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## A balancing act in an unknown territory: A metasynthesis of first-time mothers' experiences in early labour



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### ABSTRACT

**Objective:** to integrate findings of individual studies in order to broaden the understanding of first-time mothers' experiences of early labour.

**Design:** the methodology was metasynthesis which is based on the interpretive meta-ethnography described by Noblit and Hare (1988). Metasynthesis is research on research which synthesises the findings of previous qualitative studies, and the focus is on interpretation and the creation of new knowledge.

**Setting:** all included studies originated from high resource countries (USA 2, UK 4, and Scandinavia 5) and all were carried out in a context of hospital based maternity care.

**Participants:** a total of 231 women participated in the studies.

**Findings:** 11 articles were included. The main results are presented with the metaphor a balancing act in an unknown territory. The 'unknown territory' has a double meaning: as the personal experience of going into labour for the first time and as encountering the maternity care system. On both levels women have to make significant decisions: whether labour really has started and subsequently when to go to the hospital. A key challenge is to balance the arrival on the labour ward at the 'right' time, not too early and not too late. Arriving at the 'right' time leads to a positive path, while arriving 'too soon' might lead to a cascade of negative experiences. The results are further presented with five central themes: 'Finding out if labour has started is absorbing'; 'Dealing with labour at home'; 'Trying to arrive at the labour ward at the right time'; 'There is always a risk of being sent home'; 'Encountering health professionals arouses strong emotions'.

**Conclusions:** the metasynthesis broadens the understanding of first-time mothers' experiences of early labour, and suggests that women's needs when planning a hospital birth are not being adequately met at this stage in the labour process. Three areas of future research are suggested: how to support and strengthen women during pregnancy in order to cope with early labour; women's experiences of early labour when planning a birth in contexts other than hospital; and to continue to investigate new ways of giving care during early labour.

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### Introduction

Early labour marks the transition from pregnancy into active labour and birth and constitutes the first of the stages of labour (Gross, 2002). Some women may experience its onset over a relatively short period while for others it may last several hours or even days (Gross et al., 2009). Symptoms that define the onset

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of early labour include: regular and/or irregular contractions, watery fluid loss, gastrointestinal disorders, sleeping disorders, and emotional upheaval (Gross et al., 2003, 2009). The early labour phase ends with the start of active labour which is variably defined as cervical dilatation of 3–5cm in the presence of regular uterine contractions (Neal et al., 2010).

Recognition of the onset of early labour lies in the mother's domain, rather than in health professionals', as it is dependent on her identification of the relevant signs and symptoms. This can be particularly challenging for a first time mother. Despite participation in antenatal education, it may be difficult for the first time mother to recognise and manage early labour by herself in a new and vulnerable situation (Lauzon and Hodnett, 1998; Bondas, 2002). Women's definitions of their onset of labour and those of midwives' may vary greatly (Gross et al., 2009).

Several aspects of care during early labour have been investigated. While studies have suggested that home-based versus telephone assessment and support, (Janssen et al., 2006; Weavers and Nash, 2012), social support (Hodnett et al., 2008), and an algorithm for defining active labour (Cheyne et al., 2008) are all likely to contribute both to women's knowledge and behaviour changes, randomised controlled trials have so far failed to demonstrate improvements in maternal and neonatal outcomes. Thus, many questions regarding the relationship between women's experiences of early labour and birth outcomes remain to be addressed (Lauzon and Hodnett, 2001; Janssen et al., 2009). Although the past four decades have seen much research on women's experiences of labour and birth in general (Cartwright, 1979; Oakley, 1983; Green et al., 1990; Waldenström et al., 1996; Waldenström, 1999; Lundgren et al., 2008) it is only relatively recently that attention has been paid specifically to women's experiences of *early* labour (Gross et al., 2003; Andren et al., 2005; Beebe and Humphreys, 2006; Low and Moffat, 2006; Beebe and Lee, 2007; Cheyne et al., 2007; Barnett et al., 2008; Carlsson et al., 2009; Nolan et al., 2009; Eri et al., 2010b, 2010a; Nolan and Smith, 2010; Eri, 2011; Green et al., 2011; Nyman et al., 2011; Carlsson et al., 2012; Janssen and Desmarais, 2013b; McIntosh, 2013). The aim of this metasynthesis was to integrate findings of individual studies and thus broaden our understanding of first-time mothers' experiences of early labour.

