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ARTICLE

Caring for Everyone: Effective and Inclusive Communication in Perinatal Care

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Abstract
We advance a novel approach to gender inclusive language, showing how it can be used in perinatal and postnatal care. Existing attempts to use language inclusive of trans and non-binary parents have faced objections, prompting calls to use trans-exclusionary "sexed" language as a default (Gribble et al. 2022). We show that these objections attach only to some unsatisfactory attempts at inclusive language. We articulate the moral and communicative goals at stake, and then work through a range of examples to show that no single linguistic strategy can meet these goals in all contexts. A pluralistic approach is needed. Our pluralistic approach draws on gender neutral, gender additive, and second-person locutions, as well as taking advantage of the possibility for multiple targeted communications. Moreover, this pluralistic approach highlights the gaps in research and understanding needed to ensure substantively inclusive care in future.

1. Introduction

There are increasing moves to revise gendered language around pregnancy, childbirth, or the care of infants on the grounds that it excludes trans and non-binary parents. This forms part of a general movement to change policy around perinatal care in particular and healthcare in general to improve experiences and outcomes of trans and non-binary parents/patients.[1] However, well-intentioned attempts to make language more inclusive have often been done in a less than ideal manner. This fuels pushback against such attempted reforms. One key example of pushback is a paper poised to influence policymakers and practitioners by Kathleen Gribble et al. (2022), which argues that inclusive language is dehumanizing, disembodying, and in fact reduces inclusivity. Instead, Gribble et al. defend the use of what they call "sexed" language in communication around perinatal care, with terms such as "mother" and "woman" being used as the default and understood as having a "sexed meaning" such that everyone who gives birth is a woman (2022, 3). More recently, Webb et al. (2023) draw on Gribble et al. (2022) to argue that recommendations to use inclusive language (from

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the LGBTQ Foundation 2022 report) may be detrimental to the majority of perinatal service users if followed.

Our arguments show that inclusive language need not be problematic in the ways these authors worry about. Their concerns apply to only some unsatisfactory attempts at inclusive language. We use the tools of moral philosophy and philosophy of language to provide a framework for adequately formulating healthcare messages in an inclusive manner. We focus on perinatal care because this is an area where there has been significant pushback against inclusive language, possibly because it can seem particularly challenging to use inclusive language effectively in this area. However, our framework can be applied more generally. Our pluralist framework emphasizes three elements that are often missing from discussions of language in healthcare, but are essential to establish strategies that are both inclusive and feasible.[2] The first is the importance of attention to context: approaches that are appropriate and effective in one communicative context may not be so in another. The second is an awareness of the variety of linguistic devices available for communication: many problems can be avoided by creative use of alternatives to noun-phrases; in other contexts additive language may be appropriate; whilst sometimes gender neutral language better meets the moral and communicative goals. Thirdly, we highlight the different ways language can fail to include trans, non-binary or gender-non-conforming parents and patients: false universals, misgendering, and marginalization. Different types of failures have different implications for overall inclusivity.

We illustrate our framework with a number of examples, and show how our approach avoids a number of objections to inclusive language. We also demonstrate that reliance on the default option of using "woman" to refer to people assigned female at birth, writing as if all users of perinatal care are cis women (as Gribble et al. 2022 do), fails to meet legitimate moral and communicative goals.

Some notes on the scope of our claims: first, we are addressing contexts, such as care provision in the UK, in which moves are already under way to develop inclusive language in perinatal care, where recipients of care include openly trans and non-binary people. Currently, data is very limited with respect to how many trans or non-binary people require perinatal care (see Greenfield and Darwin 2021, 203). The CQC National Maternity Survey is given to all persons who gave birth in England from 1 February to 28 February. In 2022, 136 respondents reported that their gender does not match the one that they were assigned at birth; that is, over 130 people on record in one month *alone*.[3] Over 1 percent of births in England are to people whose gender does not match that which they were assigned at birth (CQC 2022, see also Pearce et al. 2023).

These data are incomplete as an estimate of trans and non-binary people requiring perinatal care in two ways: first, they focus only on numbers giving birth and do not include other aspects of perinatal care;[4] second, it is likely an underestimation due to some individuals choosing to give birth without accessing healthcare, and due to some doing so without disclosing their gender identity (see LGBTQ Foundation 2022, 8–9).[5] Nonetheless, it suggests that trans and non-binary people giving birth, and thus in need of access to other aspects of perinatal care, is (perhaps increasingly) common.

Second, we make no claims about the appropriate language to use in contexts where there are legal constraints preventing free expression of gender identity and where considerations of safety arise.[6] Finally, our claims are about inclusive language, at present, in English language-speaking contexts: the extent to which the linguistic strategies we recommend are available in other languages remains an open question and depends on features of the particular language (for further discussion, see Dembroff and

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Wodak 2018, 2021; also González Vázquez et al. 2024). Strategies for inclusive language in other languages will have to proceed and be evaluated on a case by case basis. Moreover, we recognize that even within the English language, apt language evolves rapidly in a community-led way. However, we expect that our overarching claim that we should be attentive to communicative context and may need to employ multiple strategies in order to meet our communicative and moral goals will hold across languages and in future.

We start by identifying the moral and communicative goals that guide provision of and communication about perinatal care (section 2). We argue that these goals are not met by either "sexed" language, or by simply stating that traditional language "should be taken to include people who do not identify as women but are pregnant or have given birth" (National Institute for Health and Care Excellence and Royal College of Obstetricians 2021, 6).[7] We then address concerns raised about inclusive language in the light of those goals. We respond to and set aside some of these concerns relatively briefly (section 3). Other concerns we take up and address in more detail (section 4). There, we present a series of examples that enable us to show how the goals and constraints can be successfully navigated, in a range of contexts, by creative and careful uses of language. Crucially, the approach we advocate is pluralistic. No single linguistic strategy—whether gender additive or gender neutral—can meet the various moral and communicative goals in all contexts. We close by teasing out general lessons, and remaining questions.

