008.154856

Berger, I., & Mooney-Somers, J. (2017). Smoking cessation programs for lesbian, gay, bisexual, transgender, and intersex people: A content-based systematic review. *Nicotine & Tobacco Research*, *19*(12), 1408–1417.

Bias-free language. (n.d.). https://Apastyle.Apa.Org. Retrieved March 20, 2023, from https://apastyle.apa.org/style-grammar-guidelines/bias-free-language.

Boehmer, U., Miao, X., & Ozonoff, A. (2011). Cancer survivorship and sexual orientation. *Cancer*, *117*(16), 3796–3804. https://doi.org/10.1002/cncr.25950

Botelle, R., Connolly, D., Walker, S., & Bewley, S. (2021). Contemporary and future transmasculine pregnancy and postnatal care in the UK. *The Practising Midwife*, *24*(5), 8–13. https://doi.org/10.55975/FOYH6276

Braveman, P. A., Kumanyika, S., Fielding, J., LaVeist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: The issue is justice. *American Journal of Public Health*, *101*(S1), S149–S155. https://doi.org/10.2105/AJPH.2010.300062

Brookfield, S. (2023). What isn't public health? *Journal of Public Health Policy*. https://doi.org/10.1057/s41271-023-00404-x

Camara, H., Zhang, Y., Lafferty, L., Vallely, A. J., Guy, R., & Kelly-Hanku, A. (2021). Self-collection for HPV-based cervical screening: A qualitative evidence meta-synthesis. *BMC Public Health*, *21*(1), 1503. https://doi.org/10.1186/s12889-021-11554-6

Cooper, R. L. (1989). *Language planning and social change*. Cambridge University Press.

Creagh, N. S., Zammit, C., Brotherton, J. M., Saville, M., McDermott, T., Nightingale, C., & Kelaher, M. (2021). Self-collection cervical screening in the renewed National Cervical Screening Program: A qualitative study. *Medical Journal of Australia*, *215*(8), 354–358. https://doi.org/10.5694/mja2.51137

Curmi, C., Peters, K., & Salamonson, Y. (2016). Barriers to cervical cancer screening experienced by lesbian women: A qualitative study. *Journal of Clinical Nursing*, *25*(23-24), 3643–3651. https://doi.org/10.1111/jocn.12947

Dahlen, S. (2021). Do we need the word 'woman' in healthcare? *Postgraduate Medical Journal*, *97*(1150), 483–484. https://doi.org/10.1136/postgradmedj-2021-140193

Davis, S. (2022). Inclusivity starts with language – Author's reply. *The Lancet*, *399*(10323), 435–436. https://doi.org/10.1016/S0140-6736(21)02504-6

Doyal, L. (1996). The politics of women's health: Setting a global agenda. *International Journal of Health Services*, *26*(1), 47–65. https://doi.org/10.2190/U7PN-B17E-JQBL-MRG4

Doyle, M. (1998). Introduction to the AZ of non-sexist language. *The Feminist Critique of Language: A Reader*, *2*, 149–154.

Drysdale, K., Cama, E., Botfield, J., Bear, B., Cerio, R., & Newman, C. E. (2021). Targeting cancer prevention and screening interventions to LGBTQ communities: A scoping review. *Health & Social Care in the Community*, *29*(5), 1233–1248. https://doi.org/10.1111/hsc.13257

Dutton, T., Marjoram, J., Burgess, S., Montgomery, L., Vail, A., Callan, N., Jacob, S., Hawkes, D., Saville, M., & Bailey, J. (2020). Uptake and acceptability of human papillomavirus self-sampling in rural and remote aboriginal communities: Evaluation of a nurse-led community engagement model. *BMC Health Services Research*, *20*(1), 398. https://doi.org/10.1186/s12913-020-05214-5

Erdocia, I. (2022). Participation and deliberation in language policy: The case of gender-neutral language. *Current Issues in Language Planning*, *23*(4), 435–455. https://doi.org/10.1080/14664208.2021.2005385

Fforde, C., Bamblett, L., Lovett, R., Gorringe, S., & Fogarty, B. (2013). Discourse, deficit and identity: Aboriginality, the race paradigm and the language of representation in contemporary Australia. *Media International Australia*, *149*(1), 162–173. https://doi.org/10.1177/1329878X1314900117

Garad, R. M., Bahri-Khomami, M., Busby, M., Burgert, T. S., Boivin, J., & Teede, H. J. (2023). Breaking boundaries: Toward consistent gender-sensitive language in sexual and reproductive health guidelines. *Seminars in Reproductive Medicine*, *41*(1/2), 5–11. https://doi.org/10.1055/s-0043-1777323