## Methods

Our methodology was metasynthesis which is based on the interpretive meta-ethnography described by Noblit and Hare (1988). Metasynthesis is research on research which synthesises the findings of previous qualitative studies. In the metasynthesis approach, the focus is on interpretation and the creation of new knowledge, not aggregation of findings (Noblit and Hare, 1988; Paterson et al., 2001; Thorne et al., 2004; Sandelowski and Barroso, 2007). Meta-ethnography (Noblit and Hare, 1988) was chosen because of the interpretative potential to deepen the understanding and nuances of the phenomenon. Several other metasynthesis methods have been developed such as meta-study (Paterson et al., 2001), metasummary (Sandelowski and Barroso, 2007), and thematic synthesis (Thomas and Harden, 2008), with different philosophical assumptions and measures. Noblit and Hare (1988) point to the methodological steps which can be understood as the analytic phase: determining how the studies are related, translating the studies into one another and synthesising the translations. Following this, papers were read repeatedly, to get to know each paper in detail. We were able to determine how studies were related by extracting the categories, phrases, ideas, concepts and themes used to describe or interpret the women's accounts in the original papers. Table 2 presents the

themes identified from the individual studies. Data matrices of the findings in each study were constructed and systematically juxtaposed, compared and contrasted to establish inter-relationships. The next step was reciprocal and refutational translation to find out if the themes arising from the included papers were similar or different. All included studies, independent of analytic technique, underwent the same procedure of extracting categories, phrases, ideas and themes used to describe and interpret the women's accounts. Metasynthesis needs to include studies that are broad enough in design and interrelated to allow for inclusion of evidence collected by various methods (Noblit and Hare, 1988). The translation from one study to another was idiomatic rather than word-for-word translation. Interpretive explanation is essential translation when the findings of one study can be presented in terms of another study using metaphors and concepts that can be applied to both by comparing and contrasting the findings in each study. The findings in the primary studies were analogous, not in opposition. Finally, the themes arising from the preceding steps were synthesised to form an integrative interpretation that is more substantive than the level of the individual studies. The research team collaborated in the analysis, two of the team members assessed each article and the emerging themes and synthesis were thoroughly analysed and discussed by the team. The team has a multicultural, multidisciplinary and multiprofessional background from nursing, midwifery and psychology that led to several fruitful discussions.

## Search strategy

We included peer reviewed empirical studies of all qualitative methodologies in English, German or Scandinavian languages which dealt with first-time mothers' experiences of early labour. No restrictions of time period or geographical area were imposed. We excluded quantitative studies. Mixed methods studies were included if it was possible to separate qualitative findings related to women's experiences. We included studies of both primiparous and multiparous women if it was possible to identify primiparous women's experiences separately. Papers which focused on the labour process as a whole were included if it was possible to separate findings related to early labour.

Relevant databases were identified, and searched with the chosen key words in English by a librarian with specialised competence. The main keywords were early labour, first-time mother, women's or mother's experiences and qualitative research. Because many alternative terms are used for early labour and first-time mothers, key words had to be expanded. To cover the concept 'early labour' the terms labour onset, labour start, latent phase of labour, latent labour, first part of labour, pre-hospital labour, first stage, signs of labour, symptoms of labour, false labour, parturition and spontaneous onset of labour were also used. To cover the concept 'first-time mother' the terms nullipara, primipara, first labour and first birth were also used. To expand the term 'experiences', the terms perceptions, feelings, emotions and sensations were added. Alternative spellings, e.g. labor, were used. In a last search the key words admission, assessment, triage and transition were added and combined with the other terms. The following databases were searched: Cinahl, Maternity and Infant Care, BNI, AMED, Medline, Embase, PsykINFO, Ovid nursing, ISI Web of Science and PubMed. The searches yielded a total of 590 papers, of which 79 were duplicates. The majority of exclusions could be made on the basis of the title alone, but if this was not clear, the abstract was reviewed. Five hundred and fifty-four papers were excluded, because they did not match the inclusion criteria. Excluded papers were for example: not qualitative studies, mixed-method studies in which qualitative findings could not be separated from quantitative findings, papers focusing on the

overall labour experience, or papers about premature labour. The remaining 36 papers were read in full text. Additionally, two newly accepted papers were retrieved directly from the authors. Twenty-four papers were excluded at this stage because they did not meet all the inclusion criteria, leaving 14 papers for appraisal. [Flow diagram 1](#) shows the searching and selection of studies.

