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Intersectionality and challenges in support for chest-feeding transgender men

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Abstract *This article tried, from an intersectional standpoint, to grasp the challenges experienced by health professionals and service users of human milk banks in provision of care for transgender men chestfeeding. This exploratory, descriptive qualitative study drew on interviews of six human milk bank staff, who had previously assisted trans men in relation to chestfeeding and two bisexual trans men, who chestfed. The data was treated by thematic analysis, supported by Atlas.ti software, version 9.0. Lacunas in the educational, institutional and management spheres, associated with personal and social issues, reproduce a pre-conceived normative model and disregard the special demands of providing chestfeeding care for the trans population. Cisheteronormativity and "professional supremacy" operate in personal, social and institutional respects to segregate transgender men in lactation support services. Intersectional analysis of these challenges affords an overall view of segregative factors and enables public policies to be introduced to promote social justice.*

Key words *Transgender, Lactation, Health service access barriers, Milk banks, Intersectional framework*

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Introduction

Society is made up of families in a plurality of formations. Families of people who are Gay, Lesbian, Bisexual, Transgender, Queer, Intersex, Asexual, Pansexual and other variations of gender identity and sexual-affective orientation (LGBTQIAP+) are a kind of arrangement that deviates from cisheterosexual norms. Given this variation in family constitution, emerging forms of parenthood, which can happen by way of natural pregnancy, adoption or assisted reproduction techniques, are involving parents in a constant movement of resignification of identities, gender relations and social norms[1].

Just as with the right to family and parenthood, there are reproductive rights, which demand support for children's nutrition and suitable food and raises the issue of breastfeeding a manner of exercising those rights[1].

Breastfeeding, a practice encouraged worldwide, offers advantages well substantiated in the literature, as well as reducing infant morbidity and mortality. The Brazilian network of human milk banks (HMB) acts strategically in this process, as a reference point in promoting and supporting breastfeeding and offering guidance for nursing mothers and human milk processing[2].

Human milk banks in Brazil cite promotion of women's and children's health as a guiding principle and act as an important component in efforts to reduce maternal and neonatal mortality. Accordingly, breastfeeding at human milk banks is regarded as a female act, contributing to the invisibility of this reproductive right of trans men, who can breastfeed[2].

The transgender population faces numerous obstacles in accessing health services marred by prejudice and marginalisation and resting on cisheteronormativity. Patterns of behaviour and social expectations shape the stance from which professionals tend to perform their activities and involve interconnected personal, social, cultural and historical issues[3].

In that light, intersectionality offers an analytical framework that encompasses and connects the component elements which result in this population's being segregated in various health services[4]. The social actors involved in the breastfeeding support process require qualified listening to reveal the challenges that have marred care for nursing transgender men. This study is unique in exploring the obstacles to this interaction in breastfeeding care in Brazilian scenarios, with a view to informing efforts to address the inequities.

Given the above, this study endeavoured, in the light of intersectionality, to understand the challenges posed by the experiences of HMB users and health professionals in care for transgender men in relation to chestfeeding.

Methodology

This exploratory, descriptive, qualitative study involved health professionals from three public HMBs in the State of Pernambuco, who had previously assisted trans men in relation to chestfeeding, with actions to promote, protect and support chestfeeding and carry out human milk collection activities.

The health professionals were selected initially following contact with the managers of Pernambuco's nine public HMBs. Face-to-face visits were made to all shifts so as to include all professionals in these sectors, to present the study and ascertain their interest in participating. The respective managers were asked to message their work groups via WhatsApp, every two weeks for six weeks, to remind teams of the possibility of participating in the study.

The convenience sampling concluded when two weeks passed with no further responses from potential volunteers. Data collection, based operationally on exhaustion-saturation[5], ended with six health professionals included. Professionals absent during the data collection period were excluded.

Trans men who had chestfed their babies for at least 1 month in the last 5 years were selected by "snowball" sampling, the first participant being nominated by a specialised LGBT care service. The researcher contacted this trans man via WhatsApp to provide information about the research and, through him, it was possible to nominate another participant, totalling two bisexual trans men. A third trans man withdrew from participating in the research, citing personal reasons.