2. Moral and communicative goals

In the UK, the National Health Service (NHS) has been providing healthcare since 1948; perinatal care in particular is provided free at the point of need, irrespective of immigration status. This provision is guided by values articulated in an NHS constitution, which includes the specifications that the NHS: "has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population." In line with the provisions of the UK's Equality Act 2010, the constitution of the NHS stipulates that all staff "have a duty not to discriminate against patients" and they should aim to: "contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care."[8] The supplementary handbook specifies that everyone who comes into contact with the NHS should be treated with "respect and dignity," and compassion, which includes "sensitivity and kindness." Patients should be "treated as equal, informed and active partners."[9]

One important forum in which these values are at stake concerns the language that is used across healthcare contexts. Language can be used in an inclusive way, making space for, and affirming the entitlement to care of, all users of the NHS (and providers of that care), rather than in an exclusionary way. In promising steps, the NHS digital style guide applies these principles of respect, equality, and compassion to inform prescriptions for inclusive language. They stipulate that gender neutral language is the means through which language can be made inclusive: "We make content gender neutral as far as possible. In general, we word our content to avoid masculine and feminine pronouns ('he' or 'she'). Instead we use 'you' where appropriate and sometimes 'they' when we need a gender-neutral pronoun (unless this is confusing)."[10] However, there are three reasons that more work is needed specifically with respect to perinatal care. First,

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questions arise about the scope of "as far as possible." Perinatal care is a context in which gender may be highly salient—to what extent, and in what ways, can inclusive language be effectively used in that context?[11]

Second, recent work suggests that much public-facing language about perinatal care fails to conform to this guidance. Jennings et al. (2022) report that, in a survey of public-facing NHS perinatal services "[m]ost websites referred to pregnant patients as women and mothers or mums." Moreover, it seems practice is far from in conformity with these aspirations for inclusion. Recent reports on the experiences of trans and non-binary people accessing perinatal care indicate that "28% of trans and non-binary respondents [to a survey about perinatal care] said they were not treated with dignity and respect during labour and birth" (LGBTQ Foundation, 2022, 9). Interviewees in the report describe their experiences of exclusion, and the harms experienced as a result: "I felt there was no framework of language that was inclusive of people who do not identify within the gender binary so it was consistently a triggering experience" (2022, 22).

Thirdly, there are different strategies for inclusive language. Whilst, as described above, the NHS digital style guide advocates a gender neutral approach, other recent proposals have recommended adopting a "gender additive" approach (Jennings et al. 2022). For example, in their "Mission statement and rationale" for gender inclusive language, Green and Riddington write that for them "a gender-additive approach means using gender neutral language alongside the language of womanhood, in order to ensure that everyone is represented and included" (2020, 12–13). What approach, if any, is best suited to serving the moral goals of inclusion, as well as of dignity, respect, and equality?

In addition to these moral goals, it is worth also remarking on the communicative goals. Communications in healthcare contexts have a range of communicative goals:

- Reach: language used should address all those who are apt addressees. For example, a message about postnatal care should address all those in the relevant scope who have recently given birth.[12]
- Clarity: language used should be clearly understood by all of the audiences it aims to reach. For example, it should not use unnecessarily technical terms that may mean some audiences cannot grasp its meaning.
- Accuracy: language used should not express, or imply, falsehoods. For example, content about birth should not express, or imply, that only cisgender women give birth.
- Feasibility: language used should respect constraints of format. For example, some communications are of necessity limited in length and content, whilst others are not.

In relation to both these moral and communicative goals, there are different ways in which our language can fail to be inclusive. Our language might involve:

- Explicit denials of individual identity: An explicit denial of individual identity ascribes an identity to a person that conflicts with that person's identity. For example: referring to a parent with a gender neutral parental identity as "Mum," referring to a father as "Mum" or a mother as "Dad."[13]
- False universals: False universals purport to cover all cases while not including the experiences of some groups. In our case, they assume that a given reproductive role is always associated with a particular gender, denying the experiences of those of

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other genders who play the same role. For example: "Fathers cannot breastfeed but can do many other things to support their partners."[14]

- Incomplete non-universals: A non-universal does not purport to cover all cases. A non-universal is incomplete with respect to a group if it provides accurate information about some experiences but does not mention other experiences. For example: "Most women can leave hospital 1 or 2 days after having a caesarean section."[15] This is incomplete because it fails to mention those who have caesareans who are not (cisgender) women.

Explicit denials of individual identity and false universals conflict directly with respect and dignity. They misgender some of their target addressees; such language is clearly incompatible with respect and dignity. Incomplete non-universals are concerning because they fail to include all relevant individuals. However, the problem here is one of leaving people out or ignoring their existence. There is also the risk of implicating something false (e.g., that it is only women who have caesareans). This means that when assessing incomplete non-universals, it makes sense to look at the communication as a whole, rather than at specific statements. For example, a leaflet containing incomplete non-universals addressing women who give birth could be supplemented with a section or even separate leaflet addressing trans or non-binary people who give birth. The messages as a whole might be inclusive, even if specific token sentences within them are incomplete. Again, context matters.

3. Misplaced concerns

It should be clear that using "woman" or "mother" to refer to all those who gestate will not meet these moral and linguistic goals (instead committing explicit denials of identity, false universals). Nor will using only "sexed" language such that only "mothers" (referring to cisgender women) are addressed meet the moral and communicative goals of contexts in which people other than cisgender women gestate and give birth (incomplete non-universal). Such usages fail the moral goals of respect, dignity, sensitivity, kindness, and equality, since these usages respectively misgender, and marginalize trans men and genderqueer or other non-binary people who gestate and give birth. That usage also fails to meet the communicative goals: messages framed in those terms fail in terms of reach (excluding some people who give birth), accuracy, and clarity. So we consider this usage (which Gribble et al. advocate for) a non-starter (2022, 2 n. 2).

Likewise, attempts at inclusion that may be well intentioned but appear to pay only lip service to inclusion are also set aside. For example, consider the National Institute for Health and Care Excellence guidelines, which specify: "The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth" (2021, 6).[16] Just saying that these terms include people who do not identify as women doesn't make the language inclusive, and indeed fails to respect the self-identifications of people who would not use that language to describe themselves, instead misgendering them (an explicit denial of identity).

Whilst these approaches are obviously inadequate, articulating principles or guidance for more rigorously inclusive approaches requires careful thought. In this section we head off some concerns about inclusive language, and acknowledge that some attempts at inclusion are well intentioned but not well executed. Whilst unsuccessful attempts can fuel concern, it should not lead us to abandon inclusive language, but rather motivate endeavors to do it in a way that better meets the above moral and communicative goals.

