


EMPIRICAL STUDIES

Professionals' experiences of supporting two-mother families in antenatal and child health care in Sweden

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Abstract

Background: In Sweden, antenatal and child health care are offered free of charge to all expectant and new parents. Professionals in antenatal and child health care play an important role in supporting parents. Previous research shows that same-sex mothers face heteronormative assumptions and insufficient support during their transition to parenthood.

Objective: To explore professionals' experiences of supporting two-mother families in antenatal and child health care.

Method: A qualitative method with focus group discussions was used. An interview guide was followed, and the discussions were held online. The data was analysed according to inductive content analysis.

Settings and participants: The participants were midwives ($n = 8$) and nurses ($n = 5$) in antenatal and child health care from different parts of Sweden. Participants were recruited through the coordinating midwives and child health care nurses in the different regions.

Findings: One main category was identified: *Striving to be open-minded in supporting same-sex mothers*. Health care professionals described meeting well-prepared mothers, with an equal commitment between each other, and mothers on guard against heteronormative views. Professionals provided support through empowerment by creating a safe environment and aiming at providing equal support to all parents or tailored support to same-sex mothers. Mothers described handling challenges, as a balancing act to acknowledge both mothers. Struggling with documents and communication and a lack of information were other challenges to be handled. Professionals reflected on their own professional competence and expressed that knowledge acquired through education, experience and personal interest all contributed to their competence.

Conclusions: Forms and documentation need to be updated to be gender neutral to be including to a variety of family constellations. Health care professionals need time to reflect on norms and challenges to better support both mothers in a two-mother family.

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KEYWORDS

antenatal care, child health care, focus groups, health care professionals, parental support, qualitative, same-sex mothers

INTRODUCTION

Professional support is important during the transition to parenthood. Health care professionals in antenatal and child health care have the important task of supporting expectant and new parents [1, 2] both during encounters with parents and parents-to-be and in the parental groups. Heteronormative assumptions, that is, a norm where heterosexuality is taken for granted [3] and insufficient support in antenatal and child health care are reported by same-sex mothers [4–8].

Especially non-birth mothers lack sufficient support [8, 9].

BACKGROUND

The goal of Swedish health policy is to offer good health care to all on equal terms [10], and Sweden offers antenatal and child health care to all expectant and new parents free of charge. In 2005, female couples gained access to assisted reproduction with donated sperm at Swedish clinics [11], and professionals in antenatal and child health care are now likely to encounter two-mother families. Midwives and child health care nurses play an important role in supporting parents both in individual meetings and parental groups. Within antenatal and child health care, a heteronormative nuclear family ideal still prevails [4–8], even though changes in legislation and in society to some extent have modified this biased view of family formation.

Previous research reviews show that same-sex mothers face heteronormative assumptions and insufficient affirmation and support within antenatal and child health care [6, 12, 13]. Same-sex mothers experience the transition to parenthood as stressful and parental groups in antenatal and child health care as not very supportive, and non-birth mothers lack sufficient support in their transition to parenthood [9].

Previous international and national research

A Swedish study describes that some midwives and child health care nurses found it challenging to handle diversity in parental groups and expressed a lack of competence to identify the parents' needs and provide

individual support [14]. Targeted parental groups are offered within Swedish child health care to reach parents with twins or adopted children, young parents, single parents, fathers, and parents with a foreign background [15]. Nordic studies highlight that targeted parental groups for same-sex mothers could be one way of reaching two-mother families [5, 6, 9]. A recently published meta-ethnographic study of 14 studies from four countries concluded that midwives strived to provide personalised, flexible, evidence-based and family-centered care and to listen to the parents-to-be [16].

Midwives in a Norwegian study expressed that they needed more time to create a trusting relationship with same-sex mothers [17]. Swedish child health care nurses described wanting to establish a relationship with the non-birthing parent although they needed more time and resources to provide proper support to both parents [18]. Nurses in an Australian study reported needing training to better understand lesbian, gay, bisexual, transgender and queer (LGBTQ) parents' unique challenges [19]. Furthermore, in a recent systematic review of 25 studies within fertility care, it was concluded, from both patients' and professionals' perspectives, that LGBTQ individuals face unique barriers, such as heteronormativity, lack of tailored information and education, insufficient understanding of LGBTQ care among providers, and a lack of psychological and social support [20]. Feelings of uncertainty may influence health care professionals when caring for same-sex mothers [17].

