

Academy of Breastfeeding Medicine Position Statement and Guideline: Infant Feeding and Lactation-Related Language and Gender

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Introduction

THE ACADEMY OF BREASTFEEDING MEDICINE (ABM) is a global community of physicians and affiliates working to reduce the gap between clinical care and scientific knowledge by creating internationally applicable evidence-based protocols. Language, interpretation, and translation are constant considerations for ABM. We affirm that language has power. This is demonstrated in linguistic relativity and determinism, both theories explaining how the structure of a language impacts thought and behavior. Implicit biases affect the language we use, and thereby contribute to gender inequality and health inequities, which contribute, in turn, to rising morbidity and mortality of vulnerable populations.^{1,2}

ABM Support for LGBTQI+ Individuals

The ABM is acting in accordance with the United Nations (UN) and World Health Organization (WHO) 2030 Sustainable Development Goals³ and the specific UN and WHO call for “ending violence and discrimination against lesbian, gay, bisexual, transgender, and intersex people,”⁴ and the ABM affirms “the highest attainable standard of health as a fundamental right of every human being.”⁵ As a nongovernmental organization comprising health care professionals, both the organization and ABM membership have important roles to play while striving toward the goal “to respect, promote, and fulfill the human rights of all LGBTI people.”⁶ To this end, the ABM is committed to working with communities to identify additional inclusive language and behaviors to attain these goals.

The ABM Affirms That Language Should Be as Inclusive as Possible When Discussing Infant Feeding

Building on the recommendations of Rasmussen et al.⁷ and Dinour⁸ regarding acceptance and consistent use of specific, comprehensive, and nonjudgmental language describing infant feeding, and as a complement to ABM Clinical Protocol #33: Lactation Care for Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Plus Patients,⁹ the ABM recognizes that not all people who give birth and lactate identify as female, and that some of these individuals identify as neither female nor male. To be inclusive of all people in our written materials, use of desexed or gender-inclusive language (e.g., using “lactating person” instead of “mother”) is appropriate in many settings. In some situations, however, use of sex-specific language may be preferable, for reasons we state hereunder. In such cases, our readership should be aware that the intention of our written materials, such as protocols and position statements, is to be inclusive of all breastfeeding/chestfeeding and human milk-feeding individuals. *With individual families, it is important to ask about and use the pronouns and words with which they identify.*

It should be clear that the term “sex” refers to a biological assignment of female and male, whereas “gender” refers to one’s cultural roles, and includes personal and social identity. Pronouns are often gender-specific and can be confusing in many languages when an individual identifies as gender-neutral or nonbinary. By “gender-inclusive language,” ABM means language intended to include those who identify as men, women, intersex, nonbinary, or

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gender-fluid. [Note that some sources, such as the UN, use the term “gender-inclusive language” only to mean language that includes both men and women (e.g., “human-kind” instead of “mankind,”) and do not use this term to extend to an LGBTQI+ context.] In addition, although the UN uses the term LGBTI, ABM prefers the more inclusive term “LGBTQI+,” because it includes intersex people as well as others who identify outside of specifically labeled groups (e.g., “gender-diverse”).

Some Considerations of the Use of Gender-Inclusive Language

Legal considerations and censorship

Although the ABM recognizes that diversity in sexual orientation and gender identity occurs worldwide, there are many heteronormative and cisnormative countries where being anything but heterosexual and cisgender is illegal, and where such individuals are subject to legal and illegal persecution. Although we affirm and support gender-diverse lactating persons around the world, using desexed or gender-inclusive language in places where being LGBTQI+ is illegal may do more harm than good and prevent important information from reaching families. In such settings, documents that use desexed or gender-inclusive language may be censored, and readers who possess documents with such language, or authors who wish to write documents with such language, could be subject to arrest, persecution, or other sanctions.

Translation concerns, literacy, and clarity

Desexed or gender-inclusive terms may be confusing in languages other than English. Many languages assign gender to every noun, so that such terms cannot be gender-neutral. For example, in an attempt to be gender inclusive, the word “parent” is often substituted for “mother,” but in many languages, “parent” is a masculine noun that could mean “father.” Many languages have no gender-neutral equivalent for relevant words. For example, in many languages, the term for “breast milk/human milk” is “mother’s milk.”

In addition, some terms may be distracting or difficult to understand for readers who come from cultures where there are no apparent nonfemale lactating people, as well as for people who have low literacy, and for people who are not reading in their native language. In these circumstances, when a term such as “lactating parent” is substituted for “mother” or “breastfeeding mother,” it may not be understood easily, and use of gender-neutral pronouns for these terms (e.g. “they/them”) create additional confusion.