The interview scripts were used for each group of participants to consider the challenges in caring for trans men in breastfeeding support services. Each participant was interviewed once, between August and October 2022. Interviews lasted an average of 30 minutes and, with the prior authorisation of the participants, were recorded and transcribed. Each transcription was then validated by the respective interviewee. After responding to a questionnaire to record their socio-demographic characteristics, participants were interviewed and their physical characteris-

tics were recorded in a field notebook, along with those of the HMB environment.

The health professionals were interviewed in person, in private rooms at their workplace. One trans man was interviewed online via Google Meet and the other, in person, in a private setting in a shopping centre in the Recife metropolitan region, Pernambuco.

With a view to anonymity, participating health professional were designated as PS, followed by an ordinal number, in order of interview, plus the letter M or F, depending on their sex at birth, and another ordinal number for their age (example PS1-M40). The same logic was applied to the trans participants: the term USS signifying health service user, plus the letter M, as they all described themselves as trans men (example USS2-M32). The mention of the health professionals' biological sex was justified by a lack of knowledge, on the part of some of them, of the meaning of gender identity.

The analysis was carried out in pairs following the thematic analysis proposed by Braun and Clarke[6], for each segment of group of participants, following the six steps and using Atlas.ti (version 9.0) software as a support tool (Figure 1).

The interviews began after a declaration of free and informed consent was read, explained and formally consented to, in person or virtually. The study was approved by the research ethics committee of the Universidade Federal de Pernambuco under Ethical Appreciation Presentation Certificate No. 58300022.1.0000.5208 and conducted in accordance with the topics of the Consolidated Criteria for Reporting Qualitative Research (COREQ)[7].

Results

The presentation of chestfeeding experiences with HMB professionals and trans users of health services were preceded by participant characterisation data.

The health professionals' ages ranged from 25 to 60 years, a mean of 43 years. Mean length of professional experience was 18.5 years, of which mean time working with the HMB was 10.8 years, ranging from 18 months to 18 years. Four professionals were born in Pernambuco, one in Santa Catarina and another in Ceará. All self-declared themselves to be heterosexual. Two declared they were cisgender; the others did not know the meaning of gender identity and could not self-declare. Four reported their biological sex as female and two, as male. All had higher education; two were coordinators, three, nursing technicians and one, a nursing auxiliary. The four women were married, one male participant was single and one reported 'living together'. One professional worked in the HMB1, two, in HMB2 and three, in HMB3.

All reported assisting only one trans person in relation to chestfeeding. One of them mentioned prior training in assisting the public in view of gender diversity and sought further training af-

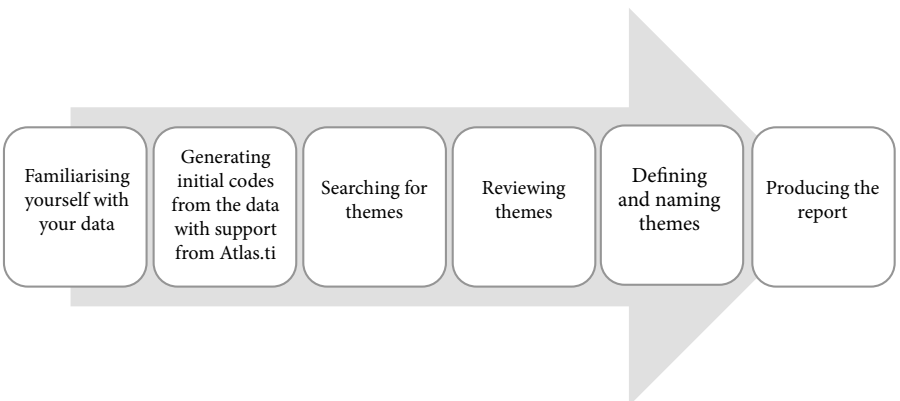

Figure 1. Steps for performing Thematic Analysis, Recife-PE, Brazil, 2022.