#### *Assessment of included studies*

Two members of the team assessed each paper for quality and eligibility. The appraisal tool used was based on the work of [Paterson et al. \(2001\)](#) and [Sandelowski and Barroso \(2007\)](#), and focused on both appreciation and evaluation. Appreciation means to understand what is said by paying attention to details. Evaluation implies judgement of the usefulness of the study based on what is stated in the report. ([Bondas et al., 2013](#)). The tool assessed whether the paper had: a clear and explicit purpose, purpose and questions amenable to qualitative study, a literature review, a clear and appropriate theoretical perspective and study design, appropriate description of sampling strategy, appropriate description of data collection, appropriate analysis of data, clear presentation of findings, new information of target phenomenon, discussion of the role of the researcher and reflexivity, and reference to ethical concerns. The majority of the studies lacked a discussion of the role of researchers and reflexivity. Three papers were excluded in the appraisal process; one was an evaluation of an intervention during early labour ([Andren et al., 2005](#)) and in the two remaining papers ([Gross et al., 2003](#); [Gross et al., 2006](#)) it was not possible to separate the findings related to women's experiences after all. No papers were excluded due to low quality because we believed that all studies contributed to the emerging understanding of this field. Finally, 11 papers were retained for metasynthesis (see [Flow diagram 1](#)). All articles originated from high resource countries (USA 2, UK 4, and Scandinavia 5) and all were carried out in a context of hospital based maternity care. All studies were published in English, and a total of 231 women participated. Two of the included articles were based on the same sample ([Eri et al., 2010b, 2010a](#)). See [Table 1](#) for description of the included papers.

## **Findings**

We identified 16 themes from the data. The results of this metasynthesis are presented in terms of the five emergent core concepts 'Finding out if labour has started is absorbing', 'Dealing with labour at home', 'Trying to arrive at the labour ward at the right time', 'There is always a risk of being sent home', 'Encountering health professionals arouses strong emotions'. The key themes constituting each core concept are outlined, with supporting quotes from the original texts. Finally, the synthesis is presented. [Table 3](#) shows the emerging themes, key concepts, and the synthesis.

### **Finding out if labour has started is absorbing**

#### *Expectations about the signs of labour*

Women's expectations of how labour onset would feel stemmed from information in ante-natal classes, from reading books and from information given by labour ward personnel. In several of the studies, women described the mismatch between their expectations and experiences. Signs of labour onset that were different from those anticipated were mistaken for a bladder infection, food poisoning, constipation or an upset tummy:

...it just felt more like cramps. I don't know, the two just didn't go together for me. They didn't feel the way I was expecting them to. ([Beebe and Humphreys, 2006](#))

This applied also to expectations about the frequency of contractions:

I'd read that the contractions were supposed to be 20 minutes apart. That's why I didn't believe it. My contractions were coming so quickly, so I thought it must be something different. Because this isn't like what I'd read about. ([Eri et al., 2010b](#))

The task of recognising labour onset and making the diagnosis of labour at home was marked by intense attention to bodily experiences. Every possible sign of labour was 'screened' with the questions 'is this it?' or 'is this the real thing?'. The sensations were compared with late pregnancy symptoms to find out if this was something different or new.

Blood! There was a small spot of blood on the toilet-paper. I've had these pains coming all day, but I don't think they're contractions. They come too often and not very regular, but I must say that I'm very excited if this is the start. ([Eri et al., 2010a](#))

#### *The waiting mode*

In several studies, women reported strong feelings of uncertainty in early labour. The uncertainty was very much related to how to understand and interpret the possible signs of labour. To wait for labour onset was experienced as being in a 'waiting mode', a state of mind where women directed their attention more and more to the task of recognising the signs of labour. The feeling of uncertainty was related to not knowing when labour would start, not knowing what labour onset would feel like, not knowing if the labour had started and not knowing how far the labour had progressed:

So you just wait and wait and nothing happens, it's actually quite hard. It's like you're waiting for something, and you don't know when it'll happen. ([Eri et al., 2010a](#))

## **Dealing with labour at home**

#### *Support and pressure from family members*

Having family members around in early labour gave both support and pressure. The support person was in most cases the partner, but mothers, mothers-in-law and sisters were also mentioned. Many women described how difficult it was for family members to see them in pain, leading to pressure to go to hospital earlier than the woman felt was necessary:

...my mum was like that, 'no I canna watch you doing this anymore. I've got to take you up'. 'So I ended up going back to the hospital still 2 centimetres dilated... She couldn't see me in that much pain any longer'... ([Barnett et al., 2008](#))

#### *Coping strategies*

Women used a variety of coping strategies to reduce pain and distress and to relax in early labour at home. Environmental factors could act as a distraction, for instance visiting others, watching films or just doing everyday things and some women found this effective:

It was quite calm actually... it was just the mundane things; going through and cleaning the bathroom and putting the laundry in the washing machine and making sure it got to the dryer... it was just the everyday chores that took your mind off things ([Beebe and Humphreys, 2006](#))

**Table 1**  
Description of included studies.

Author, country	Purpose	Design and methods	Inclusion criteria	Participants and sampling	Setting
<b>Barnett et al. (2008); Scotland</b>	To explore the factors that influence a woman's decision to go to a maternity unit in latent labour and the impact that being sent home 'not in labour' has on her and her family	Self-complete semi-structured diaries and follow-up interviews one to four months after birth	Women, who met the trial criteria, were diagnosed not in labour and were sent home	Six primiparous women recruited in four maternity units. Some demographics given	Both urban and rural areas in the central belt of Scotland
<b>Beebe and Humphreys (2006); USA</b>	To explore the phenomenon of labour prior to hospital admission from the perspective of nulliparous women	Ethnographic, individual interviews in the early postpartum period	Nulliparous women with uncomplicated, singleton, term pregnancies who began spontaneous labour outside the hospital, planning hospital births	23 primiparous women were recruited through convenience sampling at childbirth preparation classes or inpatient postpartum units. Data from 19 women from a previous study, four additional women recruited. Demographic data given	Two locations on the West Coast; a large city and a suburban/rural setting
<b>Carlsson et al. (2009); Sweden</b>	To gain a deeper understanding of how women who seek care in an early stage experience the latent phase of labour	Grounded theory, individual interviews in the women's homes two to six weeks after birth	Women with uncomplicated pregnancies, admitted in the latent phase of labour	11 primiparae and seven multiparae recruited through purposive sampling on the postnatal ward. Demographics given	Hospital in the southwest part of Sweden with 16–1700 deliveries per year. Uncomplicated and complicated deliveries
<b>Carlsson et al. (2012); Sweden</b>	To obtain a deeper understanding of how women who remain at home until the active phase of labour experience the period from labour onset before admittance to the labour ward	Grounded theory, individual interviews either on the postnatal ward or in their homes two days to two weeks after birth	First time mothers with an uncomplicated, single, full-term pregnancy with spontaneous start of labour at home, admitted during the active phase of labour, understand and speak Swedish	19 primiparae purposively selected from the birth register after birth. Demographic data given	A county hospital in the south-west of Sweden where the women are encouraged to call the clinic when their labour starts before seeking care at the labour ward
<b>Cheyne et al. (2007); Scotland</b>	To determine the main themes and issues surrounding women's early labour experiences and factors which influence their decision making processes regarding when to go to the hospital	Exploratory, individual semi-structured interviews	Primiparous and multiparous women who had recently given birth	16 primiparae and five multiparae were recruited in two pregnancy and childbirth support groups and one breast-feeding support group and interviewed during group meetings. Demographic data given	Inner city area
<b>Eri et al. (2010a); Norway</b>	To explore first-time mothers' experiences of waiting for labour onset, and to contribute to the discussion of existing practices surrounding perinatal care	Qualitative/interpretive, life-world phenomenology approach. Diary writing before birth, interviews in the women's homes one to six weeks after birth	Women expecting a first child with uncomplicated pregnancy, anticipating a normal course of labour and knowledge of the Norwegian language	17 primiparous women recruited during third trimester when attending childbirth education classes at a university hospital and at a primary health care centre. Some demographics given	Participants from urban and suburban areas, all but two gave birth at the university hospital, one moved to another region and one chose a smaller hospital
<b>Eri et al. (2010b); Norway</b>	To explore Norwegian nulliparous women's experiences of communication and contact with midwives at the labour ward in the early phase of labour	Qualitative/interpretive, diary writing before birth, interviews in the women's homes one to six weeks after birth	Women expecting a first child with uncomplicated pregnancy, anticipating a normal course of labour and knowledge of the Norwegian language	17 primiparous women recruited during the third trimester. Some demographics given <sup>a</sup>	Participants from urban and suburban areas, all but two gave birth at the university hospital, one moved to another region and one chose a smaller hospital
<b>Green et al. (2011); Wales</b>	To report a study of women's experience of, and satisfaction with, telephone communications within the All Wales Clinical Pathway for Normal Labour ('the Pathway')	Mixed methods, telephone interviews, iterative quantitative and qualitative analysis	Women in Wales who had recently given birth to their first baby, were deemed low risk at labour onset (and thus on the Pathway), had phoned the maternity unit at least once when they thought that labour was starting	46 primiparae recruited from six different areas (NHS Trusts). Some demographics given	The All Wales Clinical Pathway for Normal Labour ('the Pathway')
<b>Low and Moffat (2006); USA</b>	To explore women's perceptions of transitioning to the birth facility when in labour	Qualitative with feminist perspective, interviews in the women's homes within one week to three months after birth	Uncomplicated term pregnancy (> 36 weeks), expecting their first birth, age > 18, able to speak and read English, planning a vaginal birth	24 nulliparous women were recruited from obstetric clinics and in childbirth education classes, independent of their planned site of birth or the type of health care provider. Demographic data given	Midwestern suburban community
<b>Nolan and Smith (2010); England</b>	To explore women's experiences of staying at home following advice from an obstetric triage unit	Qualitative, interviews in the women's homes approximately one month after birth	Not stated	Seven primiparae, one multipara (cs in first birth) were recruited when they rang the obstetric unit to seek advice in early labour. Some demographic detail	A West Midlands consultant led unit with 3800 births per year