Scientific accuracy

We also recognize that most desexed or gender-inclusive terms do not have equivalent meaning to the words they replace. For example, in medical terminology, “breast” refers to both the male and female body part. “Chest” is often substituted but has a different anatomical meaning and thus is not used this way in medical settings. “Breastfeeding” could be construed to mean the act of feeding and nurturing one’s own children at the breast, and thus to some implies a physical and/or emotional connection between the dyad, but “lactating” does not require any physical or emotional connection between the dyad. “Birthing people” may be

substituted for “mothers” so that nonfemale people are included, but this term would also include gestational carriers, gestational surrogates, and women whose infants are adopted by others, and such people may not fall within an author’s intended meaning.

In clinical settings, health effects seen in mother–infant breastfeeding dyads cannot be generalized to other dyads due to lack of data and known or predictable differences with other dyads based on chromosomal, hormonal, and anatomic factors. Thus, substituting “parents” for “mothers” may be factually inaccurate. For example, a dyad in which a birthing transgender father who has had gender-affirming male contouring surgery feeds his infant artificial milk through a supplemental nutrition system at the breast may have some of the same health risks as a cisgender *nonbreastfeeding* mother and infant: for example, the infant will have an increased risk of otitis media, gastrointestinal infection, and formula intolerance. The father is also at risk for common complications of *chestfeeding/breastfeeding* such as engorgement, cracked nipples, and mastitis. Because the father likely has some residual lactating breast tissue, it is unclear how his risk of type 2 diabetes and cardiovascular disease compares with that of a cisgender nonbreastfeeding mother—it may be slightly lower (or higher), but data are lacking for people assigned female at birth who take male hormones and lactate with reduced mammary tissue.

Masking research needs

Studies on breastfeeding and maternal mortality have included subjects who are presumed to be cisgender. Therefore, data on the health effects of lactating, chestfeeding, or breastfeeding transgender parents are lacking. For some conditions, a conflation of the terms “mothers” and “lactating parents” will mask the need for future and specific research by assuming that scientific knowledge about the former applies uniformly to the latter, or by homogenizing a nonhomogeneous group. For instance, compared with a cisgender nonbreastfeeding mother, breast cancer risk may be increased for a birthing father who feeds his infant artificial milk (due to the residual breast tissue and the lack of desire or ability to lactate), or decreased if he is able to partially lactate with the remaining mammary tissue. Similarly, because breast cancer risk is influenced by parity, the expected breast cancer risk in people assigned male at birth who take female hormones and lactate is unknown. Gender-affirming hormone therapy complicates this further, as these hormones may contribute to health conditions, most notably an increased risk of cardiovascular disease.¹⁰

It follows that though some lactating transgender parents may have reduced mortality related to lactation, as a non-homogeneous group, these associations will be complicated by their gestational status, hormone, or surgical histories. Stating that breastfeeding reduces “parental” mortality is, at this point, inaccurate. It also risks masking the need for future research by allowing scientists, funders, and advocates to believe these questions have already been answered.

Personal preferences

“Breast milk” may be preferred by some when discussing a mother’s own milk, because a family connection may be implied, whereas “human milk” may be preferred for milk that is donated or sold, as no family connection is implied.

Other terms could be used as well, such as “expressed milk,” “father’s milk,” or simply “milk.” *A lactating person should be encouraged to choose whichever terms for milk and feeding with which they identify.*

A “mother” implies a family connection and the complex relationships embodied therein, but a “lactating person” does not imply family connections, and could be a person who is producing milk for donation or sale. Desexed language may also alienate some readers. For example, a cisgender woman may strongly identify as being a “mother,” and such women, in some cultures, may avoid materials in which they are described as a “lactating person” or a “parent.” When selecting the best terms, the context and audience should be considered.

Citation and reuse of other organizations’ guidelines

When describing the words or recommendations of any other author or organization, it would be incorrect and unethical to use desexed or gender-inclusive language if the original author or organization did not use such language. For example, the WHO uses sex- and gender-specific terms related to infant feeding and birth, and this may be intentional, given its need to reach people in all countries. Its policies and recommendations thus cannot be reworded using desexed or gender-inclusive terms, for example, by substituting “parents” for “mothers.”

Similarly, when research on women’s health is described, words such as “people” or “parents” cannot be substituted for words such as “women” or “mothers” unless people with genders other than female were specifically included in the study population (see Scientific Accuracy section and Masking Research Needs section).

Circumstances in which gender-inclusive language should be standard and not standard

Appropriate circumstances where desexed or gender-inclusive terms can replace sex-specific terms may include a document with an audience of health care professionals in a country where openly transgender or nonbinary persons give birth and breastfeed or chestfeed, such as a hospital policy in the United Kingdom or United States. See Table 1 for a list of

traditional and gender-inclusive terms. Circumstances where traditional gendered terms are more appropriate include documents written for a worldwide audience, and documents written for the general lay public.