Gibson, A. F., Drysdale, K., Botfield, J., Mooney-Somers, J., Cook, T., & Newman, C. E. (2021). Navigating trans visibilities, trauma and trust in a new cervical screening clinic. *Culture, Health & Sexuality*, 1–14. https://doi.org/10.1080/13691058.2021.1952307

Gribble, K. D., Bewley, S., Bartick, M. C., Mathisen, R., Walker, S., Gamble, J., Bergman, N. J., Gupta, A., Hocking, J. J., & Dahlen, H. G. (2022). Effective communication about pregnancy, birth, lactation, breastfeeding and newborn care: The importance of sexed language. *Frontiers in Global Women's Health*, *3*, 818856.

Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLoS One*, *15*(5), e0232076. https://doi.org/10.1371/journal.pone.0232076

Hall, M. T., Simms, K. T., Lew, J.-B., Smith, M. A., Brotherton, J. M., Saville, M., Frazer, I. H., & Canfell, K. (2019). The projected timeframe until cervical cancer elimination in Australia: A modelling study. *The Lancet Public Health*, *4*(1), e19–e27. https://doi.org/10.1016/S2468-2667(18)30183-X

Kerr, L., Fisher, C. M., & Jones, T. (2022). Improving cervical screening in trans and gender-diverse people. *Cancer Nursing*, *45*(1), 37–42. https://doi.org/10.1097/NCC.0000000000000890

Lakoff, R. (1973). Language and woman's place. *Language in Society*, *2*(1), 45–80. https://doi.org/10.1017/S0047404500000051

Landmark Changes Improving Access to Life Saving Cervical Screenings. (2021). *Greg Hunt MP*. https://www.greghunt.com.au/landmark-changes-improving-access-to-life-saving-cervical-screenings/.

Lea, T. (2020). *Wild policy: Indigeneity and the unruly logics of intervention*. Stanford University Press.

LGBTIQA+ inclusive language guide. (2023, October 27). https://www.vic.gov.au/inclusive-language-guide.

MacDonald, T. K. (2019). Lactation care for transgender and non-binary patients: Empowering clients and avoiding aversives. *Journal of Human Lactation*, *35*(2), 223–226. https://doi.org/10.1177/0890334419830989

Miyagi, M., Guthman, E. M., & Sun, S. (e) D.-K. (2021). Transgender rights rely on inclusive language. *Science*, *374*(6575), 1568–1569.

Mooney-Somers, J., Deacon, R. M., Scott, P., Price, K., & Parkhill, N. (2019). *Women in contact with the Sydney LGBTQ communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018*. University of Sydney, ACON.

Moore, D., & Meads, C. (2013). *Breast cancer in lesbians and bisexual women: Systematic review of incidence, prevalence and risk studies.*

Moseson, H., Zazanis, N., Goldberg, E., Fix, L., Durden, M., Stoeffler, A., Hastings, J., Cudlitz, L., Lesser-Lee, B., Letcher, L., Reyes, A., & Obedin-Maliver, J. (2020). The imperative for transgender and gender nonbinary inclusion. *Obstetrics and Gynecology*, *135*(5), 1059–1068. https://doi.org/10.1097/AOG.0000000000003816

Newman, C. E., Smith, A. K. J., Duck-Chong, E., Vivienne, S., Davies, C., Robinson, K. H., & Aggleton, P. (2021). Waiting to be seen: Social perspectives on trans health. *Health Sociology Review*, *30*(1), 1–8. https://doi.org/10.1080/14461242.2020.1868900

Nhmrc Centre of Research Excellence in Cervical Cancer Control. (2022). *Cervical Cancer Elimination Progress Report: Australia's progress towards the elimination of cervical cancer as a public health problem* (p. Melbourne, Australia). https://www.cervicalcancercontrol.org.au.

