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A qualitative study of Norwegian first-time mothers' information needs in pre-admission early labour

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ABSTRACT

Objective: To explore women's experience with information, and their information needs in pre-admission early labour.

Design: A qualitative study with an exploratory and descriptive approach.

Setting: Five focus group interviews with women attending post-natal care at five different well-baby clinics in South-Eastern Norway in 2019.

Participants: Sixteen first-time mothers who had given birth to a baby 3–17 weeks prior to the focus group interview. All had experience of staying at home in early labour.

Findings: Three themes emerged from the analysis. The first and most substantial theme involved information. The women considered it necessary to have easy access to a suitable amount of trustworthy information at the appropriate time. The second theme described that the women were surprised at how early labour manifested, despite having prepared for it. The third theme was about receiving acknowledgement and support, revealing that information did not meet all woman's needs.

Key conclusions and implications for practice: The women found it challenging to prepare for early labour, and no matter how prepared they felt beforehand, unexpected situations arose. Easily accessed online information from reliable sources was useful in early labour, but in order for women to feel safe at home, this should be complemented by telephone conversations with skilled and welcoming midwives in the labour ward. More knowledge about women's information needs in early labour is required, including studies exploring how the information should be provided to help women feel safe when staying at home in early labour.

Introduction

The period of painful uterine contractions prior to five centimetres of cervical dilatation is often referred to as the 'latent phase' or 'early labour'. The World Health Organisation favours the use of the term latent phase (World and Health Organization, 2018). In this article, we use 'early labour', as this captures the fact that the phase is part of the labour process, and as stated by Dixon et al. (2013), women do not consider labour to be different phases. For some women, early labour is short, while for others it may continue for hours or even days (Gross et al., 2009; Tilden et al., 2019; Ängeby et al., 2018).

Two large retrospective cohort studies (Holmes et al., 2001; Klein et al., 2004), and one interventional study (Rota et al., 2018) have investigated outcome differences between women presenting in early and active labour. Results suggests hospital admission in early labour is associated with increased risk of medical interventions, including electronic foetal monitoring (Klein et al., 2004), epidural analgesia (Holmes et al., 2001; Rota et al., 2018), oxytocin stimulation (Holmes et al., 2001; Rota et al., 2018) and caesarean section (Holmes et al., 2001; Rota et al., 2018). Still, WHO recommends delaying admission only for research purposes (World and Health Organization, 2018). However, clinical practice recommendations in Norway state that women in early but not active labour should generally not be admitted to hospital (McNiven et al., 1998; Norsk Gynekologisk Forening, 2014). This is consistent with NICE UK guidelines, who emphasise that the decision should be made in consultation

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with the women (National Institute for Health and Care Excellence, 2017).

Several studies describe a lack of satisfaction with care provided in early labour prior to admission (Beake et al., 2018; Eri et al., 2015). In 2015, Eri et al. published a metasynthesis exploring first-time mothers' experiences of early labour (Eri et al., 2015). The findings suggest that women's needs are not adequately met in early labour, describing a mismatch between women's expectations and experiences. Women expressed uncertainty in interpreting possible signs and symptoms to determine the start of labour requiring admission (Eri et al., 2015). It was important to know how far labour had progressed, and if everything was normal. Further, in a systematic review, Beake et al. concluded that women, labour companions and health professionals found early labour difficult to manage well (Beake et al., 2018). Nevertheless, delaying admission until active labour results in fewer epidurals and fewer caesarean deliveries (Tilden et al., 2015), which are factors that likely influence satisfaction and experience of care.