Source: Adapted from Braun and Clarke[6], with the addition of specifics of this study.

ter the initial session. None of the participants' training or undergraduate courses addressed the subject of gender and sexuality. During visits to the HMB facilities, there were publicity materials encouraging breastfeeding by cisgender women and photographs of family formations with cisheterosexual parents, but no references to the LGBTQIAP+ population.

The transgender men who were SUS national health service users, were of mean age 32.5 years. They had facial hair, short hair and used loose clothing during the interview. Both were bisexual, white and had suffered embarrassments in health services because of their gender identity. At time of interview, none had undergone breast surgery or procedures. Other sexuality-related characteristics and socio-demographic markets are described in Chart 1.

Analysis of the interviews and field diary resulted in three thematic categories: I - Trans men in the HMB? Who are they?; II - Personal/social challenges in assistance for trans men in an HMB; and III - Institutional/management challenges in assistance for trans men in an HMB.

Trans men in the HMB? Who are they?

The first thematic category related to the professionals' impressions of the presence of trans men in the HMB environment. It revealed that, in that contact, there were doubts as to sexuality-related terms and in the notion that body-modification surgeries were necessary in order to be a trans person. Although they had assisted only trans men, the professionals used female adjectives in their reports:

[...] First, I didn't know what a trans was. No-one had told me anything. They just said to go to such-and-such a ward. I imagined it was someone wanting to breastfeed, but when I got there, I found a male individual [trans man] (PS1-M25).

[...] The first difficulty was this question of addressing him or her. Because the thing wasn't very clear yet and then there were problems of him asking to be called 'he', but then the official name was a female name. He didn't have a male [social] name yet. Partly because he hadn't even had any surgeries yet (PS4-F50).

The sensation of strangeness was present in the professionals' accounts of when they realised that a man would like to chestfeed. The perception was that the chestfeeding would not take long, surprising the HMB staff.

[...] I felt the impact of the beard and was afraid that the [female] patients who used the milk collection room would feel some kind of constraint towards him, because of his physical appearance (PS2-F60).

[...] When I arrived, I found it strange. I swore she [trans man] wasn't going to want to chestfeed. Because, like, in my mind, someone who wants to change sex, wants to be a man, isn't going to want to have a baby at breast... But, after four months, she came in and said: "It's just chestfed". That was a surprise for everyone (PS3-F36).

[...] It blew my mind, because how is it that a person wants to change their body type completely, not see themselves as a woman, take on the physical characteristics, everything, of a man... It's a man who's going to chestfeed. It's strange dealing with that (PS4-F50).

Personal/social challenges in assisting trans men at a HMB

In this category, what emerged were personal and social challenges in assisting trans men in lactation support services.

Reports from other colleagues of previous negative experiences in the hospital environment raised fears of dealing with trans men in the HMB environment and fear of committing transphobia. One [female] professional felt oppressed in entering dialogue with the user:

[...] There had already been a problem with another professional, not at the milk bank... So I think that this already caused this reluctance... about saying something that might cause some upset. I was always remembering, used the fewest words, just whatever was important... I said [neutral] "you" a lot and even avoided conversation (PS4-F50).

[...] Sometimes it ties your head in knots and the fear of saying something that will cause the person harm, to get hurt... You want to do your best, but without discriminating in any way (PS5-F48).

Professionals reported their perceptions of trans men during chestfeeding-related care. They told of apparent embarrassment, neediness and misgivings about the attitudes of professionals and other women in the HMB environment. These perceptions aroused empathy and a wish to minimise discomfort during their stay at the hospital and the HMB:

[...] I noticed he was very quiet... It seemed there had been a moment when he wasn't so happy or comfortable in that situation. Being trans and being in a ward with a number of young mothers, you may feel out of place. I think that with a little more care, he could have been placed in isolation.

Chart 1. Characteristics of trans health service users, Recife-PE, Brazil, 2022.