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Gribble et al. raise six main concerns about gender neutral language (to which they refer as 'de-sexed language' (2022, 2)):

(1) reduction of overall inclusivity: gender inclusive strategies may violate "the plain language principle of health communication"; members of vulnerable groups may be excluded by language that they struggle to understand (2022, 3);
(2) dehumanization: some language marginalizes women ("non-males"), or their humanity ("gestational carrier" (2022, 3);
(3) wrongful inclusion: phrases such as "pregnant families" or "breastfeeding parents" might include partners who are not pregnant or other family members and infringe on the autonomy of the person gestating, giving birth, or lactating, by implying that these others have rights regarding decisions that should be made unimpeded (2022, 3–4);
(4) inaccuracy, imprecision, and confusion: careless replacement of sexed terms can lead to inaccurate or misleading representations of research in health communication, for example, when the comparison class is misdescribed or badly chosen (2022, 4);
(5) disembodying: failure to use terms such as "breastfeeding" can detach those doing it from the process and erase the person feeding (2022, 5);
(6) cultural imperialism: inclusive language policy can impose a Western worldview (2022, 6).

Concerns (2), (5), and (6) can be dealt with fairly straightforwardly, so we address and set them aside here.

3.1. Dehumanization and disembodiment

Concerns about dehumanization and disembodying only arise with some versions of inclusive language. These worries provide legitimate constraints on the kinds of inclusive language to be used. For example, Gribble et al. object to using language such as "gestational carrier," which reduces persons to their function as gestators, seeing them as disembodied uteruses; or describing people as "non-males," thus describing people in terms of what they are not, rather than their own identities (2022, 3). Describing people as "gestators" runs the risk of reducing persons to their bodies, and instrumentalizing them as reproductive "baby factories". Excessive focus on this bodily process may lead some to overlook the subjectivity of the pregnant person (see Nussbaum 1995; Langton 2009). These forms of reductive treatment have been described in the philosophical literature as "objectifying", which is often taken to be a way of failing to regard or treat people as persons, which may in that sense be a form of dehumanization (however, see Mikkola 2021 for argument that even these reductive forms of objectification are distinct from dehumanization).

Meanwhile, describing people who give birth as "non-males" need not be objectifying or dehumanizing, but it is nonetheless insulting to women, non-binary people, and trans men who give birth, and thus fails the dignity, respect, and kindness constraints. It also fails to meet the communicative goals, of clarity in particular—kettles and windmills are "non-males," but are not the target addressees.

But just as poor experiences of healthcare don't speak against healthcare as a goal, poorly executed attempts at inclusive language don't speak against inclusive language as a goal. Fortunately, our language is flexible and expansive enough to use terminology

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that does not reduce people to biological functions, or identify them in terms of what they are not. For example, expressions such as "persons who give birth" foreground the personhood of those gestating (though we discuss in section 4 some of the issues that need to be carefully considered when such language is used). When aiming for inclusive language, we should avoid dehumanizing or disembodying locutions. As we argue below, there are alternative ways of meeting our moral and communicative goals with inclusive language.

3.2. Cultural imperialism

The worry about cultural imperialism is that moves towards gender inclusion impose a particular cultural shift (towards inclusion) currently prominent in "Western" cultures upon other global contexts in a way reminiscent of imperial projects.[17] However, insofar as the worry sees inclusiveness of genders "beyond the binary" as a "Western" construct, it misrepresents the history of colonialism, trans and non-binary families and gender-diverse people in "non-Western" contexts. As various authors have articulated, part of "Western" colonial projects was the attempt to impose a rigid sex and gender binary, and exclude the possibility of life beyond the binary, often with violent force. Morgensen recounts one such case:

> Early colonists recurrently exacted a terrorizing sovereign right of death in order to educate Native people in the new colonial moral order. While interpreting Peter Martyr's account of Vasco Nunez de Balboa's 1513 expedition in Panama, Jonathan Goldberg notes that Balboa's victorious arrival after battle at the house of the Indigenous king was framed by his condemnation and elimination of what he perceived to be gender and sexual transgression. On reportedly finding the king's brother and about forty other men dressed in women's apparel or living in sexual relationships, Balboa threw them out to be eaten alive by his dogs. (Morgensen 2011, 64–65)[18]

Gender exclusion, rather than inclusion, was the mark of "Western" colonial projects. That said, there is ongoing debate within many indigenous groups about whether or not the term "trans" should be adopted for self-description. Importantly, the proposals we put forward do not insist that anyone use a particular label to refer to themselves or others (this is in marked contrast to those who would impose the label "woman" on anyone with a cervix or uterus, for example). Nonetheless, given the history of colonial violence, any interactions in a multicultural and/or global context need to be sensitive to the history of oppression in which nations, cultures, and economic systems have been implicated, such that linguistic policies are not simply imposed.[19]

Having briefly addressed these worries about dehumanization and disembodiment, and cultural imperialism, in the following we set them aside, since we believe that they will not beset more adequate attempts at inclusive language use.

We thus focus on (1) reduction of overall inclusivity; (3) wrongful inclusion; and (4) inaccuracy, imprecision, and confusion. Each reflects that problems with language arise where there is a need to reach or discuss everyone with a particular trait, and this trait does not correspond to social gender kinds. We use examples to explore how to respond to these concerns. We show that "sexed language" (in Gribble et al.'s sense) should not be treated as a neutral default option, but nor can the "gender additive" or "gender neutral" approaches alone be adequate.[20] Instead we endorse a pluralistic

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approach, exploring a range of options that exploit well-established alternatives to noun phrases to find appropriately inclusive language.

4. Pluralism about inclusive language strategies

A pluralistic approach acknowledges that a range of different linguistic devices may be needed in order to meet moral and communicative goals. To motivate a pluralistic approach, we set out in more detail the worries about under- and over-inclusion, and show how multiple approaches are needed to address these. Notably, neither a gender neutral nor additive approach is adequate alone: some combination of these, along with forms of second-personal address, are required. But note that, even amongst gender neutral and additive strategies, there are better and worse ways of using such language. So a genuinely inclusive approach needs careful attention to what is communicated in each context, and which strategy best serves communicative and moral goals.

4.1. Inaccuracy, imprecision, and confusion

In attempts to use inclusive language, attention to the communicative context and the semantic content of a sentence are absolutely essential. Gribble et al. (2022) note some instances in which gender neutrality has been sought by simply replacing all instances of "woman" with "person". There are clearly some contexts in which substitution may be a legitimate move, for example:

1) All women who give birth should be offered a postnatal check at 6 weeks.

