Gender Inclusive Language in Perinatal Services:

Mission Statement and Rationale

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1.0   Introduction: Perinatal Care at Brighton and Sussex University Hospital NHS Trust

1.1. Significance of the Perinatal Period

Pregnancy, birth and parenting have a profound impact on an individual's life. At Brighton and Sussex University Hospitals NHS Trust (BSUH), we recognise the importance of providing compassionate, holistic and culturally safe antenatal, intrapartum and postnatal care. This care is founded on a respect for the unique psychological, physiological, and social needs of each individual. Within our care, we honour and uphold the right to self-determination and bodily autonomy for all people. We are especially proud of the care we provide for transgender (trans) and non-binary (including agender, bigender and genderqueer) people as birthing parents and co-parents.

We understand that the childbearing continuum is a period of significant vulnerability and growth, and we value all the intersecting identities that contribute to a person's experience of this, including but not limited to race, gender identity, sexuality, age, religion and ability. The lives of people experiencing multiple, intersecting marginalities on the basis of their unique identities are especially in need of the inclusive, respectful and individualised care that midwives and fellow health professionals offer.

1.2. Professional Responsibilities

As professionals, and as an organisation, we have a responsibility to promote good health. We do this not only through quality care, but also by creating policies and developing service provision that contributes to societal and cultural progress, promoting tolerance and equity, whilst striving to eliminate discrimination, prejudice and stigma (International Confederation of Midwives (ICM), 2014; Royal College of Nursing (RCN), 2017; The World Professional Association for Transgender Health (WPATH), 2012; General Medical Council (GMC) 2018).

This approach requires that health policy and programmes prioritise the needs of those furthest behind towards greater equity. Research shows that trans and non-binary people experience poorer mental and physical health than the general population (House of Commons Women and Equalities Committee (HoCWEC), 2016; Vincent, 2018; McNeill et al, 2012). Those who also identify as Black, Asian or Minority Ethnic (BAME) or disabled experience reinforced inequalities. This is especially pronounced when looking at the social determinants of health such as housing, employment, social acceptance, discrimination/transphobia, legal status and rights (HoCWEC, 2016). We acknowledge that those with marginalised identities may have greater difficulty accessing our services, including trans and non-binary people, and this in turn contributes to health inequalities within these communities.

1.3. Health and Social Inequalities

Social disadvantage and marginalisation contribute to poorer health outcomes, as do barriers to quality healthcare.

Examples of these specific barriers for trans and non-binary people in perinatal care include:
- Discriminatory policies, service provision and language;
- Overt or implicit discrimination within the delivery of health service;
- Concerns about whether healthcare professionals will understand a person's specific identity, needs and concerns (British Association for Sexual Health and HIV (BASHH), 2019; McNeil et al, 2012);
- The health care setting itself, which can present a risk of heightened exposure to human rights abuses (World Health Organisation (WHO), 2017) and;
- The heavily gendered nature of perinatal care.

1.4. Service Improvement

It is within our power as midwives, as obstetricians, and as an organisation to make continual improvements to our services, practices and policies towards the fulfilment of human rights (WHO, 2017).

This is known as 'progressive realisation' and is congruent with NHS guidance which advocates services taking additional steps in order to overcome, and reverse, the effects of previous exclusion or marginalisation on trans and non-binary people (Department of Health (DoH), 2008). The result is perinatal services that are available, accessible and acceptable to the trans and non-binary community, fulfilling our professional, statutory and ethical responsibility to address health inequalities in marginalised populations.

2.0 Legal Frameworks in Relation to Perinatal Care

Considerable legislation already provides explicit protection and rights for trans people.

2.1. Human Rights Act

The Human Rights Act 1998 protects and upholds the rights of trans people in the same way as for all citizens.

2.2. Equality Act

The Equality Act 2010 prohibits discrimination, harassment and victimisation of trans people in the workplace and in wider society. It is designed to ensure people with certain 'protected characteristics' are not disadvantaged or subjected to unwanted conduct because of that characteristic. Public bodies (such as local authorities and NHS trusts) have an active duty to eliminate discrimination, harassment, and victimisation of

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anyone who is protected under the Act, and foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

'Gender reassignment' is one of the nine protected characteristics under the Equality Act. It covers anyone who is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning their sex by changing physiological or other aspects of sex.

For perinatal services, it is important to note the broad definition of 'gender reassignment' in the Equality Act - implying that a person does *not* need to have formally changed their name or gender marker, be under medical supervision, or have had any hormonal or surgical treatments to be considered as having the protected characteristic (BASHH, 2019).