In all, previous findings suggest easy access to relevant and reliable information could be a way of supporting and empowering women to cope with early labour. Research on enhancing women's confidence for labour suggests that women desire information during pregnancy and want to use that information to participate in care decisions (Avery et al., 2014). Additionally, this could enable labour companions to feel more confident and thus provide better support at home (Beake et al., 2018). To provide this information, we must first understand these women's information needs. Several studies have examined the information needs of pregnant woman (Ghiasi, 2019), and first-time mothers' information needs in pregnancy seem to be increasing (Chung et al., 2020; Singh et al., 2002). Advances in information technology facilitate the transfer of knowledge, but it is important for health professionals to consider the amount and type of information they communicate (Carolan, 2007; Chung et al., 2020). The NICE UK guidelines recommend information about what to expect in the early stage of labour to be shared both in antenatal care and in early labour. (National Institute for Health and Care Excellence, 2017). However, the research to date has not been able to provide specific advice on first-time mothers' information needs particularly in early labour. A Swedish study from 2015 investigated first-time mothers' care preferences during prolonged early labour (as defined by the authors to be > 18 h) (Angeby et al., 2015). They discovered that participants all knew about the importance of staying home during the early labour. Nevertheless, they had trouble understanding the different phases and stages of labour, and wanted more information especially about the latent phase. However, as the study focused on women with prolonged early labour, it cannot be assumed that the results are transferable to all first-time mothers.

Beake et al. point out the need for further research on the increasing use of web-based information (Beake et al., 2018). This article presents findings from the first study in *The PreCare Study: Pre-admission early labour care: An electronic educational intervention to improve information flow in early labour care and women's pre-admission early labour experience*, set in Norway, and founded by The University of South- Eastern Norway. *The PreCare Study* aims to develop and test a website with easy-to-access high-quality information about early labour. This first study will inform the development and content of the website. In subsequent studies, we will test the website to ensure suitability and usability for the target group. In addition, we will investigate whether the website improves women's knowledge of early labour, experience in early labour, and explore if use of the website affects clinical birth outcomes related to giving birth. The aim of this study was to explore women's experience with information in early labour, and what information women who had gone through labour missed and/or appreciated in early labour.

Methods

As we wanted increased understanding into information in early labour from the women's perspective, an exploratory and descriptive design was chosen. We used systematic text condensation (STC) to analyse the data, a method suitable to develop new descriptions without applying a theoretical framework (Malterud, 2012b, 2017). STC is inspired by Giorgi's phenomenological analysis and modified by Malterud and presents a strategy for thematic cross-case analysis (Malterud, 2012b). Multi-site focus group interviews were conducted in South-Eastern Norway between May and October 2018. Group discussions provide direct evidence about differences and similarities in opinions and experiences (Morgan, 1997). In addition, our participants already had planned maternity groups, which facilitated focus group interviews.

The inclusion criteria were that women were first-time mothers having given birth to one child in cephalic presentation, ≥ 37 weeks, with a spontaneous start of labour and having stayed at home in early labour (as defined by the women themselves). Exclusion criteria included induction of labour and conditions in pregnancy that precluded women from staying at home in early labour. The participants needed to be able to read and speak Norwegian to understand the information and the consent form and to participate in the focus group interview.

To achieve variety in background characteristics, seven well-baby clinics, both rural and urban, were contacted. Five clinics responded in a positive manner and helped recruit first-time mothers within 3–17 weeks after birth. Women were identified, informed about the study and invited to participate by their midwife or public health nurse at the well-baby clinic.

Staff invited twenty-nine women to join the study and twenty-two agreed to participate in a focus group interview. Six participants did not attend, leaving us with a sample of sixteen women. The participants received post-natal care at five different well-baby clinics, and gave birth at four different hospitals in South-Eastern Norway. The age of the participants ranged from 24 to 38 years, and they lived in both urban and rural areas. Four of the participant had immigrant non-western background. One of the participants was a single mother, who had support from her own mother while in early labour. The rest lived with a partner (male or female) who was with them in early labour.

Five focus group interviews were conducted, with respectively four, two, two, six and two participants in each group. A focus group interview guide containing a few open-ended questions about what information the participants missed and/or appreciated in early labour was developed in collaboration between the authors (Table 1). The guide was piloted on a group of five midwife colleagues who had given birth themselves, and slightly modified, but the data from this pilot focus group was not included in the current study. The first author was the moderator in all focus group interviews, she was not known to any of the participant, and presented as both midwife and researcher. The other authors alternated as secretary, taking notes. The participants were instructed to take turns to talk and told that the moderator would only interrupt the focus group interview when necessary. The focus group interviews lasted for 29–53 min (mean 40 min) and were audio-recorded and transcribed verbatim.