1a) Every person who gives birth should be offered a postnatal check at 6 weeks.

1a better meets the communicative goals of 1, avoiding false universals which suppose all who give birth are women, or incomplete non-universals that fail to address some people who give birth. However, there are clearly other contexts in which such substitutions will be inadequate, both hindering goals of clarity and accuracy, and therefore threatening the reach of any messages framed in those ways. For example:

2) Pregnant women [target class] with COVID-19 have a higher risk of certain complications compared to non-pregnant women [comparison class] with COVID-19 of the same age ...

2a) Pregnant people with COVID-19 have a higher risk of certain complications compared to non-pregnant people with COVID-19 of the same age ...[21]

Without further context, it is not clear whether the move from describing the target class in 2 as "pregnant women" to "pregnant people" (in 2a) is legitimate. In order to know that, we would need to know whether the data described in 2 pertained to all pregnant people, misdescribed as "pregnant women"—in which case the change improves accuracy and inclusion. On the other hand, if the data pertain to only pregnant cisgender women, the move to gender neutral framing distorts meaning and produces inaccuracy. The use of "pregnant women" in 2 is either an exclusionary erasure, or an underdescribed imprecision that fails to indicate the true scope of the data.

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Nor is it clear whether the comparison class in 2 refers to all non-pregnant women (cis and trans), or rather refers to only cis women, or cis women and those assigned female at birth who do not now identify as women. Without that clarity, the ways in which 2a distorts meaning is unclear, though it surely does so: on no reading is it reasonable to assume that cisgender men are intended to be part of the comparison class, but they are captured by "non-pregnant people."

Even upon closer examination of the studies it is not entirely clear whether the most accurate rendering of the information is:

> 2b) Those who contract COVID-19 whilst pregnant have a higher risk of certain complications compared to a sample of non-pregnant (cisgender) women of the same age who contract COVID-19.

Or

> 2c) Those who contract COVID-19 whilst pregnant have a higher risk of certain complications compared to a sample of non-pregnant adults assigned female at birth who contract COVID-19.[22]

Obviously, then, the goals of inclusion, clarity, and accuracy cannot be secured simply by replacing "woman" with a gender neutral term (as in 2a). But contra Gribble et al. (2022) nor are those goals well served by simply using the default terminology of "woman" which is either exclusionary or imprecise (as in 2). Attention is needed to the details of the semantic content; more precision is needed than is present in either 2 or 2a; more respect and inclusion is needed than is secured by default exclusionary usage. Accordingly, careful attention to the context of communication is needed to ascertain whether and how the moral and communicative goals are served by attempts to introduce inclusive language.

4.2. Reduction of overall inclusivity

Gribble et al. worry that, in some contexts, replacing the term "woman" with "person with a cervix" may mean that some of the intended addressees of a message are not reached (2022, 3, drawing on Hunter 2005). For example:

> 3) All women with a cervix between the ages of 25 and 64 should go for regular cervical screening.

> 3a) All people with a cervix between the ages of 25 and 64 should go for regular cervical screening.

The message of 3a may not be clear to some people who are unaware that they have a cervix: some people may not know what cervixes are (cf. Hunter 2005); others may know what cervixes are but be unsure of whether they have one. This problem may be particularly acute for those assigned female at birth and denied access to education on the basis of their sex. Using completely gender neutral language, in this context, may fail the goals of reach and clarity. Gribble et al. take this to support the thought that retaining "sexed" language (whereby "woman" refers to all those people with a cervix) has some

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merit. In our terms, Gribble et al.'s worry is that the reach and clarity of the message is likely to be better served by using "woman" in that way.

This does not follow, for two reasons. First, some trans men or non-binary people may be unaware that the description "person with a cervix" applies to them. So language is needed that makes clear that they are potential addressees of the message. Using "woman" to apply to all those with a cervix does not do that. Second, there are other linguistic strategies available than using the "sexed" default, although identifying an adequate one requires careful attention. One option that we have already encountered is a gender additive approach, e.g.:

> 3b) All women and people with a cervix between the ages of 25 and 64 should go for regular cervical screening.[23]

An even more precise message regarding its addressees would be:

> 3c) All women and people with a cervix (which includes many women and trans men, and genderqueer and other non-binary people) between the ages of 25 and 64 should go for regular cervical screening.

These formulations are consistent with the gender additive approach prescribed by Green and Riddington (2020), but they are unsatisfactory. Note that in 3b and 3c, scope issues arise. Is the message addressed to

> i) all women, and all people with a cervix?

Or

> ii) all women with a cervix and all people with a cervix?

If i) there is a problem of overreach, since not all women have cervixes (some cisgender women and most trans women do not have cervixes). The sentence needs to capture the subset of women who have cervixes, and those people who have cervixes that are not women, in order to avoid exclusion and overreach. If ii) there is a problematic implicature: since the message does imply that women are not included in the group of people with cervixes. Thus construed the concerns about the implied dehumanization of women aired in section 3.1 arise once again (see also Gribble et al. 2022, 4). This could be resolved with the following reformulations:

> 3d) All women, trans men, genderqueer and other non-binary people, who have a cervix and are between the ages of 25 and 64, should go for regular cervical screening.

Most people will understand 3d in the way it is intended—the scope of "have a cervix" includes all the groups mentioned in the sentence. However, some readers might read the sentence as referring to all members of the groups women, trans men, and genderqueer and other non-binary people, including those who don't have a cervix. Given this, one might instead opt for 3e:

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> 3e) Everyone with a cervix (which includes many women and trans men, and genderqueer and other non-binary people) between the ages of 25 and 64 should go for regular cervical screening.

Given the epistemic issues mentioned above, we have specified that *many* women and trans men, and genderqueer and other non-binary people have cervixes.[24] It could also be worth adding:

> Consult with your care provider if you are unsure whether this applies to you.

Clearly, neither 3d nor 3e imply that women are not persons. They also have the virtue of not implying that some people with cervixes are considered the "default" or "typical" case, with others (trans men, genderqueer, and other non-binary people) considered "marginal" (see Bettcher 2013, 237, 242). So gender additive approaches themselves admit of different variations, and attention is needed to the reach, implications, and inclusivity of these different formulations. Whilst some additive language is problematic, other uses of additive language can avoid those problems.