Previous research indicates insufficient parental support for same-sex mothers [9, 20]. Ethical codes for nurses and midwives [1, 2] stress the importance of providing respectful care regardless of family structure. Halldorsdottir [21] described a trusting relationship between professionals and patients as a key aspect when providing professional care and as the one characteristic that distinguishes between caring and uncaring encounters. Knowledge about professionals' experiences of encountering and supporting same-sex mothers is limited; therefore, this paper aims to contribute to this.

AIM

The aim was to explore professionals' experiences of supporting two-mother families in antenatal and child health care.

METHODS

A qualitative study based on online focus-group discussions with midwives and child health care nurses from antenatal and child health care was undertaken. The focus-group discussions were analysed using inductive qualitative content analysis, following the data extraction process of Elo and Kyngäs [22].

Participants and data collection

Data collection was performed in central Sweden between October 2020 and May 2021. Through purposive sampling, participants were recruited with the help of coordinating midwives and child health care nurses in the different regions.

Inclusion criteria were that participants were midwives or nurses working in antenatal or child health care with experience in supporting same-sex mothers. Interested professionals contacted the first author for more information about the study. All agreed to participate in the study and were invited to a focus group, held online due to the Covid-19 pandemic.

An interview guide with themes based on previous research (authors) was employed to explore how professionals provide support to families with two mothers. Themes in the interview guide were *experiences of encountering two-mother families, experiences of equality and parenthood in two-mother families, heteronormative information and informational material at their own workplace, knowledge to encounter two-mother families, experiences of supporting two-mother families and supporting two-mother families in parental groups*. The interview guide was pilot tested in a small focus group consisting of participants with similar experiences as the target group. During the pilot interview, the guide was well understood by the participants and no changes were made to the interview guide.

The focus groups were conducted following Krueger and Casey [23]. During the sessions, the first author acted as a moderator and led the discussion while one co-author at a time acted as an assistant moderator and took notes. The moderator began with an introduction, informing the participants about the aim of the study and their ethical rights while participating. The discussion then started with an open-ended question; "Please, tell us about who you are and your experiences of encountering two-mother families". The moderator's role was to stimulate participation and "keep the discussion on track". When the topic was fully discussed the assistant moderator summarised what had been said, checked if participants accepted the summary, and asked if there was anything they wanted to add. Finally, we thanked all participants and ended

the focus group. The length of the focus groups varied between 46 and 84 minutes. The focus-group discussions were audio recorded and transcribed verbatim by the first author. Field notes from the assistant moderator were used in the analysis process.

When conducting focus groups, a rule of thumb is to decide if additional groups should be added after three or four sessions. After five very small focus groups (VSFG) [24] had been conducted, the material was read through and the authors decided to conduct one more focus group. A total of six VSFGs were finally held (2–3 health care professionals in each group) with 13 participants (eight midwives and five child health care nurses).

The participants were all women. Some had experience from ordinary antenatal and child health care clinics, while others had experience from targeted clinics for LGBTQ parents. There was a large amount of diversity in the participants' experience of meeting same-sex mothers, ranging from having met two or three same-sex couples to meeting same-sex mothers daily. Participants came from smaller and larger cities in central Sweden.

Data analysis

As there are limited studies from a caregivers' perspective on encountering and supporting same-sex mothers, a qualitative inductive content analysis was deemed suitable for analysing this phenomenon [22]. The pilot focus group was not included in the analysis. Content analysis [22] comprises three phases: preparation, organisation and reporting. The first step was to get familiar with the data by reading and rereading the transcribed focus-group discussions. The second step was to organise the data, which means that notes and headings describing the phenomenon were written in the margins. The headings were then grouped into subcategories describing similarities and differences. Subcategories describing similar experiences were grouped together as categories. The abstraction process continued until the main category was identified [22]; see Table 1 for an example of the analysis process. All authors read and coded part of the data. Finally, in the third step, the findings are presented as a text through the main category, categories and subcategories labelled with content-characteristic words, and clarifying quotes. Participant (p) and focus group (fg) are indicated for each quote.