Table 1 (continued)

Author, country	Purpose	Design and methods	Inclusion criteria	Participants and sampling	Setting
Nyman et al. (2011); Sweden	To explore the meaning of first time mothers' and their partners' first encounter with midwives and other maternity care staff when they arrive on a hospital labour ward	Hermeneutic, reflective lifeworld approach. Either individual interviews on the maternity ward or focus group interviews two months after birth	Swedish speaking first time mothers with spontaneous onset of labour and with a live fetus.	49 primiparae (and their partners) were purposively recruited consecutively from the labour ward register. 30 mothers were interviewed within 72 hours after birth, 15 mothers and 13 partners participated in focus group discussions two months after birth. Some demographic detail	A hospital located in western Sweden

<sup>a</sup> Same sample as Eri et al. (2010a).

Table 2

Themes identified from the individual studies.

Author	Themes, first iteration
Barnett (2008)	Influence of others/Not coping with pain at home/Pain worse than expected/Pain the major reason for going to hospital/Being sent home increased anxiety/Confirmation of normalcy/Undervaluing of the latent phase/
Beebe and Humphreys (2006)	The influence of social support members/Managing symptoms/Doing it right/The fear of going in too soon/Distressing if sent home after labour evaluation/Need to know labour progress/Uncertainty about labour onset/The real thing/Immense importance assigned to the task of properly diagnosing labour/Physical sensations overlooked if they did not match expectations/Bodily power/
Carlsson et al. (2009)	Decision to go to hospital the initiative of others/Support from partners important during periods of powerlessness/Suffering from pain to no avail/Pain the reason to go to hospital/Having difficulty enduring the slow progress/Fear of giving birth at home/Being safe in the hospital/Having difficulty managing the uncertainty/Knowledge about progress enhanced feelings of safety/Confirmation of normalcy/Not knowing what labour onset would feel like, or when labour would start/Not knowing if labour had started/Doubt their bodies/Doubt own ability to manage labour/Lack of understanding from the midwives/Feeling helpless/
Carlsson et al. (2012)	Sharing the experience with the partner/The partner as a participator/Distract oneself reduces pain and distress/Coping with pain/Confirmation of normalcy/Did not recognise labour signs/Unfamiliar bodily sensations/Listen to the rhythm of the body/Trusting the body/
Cheyne et al. (2007)	Pressure from partner/Pain the primary reason to go to hospital/Anxiety and pain/Coping at home/Stay home as long as possible/Disappointment because not in established labour/Reassurance was positive and gave confidence/Want to know about labour progress/Uncertainty about the signs of labour onset/Trusting the body/
Eri et al. (2010a)	More and more body /Is this it?/Constant bodily alertness/Identifying signs of labour/
Eri et al. (2010b)	Negotiating with partner or mother/Stay home as long as possible/Seeking admission at the right time/Need to be 'ready' on arrival/Praised for coming in late/'Five-one' the time to seek admission/Concerned about being sent home/Embarrassing to come too early/Uncertainty about labour onset/Searching for regularity/ Experiencing vulnerability/The caring midwife/
Green et al. (2011)	Coping with pain/Expectation that contractions 5 m apart would lead to admittance, if not shock and panic/Needed clear instructions to know/Women who were sent home were often dissatisfied/Being safe in the hospital/Need to know how to proceed/Feeling welcomed/Be treated as an individual/Midwives' manner/
Low and Moffat (2006)	Pain as indication for labour/Women see pain as indication for admission/health care personnel do not/Pain worse than expected/Identifying the right time/Underlying stress of needing to be right about the timing/Making a mistake/The risk of being sent home if not dilated enough/Women asked to identify signs of labour but health care personnel diagnosed by cervix dilatation/Disappointment/To be trusted/
Nolan and Smith (2010)	Pressure from family to go to hospital/Managing symptoms/Seeking permission to come in/Decision taken by midwifery staff/Reassurance/Not able to relax because not knowing/Uncertainty in early labour relating to expectations/Women desiring individualised care/
Nyman et al. (2011)	How to cope with pain at home/Timing it right/Waiting to arrive at the appropriate time according to the hospital staff/The perfect patient/To pass the test of getting through latent phase at home/Afraid of being sent home/Waiting to be informed/Women judged how far they were in labour based on embodied sensations/Being in an inferior position/Being seen as an individual/Caring midwives/