Whilst some form of gender additive language might be the most appropriate strategy for single sources of information (such as the NHS website, which aims to provide information for all users), other sources of information may be more targeted. Another option that may serve the goals of reach, clarity, accuracy, feasibility, and inclusion would be to have multiple messages (each with incomplete non-universal statements) for different audiences. For instance, a medical centre for GP services may provide information pamphlets, and in that context more targeted messages may be feasible, including messages for cisgender women, and pamphlets about trans healthcare. It need not be problematic to have some messages addressed to "women who have a cervix" and other messages addressed to "anyone who has a cervix", so long as both are visible to the audiences to whom they are intended: for example, suitably revised versions of messages 3, such as 3d or 3e, on posters or pamphlets alongside each other. The reach, accuracy, and inclusiveness of the non-universal messages should be evaluated in their totality in these instances (rather than in isolation).

Accordingly, maximizing the overall inclusion of a message is not best done by defaulting to "sexed" language. It is better done by (careful) use of inclusive language—in this context, additive language—or multiple targeted messages, with careful attention to the reach of each message. This example focuses on a case highlighted by Gribble, but is not specific to perinatal care. So we next think through an example specific to perinatal care. Consider the following message:

> 4) All pregnant women in England are offered a blood test to find out if they carry a gene for thalassaemia.[25]

A purely gender neutral alternative would be:

> 4a) All pregnant people in England are offered a blood test to find out if they carry a gene for thalassaemia.

It is unclear whether Gribble et al.'s concern arises here: namely, that the use of gender neutral language may obscure understanding about whether the claim applies to oneself,

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because of a lack of knowledge about one's own body. Obviously sometimes people are unaware about being pregnant, but this unawareness would not be remedied by language that addresses members of one gender kind or another. (In contrast, in the case of cervical screening (discussed above), gender categories can serve as a means of making salient that someone might be in the relevant group.[26])

In this context, a gender neutral option like 4a seems preferable to some gender additive formulation as follows:

> 4b) All pregnant women and pregnant people in England are offered a blood test to find out if they carry a gene for thalassaemia.

Or even a more informative gender additive approach that specifies the groups addressed by "pregnant people":

> 4c) All pregnant women and pregnant people (which can include trans men, along with genderqueer and other non-binary people) in England are offered a blood test to find out if they carry a gene for thalassaemia.

These gender additive messages (4b and 4c) face similar worries about dehumanization that arose in relation to 3c—the implication is that women are not people (see also Cavaliere n.d.).[27] Moreover, like 3c, 4c suggests that the focus is on cisgender women who are pregnant, with other pregnant people treated as marginal. As mentioned above, a non-negligible number of trans men, non-binary genderqueer, and other non-binary people give birth using the NHS, and this number is likely under-reported. Moreover, even if statistically infrequent, it is problematic to treat trans and non-binary people as marginal: first, because this compounds their oppression; secondly, because the experience of pregnancy is rarely marginal in the life of the person experiencing it! A formulation which does not have this marginalizing implication is as follows:

> 4d) All women, trans men, genderqueer, and other non-binary people who are pregnant in England are offered a blood test to find out if they carry a gene for thalassaemia.

The gender neutral option 4a and the gender additive option 4d have the same semantic content and reach, and seem on a par for clarity and accuracy. The gender neutral expression is shorter and simpler and may be preferred for this reason. On the other hand, one concern that may favour the additive over the neutral expression (4d over 4a) is the often expressed concern that neutral language renders women invisible. This is problematic insofar as women and women's work in pregnancy and childbirth has been unrecognized and because we need to understand experiences of pregnancy and childbirth in the light of wider patterns of gender injustice. This complaint often focuses on the erasure of women, and is thus often put forward by those who would reject gender-inclusive language altogether. However, if gender neutral language renders women invisible, it does the same to trans men, genderqueer, and other non-binary people. If rendering women invisible is objectionable, then rendering trans men, genderqueer, and other non-binary people invisible is also objectionable, for their work in pregnancy and childbirth is also unrecognized—and their experiences also need to be understood in the light of gender injustice (see Cull, Holroyd and Woollard n.d. for

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further discussion of this point). However, it should be clear that women, trans men, genderqueer, and other non-binary people are not rendered invisible by the additive statement in 4d. Thus 4d recognizes the important labor of all those engaged in pregnancy and childbirth.[28] Whether considerations of recognition are more important than length and simplicity will be determined by context. A mixed approach is also possible, which initially uses the most defensible gender additive formulation to ensure recognition followed by mainly gender neutral formulations for brevity. Moreover, once again, there may be choices to made as to whether to have one maximally inclusive message (as is apt for a context that provides information to as wide an audience as possible), or multiple messages with different target audiences, as with pamphlets that provide information specifically about pregnancy to trans and non-binary audiences. If in the latter cases the formulations of the messages did not include cisgender women who are pregnant, this need not be a flaw; so long as other messages do reach cis women. The reach and accuracy of the multiple messages as a whole should be evaluated.

However, there is an additional option in this case: when addressing those who are pregnant directly, we can use the second-person and avoid either gender kinds or noun phrases altogether:

> 4e) If you are pregnant you will be offered a blood test to find out if you carry a gene for thalassaemia.[29]

In the context of perinatal care too, then, maximizing the overall inclusion of a message is not best done by defaulting to "sexed" language. It is likely better done by (careful) use of neutral or additive language, second personal language, or multiple targeted messages, with careful attention to the reach, accuracy, and clarity of each message.

4.3. Wrongful inclusion

A further worry with moves to inclusive language is that doing so may include too many people, and do so in a way that overlooks the particular kinds of care undertaken, or particular vulnerabilities faced, by those who give birth. This might be particularly problematic where there are gendered forms of vulnerability and discrimination that it is important not to obscure. Another more pragmatic worry is that overreach may have resource implications in healthcare contexts, where resources may be overstretched or misdirected.

For example, concerns about over-inclusion are raised about the language of "birthing families," or "breastfeeding families," since this may obscure the role of the person gestating and giving birth specifically, or doing the infant feeding with their body, and undermine their autonomy in relation to choices about how to do so (Gribble et al. 2022, 4; drawing on Munzer 2021). Consider the following message:

> 5) A woman's experience of childbirth can also improve with a labor companion of her choice.[30]

5 obviously fails in reach and inclusion, since it fails to address those who give birth who are not women, or does so whilst misgendering them. But substituting some gender neutral language could be problematic, such as:

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> 5a) A birthing family's experience of childbirth can also improve with a labor companion of their choice.