In addition, the Equality Act protects people associated with those who have protected characteristics from the same discrimination. For example, it would protect a cisgender (cis) person who is partnered with a trans or non-binary person, regardless of who is pregnant.

The Equality and Human Rights Commission particularly recommend that public bodies should take action wherever possible to include trans and non-binary people in the widest sense (DoH, 2008). In this context it is generally taken to mean unwanted conduct related to a protected characteristic that has the purpose or effect of violating someone's dignity or creating an intimidating, hostile, degrading, humiliating, or offensive environment for them. Harassment could include accidentally or intentionally misgendering a patient (BASHH, 2019).

2.3. Gender Recognition Act

The Gender Recognition Act 2004 enables binary trans people to apply to receive a Gender Recognition Certificate (GRC), which recognises that a person has satisfied the Act's criteria for legal recognition of the acquired gender. The GRC recognises the individual's acquired gender for all purposes in law from that moment forward.

It is important to note that a GRC is not required for people to change their sex or gender marker on most legal or identification documents, including NHS records. It is illegal for a care provider to ask if an individual has a GRC as a way of finding out about gender history (Galop, n.d.). Many trans and non-binary people do not have a GRC, and should be treated with the same respect regardless of GRC status.

2.4. Data Protection Act

The Data Protection Act 2018 grants trans and non-binary people the right to control information about themselves, as well as obligating public bodies to protect the human rights of service users by ensuring information about them is held securely, with consent, shared only on a 'need to know' basis and is accessible to them.

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3.0   Statutory Frameworks for Perinatal Care

3.1. NHS Guidance

Public Sector guidance (National Health Services England (NHSE), 2019) builds upon legal frameworks. NHS organisations must consider the needs of trans and non-binary people when developing equality schemes, and must be proactive in promoting their equality. This includes the commissioning of services and development of policies (DoH, 2008).

NHS commissioners and service providers are encouraged to go beyond their statutory responsibilities and think more expansively about how best to provide care. The law should be seen as a baseline for policies and conduct within NHS organisations. The fact that the law does not strictly require an action to promote equality, dignity and respect does not preclude us from aiming high and striving for inclusive progressive care beyond what is mandated (DoH, 2008).

Similarly, with regard to the protected characteristic of 'gender reassignment' under the Equality Act 2010, the existence of limitations should never be seen as an opportunity to exploit them. Services should move from a disorder model of diverse gender identities to a wellbeing model that recognises that many of the health inequalities trans and non-binary people face are consequent to societal prejudice, discrimination and stigma.

NHS organisations should strive to be a place in society where trans and non-binary people can bring their whole identities, free from fear of hostility and oppression. In addition, we can affirm and celebrate diverse gender identities knowing that when people feel seen and valued they are more likely to experience better health and access health care that supports their wellbeing.

The NHS Long Term Plan (NHSE, 2019) outlines the NHS's commitment to stronger action on health inequalities. The Plan recognises the disproportionate impact of the social determinants of health on marginalised communities. It advocates that perinatal services take a concerted and systematic approach to tackling health inequalities, recognising that intersecting oppressions such as race, deprivation, and gender increase morbidity.

3.2. NICE Guidance

National Institute for Health and Care Excellence ((NICE), 2018) guidance for perinatal services explicitly addresses health inequalities in the pregnant population. It recognises that those navigating complex social factors may have additional needs and difficulties accessing standard care pathways. It sets out what healthcare professionals as individuals, and antenatal services as a whole, can do to address these needs and improve pregnancy outcomes in these groups. Trans and non-binary people can reasonably be included in those experiencing complex social factors given the significant impact diverse gender identities have on levels of disadvantage, particularly with regard to the social determinants of health (HoCWEC, 2016). We can use this guidance to support individualising care for trans and non-binary people within perinatal services, as

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part of our duty to commission and deliver non-discriminatory, evidence-based care that seeks to address health inequalities in marginalised populations (Nursing and Midwifery Council (NMC), 2018, General Medical Council (GMC), 2019a; NHSE, 2019).

3.2. Professional Regulation

Regulatory bodies, the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC), require their members to operate within a code of conduct and uphold professional standards. They are prescriptive in describing expected behaviours for midwives and doctors.

NMC and GMC guidance is inclusive of all people who may require the care of midwives and doctors, and therefore is inclusive of trans and non-binary people.

All birth workers should have competency about sex and gender; both for the pregnant women and people we serve but also for the whole family, including infants born with variations in sex anatomy. To achieve these outcomes midwives and doctors have a professional responsibility to ensure they have the expertise and competence, and practice cultural safety, in order to care for a diverse population including trans and non-binary people. This should be achieved by continuous education and the application of research and evidence (ICM, 2014; GMC, 2019a; NMC, 2018).