Data analysis

As mentioned, we used STC to analyse the data. This four-step strategy for thematic cross-case analysis (Table 2), represents a pragmatic approach to analyses of different types of qualitative data, while maintaining a responsible level of methodological rigour (Malterud, 2001, 2012b).

In step one, the first and last author read through all the focus group interviews to gain a general impression of the preliminary themes. Secondly, meaning units describing the women's early labour experiences related to knowledge and information were identified and organised into code groups by both authors. In step three, we identified subgroups in each code group (Table 3), and meaning units in all subgroups were summarised and condensed. Lastly, a description of the content was drawn up and presented as an analytic text (Malterud, 2012b, 2017).

Table 1
Interview guide.

Interview guide The main questions are numbered. The remaining questions were only asked if needed, to keep a good flow in the focus group interview.
1. Can you tell me a bit about your early labour? - What role did your partner have in this phase of the labour? 2. What did you know about early labour beforehand? - How did you get this knowledge? - Did early labour lastfor as long as you thought it would? - Was there anything you thought you knew about early labour that turned out not to be true? 3. What information did you receive when you contacted the hospital for the first time? - Did you understand the information you were given? - Was the information useful? - Would it be useful to have this information in writing? 4. What information did you miss when in early labour? - If nothing, what information did you perceive as useful? 5. What information do you think a website with information on early labour should contain? - At what time in your pregnancy would you access such a website? - How would you find such a website? - What would you google in early labour? - Do you have any examples on what constitutes a good website?

Table 2
The four steps of analysis in systematic text condensation.

Total impression-from chaos to themes.
Identifying and sorting meaning units- from themes to codes
Condensation- from code to meaning
Synthesizing- from condensation to descriptions and concepts

Ethical considerations

The study was conducted in accordance with the WMA Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects (World Medical Association, 2017). Participants were provided with written information, and given time to consider whether they wanted to participate. Written informed consent was obtained from all participants. They were advised that participation was voluntary and that they could withdraw from the study at any time without giving reasons. All participants were given the possibility to talk to the first author after the focus group interview should they require debriefing. The study was assessed by the Regional Committee for Medical and Health Research Ethics in South-Eastern Norway (REC: 2018/540) and was considered to be outside the remit of the Health Research Act (2018), which applies only to research that aims to generate new knowledge about health and disease, and not patient experiences. Approval for the study was granted by the Norwegian Centre for Research Data (NSD: 60109).

Findings

Three themes emerged as a result of the analysis. The first and most substantial theme involved information. The women considered it necessary to have easy access to a suitable amount of trustworthy information at the appropriate time. The second theme described how the women were surprised at how early labour manifested, despite having prepared for it. The third theme was about receiving acknowledgement and support, revealing that information did not meet all woman's needs. In Table 3, we present an overview of the code groups and subgroups. Table 4 provides an example of a meaning unit, subgroup and code group. An extensive presentation of meaning units, subgroups and code group is found in supplementary Table 1 (S.1).

Easy access to trustworthy information at the right time

The women felt that access to information on what to expect or on what were considered normal early labour experiences would have helped them cope with early labour. They wished they had information about signs and symptoms of the start of labour, about contractions, and the differences between labour contractions and Braxton Hicks contractions. Some found it difficult to assess when their contractions started and stopped, and one woman pointed out that it was difficult to know if she was in labour, since she had never done this before. They did not necessarily need large amounts of information, but wished for useful, readily accessible information about the "usual stuff" that was easy to comprehend and relate to. They were preoccupied with the different stages of labour, and one woman stated that learning about the different stages calmed her down because she knew that things were supposed to happen in a certain order, and that early labour took place at home. They also wished for information about when to phone the hospital, and advice and ideas on what they could do at home, and some wanted detailed information about the physiology of early labour, such as cervical and hormonal changes and statistics. The women also appreciated practical information about what to take to hospital, and what happens when you arrive there. Being in control of the practicalities was important in an otherwise chaotic situation. One woman wished she had known that early labour usually progresses slowly:

Because… I felt a bit kind of… in fact, I thought I was suddenly going to give birth when my contractions were three minutes apart and lasted

Table 3
Overview of code groups and subgroups.