However, coping strategies were not always successful. In spite of preparations for labour, some women were surprised by the intensity of the pain and how slow and long the process seemed to be:

...I thought I had prepared myself for the worst but it was ten time worse than that (Barnett et al., 2008)

#### Trusting/doubting your body

When dealing with early labour at home, some of the women talked about bodily power and how they could either trust or feel betrayed by their own body. Different aspects of bodily trust were referred to including 'the body taking over', 'a gift of nature' and 'something that women's bodies have always done'. Some women trusted that this was labour even though their symptoms did not match what they had learned and expected:

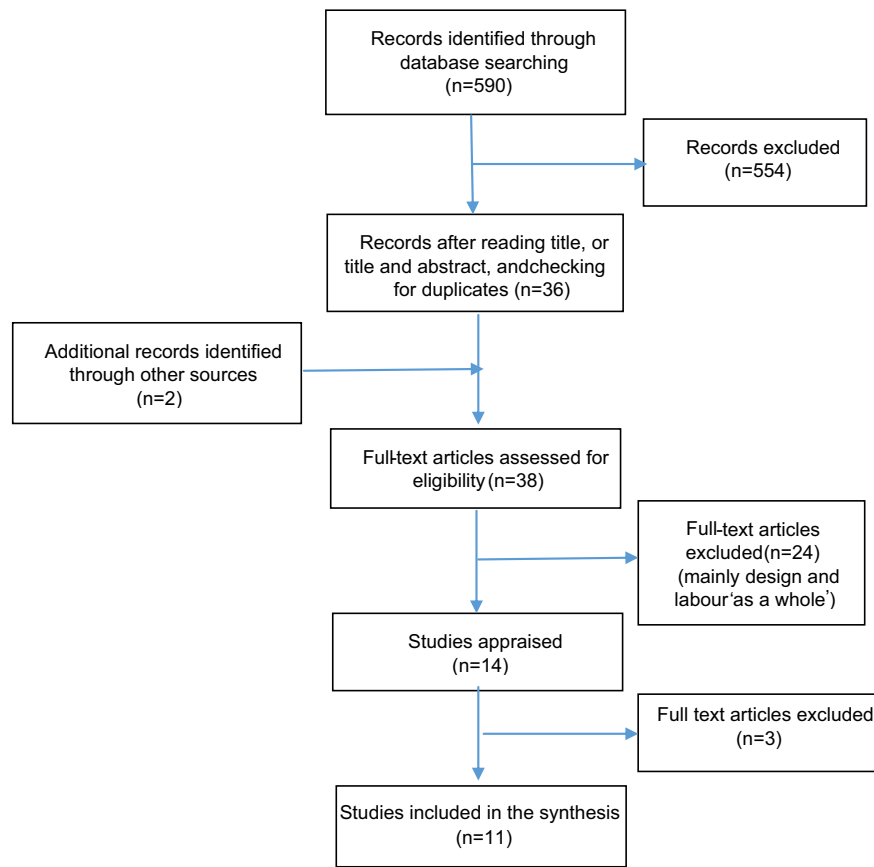
my body was just moving me around (Beebe and Humphreys, 2006)

A few women had doubts about their own ability to manage labour pain, and felt that their body was failing them:

all along I felt that something was wrong, I was completely sure of that. There is something wrong, how can I have had this pain for such a long time, and still nothing happens (Carlsson et al., 2009)

#### Seeking advice and knowledge about labour progress and baby's well-being

It was of great importance to women to know if everything was normal, and how far the labour had progressed. They particularly sought reassurance that everything was fine with the baby, and



Flow diagram 1. Searching and selection of studies.