3.3. NMC: The Code

The NMC Code lays out the professional standards of practice and behaviour for midwives and nurses. The following sections are particularly relevant to caring for trans and non-binary people (NMC, 2018):

> *"You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged."*

> *"1 Treat people as individuals and uphold their dignity*

> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.3 avoid making assumptions and recognise diversity and individual choice*
> *1.5 respect and uphold people's human rights"*

> *"2 Listen to people and respond to their preferences and concerns."*

> *"3 Make sure that people's physical, social and psychological needs are assessed and responded to."*

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3.4. GMC: Good Medical Practice

The GMC Good Medical Practice guidance describes the professional values and behaviours expected from any doctor registered with the GMC. The following sections are particularly relevant to caring for trans and non-binary people (GMC, 2019a):

> *"47 You must treat patients as individuals and respect their dignity and privacy."*

> *"48 You must treat patients fairly and with respect whatever their life choices and beliefs."*

> *"59 You must not unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance, and follow the guidance in paragraph 25c if the behaviour amounts to abuse or denial of a patient's or colleague's rights"*

4.0   Professional Guidance

Professional bodies have produced specific guidance for trans and non-binary people's healthcare.

4.1. General Medical Council

The GMC (2019b) offers specific guidance for caring for trans patients, recognising that:

> *"the way you address patients who are transitioning or have transitioned is extremely important. Taking care to use the right (i.e. the patient's preferred) name and title shows that you are treating them with respect."*

4.2. Royal College of Nursing

The Royal College of Nursing (RCN, 2017) and the British Medical Association (BMA, 2016) have developed this even further. They have published guidance reaffirming their commitment to using their members' collective and individual power to address the severe and persistent disadvantage trans and non-binary people experience in accessing appropriate health care (RCN, 2017; BMA, House of Commons). The RCN (2017, p.4) states that:

> *"the nursing community can, through its professional actions and interests, work to eliminate and significantly reduce this at both an individual and societal level."*

This guidance represents a vast membership body, which includes midwives, and offers perinatal services a valuable national derivation of national research (HoCWEC, 2016) and international guidance (WHO, 2017; ICM, 2017).

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4.3. British Medical Association

The BMA (2016) recognises that a large majority of people who get pregnant and give birth are women however some may be trans men or non-binary people. As such they recommend that the term "pregnant people" can be used instead of "expectant mothers". This is part of their commitment to using inclusive language that reflects and celebrates an increasingly diverse society, and which creates an open environment where everybody's needs are respected and responded to sensitively (BMA, 2016).

4.4. British Association of Sexual Health and HIV

The British Association of Sexual Health and HIV (BASHH, 2019) have developed comprehensive recommendations for providing integrated services to trans and non-binary people. Barriers to accessing sexual and reproductive health services are comparative to accessing perinatal services, given the similarly physically and psychologically intimate/sensitive nature of the care provided. Such barriers include:

- o Constant explanation of identity;
- o Service users' worries about how they will be treated because of their gender identity or history or both;
- o Non-inclusive registration forms and processes;
- o Insensitive history taking and;
- o Inappropriate clinical care

BASHH (2019, p.4) advise that:

"inclusive and welcoming services… avoid reinforcing essentialising ideas about gender (for example, that someone with a uterus is always female), or binary thinking (for example, that everyone will fit into the traditional categories of either 'male' or 'female')".

4.5. Application to BSUH

At BSUH, we can utilise this guidance within perinatal services by ensuring we use language, train staff and design services that include trans and non-binary service users. We recognise that it may be necessary to take additional steps to mitigate against previous negative experiences and human rights abuses/infringements in healthcare settings (DoH, 2008; WHO, 2017).

5.0 <u>International Context</u>

There is no known UK precedent for the additive use of gender-inclusive language in perinatal services. In this respect, BSUH are leading the way.

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As supporters of the International Confederation of Midwives Model of Midwifery Care (ICM 2014), we are collectively responsible for the development of our practice. This means that where we see examples of best practice care locally or internationally, we are free to incorporate them into our own work.

We stand in solidarity with our midwifery colleagues around the world who have already moved to culturally appropriate language. Learning from their example, we advance the care of all who use our perinatal services.

5.1. Examples

Position statements issued by the Midwives Alliance of North America ((MANA), 2015) and the American College of Nurse-Midwives (2012) establish their decision to move to gender-inclusive language, endorsing the WPATH Standards of Care (2012).