Code groups	Subgroups
Easy access to trustworthy information at the right time	Type of information Time of information needs Where information is obtained from Trustworthiness of information
Surprised at how early labour manifested	Prepared, yet still lacking knowledge How to manage
Limitations of information	To feel safe and supported To feel welcome

Table 4
Example of meaning unit within a subgroup and code group.

Code Group	Subgroup	Meaning unit
Surprised at how early labour manifested	Prepared, yet still lacking knowledge	I was not aware that it could be that painful and protracted. So that was a surprise, really. So we... we were prepared that it could take a long time. I was just surprised that it could... so quickly... that it happened so fast, got very painful so fast. That caught me by surprise. It was a situation we did not know how to react to. (focus group # 1)

for 45 s. I was thinking, now the baby's coming. But it actually took a few more hours. (Focus group # 2)

One woman explained how she had spent considerable time reading about early labour on the Internet prior to her labour, preparing herself and learning what was normal, and what was not normal. This made her feel more in control of her early labour. Others said that they had not given early labour much thought before it happened, as the birth had been their focus. Still, most women actively looked for information about labour when their maternity leave started, three weeks before their due date. Furthermore, they expressed a desire for information about early labour when they were in early labour themselves and explained how they wanted to read information over and over again:

To find out the differences. Like what's this? Is this the important thing? Do these criteria apply to me? Or, well, not like… I mean, you can't have a blueprint for exactly when it starts, can you? But it's more like, is there anything here that… Does this reflect what I'm experiencing right now? (Focus group # 5)

The women obtained information from different sources. Some had learned "the basics" at antenatal classes, others appreciated written information, such as books, newspapers, pamphlets or articles, and one woman said she preferred to watch videos to gain knowledge. Talking to family and friends was also an option, as were conversations with the midwife at the antenatal check-ups. In addition, all participants had searched the Internet for information. Webpages mentioned were Google and Norwegian official sites. One woman pointed out that when she was at home with contractions the Internet was easily available. Another explained that she and her partner were both very hungry for knowledge, and found the Internet to be the only solution:

It was the only thing… it was the only thing I did. Because I felt like I needed help, or information… from someone with knowledge. It was the only help I could get. I couldn't talk to the hospital for hours. So the only thing left to do was to google and read. (Focus group #2)

One woman pointed out that having access to a reliable website would have helped her in early labour. Women found it challenging to know which information they could trust, and critically assessed all information. One immigrant woman preferred to receive her information from someone she knew who had experienced labour herself. However, most women preferred more carefully prepared information, like "official" or "well known" websites. They remarked that when they recognised the information or had heard something similar before, they could more easily trust the source. "If it sounded familiar, I trusted it". They suggested that the information they received should be credible, because there is so much information to choose from on the Internet. As one woman put it:

These mum forums that you find when you search the web, they're like… you can't always trust them. It's almost… like upsetting. Reading them upsets you. (Focus group # 1)

Surprised at how early labour manifested

Some participants thought they had gathered enough information, while others had not familiarised themselves with this stage of labour at all. Most had learned about the different stages of labour, but lacked knowledge about early labour. They felt that the focus had been primarily on the birth. Although they had read a great deal, they found that unexpected things arose, causing uncertainty. The women expressed surprise and frustration at the sensation of their contractions. One participant explained that she was'… frustrated, because my contractions were so powerful and so frequent, but still nothing happened'. Another disclosed that she had prepared for her first birth to take some time and was surprised to discover that it did not take very long. In addition, several participants were surprised when their waters broke. As stated by one woman: 'I was thinking that my waters would not break, because this only happens to 10%. But it did'. Others were surprised that it was difficult to be certain as to whether their waters had broken or not. For some, early labour was a greater ordeal than the rest of labour, and they were distressed when at home:

After a while, I began to think it was torture. Like I was in a torture chamber, where you just go around, waiting for… when will the pain come? And you don't know how long you'll be trapped in there. (Focus group # 2)