Ethical considerations

The Swedish Ethics Review Authority approved the research project, Dnr 2020-01334. The study was planned,

TABLE 1 Example of the analysis process

Simplified quotes/codes	Subcategories	Categories	Main category
Mothers share parental leave equally Want same access to their child	Equal commitment among mothers	Meeting well-prepared mothers	Striving to be open-minded in supporting same-sex mothers
Moms are used to getting weird questions	Mothers on guard against heteronormative views		
Rainbow flag in the waiting room Asks open-ended questions	Creating an inclusive environment	Providing support through empowerment	
I treat everyone equally All parents need support, there is no difference	Providing equal support to all parents		
Norms and parenthood Talk about minority stress Informs about initiated breastfeeding	Providing tailored support to same-sex mothers		
The pregnant women get most attention	A balancing act to acknowledge both mothers	Handling challenges	
Says mother and father in the documentation-system Afraid to say anything wrong	Struggling with documents and communication		
Heredity significant in developmental assessment of children	Lack of genetic information		
Received LGBTQ training	Knowledge acquired through education	Reflecting on one's own professional competence	
Interest in LGBTQ-issues Own experiences	Experiences and personal interest		

TABLE 2 Overview of main category, categories and subcategories regarding health care professionals' experiences of supporting same-sex mothers

Main category	Categories	Subcategories
Striving to be open-minded in supporting same-sex mothers	Meeting well-prepared mothers	Equal commitment among mothers
	Providing support through empowerment	Mothers on guard against heteronormative views
		Creating an inclusive environment
		Providing equal support to all parents
	Handling challenges	Providing tailored support to same-sex mothers
		A balancing act to acknowledge both mothers
		Struggling with documents and communication
Reflecting on one's own professional competence	Lack of genetic information	
	Knowledge acquired through education	
		Experiences and personal interest

conducted, and reported in accordance with ethical guidelines [25]. Participants were provided with written and oral information about the study, including information about the possibility to withdraw at any time. When entering the Zoom link, participants gave their informed consent to participate in the study. The data are stored in a secure file, accessible only to the first author.

FINDINGS

Striving to be open-minded in supporting same-sex mothers

The analysis resulted in the main category, *Striving to be open-minded in supporting same-sex mothers*, which appeared prominently in all focus groups and is visible in

four categories and 10 subcategories (see Table 2). Health care professionals reported meeting well-prepared mothers, equal commitment between mothers, and mothers on guard against heteronormative views. Health care professionals empowered the mothers by creating an inclusive environment, providing equal support to all parents or tailoring support to same-sex mothers. Providing support was also described as involving a balancing act to acknowledge both mothers. Other challenges that needed to be handled were a struggle with documents and communication, and a lack of genetic information about sperm donors. The last category illustrates health care professionals' reflections on their own professional competence regarding supporting same-sex mothers.

Meeting well-prepared mothers

The category *Meeting well-prepared mothers* includes two subcategories: *Equal commitment among mothers* and *Mothers on guard against heteronormative views*.

Equal commitment among mothers

Participants encountered equally committed mothers with a plan for shared parenting. They encountered mothers with a plan for feeding and parental leave. Some midwives had met non-birth mothers who tried to initiate breastfeeding in order to share the responsibility and get the same closeness to the baby. In one focus group, this was expressed as follows: "I've also met mothers who've both breastfed; then there's more dialogue about how we should take care of this child" (p2fg4). Participants also experienced that they encountered families with more financial resources, where both mothers stayed at home with the child for several months. Regardless of whether or not the birth mother seemed to take the most parental leave, professionals found the commitment was equal between the mothers.

Mothers on guard against heteronormative views

Participants experienced that same-sex mothers unknowingly defend their parenthood against the outside world. They experienced the reasoning of mothers like this: "I put on my armor because I think I won't get any support" (p3fg1). One focus group reflected that they encountered some mothers who were afraid or had been treated badly in some other places and therefore turned to a more LGBTQ-friendly clinic. One participant said: "I know

that LGBTQ people must constantly defend themselves, because you're constantly questioned" (p2fg1). Moreover, health care professionals described same-sex mothers as well-read and knowledgeable, and one midwife felt scrutinised by the mothers.

Providing support through empowerment

Providing support through empowerment includes three subcategories: Creating an inclusive environment, Providing equal support to all parents, and Providing tailored support to same-sex mothers.

Creating an inclusive environment

Participants described trying to create an inclusive environment so that same-sex mothers would feel safe. To create this safe environment, they had looked over the environment in the waiting room to make sure that magazines and pictures included a variety of family constellations. Some of the health care professionals highlighted the importance of attributes such as rainbow flags and signposting about lesbian pregnancy podcasts as a way to show that their clinic or practice was LGBTQ-friendly. They reported having worked very hard to make same-sex mothers feel safe and secure in their contact with health care so that they can feel well cared for throughout the entire pregnancy.