Number	USS1	USS2
Age	32	33
Place of birth	São Lourenço, Pernambuco	Recife, Pernambuco
Religion	None, but believed in God	Atheist
Marital status Civil	Engaged	"Living together"
Education	Upper secondary	Postgraduate
Profession	Barber	System developer
Family income	<2 minimum wages	2 to 4 minimum wages
Residence	Owned	Rented
Lived with	Father/mother/son/nephew	Son/partner
How many living in household (including you)	5	3
How many children?	1	1
How did you become a father/ mother?	Natural pregnancy	Natural pregnancy
Pregnant how many times? Desired/planned pregnancy? Miscarriages?	1 No No	1 Yes No
Health problems? Which?	Glaucoma, Systemic arterial hypertension, Type 1 Diabetes mellitus, Hypothyroidism	No
Medications? Which?	Insulin, Levothyroxine, Losartan/ hydrochlorothiazide, Atorvastatin, Testosterone	Testosterone
Who do you usually go to when you have health-related problems/doubts?	Friends Health professional	Health professional
Do you avoid health services for fear of embarrassments?	No	Yes

Source: Authors.

I'm not saying to isolate him, but he would feel more comfortable, because they are different realities (PS1-M25).

[...] What I felt was that he was needy, that he needed support... He felt very comfortable. He talked openly with me... His reception had an initial impact with the 'he said, she said', people laughing, but then the mothers themselves [attending the HMB] gave him a wonderful welcome... He also reported being a little embarrassed (PS2-F60).

[...] She [trans man] came in a little defensive... She felt excluded at some point and that meant she was sometimes a little harsh with the staff. At some point she must have been upset, but she didn't bring that to the chestfeeding moment... If she needed anything, had any difficulty, then she could come to the room for more intimate assistance which would be working directly with the patient (PS5-F48).

[...] At first he wanted to [milk alone], but later he got into the routine of milking at the same time as the other patients. At first, he needed that care because he said, I don't know how it will be with the others, right? How the women will react (PS6-M39).

Personal elements may have hampered interaction between professionals and users. The professionals' religiosity and upbringing within normative social expectations are recognised to be possible obstacles, while there are efforts to redefine their worldview on gender issues:

[...] I come from a very religious family. And, like it or not, prejudice exists. What's more, it's not that easy for a trans person to arrive at the service and be well attended to (PS1-M25).

[...] To me, it was really challenging and I was a little reluctant, because I am evangelical and I confess that at first you start to think about the values that are built up in the course of your life, as well as the things that are taught through religion. There are a lot of trans people, a lot of LGBT people. I know that everyone has rights and duties, but sometimes they don't remember that we were raised and came here in line with the standard

– and we are moving away from that standard (PS5-F548).

One professional mentioned the possibility that care would be more inclusive if the trans person verbalised information about their sexuality, their family structure and their expectations regarding breastfeeding to the HMB team:

[...] There are cases of homoaffective relationships... that arrive here and no-one realises and we don't even have the opportunity to provide proper care, that different view, because of the patients' own failure to say what their situation is (PS2- F60).

Transphobia was present in the public environments, in the public's acts of extreme curiosity, staring, unauthorised photographing and filming of chestfeeding trans men:

[...] breastfeeding is a more sensitive issue. I say that because, when I used to go out with a beard, with my daughter, I would take my breast out to chestfeed. I've seen people filming, staring. If I didn't have a firm hand to stand up to them, stare back and say, what's up? My daughter's not going hungry! Want to take a photo? Never seen a man chestfeed, have you? I'm not a freak. She's my daughter. And it was me who gave birth to her! (USS1-M32).

[...] We didn't have much of that experience of chestfeeding away from home [because of the COVID-19 pandemic], which certainly could perhaps have led to transphobia lawsuits (USS2-M33).

Despite the advantages, chestfeeding can be a difficult path to take and is sometimes romanticised as something perfect and exclusively the responsibility of the 'mother', to the exclusion of the father figure. The trans men reported difficulties including pain and engorgement, which are conditions encountered by cis women:

[...] Breastfeeding is not normally easy and it's not as romantic as people say.... What often happens is that we see that the burden is on the mother alone, only the mother takes the load and the father is often excluded (PS5-F48).