These position statements reaffirm the need for midwifery culture and practice to reflect the community it serves. Each organisation celebrates the role of midwives in providing gender-affirming care, improving education and cultural competency. They also support policies that seek to prohibit discrimination based on gender identity.

MANA (2015) recognise that as long as a single person is excluded from the midwifery community, all are vulnerable to discriminatory treatment. The rights of all who experience pregnancy are inextricably linked. Improving the treatment of trans and non-binary people serves to maintain focus on addressing all discrimination and rights-based abuses, which women are particularly vulnerable to. In their position statement, MANA (2015) assert that:

> *"The same elements that threaten holistic care for pregnant and birthing folks also perpetuate violence against trans, queer and non-gender conforming people. These systems include, but are not limited to… industrialized medical care, colonialism, sexism and patriarchy. When gender-nonconforming folks are also people of color, low-income or disabled folks, they disproportionately experience discrimination. As a result we are committed to promoting the additive use of gender-neutral language in traditionally woman-centric movements (birth and reproductive justice) because doing so disrupts those systems and supports gender liberation."*

The Association of Ontario Midwives in Canada recognises the impact of transphobia on access to health care for trans and non-binary service users, as well as the potential impact on staff. They state their commitment to creating an inclusive environment (AOM, n.d.):

> *"Discrimination in the provision of services can cause trans, genderqueer, and intersex people to delay or avoid necessary health care services often to the point of putting their overall health at risk. Transphobia can also operate in the workplace, putting trans, genderqueer, and intersex midwives and staff at risk for violence and harassment. We are also aware that transphobia disproportionately affects those with other intersecting identities such as racialized persons, Indigenous people,*

people with disabilities, and all living with the effects of the social determinants of health … It is critical that midwives honor and respect all people's right to self-determination and right to receive health care and work in a professional environment that is free from discrimination, transphobia, and prejudice … The AOM believes that all midwives and midwifery practices can and should provide an environment where all individuals are welcomed, treated with dignity and respect, and encouraged to be active members of the community."

6.0   <u>Our Approach to Language in Perinatal Care</u>

Research shows that how we are described by others has an enormous impact on our health and wellbeing, as well as creating inclusivity and building community. It also influences how likely we are to access healthcare when necessary. Internationally, there is support for a move towards inclusive language in perinatal services, as a means to improve health outcomes and to address existing discriminatory linguistic practices (National LGBTI Health Alliance, 2013). In the absence of national guidance, we are leading the way to ensure that the language we use includes everyone. We want to ensure that all women and people see themselves reflected in the services they use.

6.1. Speaking about 'women' and 'people' side by side

Gender identity can be a source of oppression and health inequality. We are consciously using the words 'women' and 'people' together to make it clear that we are committed to working on addressing health inequalities for all those who use our services.

As midwives and birth workers, we focus on improving access and health outcomes for marginalised and disadvantaged groups. Women are frequently disadvantaged in healthcare, as are trans and non-binary people. We also recognise that women of colour, particularly black women, experience significantly higher rates of morbidity and mortality in pregnancy (Knight et al, 2018). Migrant women also face access issues due to language and cultural barriers, which contribute to health inequalities (NICE, 2018). By continuing to use the term 'woman' we commit to working on addressing health inequalities for all who use our services.

We also recognise that there is currently biological essentialism and transphobia present within elements of mainstream birth narratives and discourse. We strive to protect our trans and non-binary service users and healthcare professionals from additional persecution as a consequence of terminology changes, recognising the significant impact this can have on psychological and emotional wellbeing. Acknowledging the cultural context in which service development occurs is vital in making trans and non-binary lives safer.

6.2. Gender-additive language

We are taking a gender-additive approach to the language used to describe our services. For us, a gender-additive approach means using gender-neutral language alongside the

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language of womanhood, in order to ensure that everyone is represented and included. This decision has been taken following extensive discussions with local, national and international experts in trans and non-binary healthcare. We have also involved trans and non-binary parents who use our services, and in the wider community, in coming to this position.

If we only use gender neutral language, we risk marginalising or erasing the experience of some of the women and people who use our services. We understand the fear of erasure, however marginalising other groups because they are rare will not improve care for women. We believe in human rights-based care and we can add inclusive language to our current language without subtracting anyone (MANA, 2015).

Considering statutory and advisory guidance, local and national expert opinion, and service user experiences we are reassured that the additive use of gender-inclusive language is the right decision, at this time, for the women and people who use our perinatal services. The decision is strategic and aims to most rapidly redress the historic exclusion of trans and non-binary service users, whilst honouring and representing all who use our services.