The participants managed their early labour in different ways. Some women stated they handled it well. They managed to "keep calm", "breathe through their contractions" and "have a positive feeling in between contractions". One participant felt that women were made for giving birth, while another said she could feel the baby moving and therefore reasoned that everything was fine. Yet another woman talked about how "time went by both fast and slowly, time and space disappeared". Some found it difficult to interpret and keep track of their contractions and many participants felt insecure at the lack of regularity in their contractions. The women had prepared in different ways but even those who were well prepared expressed some degree of uncertainty:

Well, it's not easy, is it? (laughs) No matter how much you prepare, you're kind of not properly prepared anyway. (Focus group # 4)

Limitations of information

Our findings show that information did not meet all woman's needs. The participants found a sense of security in having a partner or other support person who kept a cool head with them at home. One woman mentioned the feelings of insecurity as a first-time mother, in spite of "having a lot of head-knowledge". She lacked control over what was happening, and did not feel comfortable on her own in the situation. As early labour progressed, the women appreciated others helping them with practicalities, making sure they ate and drank, and phoning the hospital if they were unable to call themselves. Others preferred to be alone, "focusing on what was going on" and "thinking about what was going to happen". Yet they underlined the importance of feeling welcome each time they phoned the hospital. They felt reassured talking to a friendly and understanding person who confirmed their thoughts about what was happening. One woman explained how a sense of security was vital to her in her early labour, and she felt it was important to receive proper attention. Nevertheless, it was not necessarily the content of the phone call that was important for the participants:

I felt that they talked to me in a very nice way on the phone… they listened to me and… yes, that's what I felt. I can't remember in detail what… But I definitely remember I felt it was a good feeling to talk to the midwives on the phone. (Focus group # 4)

Most women were not left with a feeling of being kept at home. Instead, they had a sense of an open door to the hospital: they were welcome when they felt the need to come in, and this reassured them. One woman explained that as long as she could ring the hospital as often as she liked and come in when she felt the need, she felt fine staying at home for a long time. Nevertheless, some felt they had to stay at home too long. One woman stated that the midwives were too rigid regarding her contractions, and found that they actively prevented her from going to the hospital, which led to her becoming demotivated. Another woman explained how she did not appreciate being told to wait for regular contractions, because she never had regular contractions, everything was just chaotic. She stated that due to the pain, she "could not think clearly, and just wanted help". One participant had heard that if you were afraid, you could come to the hospital. However, she was not afraid, she was just in pain, which made her sad. One woman revealed that she simply went to the hospital without calling first, because if she called they would enquire about her contractions, and another admitted to a white lie about the frequency of her contractions in order to be admitted. The women were happy when it was finally time to go to hospital, but at the same time they could not shake off the fear of being sent back home. Some were told that the hospital was full, which made them conclude that capacity issues were the reason that they had to stay at home. The participants argued that no one knows your situation as well as you do, and that you need to trust yourself. They argued that it should be easy to phone the hospital, and that going there for a check-up should be an easily available option. Being able to participate in decisions was appreciated:

I was actually pleasantly surprised at the way they made it quite clear we could come to the hospital. And we could decide on it ourselves, and we didn't have to sit alone at home worrying. So that was… that felt really good. That we weren't… didn't feel pressure to stay at home for longer than we felt comfortable with. (Focus group # 1)

Discussion

In this study, we have explored information needs related to early labour. No matter how well prepared they were, most women in our sample experienced something unexpected in their early labour. Consequently, they needed support from midwives and partner/ support person, and easy access to trustworthy concrete information.

Our findings reflect the contemporary issues in research around information needs in early labour care in other high-income countries (Beake et al., 2018; Ghiasi, 2019). The findings demonstrated that despite different degrees of preparation, many women expressed surprise at how their early labour evolved, and were frustrated in dealing with it. The unpredictable nature of giving birth makes it challenging to individualise preparation for childbirth. No matter how prepared one is, something unexpected will often occur. However, in accordance with previous studies, our results call attention to an unsatisfactory aspect of childbirth preparation (Beake et al., 2018). There was variation in how the participants managed their early labour, including surprise and frustration, and for some early labour was a greater ordeal then the rest of labour. The women who handled early labour well used a variety of coping strategies such as staying positive, trusting the body's ability to give birth and being able to let time and space disappear. Altogether, these results indicate that childbirth preparation should emphasise preparation on how to "let go", be ready to anticipate uncertainty, and build confidence in one's ability to give birth.