5a changes the meaning of the sentence, now failing to pick out the specific person who gives birth.[31] A "birthing family" could refer to the partner(s) of the person giving birth also. It also excludes those who are not part of a family. Problems arise for other substitutions, such as:

> 5a*) Everyone's experience of childbirth can also improve with a labor companion of their choice.[32]

5a* fails to uniquely refer to the person giving birth.[33] A substitution that picks out the specific birthing person would be:

> 5a**) The person giving birth's experience of childbirth can also improve with a labor companion of their choice.[34]

Another way to avoid over-inclusion is to be more precise in the description of the relevant experience: referring to the experience of giving birth rather than simply of childbirth:

> 5a***) A person's experience of giving birth can also improve with a labor companion of their choice.

Crucially, some uses of gender neutral language may include some people that it ought not (as per 5a); but some gender neutral language can avoid this concern (as with 5a** and 5a***). Consider also a formulation that uses additive language (drawing on the discussion in the previous section about the need to avoid scope-ambiguity and over-reach):

> 5b) Women and pregnant people's experiences of childbirth can also improve with a labor companion of their choice.

Again, with specific addressees:

> 5c) Women and pregnant people (including trans men, genderqueer, and other non-binary people)'s experiences of childbirth can also improve with a labor companion of their choice.

As earlier, issues arise regarding scope ambiguity and over-reach (the target is not all women, since not all women (cis and trans) give birth); what is implied (are women not people?); and the marginal status of those who are not women (those relegated to parentheses). As before, an additive option that avoids these implications better serves the goals of inclusion and reach;

> 5d) The experiences of women, trans men, genderqueer, and other non-binary people who give birth can also improve with a labor companion of their choice.

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In line with the discussion in section 4, we can agree with Gribble et al. that whilst simply "sprinkling some 'additive language' is often presented as a simple solution, it has its own risks, particularly when there is a need to be specific" (2022, 4). But this doesn't mean that additive language cannot be used in a manner that is suitably inclusive, as with 5d. Importantly, inclusive language need not be over-inclusive, so long as it is appropriately specific about who the intended audience is.

Moreover, there may be good reason to use this kind of additive, rather than neutral, language in some contexts, if one of the aims is to render visible the forms of vulnerability that women have often experienced. These forms of vulnerability may not be common to all people (in gender neutral formulation), but rather forms of vulnerability that may be experienced by women, trans men, genderqueer, and non-binary people who give birth.

It is worth considering how these issues arise in relation to inclusive language around infant feeding, since this is a particularly challenging linguistic context and one that it is important given the stakes. Breast/chestfeeding is widely recommended due to its positive impact on the health of both the lactating parent and the baby (Renfrew et al. 2012). Infant feeding decisions matter a lot to parents and are emotionally fraught, with many parents reporting significant negative experiences including guilt, shame, lack of support, judgment, or pressure from others and feeling required to justify their decisions, however they intended to feed their baby (see Brown 2018; Lee 2007; Murphy 1999). Infant feeding is also a site at which exclusion and discrimination occurs for trans and non-binary people who have given birth. For example, the LGBTQ Foundation reports that the terminology of "breastfeeding" "may induce dysphoria or discomfort for trans and non-binary parents" (2022, 10). Their survey respondents reported a lack of information about feeding their babies, and "less than half of the trans and non-binary respondents felt that their decisions around feeding their baby were always respected by midwives" (2022, 9, see also 26–31). Consider this example of language in the context of advice on how to "get the hang of breastfeeding":

> 6) This happens faster for some women than others. But nearly all women produce enough milk for their baby.[35]

This kind of language is obviously problematic in terms of inclusivity and clarity, both with reference to women, and exclusive mention of "breastfeeding" (rather than "breastfeeding/chestfeeding, or expressing your milk"). In the context of an advice page about lactation, a better gender neutral option is:

> 6a) Getting the hang of feeding can take longer for some than others. But nearly all people who have given birth produce enough milk for their baby.

Given the discussions above (and skipping additive formulations 6b, 6c, akin to 5b and 5c above), the most defensible gender additive option would be:

> 6d) Getting the hang of feeding can take longer for some than others. But nearly all women, trans men, genderqueer, and other non-binary people who have given birth produce enough milk for their baby.[36]

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However, in this context, 6a and 6d, the analogues of the gender neutral and gender additive language that appeared to be good options in the context of other examples above, are problematic. In particular, there is not yet extensive data about what trans men who have had top surgery can expect regarding lactation—because there are considerable data gaps about breastfeeding or chestfeeding for trans parents who have given birth.[37] Moreover, some trans people reportedly felt access to surgery may be jeopardized by revealing desires for future pregnancy (MacDonald et al. 2016), so discussions of potential paths (or obstacles) to lactation are often not discussed with trans men.[38] There are also other groups who may face specific obstacles to infant feeding via lactation. Those who have had mastectomies for other reasons such as cancer treatment and those with Poland Syndrome may also experience difficulties. The message above marginalizes those who cannot produce sufficient milk—and as we have noted with respect to pregnancy, these experiences are not marginal in the life of the person experiencing them.

The statement that "nearly all women produce enough milk to feed their baby" is intended to reassure parents that milk insufficiency is rare. Many people who would like to continue feeding their baby with their milk stop because of such concerns (Dykes & Williams, 1999; Tomori 2022). It may seem as if we have here a conflict between this goal of reassurance and the goal of inclusivity. It may seem that we cannot make the broad reassuring statement that almost everyone can produce enough milk to feed their baby without marginalizing those who cannot do so. However, this conflict may be merely apparent. Consider:

> 6e) Getting the hang of feeding may take a little time. But most people who have given birth produce enough milk for their baby.
>
> *Some people do require additional support with infant feeding; if you think this applies to you, do ensure this is discussed with your care providers.

or

> **Some people do require additional support with infant feeding; for more information and support click here [link to page with additional information and support].

These versions highlight the importance of being aware of the different ways particular sentences can fail to be inclusive, discussed in section 2. The first part of 6e is an incomplete non-universal. Unlike a false universal, it does not purport to cover all experiences (referring to "most people"). However, it is incomplete—and potentially marginalizing–because it leaves out other experiences. Unlike false universals, incomplete non-universals need to be assessed within the context of the overall communication. The first statement is potentially marginalizing to those who cannot produce sufficient milk or have other concerns about infant feeding and lactation; but this effect is counteracted when accompanied by the second statement (* or **) which explicitly acknowledges their needs.