[...] You can't pre-define it and think that breastfeeding is wonderful. I'm not talking about the value of breast milk or breastfeeding or bonding or anything (PS2-F60).

[...] When she [the baby] started to chestfeed, she was suffocating, because I had a huge breast, my breast grew I think about three times bigger... a nurse and her father helped me (USS1-M32).

[...] This first month was terrible. It hurt like hell... (USS2-M33).

In this category, breaking with a romanticised idea, there is a consensus between users and professionals as to the difficulties in the act of breastfeeding. Fear was felt by the groups of participants and affected the dialogue between them. The PSs expressed fear of acting with prejudice and reported a variety of USS attitudes, ranging from shyness to harshness. Fear was also reported by the USSs, who perceived a vulnerability to exposure to violence, because of the act of breastfeeding.

The PS acknowledged the influence of religion and normative cultural standards in shaping relationships between professionals and trans men in the chestfeeding process.

Institutional/management challenges in assisting trans men at the HMB

Both trans men wanted to chestfeed. One of them attended a public HMB and reported having been asked by a professional how a man could chestfeed. The other trans man was seen by a private consultant, who saw lesbian women and had a better idea of inclusiveness, and he commented on health professionals' lack of knowledge of gender-inclusive terms:

[...] The professional asked me, "How's that, a father who breastfeeds? Excuse my rudeness, but I'd like to understand". I sat down with her and explained, I have a uterus, I have a vagina. I couldn't get pregnant, but God wanted me to get pregnant. She said, "But didn't God allow that as a sign to you to recognise yourself as a woman?" I said, "I don't have to be ashamed". Then she said, "But aren't you afraid your daughter won't accept you?" She will grow up knowing the truth... I want to raise her free, so she can understand and be unprejudiced. That's when she said, "Really, you're right, I'd never thought of it that way" (USS1-M32).

[...] I had a very good experience, because my chestfeeding consultant was already working with a lot of lesbian women. She said: "I'll be very honest, I'm not prepared to serve you. Here, I'm looking at all my materials and they're not inclusive". It was amazing! Because it is not easy for us to find people in the health sector who understand that they are getting the terms wrong. It's not breast milk, it's human milk (USS2-M33).

The trans man perceived the HMB as feminine, with a tendency to use feminine terms when addressing users and corrections by users as to names suited to their gender identity. The apparel for expression was a cause of discomfort and endeavours were made to be inclusive by listening to the user to minimise anguish:

[...] It was difficult for me to express milk, because I saw that there were only women there and I didn't want to wear the gown, I felt very bad about it. I felt feminine. The doctor said "Feel free to be

who you are". But regardless of the prejudices, of people calling me 'her' and me correcting to 'him', I had to be there because it was a matter of my daughter's depending on it (USS1-M32).

The lack of professional preparedness associated with the HMB team's scant contact with trans people meant they knew little about chestfeeding in the trans population and, consequently, could not share that experience with their peers. All participants saw only one trans man at their respective services.

[...] I think that if there were more [trans patients], we would have more experiences to be able to share (PS1-M25).

[...] I don't know much about this, because I only had this contact, with one person [trans man] and… I don't know much about transsexuality either (PS3-F36).

Aggravating this situation, professionals point to difficulties in accessing scientific studies on chestfeeding in trans men. The doubts arose as to whether pregnancy could occur while testosterone was being used. One professional discussed the lack of care protocols for this population from higher authorities:

[...] We have a state breastfeeding committee that holds very important discussions... We have important protocols abroad, thinking about inducing lactation in same-sex couples with results, but we don't have validation here yet (PS6-M39).

[...] It is very difficult to get a scientific study, it is not easy for you to study (PS2-F60).

[...] This change of taking male hormones and even then ovulating, getting pregnant... That part was a bit lacking, that scientific understanding of what could be happening (PS4-50).

One trans man noted gaps in knowledge about the chestfeeding pathway, mainly about the safety of testosterone during lactation:

[...] We need to think about studies that can guarantee that we use testosterone [during chestfeeding] or can actually provide an answer to this (USS2-M33).