However, as revealed in this study, information does not meet all needs in early labour. Women also have the need for support, safety and feeling welcome at the hospital. Previous research shows that the feeling of not being seen or heard during childbirth contributes to a negative birth experience (Henriksen et al., 2017; Hodnett, 2002). Here, our findings complement those of previous studies. The women in our study described the importance of feeling welcome even when calling the hospital several times. It was vital to receive proper attention when they called, and they reacted to the midwives' tone of voice and choice of words. Talking to someone that listened and acted in an understanding manner was of greater importance than the content of the telephone conversation. This concurs with other research demonstrating that pregnant women are sensitive to the way the midwives speak to them, and that they want to be listened to by sympathetic midwives (Beake et al., 2018; Eri et al., 2015).

Interestingly, most women spoke warmly of the midwives they talked to on the phone. They were not left with a feeling of being kept at home, but rather had a sense of an open door at the hospital, and that they were welcome when they felt the need to come in. These findings are somewhat surprising, given that other research from Norway shows that women's needs in this stage of labour are not met, and that first-time mothers in early labour feel they have to negotiate their credibility with midwives (Eri et al., 2010, 2015). One possible explanation for our results might be that midwives' ways of caring for women in early labour on the phone have improved in the last few years due to the increased focus on this stage of the labour.

While the majority of our participants found a sense of security in having a partner or other support person with them at home, some women preferred being alone. Previous studies confirm that labour companions at home can give both support and pressure (Beake et al., 2018; Eri et al., 2015). Traditionally, women in early labour were cared for by family members or other women with experience of childbirth (Janssen et al., 2009). However, because of increased medicalisation in Western society, assistance by experienced women at home is now rare. One participant in our study was with her mother at home, while the remainder had support from a partner or were alone. Although most women felt more secure having a partner or other support person with them at home, this was just as much about practicalities as emotional support. All participants, however, demonstrated the need for support by the midwife on the phone. Women giving birth today have grown up in a society where childbirth tends to be viewed as a clinical phenomenon, which can be best managed by hospitalisation and by the use of science and technology (Van Teijlingen, 2004). This may explain why in our study the women needed contact with health personnel in addition to the support from their partner, which emphasizes the midwife's unique role.

An interesting finding was that women called for specific information about early labour. Prior studies investigating information needs of pregnant woman list labour/delivery as a frequently mentioned topic (Ghiasi, 2019). Furthermore, research has shown that women require realistic information on what early labour may feel like and what to expect (Avery et al., 2014; Beake et al., 2018). To our knowledge, the present study is one of the first to explore information needs in early labour, and we have been unable to find other clear descriptions of specific information needs at this stage. In their postnatal reflections, the participants in our study made it clear that they did not necessarily need large amounts of information. However, they were quite specific about the need for easily accessible information about the "usual stuff", such as what to expect, signs and symptoms of the start of labour, and the differences between labour contractions and Braxton Hicks contractions. In addition, they expressed that they were not prepared for the unpredictability of labour.

Having easy access to information was important to the women. In addition to being able to find information whenever and wherever they wanted, easy access made them able to re-read the information. During pregnancy, but especially in early labour, repetition was welcome. They appreciated hearing the same information many times; it was reassuring and made them trust the information more. Furthermore, our results demonstrated that credibility was an important aspect of the information, and all participants critically assessed both the source and content of the information they received. This is a positive finding, given the fact that the ease of accessing online health information, paired with the lack of moderators to filter the content, make health information credibility an extremely important issue (Yang and Beatty, 2016). However, the

participants differed as to what they considered trustworthy information. This finding reflects that of Yang and Beatty (2016), who found that while participants perceived health information provided by experts to be more credible, perceptions were moderated by demographic characteristics. For example, in our study, immigrant women were more likely to trust information from friends and relatives than from healthcare personnel.