A common phrase used by health care professionals was that they strived to be open-minded. Moreover, they described giving thought to what kind of terminology they used; they used the terms parent and partner in order to be inclusive. Several professionals said that they posed open-ended questions, for example: "What does your family look like?" (p1fg3).

Providing equal support to all parents

Some focus groups stated that they treat all parents equally, that all parents need support and that there is no difference between same-sex mothers and heterosexual couples. "We treat everyone equally; we don't judge" (p1fg3). Participants stated that they provide support based on the parents' needs. A common reflection was that they treated everyone equally and equated non-birth mothers with fathers in heterosexual relationships. They explained that parental groups are the same regardless of the family constellation. "I separate the women in one place, and the men in another place ... and have prepared same-sex couples ahead of time so they can decide for

themselves which group they want to join” (p1fg4) “I appreciate knowing before hand if there will be a same-sex couple ... then maybe you phrase things a bit differently ... make sure to always say partner” (p2fg4). They furthermore argue that there is an organisational limitation to how parental groups can be arranged. In smaller communities, it was not considered possible to have parental groups tailored for same-sex mothers.

Providing tailored support to same-sex mothers

Parental groups for same-sex parents were highlighted as important spaces for meeting other same-sex parents and reducing feelings of loneliness. The health care professionals discussed norms and parenthood and the fragile position of the non-birth mother. One participant stated: “We try to make sure that everyone gets the same amount of speaking time ... to include them [the non-genetic parents] ... because we know that they are a group that can feel very excluded” (p1fg2)...A participant in the same focus group added: “yes exactly ... trying to provide support ... starting a conversation ... that you’re not alone with your questions, both about non-genetic parenting or the fear of not being called mother” (p2fg2). They also discussed minority stress and how to respond and defend oneself against any questioning of one’s parenthood. The professionals said that the mothers discussed their complex attitudes toward the donor. In a way, the donor was insignificant, but at the same time, the mothers often wanted the same donor for the next child.

Furthermore, participants discussed how the baby might prefer the breastfeeding mother, and that this might make the non-birth mother feel excluded. Some focus groups said they held breastfeeding meetings for rainbow families and instructed/informed the non-birth mother about how to breastfeed their baby. However, some of the participants did not know that non-birth mothers could breastfeed.

All the focus groups concluded that the main purpose of parental groups is to create networks. Most of the health care professionals experienced that same-sex mothers had a network with other same-sex couples; otherwise, they tried to mediate contact with other same-sex couples. They also referred same-sex mothers to parental groups for same-sex couples and informed them about open pre-schools for LGBTQ families.

Handling challenges

The category *Handling challenges* includes three sub-categories: *A balancing act to acknowledge both mothers,*

Struggling with documents and communication, and *Lack of (genetic) information.*

A balancing act to acknowledge both mothers

The health care professionals described that it goes without saying that they should include and support both mothers in two-mother families. In addition, they described that birth and non-birth mothers have a close relationship, but need to be strengthened in their different parental roles. One midwife expressed this as follows: “The pregnant mother needs to be strengthened; you can do this alone; you’re a person in your own right; you’re not just part of the couple” (p2fg2). In all this striving for total equality, “it’s almost forgotten that one of the mothers is the one who will go through pain and give birth to the child” (p1fg2). A common statement expressed in the focus groups was “It’s inevitable that the pregnant mother gets the most attention.” The health care professionals experienced that the pregnant women could be stressed by receiving most of the attention, as they wanted to be treated as equal mothers. The participants described that it is their responsibility to build a caring relationship with both parents, but that the focus is on the pregnant woman.

The health care professionals also reported that the mothers experience stress due to a lack of clarity about the parental role of the non-expectant mother. Participants reflected that both mothers should feel secure about childbirth and parenthood, which was expressed in one focus group as follows: “ask the person who is not carrying the baby how or what she feels about the birth and how she thinks it feels to be expecting a child (p2fg2)”.

Struggling with documents and communication

Participants in all focus groups reported that it was problematic that almost all documents are heteronormatively designed. The existing medical records system caused uncertainty or irritation among health care professionals, because it was only possible to fill in the mothers’ and fathers’ names. It is not possible to fill in both mothers’ names in the medical file. Moreover, participants said that informational materials are heteronormatively designed, and they felt they needed to inform the mothers about this and to apologise.