6.3. Using the right language in the right time

The language we use is often specific to the cultural and time in which it is used. It is dynamic and rapidly evolving. We need to be sensitive to changing expressions and meanings, recognising that terminology may be specific to local communities (WPATH, 2012; BMA, 2016). So our approach to using gender additive language is iterative in nature. In line with best practice (BASHH, 2019), we listen to those who use our services and continually re-evaluate the language we use. This ensures it is acceptable to the women and people we are providing care for.

Modelling competency through the additive use of gender-inclusive language, and being able to adapt the language we use to the communities we serve, does not undermine the status of women in birth. Instead, it sets a standard for birth workers to be professionals with the expertise to serve a diverse range of people.

7.0   <u>Specific Language Replacements</u>

The move to the additive use of gender-inclusive language represents a structural and systemic change, at a departmental and Trust-wide level. The guidance below is for the production of documents, protocols and communications. It should also be used when discussing pregnancy, birth and parenting at a population level (for example, at meetings, study days or antenatal parent education).

Please note that these language changes do not apply when discussing or caring for individuals in a one-on-one capacity where language and documentation should reflect the gender identity of the individual. When caring for cis women it is good practice to

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use terminology that is meaningful and appropriate to the individual; this may include terms such as woman, mother or breastfeeding.

It is important to note that the term "women" encompasses both cis and trans women. Professionals should be aware that co-parents could have any gender identity, and could also be cis, trans, non-binary, and/or intersex.

Unless conversation is focussed on gender identity with relation to cis, trans or non-binary status, it is not necessary to include the adjectives "cis" or "trans" before the words "woman", "man", or "person".

In addition to the guidance below it may also be helpful to include a qualifier if you wish to refer to a woman or person at a specific point in their perinatal journey. For example:

- o *Pregnant* women and people
- o *Birthing* women and people
- o *Breast/chestfeeding* women and people
- o *Postnatal* women and people

The examples below are not exhaustive and the Gender Inclusion Midwives can be contacted for advice and support as needed.

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Table 1 **When referring to the birthing parent:**

Previous term	New term	Previous example	New example
"Breastfeeding"	"Breast/chestfeeding"	"The value of breastfeeding as protection, comfort and food"	"The value of breast/chestfeeding as protection, comfort and food"
"Breastmilk"	"Human milk" or "breast/chestmilk" or "milk from the feeding mother or parent"	"The nutrients in breastmilk are unique"	"The nutrients in human milk are unique"
"Her"	May need to use "them" or "their" when replacing "woman" with "woman or person"	"The screening midwife contacts the woman by phone to inform her of the result, discuss options and arrange follow up care."	"The screening midwife contacts the woman or person by phone to inform them of the result, discuss options and arrange follow up care."
"Maternal"	"Maternal and parental" or "maternal/parental"	"Take maternal pulse every hour"	"Take maternal or parental pulse every hour"
"Maternal" or "maternity"	"Maternity" or "perinatal" (this acknowledges that "Maternity" sometimes refers to terminology which it is not possible for BSUH to change at present)	"Maternity care should be available to all"	"Perinatal care should be available to all"
"Maternal consent"	"Informed consent"	"Maternal consent given to continue"	"Informed consent given to continue"
"Maternal notes" or "maternity notes"	"Hand held notes" or "Antenatal/Labour and Birth Care/Postnatal Care Record"	"The discussion should be recorded in the maternal notes"	"The discussion should be recorded in the hand held notes"
"Mother/s"	"Mother/s or birthing parent/s" or "mothers and birthing parents"	"The mother's blood group should be documented"	"Mother or birthing parent's blood group should be documented"
"She"	May need to use "they" when replacing "woman" with "woman or person"	"When a woman consents to a test she should be informed how she will receive the result"	"When a woman or person consents to a test they should be informed how they will receive the result"
"Woman"	"Woman or person"	"Weigh the woman, recording the weight on the combined screening request form in kilograms."	"Weigh the woman or person, recording the weight on the combined screening request form in kilograms."

"Women"	"Women and people"	"Where women require other bloods taking at the same time as the combined screening, then the combined screening sample must be taken first."	"Where women and people require other bloods taking at the same time as the combined screening, then the combined screening sample must be taken first."

Table 2   When referring to the co-parent/second biological parent:

Previous term	New term	Previous example	New example
"Father"	"Parent" or "co-parent"	"Skin to skin can be offered with the baby's father"	"Skin to skin can be offered with the baby's co-parent"
In the context of Antenatal Screening: "Father"	"Father or second biological parent"	"If the baby's father has been tested once previously, a repeat screening test should still be recommended to confirm the previous results."	"If the baby's father or second biological parent has been tested once previously, a repeat screening test should still be recommended to confirm the previous results."

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