In a systematic literature review of sources of information accessed by pregnant woman, Ghiasi (2019) found formal sources such as healthcare providers to be the most common. The women in our study obtained information from many different sources, including formal ones. However, digital media and the Internet were by far the sources they discussed the most. Ghiasi's (2019) review included studies published between January 2002 and May 2018, which may explain our findings, since the use and quality of the Internet, social media and smartphone applications have developed considerably since 2002. A study from the Netherlands reported that 95.6% of pregnant women used the Internet as an information source before or during their pregnancy (Jacobs et al., 2019). Thus, the Internet has become a very popular source of health information amongst pregnant women.

Study strengths and limitations

Our research group consisted of four persons with different healthcare backgrounds (physician and nurse-midwives) and considerable experience of antenatal, intrapartum and postnatal care. This provided us with a solid knowledge base and diverse perspectives.

The study provides important knowledge about women's specific information needs in early labour. We recruited at different well-baby clinics at different locations. However, several women who had accepted the invitation did not attend the focus group interviews, hence we ended up with a small-scale convenience sample (Patton, 2015). One possible explanation for why some invited mothers did not attend is that they all had newborn babies. The fact that our participants had newborn babies required special attention. As constraints of the field situation must be taken into account, it may be relatively rare for a project to match all focus group design criteria (Morgan, 1997). Three of our groups only consisted of two participants. In order for this to be characterized as focus groups, there must be a pronounced interaction between the participants (Malterud, 2012a). Out of respect for the respondents, we chose to conduct all focus group interviews as planned, and we experienced both noticeable interaction and rich information in the conversations.

The sample included women living in urban and rural areas, originating from both Western and non-Western cultures, of different socioeconomic status and educational level. We found that the sample provided sufficient information power to elucidate the study aim, thus strengthening the study's validity (Malterud et al., 2016).

The time of recruitment in previous publications on experiences and expectations of early labour spans from a few hours to 20 years after birth (Beake et al., 2018; Eri et al., 2015). However, to our knowledge, no published article on this subject justifies the time of recruitment. We chose to recruit within 3–17 weeks after birth because we wanted to ensure that the women's experiences were still fresh in their memory. However, as it takes time to gain strength, and to be able to reflect after birth, we wanted to allow a few weeks to pass by before we recruited. As mentioned, this time frame might be why some invited mothers did not attend. In addition, it is possible that we recruited women who generally felt OK about early labour, and that some women may not have felt ready to talk at this point.

Implications for practice

We found that the study increased our understanding of how midwives can support women when they stay at home in early labour. Women's birth experiences need continuous attention. Our findings suggest that easy access to a suitable amount of trustworthy information at the appropriate time, along with acknowledgement and support from both midwives and partners or other supporting persons, have a positive impact in reassuring the woman in early labour. Midwives should encourage women to feel the 'door is open', and as women are sensitive to midwives' tone of voice and choice of words, it is vital to pay proper attention to this during telephone calls. However, more knowledge about women's information needs in early labour is required, including studies exploring how the information should be provided to help women feel safe when staying at home in early labour. Additionally, further research should consider including the information needs of the partners.

Conclusion

The women in this study found it challenging to prepare for early labour, and no matter how prepared they felt beforehand, unexpected situations arose. Easily accessed online information from reliable sources was useful in early labour, but in order to feel safe at home it had to be complemented by telephone conversations with skilled and welcoming midwives in the labour ward.

Declaration of Competing Interest

None declared.

CRediT authorship contribution statement

Enid Leren Myhre: Conceptualization, Methodology, Formal analysis, Investigation, Data curation, Writing - original draft, Writing - review & editing, Visualization, Funding acquisition. **Mirjam Lukasse:** Conceptualization, Methodology, Formal analysis, Investigation, Writing - review & editing, Supervision, Project administration, Funding acquisition. **Marte Myhre Reigstad:** Investigation, Writing - review & editing, Supervision, Funding acquisition. **Viggo Holmstedt:** Software, Resources, Writing - review & editing. **Bente Dahl:** Conceptualization, Methodology, Formal analysis, Investigation, Writing - original draft, Writing - review & editing, Supervision, Funding acquisition.

Ethical approval

The study was assessed by the Regional Committee for Medical and Health Research Ethics in South-Eastern Norway (REC: 2018/540) and was considered to be outside the remit of the Health Research Act (2018). The Norwegian Centre for Research Data granted approval for the study (NSD: 60109).

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Supplementary materials

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