Some health care professionals described challenges with communication: “When I led parental groups a couple of years ago, I was terrified to misspeak and say mother and father instead of parents” (p2fg3); “yes, exactly, you’re careful how you talk, yes” (p1fg3). Most participants expressed that it should go without saying that

you ask about the partner, not the father, while some focus groups reflected that sometimes there is a father, and he also needs to be recognised. Professionals also reflected that the term “partner” is gender neutral and inclusive, but at the same time, it does not confirm the parental role, as it indicates the relationship to the other parent, not to the child.

Lack of (genetic) information

Some health care professionals described it as challenging to lack information about the donor when assessing the child's development. As expressed in one focus group: “you ask about heredity, and you may not always know... if there are allergies in the family ...” (p2fg3) “... or serious illnesses... all that is completely blank... I usually note this somewhere in the text, heredity unknown” (p1fg3). Lacking access to all information and documentation was also described as a challenge by participants. Some reported finding it problematic not to automatically see who the biological mother was when meeting same-sex mothers.

Reflecting on one's own professional competence

Reflecting on one's own professional competence includes two subcategories: *Knowledge acquired through education* and *Experiences and personal interest*.

Knowledge acquired through education

There was variation among the participants regarding training in LGBTQ issues. Some had undergone LGBTQ certification, and some had been involved in creating their own LGBTQ training. Several participants had attended various LGBTQ courses and worked with their own attitudes, the environment and the material. Several professionals reflected on the LGBTQ-certified training they attended. One said that she passed an LGBTQ-certification course many years ago but does not really remember it; another highlighted that the LGBTQ certification made her interested in this issue. Participants stated that self-reflection is important in order to become confident and convey a sense of security to parents and children. Moreover, they mentioned the value of time for reflection and time to question their own norms and values.

Experiences and personal interest

Most health care professionals expressed a strong interest in LGBTQ issues. Participants described seeking knowledge in the field themselves. At the same time, they said that the topic of LGBTQ was lacking in both nursing and midwifery education. The participants reflected that through their own experiences and by having friends who are homosexuals, they have acquired knowledge in the field. In this way, they have developed a sense of issues that may be especially relevant for same-sex couples and understood that you must be open to every individual; there is no specific education on these topics. One midwife described that she tries to follow the debate on radio and television. Another participant said that she herself lives in a lesbian relationship and has guided her colleagues when it comes to same-sex couples. One midwife said: “In addition to my personal experience I always try to be open, humble... uh... curious, but not curious in that I ask questions, but curious in that I read and deepen my knowledge and read articles and so on, because I also come from a completely different background both culturally and regarding care culture that is completely different” (p2fg5). Health care professionals reflected on the difficulty of having knowledge about “everything”. “I have an open attitude, but do not know everything” (p2fg6); “I'm open, curious, a listener ... but I ask the parents about the legal aspects” (p1fg6). They described complicated laws and different rules and routines in different regions and referred to the information on the internet as a “jungle”, all of which can make it difficult to keep one's knowledge fresh if one only meets a few same-sex couples per year.

DISCUSSION

The aim of this study was to explore professionals' experiences of supporting two-mother families in antenatal and child health care. Participants reported that they encountered well-prepared mothers, equal commitment between mothers, and mothers on guard against heteronormative views. They provided support through empowerment, by creating an inclusive environment and providing equal support to all parents or tailored support to same-sex mothers. Participants described acknowledging both mothers as a balancing act. Struggling with documents and communication and a lack of information were other challenges to be dealt with. The professionals reflected on their own professional competence and expressed that knowledge acquired through education, experience and personal interest all contributed to their competence.

The health care professionals reported *meeting well-prepared mothers*, with strong parenting ideals and a desire to share their parenthood equally, which is in line with previous research among same-sex mothers highlighting equality within the couple [5, 26].

The category *supporting through empowerment* illustrates the participants' ambition to create an inclusive environment by furnishing the waiting room with rainbow flags and appropriate pictures. A supportive environment where parents feel confident and relaxed is reported to be essential by same-sex parents [27]. Health care professionals exhibited cultural sensitivity when asking open-ended questions and using the term "partner" to avoid cultural stereotyping. This term is used by midwives with the intention of treating partners equally regardless of gender [28]. Halldorsdottir [21, 29] describes caring as a mode of being and creating a connection with the patient. For health care professionals, responding to new parents by asking open-ended questions can be interpreted as a caring mode of being. Moreover, Halldorsdottir [21, 29] describes caring encounters with the metaphor of "building a bridge". Building bridges is about how professionals develop connections while maintaining a respectful distance from the patients.