Signifying inclusion and resources

Language is one of many ways to signify inclusion. Facilities and providers can use many ways to signify their openness to providing care for LGBTQI+ patients, for example, with proper education of staff, inclusive forms and non-gendered bathrooms, welcoming signage, and inquiring about preferred pronouns and names.

The UN has *linguistic guidelines*¹¹ to help writers be clearer and more inclusive of men and women when writing about gender. The guidelines specify, however, that gender should be “visible” when it is relevant for communication, as it is in the case of most aspects related to breastfeeding. The ABM recommends reviewing the content in the UN’s “English language toolbox,” in addition to their strategies, which include the following points:

- Recognize biases.
- Use nondiscriminatory language.

Summary Statement

The ABM is dedicated to the promotion, protection, and support of breastfeeding and lactation for all persons worldwide. We endeavor to create materials that are comprehensible, acceptable, and permissible in all countries, in any language, and by any reader. We welcome contributions from authors from all countries, who must be able to contribute without fear of persecution or arrest. Sociocultural and legal landscapes as well as language variability and translatability of gendered terms related to parenting and breastfeeding may limit our ability to use gender-inclusive language to provide clear recommendations around the world. This does not negate our recognition of and support for the diversity and complexities in the human experience of infant feeding and bonding.

TABLE 1. SUGGESTED TERMS IN BREASTFEEDING AND HUMAN LACTATION

<i>Traditional terms</i>	<i>Gender-inclusive terms</i>	<i>Clinical contexts</i>
mother, father, birth mother	parent, gestational parent; combinations may be used for clarity, such as “mothers and gestational parents”	Ask the patient(s) for their affirmed terminology
she, her, hers he, him, his	they/them, (if gender is not specified)	
breast breastfeeding	mammary gland breastfeeding, chestfeeding, lactating, expressing, pumping, human milk feeding	
breast milk	milk, human milk, mother’s own milk, parent’s milk, father’s milk	
breastfeeding mother or nursing mother	lactating parent, lactating person; combinations may be used for clarity, such as “breastfeeding mothers and lactating parents”	
born male/female (as applied to people who identify as anything but cisgender)	noted as male/female at birth or recorded as male/female at birth or assigned male/female at birth	

The terms on the left are not incorrect and are appropriate in many settings, but terms in the middle column are suitable substitutes when gender-inclusive language is appropriate.

Future research that includes transgender participants should be designed to improve our understanding of breastfeeding, chestfeeding, lactation, and the use of donated human milk in all people. Specifically, we recommend that future studies at least (1) include broader gender categories, (2) not assume that lactation follows a birth, and (3) include information on history of hormone therapy and surgeries for transgender participants.

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References

1. Shannon G, Jansen M, Williams K, et al. Gender equality in science, medicine, and global health: Where are we at and why does it matter? *Lancet* 2019;393:560–569.
2. Moseson H, Zazanis N, Goldberg E, et al. The imperative for transgender and gender nonbinary inclusion: Beyond women's health. *Obstet Gynecol* 2020;135:1059–1068.
3. UN General Assembly. Transforming Our World: The 2030 Agenda for Sustainable Development. New York: United Nations, 2015.
4. World Health Organization, United Nations Human Rights Office of the Commissioner, UN High Commissioner for Refugees, et al. Ending Violence and Discrimination Against Lesbian, Gay, Bisexual Transgender and Intersex People. Geneva: World Health Organization, 2015.
5. World Health Organization. Fact Sheet: Human Rights and Health. Geneva: World Health Organization, 2017.
6. Allen MP, Johnson RE, McClave EZ, et al. Language, Interpretation and Translation: A Clarification and Reference Checklist of Health Literacy and Cultural Respect, Discussion Paper. Washington: National Academies of Medicine, 2020.
7. Rasmussen KM, Felice JP, O'Sullivan EJ, et al. The meaning of "breastfeeding" Is changing and so must our language about it. *Breastfeed Med* 2017;12:510–514.
8. Dinour LM. Speaking Out on "breastfeeding" terminology: Recommendations for gender-inclusive language in research and reporting. *Breastfeed Med* 2019;14:523–532.
9. Ferri RL, Rosen-Carole CB, Jackson J, et al. ABM Clinical Protocol #33: Lactation care for lesbian, gay, bisexual, transgender, queer, questioning, plus patients. *Breastfeed Med* 2020;15:284–293.
10. Connelly PJ, Marie Freil E, Perry C, et al. Gender-affirming hormone therapy, vascular health and cardiovascular disease in transgender adults. *Hypertension* 2019; 74:1266–1274.
11. United Nations. Gender-inclusive language. United Nations. <https://www.un.org/en/gender-inclusive-language/guidelines.shtml>. Published 2020 (accessed April 11, 2021).

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