Professionals' excessively curious attitude to trans men's intimacy and sexuality can cause embarrassment. There is concern about the possibility of trans men's experiencing transphobia for chestfeeding:

[...] There is the issue of also understanding the other's intimacy, not wanting to be invasive... I'm not against answering. Because sometimes the person has a doubt, but it is the way you say it (USS1-M32).

[...] I worry a lot about the trans men who are coming, about the issue of being fathers. I've never suffered aggression, but someone could, because a man with a beard breastfeeding a child… They may end up thinking it's absurd and there could be aggression, both physical and verbal (USS1-M32).

In this category, both groups of participants were agreed regarding knowledge gaps, lack of scientific studies and protocols that result in obstacles to inclusive care. That situation meant the USS needed to act as an educator in the HMB environment.

The HMB professionals' reports showed their experiences and challenges they faced in offering safe, discerning care to trans men in the chestfeeding process. Trans men reported experiences regarding the specificities of chestfeeding and the challenges they faced in specialised lactation services. Grounding the study on the principles of intersectionality afforded a better understanding of the inequalities and discrimination suffered as a result of established social paradigms of power. The discussion that follows is based on the consolidated reports, as proposed in Figure 2.

Discussion

This qualitative study endeavoured, in the light of intersectionality, to understand challenges in the experiences of human milk bank users and staffs in the provision of assistance to transgender men in relation to chestfeeding.

The central ideas of intersectionality – social inequality, intersectional power relations, the social context, relationality, complexity and social justice – act as analytical and problem-solving tools, with a view to assimilating the social, structural and institutional reasons that associate to marginalise care for the LGBT population and to proposing public policies to favour social change[4]. Overall, the findings of this study show the need to break with breastfeeding-related paradigms shaped by cisheteronormativity.

The structure of educational institutions in Brazil reflects the scant attention given to the subject of sexuality and affects health professionals' knowledge in care for the trans population. A 2021 survey in São Paulo State revealed the existence of 264 nursing courses. Course educational plans for 19 of these were available for analysis; only nine featured curricular syllabuses with subjects relating to the health of the trans population, and approaches to the subject were limited[8].

The manner in which the trans population is approached in undergraduate nursing courses is insufficient and too superficial to guarantee com-

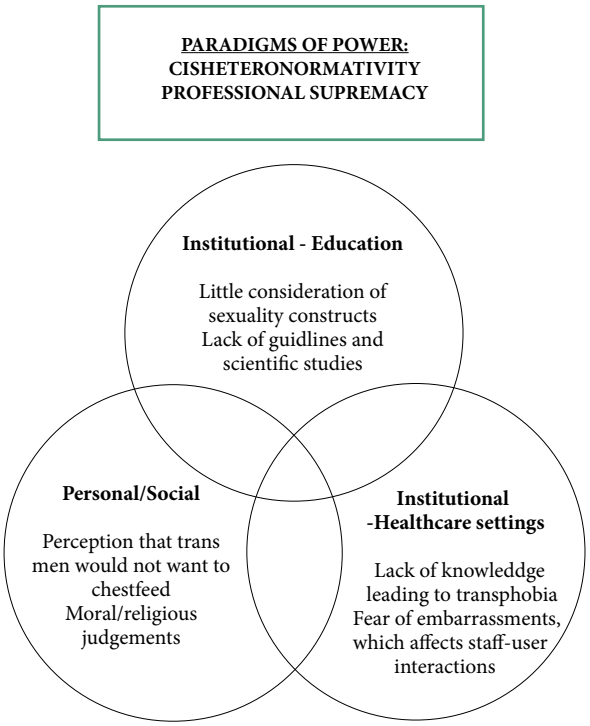

Figure 2. Social paradigms of power and an intersectional perspective on equity in support for chestfeeding by trans men. Recife-PE, Brazil, 2022.

Source: Authors.

petent, comprehensive care for this group. It is also importance that capacity be built in teaching staffs to break with cisheteronormative paradigms in the educational sphere, and practical experience with this population is important in order to develop greater understanding of gender issues[9].