Some health care professionals stated that they *provided equal support to all parents*, regardless of sexual orientation; however, providing equal support to same-sex mothers is not the same thing as providing care on equal terms. Providing equal parental support might contribute to discrimination if health care professionals have a heteronormative starting point. Equal parental support requires individualised care. Some professionals *provided tailored support to same-sex mothers*, which included discussions of norms and parenthood and the non-birth mothers' lack of role models. In a previous research, a need is described for parental groups with other LGBTQ parents to discuss these issues [30]. There was a difference between professionals who met same-sex mothers daily and those who met same-sex couples less often. Among those who had less experience in encountering and supporting same-sex mothers, some lacked knowledge about induced breastfeeding for the non-birth mother. Research among same-sex mothers highlights that they want to equally contribute to breastfeeding their child; however, they lack professional information about induced breastfeeding for the non-birth mother [31]. It would therefore be desirable if more health care professionals updated their knowledge regarding this issue. All participants expressed that it goes without saying that they should include and support both parents, even though some participants said they supported the birth mother the most. Previous research found that non-birth mothers experienced less support from health care professionals than birth mothers [9]

underlining that health care professionals need to expand their support to include the whole family. Professionals in antenatal and child health care have an important task in providing culturally respectful care [1, 2].

Heteronormatively designed informational materials, and especially the medical documentation system, were a *challenge to handle* for professionals. Heteronormative assumptions in the wording of forms are also described in a recent systematic review from the perspective of both patients and providers [20]. Antenatal and child health care policies and structures need to recognise and acknowledge a variety of family structures [27]. Considering that female couples gained access to assisted reproduction at Swedish clinics in 2005 [11], the time has come to update the documentation system to include same-sex mothers.

Health care professionals reflected on their *own professional competence*. They had a variety of formal knowledge and education in "this area", but regardless of whether or not they had special education, they highlighted that time for reflection is important to increase knowledge and awareness of these issues. The findings also revealed that health care professionals experienced there was a lack of "discussion" of LGBTQ issues in nursing and midwifery education. Previous research recommended LGBTQ-competence training for nurses [32]. Nurses and midwives are likely to encounter same-sex mothers and must therefore be prepared to meet the needs of sexual minorities. Professional caring is dependent on education and experience [21, 33], which is something that participants in this study highlighted alongside showing an interest in LGBTQ issues.

Strengths and limitations

An inductive qualitative approach was suitable to explore professionals' experiences of supporting two-mother families in antenatal and child health care. The findings are described in a conceptual form with concepts derived from the data, in line with inductive content analysis [22]. In qualitative research, the quality of a study does not depend on the number of participants, but rather on achieving saturation. The purpose of the study and the subject matter determine the sample selection and sample size. Focus groups seem to be less threatening to participants than individual interviews [23] and rich data emerged from the very small focus groups in this study. It is important to legitimise the validity of very small focus groups [24]. Having difficulty recruiting enough participants and being forced to cancel a large group would cause an incredible loss of knowledge and be an affront to the people who sought to participate [24, 34]. Smaller focus groups allow more time for sharing and comparing experiences

among participants [34]. The focus groups were held online due to the Covid-19 pandemic, which may have affected the discussion and accordingly could be a limitation. Another potential limitation is that this study was conducted in Sweden, and the results, therefore, need to be understood in terms of similar contexts with high levels of gender equality.

To strengthen transferability, clear description is provided of the study context, selection and characteristics of participants, data collection and process of analysis. To meet the criteria for trustworthiness and enable the reader to follow the process, the analysis process is described in detail. Citations are used to increase the trustworthiness of the research [22, 35]. To strengthen inter-reliability, all authors independently read and coded part of the data and discussed the formation of categories.

CONCLUSION

This study contributes knowledge on health care professionals' experiences in supporting same-sex mothers. This study proposes some concrete suggestions for improvement. Revising forms and documents to include a variety of family constellations could help guide health care professionals rather than causing them difficulties. Education, discussions, and tutorial sessions about how to support the non-birth mother in her parental role could be beneficial for health care professionals. Otherwise, there is a risk that health care professionals might lose same-sex mothers' trust, as well as fail in their professional mission of providing equal support to both parents. Finally, health care professionals need to reflect on their own norms and the challenges they encounter in the important work of supporting expectant and new same-sex mothers.

AUTHOR CONTRIBUTIONS

All authors contributed to study design, data collection and analysis as well as manuscript writing.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

ETHICS STATEMENT

This study was approved by the Swedish Ethical Review Authority (Dnr 2020-018334).

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