Østergaard Møller, M., & Sommer Harrits, G. (2013). Constructing at-risk target groups. *Critical Policy Studies*, *7*(2), 155–176. https://doi.org/10.1080/19460171.2013.799880

Peitzmeier, S. M., Khullar, K., Reisner, S. L., & Potter, J. (2014). Pap test use is lower among female-to-male patients than non-transgender women. *American Journal of Preventive Medicine*, *47*(6), 808–812. https://doi.org/10.1016/j.amepre.2014.07.031

Pendleton, J. (2022). (En) Gendering the word 'midwife': Semantics, etymology and orientations. *Journal of Gender Studies*, *31*(5), 560–572. https://doi.org/10.1080/09589236.2021.1952406

Potter, J., Peitzmeier, S. M., Bernstein, I., Reisner, S. L., Alizaga, N. M., Agénor, M., & Pardee, D. J. (2015). Cervical cancer screening for patients on the female-to-male spectrum: A narrative review and guide for clinicians. *Journal of General Internal Medicine*, *30*(12), 1857–1864. https://doi.org/10.1007/s11606-015-3462-8

Pratt-Chapman, M. L., Eckstrand, K., Robinson, A., Beach, L. B., Kamen, C., Keuroghlian, A. S., Cook, S., Radix, A., Bidell, M. P., & Bruner, D. (2022). Developing standards for cultural competency training for health care providers to care for lesbian, gay, bisexual, transgender, queer, intersex, and asexual persons: Consensus recommendations from a national panel. *LGBT Health*, *9*(5), 340–347. https://doi.org/10.1089/lgbt.2021.0464

Quinn, G. P., Sanchez, J. A., Sutton, S. K., Vadaparampil, S. T., Nguyen, G. T., Green, B. L., Kanetsky, P. A., & Schabath, M. B. (2015). Cancer and lesbian, gay, bisexual, transgender/transsexual, and queer/questioning (LGBTQ) populations. *CA: A Cancer Journal for Clinicians*, *65*(5), 384–400. https://doi.org/10.3322/caac.21288

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Saville, M., Hawkes, D., Mclachlan, E., Anderson, S., & Arabena, K. (2018). Self-collection for under-screened women in a national cervical screening program: Pilot study. *Current Oncology*, *25*(1), 1. https://doi.org/10.3747/co.25.3915

Sczesny, S., Formanowicz, M., & Moser, F. (2016). Can gender-fair language reduce gender stereotyping and discrimination? *Frontiers in Psychology*, *7*, 1–25. https://doi.org/10.3389/fpsyg.2016.00025

Silver, A. (2019). Birth beyond the binary| AIMS. *AIMS Journal*, *31*(2), 15–18.

Stout, J. G., & Dasgupta, N. (2011). When he doesn't mean you: Gender-exclusive language as ostracism. *Personality and Social Psychology Bulletin*, *37*(6), 757–769. https://doi.org/10.1177/0146167211406434

Stroumsa, D., & Wu, J. P. (2018). Welcoming transgender and nonbinary patients: Expanding the language of "women's health.". *American Journal of Obstetrics and Gynecology*, *219*(6), 585.e1–585.e5. https://doi.org/10.1016/j.ajog.2018.09.018

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. *The SAGE Handbook of Qualitative Research in Psychology*, *2*, 17–36. https://doi.org/10.4135/9781526405555.n2

United Nations. (n.d.). *UNITED NATIONS Gender-inclusive language*. Retrieved November 2, 2022, from https://www.un.org/en/gender-inclusive-language/guidelines.shtml.

Ussher, J. M., Ryan, S., Power, R., & Perz, J. (2023). Almost invisible: A review of inclusion of LGBTQI people with cancer in online patient information resources. *Patient Education and Counseling*, *114*, 107846. https://doi.org/10.1016/j.pec.2023.107846

World Health Organization. (2020). *Global strategy to accelerate the elimination of cervical cancer as a public health problem* (Licence: CC BY-NC-SA 3.0 IGO.). World Health Organization. https://www.who.int/publications/i/item/9789240014107.

World Health Organization. (2021). *WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention*. https://www.who.int/publications-detail-redirect/9789240030824.

Yu, X. Q., Feletto, E., Smith, M. A., Yuill, S., & Baade, P. D. (2022). Cancer incidence in migrants in Australia: Patterns of three infection-related cancers. *Cancer Epidemiology, Biomarkers & Prevention*, *31*(7), 1394–1401. https://doi.org/10.1158/1055-9965.EPI-21-1349

Zampini, G. F. (2018). Evidence and morality in harm-reduction debates: Can we use value-neutral arguments to achieve value-driven goals? *Palgrave Communications*, *4*(1), 62. https://doi.org/10.1057/s41599-018-0119-3

Zimman, L. (2017). Transgender language reform: Some challenges and strategies for promoting trans-affirming, gender-inclusive language. *Journal of Language and Discrimination*, *1*(1), 84–105. https://doi.org/10.1558/jld.33139