The health of the trans population is rarely described in courses in interdisciplinary health areas, such as Medicine[10] and Nutrition[11]. This is a substantial obstacle to health access, as lack of knowledge about the specifics of this population, such as failure to use social names or gender-inclusive terms and the presumption of gender identity based on appearance, can cause trans people to abstain from seeking health care when they anticipate the possibility of transphobia[12].

Cisheteronormativity is evident in the educational sphere, in that it assumes that everyone is heterosexual and cisgender. The social inequality resulting from this thinking and from gaps in education constitutes one of the pillars for intersectional analysis[4] and results in a lack of equal access to health services.

Given that not all the trans men reported problems with chestfeeding itself, it is worth considering the mental repercussions resulting from stigma in environments regarded as "feminine" and lack of professional preparedness to work with the trans population[13]. Overlaid on this is also the hierarchical power of professional knowledge, a tool based on the public health paradigm, which prioritises the advantages of human milk for children's health, without valuing the desires and feelings that permeate the act of breast-/chest-feeding[14].

Cisheteronormativity and the biomedical model of care constitute power structures that intersect in producing inequities and influence individual attitudes in society[4]. Horizontal dialogue between health professionals and users permits mutual learning, bonding and sharing of life experiences[15], and is an important factor in breaking with the power structure of the hierarchy of professional knowledge and of cisheteronormativity itself, by applying continued professional development policies in health care.

The perpetrators and locations of violence suffered by trans bodies can differ. Although a Chilean study found that transphobic attitudes occurred more prevalently among strangers, in a sample of 101 people, 16.67% of trans people suffered prejudice from health professionals and 13.3% reported violence in health centres. Participants in the study reported here said that discrimination seemed to begin when there was recognition that the person was part of the LGBT+ population, with the fear of suffering prejudice greatest among the trans population[16].

In a Brazilian study[17], when other identity markers, such as blackness and disabilities, occurred in association with transgenderism, the percentage of adverse experiences among the trans population in health services increased. Economic inequalities are also segregative factors in the trans population's access to health services[17] and may be related to the obstacles encountered by the participants in this study, both of whom were SUS users earning less than 4 minimum wages. The importance of intersectional relationality between different markers of segregation is explained, which reinforce one another in intensifying disparities[4].

The fear of violence can be seen explicitly when users avoid discussing their gender identity and other sexuality constructs with health professionals. That blockage can result in failure to include the non-pregnant partner in the chestfeeding process and to provide information to allow the family to decide how best to feed their child. These possible manners include relactation, translactation, partner-induced lactation, colactation and use of formula milk, if necessary[18,19].

Even when desiring inclusive care, HMB staff's the speech is notable for using female names when referring to trans men. "Her", "mother" and "breast milk" were used, which constituted "unwitting" micro-aggressions on the part of professionals that brought discomfort to the USSs in this study. It is more inclusive to use appropriate pronouns and avoid ingrained terms, such as breastfeeding for chestfeeding or lactation, and it is important for users to mention the terms they would like used to refer to them as parents[18,19].

The use of names that do not match patients' gender identity is called misgendering and is a micro-aggression described in the literature. Even when occurring unintentionally, it can have various adverse mental effects, including gender dysphoria or anguish related to differences between gender identity and bodily characteristics or others' perception of one's gender[12].

Despite gaps in undergraduate education and doubts during care, health education measures for HMB staffs were scarce. This finding corroborates a study in emergency environments, where most health professionals were not instructed on how to care for trans people, even though they had provided care for them[20]. There is evidence that this minority's needs are not seen clearly and continued professional development to address these limitations is lacking, exacerbating inequalities in access to health.

Difficulties were encountered in studying the topic of chestfeeding in the trans population due to the scarcity of Brazilian articles addressing the topic. One integrative review on lactation induction in trans women published in Brazil this year included nine articles, none of them Brazilian[21].