As is often the case, this revision aimed at including trans, genderqueer, and other non-binary people, will also improve things for others: there are many cis women who have trouble breastfeeding and would benefit from the addition of the second sentence.

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However, both versions of 6e need to be backed up by changes that go beyond language. More content is needed: we need to know which groups need additional support. 6e* relies on care providers knowing this information; 6e** links to a page which needs to include this information. Moreover the additional support needs to be available.[39]

5. Pluralistic approaches to inclusion: caring for everyone

We have seen that adequately formulating messages that meet moral and communicative goals requires careful thought, because well-intentioned but badly executed attempts at inclusive language can fail to meet those goals. We have defended a pluralistic approach: no one strategy will meet the moral and communicative goals across all contexts. Careful consideration of the appropriate strategy for the particular context is needed.

Our discussion provides a range of strategies to draw from. In some cases, simply replacing gendered terms with a gender neutral alternative will be sufficient. In other cases, an additive approach which explicitly names relevant gender groups is more appropriate. Some versions of the additive approach face problems, including implying that women are not people and presenting trans men, genderqueer, and other nonbinary people as marginal. We have shown that there are alternative, better versions of the additive approach. In other contexts, reference to gender can be avoided altogether by the use of the second person to address the intended audience directly.

In each case, attention is needed to potential addressees (reach); preservation of semantic content where this is appropriate, or refinement of semantic content which is presently inadequate (accuracy); inclusion (in particular with a view to avoiding misgendering and marginalization). Considerations of feasibility may also determine whether one single inclusive message is needed rather than multiple messages to multiple audiences. Thus, rather than adopting a "one size fits all" approach to linguistic inclusion, revisions to make language suitably inclusive in perinatal care must be done on a case by case basis. This is of course labor intensive, but is needed in order to ensure perinatal care is delivered to all parents in a way that accords with the goals of respect, equality, and dignity.

It is also worth noting that language that is inclusive as well as accurate can serve to highlight, rather than obscure, data gaps. For example, we have shown that inclusive language can make visible where claims about vaccination risks or infant feeding are underpinned by research on cisgender women, and thus highlights the need for more research. Such research can improve the care provided to all parents in future.

Developing inclusive language well will have obvious benefits to trans and nonbinary people accessing perinatal care. Yet the benefits will not accrue to trans people alone: we have argued that inclusive language, when done well, is consistent with caring for everyone. Rather than falsely posing a tension between recognizing cisgender women's experiences and including trans people, we have shown that contextually sensitive use of inclusive language, with the communicative and moral goals in mind, is better for everyone: cis and trans alike.

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Notes

1 See, e.g., Pezaro et al. (2023); LGBTQ Foundation (2022); Crossan et al. (2023); Hoffkling et al. (2017); Fontana and Schoenbaum (2019).

2 In discussions with healthcare workers and the general public, we have found it useful to refer to this pluralist approach as a "toolbox" approach to inclusion, since it requires using a range of linguistic tools available to us. See Woollard et al. 2024.

3 The response rate of the survey was 47 percent.

4 For example: persons who access perinatal care but do not end up giving birth due to termination/abortion or miscarriage.

5 The complexity and incompleteness here concerns potential non-disclosure at two points: first, there may be some people who did not disclose their gender identity whilst accessing healthcare, and then reported on experiences of that healthcare (healthcare provided premised on misgendering); second there may be people who (whether or not they disclosed gender identity at the point of accessing healthcare) do not disclose their gender identity at the point of reporting to the CQC survey.

6 See also Bartick et al. 2021, 2.

7 NICE and Royal College of Obstetricians and Gynaecologists 2021.

8 https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england (accessed September 19, 2023).

9 https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england#nhs-values (accessed September 19, 2023).

10 https://service-manual.nhs.uk/content/inclusive-content/sex-gender-and-sexuality (accessed September 19, 2023).

11 See Dembroff and Wodak (2021) for the claim that approaches to inclusive language must proceed on a case by case basis.

12 Relevant scope here will be a complex issue, involving the jurisdiction of the healthcare organization in question, healthcare law, whether the message is general advice or a specific offer of care, access to care, and so on. Context may make clear the scope of "recent," but clearly this will vary (depending on whether the target is anyone who has ever given birth, those who have done so within the past month, year, decade, etc.).

13 See Holroyd and Cull (2024) on ascriptions of parental roles that misgender, in the context of UK parental leave policies. See also Kukla and Lance (2023) on the way that gender ascriptions can shape social spaces; and Kapusta (2016) on the harms of misgendering.

14 In a leaflet for "Dad's and dads-to-be," there was a second-personal version of this: "If your baby is breastfed you will not be able to help with feeding initially, but experienced dads know that there are many other ways of caring for, and being close to, your baby." (https://www.oxfordhealth.nhs.uk/wp-content/uploads/2017/03/CY-173.16-Dads-and-breastfeeding.pdf, p.6). "A dad's guide to breastfeeding" shows a picture of an apparently pregnant man with the caption "You can't do this but . . . " https://www.jpaget.nhs.uk/media/415120/A-dads-guide-to-breastfeeding.pdf, p. 7.

15 https://www.nhs.uk/conditions/caesarean-section/recovery (accessed September 19, 2023)

16 NICE and Royal College of Obstetricians and Gynaecologists 2021.

17 See Mohanty 1988, 2003 for problems with the framing in terms of "Western" society.

18 See also Upadhyay 2021; Lugones 2020; Jesperson 2024.

19 In the "gender additive" strategies outlined below, we make reference to genders that are widely adopted by transgender people in the UK. In some other contexts, such as Turtle Island/North America, it may be appropriate to foreground other identities, such as two-spirit, alongside genderqueer.

20 We certainly don't object to the use of sexed language *per se*, i.e., the use of terms that pick out sex characteristics of various sorts, such as "penis," "xx chromosomes," or "prostate." Such terms can usefully be incorporated into gender neutral and additive communications in ways that aid in achieving communicative

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goals. Rather, we object to the use of "woman" as a term that designates everyone who gives birth. As noted above, such usage fails on a number of moral and communicative fronts.