Another integrative review about the experiences of pregnant trans men considers chestfeeding, but only in international articles[22]. One article reflected, from the perspective of intersectionality, on the use of neutral language in the field of lactation. It also cited obstacles, including failure to apply knowledge in lactation induction and ignorance of the fact that trans people can become pregnant and chestfeed[23]. There are no guidelines covering the necessary specifics to equip HMB professionals to accommodate this population, which leads to doubts and inequity in care.

Personal and social issues also figure prominently in this list of difficulties. These professionals culture and life history can be reflected in the treatment provided to minorities, while institutions, such as family and religion, rest on cisheteronormative norms that extend to social relationships, thus worsening discrimination[3]. The importance of this fact is exemplified in a study citing transphobia as a preponderant factor in health professionals' acquisition of knowledge, despite increasing hours spent on their education[24].

Religiosity, another personal and social issue, tends to be tied to the cisheteronormative standard, with transphobia internalised and discrimination extended to social relationships outside the religious environment. Religious groups attempt to reconcile Christianity with non-heterosexual sexualities and/or transgenderism[25], thus providing opportunities for inclusiveness. At this juncture, professionals who serve the trans population should think about their role in perpetuating inequalities and how their intersecting opin-

ions and social positions affect their relationships with minorities[26].

The interconnections among personal, social and institutional factors highlight the core of complexity in intersectional analysis of various different structures in the production and maintenance of inequalities, all added to the complexity of the act of chestfeeding itself. Also important is to understand the context where power relations occur, as well as the culture and society that shape individuals and influence their postures[4].

A Chinese study found that discriminatory attitudes in health services, dysphoria and prior hormone therapy may relate to lower rate and duration of chestfeeding in the trans population, as compared with the cisgender population. One third of the 647 participants decided to chestfeed exclusively, while 58.7% chestfed for less than 6 months[27], a percentage below the World Health Organisation target for the 2030 Agenda[28]. The desire to resume testosterone use may be implicated in cessation of breastfeeding. Despite reports of this hormone's being used during lactation[23,29], there is no evidence it is safe for the baby's health[13].

Although not related explicitly to intersectionality, there does seem to be an overlap between the tools of cisheteronormative power and the biomedical model of care in favour of early weaning, when mention is made of the violence suffered by trans bodies and this population's worsening mental health in healthcare environments.

Discourses and practices that generate and perpetuate disparities in health institutions, including HMB settings, can be analysed using intersectionality to examine accounts of individuals' experiences[26]. Broader awareness of these obstacles will permit public policymaking and implementation in favour of social justice, a pillar of intersectionality[4], in order to eradicate barriers to trans people's access to chestfeeding support services.

Final remarks

Cisheteronormativity and professional supremacy operate in the personal, social and institutional spheres to segregate the transgender population in chestfeeding. Health professionals' worldviews, imbued by family and religious institutions and society itself, operate jointly with muting of the topic in the educational contexts of health professionals' undergraduate and other training. There are also no protocols covering the possible manners of feeding a baby in non-normative families to guide professionals supporting chestfeeding.

Health professionals occupy a position of power, which is reflected in their relations with trans people in relation to chestfeeding, highlighting the importance of this practice for the child's health, on the public health paradigm, to the detriment of the subjectivity of those who chestfeed. The trans population occupies a place from which to denounce discrimination and voice demands for transcompetent care.

Intersectionality offers a broader view of these inequities for them to be considered as a whole when implementing public policies for equitable care for the trans population in HMB environments.

This study had limitations. The first was the small sample of health professionals working in HMBs and of trans health service users, which may relate to taboos on the subject of gender identity. The second was that participants were exclusively bisexual, trans men in the context of chestfeeding, while trans women wishing to lactate were not included. The lack of articles on chestfeeding among Brazil's trans population precluded comparisons with the international trans population or with cisgender women in Brazil.

Collaborations

DLS Galvão and EMM Monteiro participated in data collection and writing the article (introduction, methodological design, results and discussion and final remarks). WJS Araújo, W Brandão Neto and MBSC Barros participated in preparing the article (introduction, methodological design, results, discussion and final remarks).

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