21 See Gribble et al. 2022, supplementary materials 1, 1. This example is drawn from the Australian Government Department of Health guidelines regarding vaccinations against COVID-19.

22 See Allotey et al. 2020; Zambrano et al. 2020, as referenced in Australian Govt Dept of Health 2023.

23 Indeed, this is the language adopted by the NHS, see: https://www.nhs.uk/conditions/cervical-screening/when-youll-be-invited/ (accessed September 19, 2023).

24 Thanks to an anonymous reviewer for prompting us to do this.

25 This is the NHS guidance currently worded, here: https://www.nhs.uk/pregnancy/your-pregnancy-care/screening-for-sickle-cell-and-thalassaemia/ (accessed July 6, 2023)

26 There are interesting questions about when and why mentioning gender categories is likely to be helpful to someone unsure whether they are in the target class for a message. In line with our focus on context, we do not seek to provide general principles to pick out when this is so, but instead recommend reflection on specific cases.

27 Another example of how context matters: adding "other" to "people" might be thought to avoid implying that women aren't people. But this has marginalizing implications for trans men, genderqueer, and non-binary people, as developed below. On the other hand, using "other" in the context of "genderqueer and other non-binary people" is not necessarily marginalizing. There is an important difference between the cases to do with the relative dominance of woman versus genderqueer qua conceptual categories in the context of pregnancy, such that "genderqueer" serves not as a default non-binary identity to which there are others, but rather, just one non-binary identity among many—of which there are too many to list. That there are so many non-binary identities (and that such identities are constantly being invented) presents a real communicative issue: one cannot list them all. Using "non-binary" as an umbrella term, leads to ambiguity: "non-binary" can mean both a specific identity (that excludes genderqueer, agender, androgyne, and so on), and a general umbrella category (which incorporates genderqueer, agender, androgyne, and so on—see Cull 2020, 162–64). This ambiguity risks a failure of reach: some people who are non-binary in the umbrella sense but not the specific sense (say, someone who identifies as agender) may not see this statement as referring to them. As such, phrasing of the form "x and other non-binary people" can be employed to make clear that non-binary is being used in the umbrella sense. This is one area where evolutions in language may require revisiting the use of "other" in future.

28 An anonymous reviewer pointed out to us that in some languages, such as Spanish, the language in cases like 4b is seen as dehumanizing not because it implies women are not people, but because it creates a hierarchy in which some identities are named (pregnant women) but others (pregnant trans men, genderqueer, and other non-binary people) are referred to solely by their reproductive status, threatening to reduce them to mere bodies. As noted, our arguments pertain only to English-language attempts at inclusion, and different considerations may arise in different languages. (See González Vázquez et al. (2024) for discussion of trans inclusion in Spanish, Italian, and German.) We argued earlier that, in English, expressions such as "persons who give birth" foreground the personhood of those gestating and so should not be seen as dehumanizing. Nevertheless, in any language, the above-described hierarchy is certainly objectionable. We have already noted that some additive approaches should be rejected because they position pregnant women as the default, marginalizing trans men, genderqueer, and other non-binary people who are pregnant (see Bettcher 2013, 237, 242, for concerns about marginalization). Similarly, we should reject additive approaches that recognize women's identities, but not the identities of trans men, genderqueer, and other non-binary people—particularly in the light of the reasons that all groups have to desire recognition of their identities in the context of pregnancy. Fortunately, these objections do not apply to other gender additive approaches like 4d.

29 Notably, the concern about women being rendered invisible is rarely raised with respect to these second personal formulations, though the term "woman" is absent from them.

30 WHO 2020.

31 Notably, this complaint faces the original formulation in 5. 5 fails, after all, to specify which woman's experience can improve. Does it refer to the birthing parent? Her wife? Her mother? A female medical professional who is attending the birth? 5 does not specify this.

32 It's also worth remembering that not everyone's experience of childbirth will improve with a labor companion: the "can" is an important part of 5a*.

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33 Does really this fail to uniquely refer to the person giving birth? In correspondence, Jennifer Saul has noted that a natural reading of 5a* is that it *does* uniquely refer to persons giving birth. Compare (her example): "everyone's experience with moving to another country is packed with bureaucratic hurdles." This sentence clearly doesn't imply that every person moves to another country: it has an implicit scope-restriction. However, even if the most natural reading of 5a* is one that features such an implicit scope-restriction, the sentence still has other readings that are salient. These other salient readings generally need to be ruled out in high-stakes contexts where the audience is large and varied, such as in public health messaging.

34 An alternative phrasing would be: "the birth parent's experiences . . . " Note, though, that not all people giving birth will consider themselves parents, so this may be inapt.

35 https://www.nhs.uk/conditions/baby/breastfeeding-and-bottle-feeding/breastfeeding/the-first-few-days/ (accessed July 6, 2023).

36 We set aside other formulations: 6b) All women and people who have given birth tend to produce enough milk for their baby, though getting the hang of feeding can take longer for some than others. 6c) All women who have given birth and people who have given birth (which can include trans men, genderqueer, and other non-binary people) tend to produce enough milk for their baby, though getting the hang of feeding can take longer for some than others. These options face the same concerns about dehumanization and marginalization, and don't need to be rehearsed again here.

37 Although in fact, elsewhere on the NHS website, alternative information to this effect is available: https://www.nhs.uk/pregnancy/having-a-baby-if-you-are-lgbt-plus/chestfeeding-if-youre-trans-or-non-binary/#:~:text=Chestfeeding%20if%20you%27ve%20had,offer%20your%20baby%20supplementary%20feeds (accessed July 6, 2023).

38 See also MacDonald et al. on how informed discussions about lactation after top surgery is reportedly significantly hindered by simplistic understandings amongst some medical professionals of trans people as "trapped in the wrong body," such that the possibility of trans men's future pregnancies are not considered (2016, at 5–6, 14–15).

39 Here it is worth noting that those who have not given birth may also want to feed their babies with their milk and need support for this. Non-gestational parents often face significant barriers to breast/chestfeeding. It is often extremely difficult for them to access lactation related support because they are not recognized as patients of perinatal care, even where they may be the genetic parent. Often they may request access to the appropriate medications to induce lactation to then be refused, where a heterosexual person would be given it should they require it. They may even be denied access to their children e.g. when the children are in hospital and policies around visiting hours assume that only the gestational parent will be lactating (LGBT Mummies and Proud Foundation 2023).

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