Table 3  
Emerging themes and concepts.

Themes, second iteration	Core concepts	Synthesis
Expectations about the signs of labour The waiting mode	Finding out if labour has started is absorbing (Beebe and Humphreys, 2006; Low and Moffat, 2006; Cheyne et al., 2007; Carlsson et al., 2009, 2012; Eri et al., 2010a, 2010b; Nolan and Smith, 2010; Nyman et al., 2011)	A balancing act in an unknown territory
Support and pressure from family members Coping strategies Trusting/doubting your body Seeking advice and knowledge about labour progress and baby	Dealing with labour at home (Beebe and Humphreys, 2006; Cheyne et al., 2007; Barnett et al., 2008; Carlsson et al., 2009, 2012; Eri et al., 2010b; Green et al., 2011; Nolan and Smith, 2010; Nyman et al., 2011)	
Pain the main reasons to go to hospital "Stay home as long as possible" Being the perfect patient Seeking permission to come in	Trying to arrive at the labour ward at the right time (Beebe and Humphreys, 2006; Low and Moffat, 2006; Cheyne et al., 2007; Barnett et al., 2008; Carlsson et al., 2009; Eri et al., 2010b; Nolan and Smith, 2010; Nyman et al., 2011)	
Being sent home from the labour ward is distressing Feeling safe in the hospital Caring and uncaring midwives Being seen as an individual Making a mistake Being believed	There is always a risk of being sent home (Beebe and Humphreys, 2006; Low and Moffat, 2006; Cheyne et al., 2007; Barnett et al., 2008; Carlsson et al., 2009, Eri et al., 2010b; Green et al., 2011; Nyman et al., 2011) Encountering health professionals arouses strong emotions (Beebe and Humphreys, 2006; Low and Moffat, 2006; Barnett et al., 2008; Carlsson et al., 2009; Eri et al., 2010b; Nolan and Smith, 2010; Green et al., 2011; Nyman et al., 2011)	

this had to come from a health professional as they felt that they did not possess that kind of knowledge themselves. To have knowledge about progress enhanced feelings of safety and gave women confidence to stay at home. The contrary situation of not knowing could lead to feelings of uncertainty and anxiety:

I mean if somebody had examined me earlier on and I'd known things were ok, I'd have been quite happy to be at home, but it's just to this day I don't know if I was left at home and things were going wrong and I could have endangered the baby (Cheyne et al., 2007)

The women contacted the birthing unit for confirmation either on the phone or by a visit. To phone the birthing unit and talk to a midwife was also a way of sharing the experience with someone. When they contacted the birthing unit they wanted clear instructions on how to proceed and what to do.

### Trying to arrive at the labour ward at the right time

#### *Pain the main reason to go to hospital*

Many women described that increasing pain was the main reason to go to the hospital. They saw pain as an indication of active labour and therefore a reason for admittance. Strong pain was perceived as a signal that their labour had progressed to the point where they needed professional support:

I was getting a bit concerned ...cause by then I needed pain relief or I didn't really need it at the moment but I thought in another hour I might need it then (Cheyne et al., 2007)

Regularity of the contractions, with a pattern of '5-1' (i.e. one minute duration and five minute intervals), was also perceived as an indication of when to leave for the intended place of birth. This stood out as the fixed point that they could relate to and work towards. There were common expectations that this pattern would lead to admittance. If this expectation was not met, women reported being shocked, panicked, frightened and discouraged:

Then we made another call, and I told them that my contractions were five minutes apart, and we're getting ready to leave, just for your information. Then she (the midwife) asked 'When did you feel the first contraction?' I told her a quarter past one, and she told me I shouldn't think of coming in for a long time yet. I wonder, when in labour for the first time, you know nothing, the only thing you know is that when your contractions are five minutes apart you should go to the hospital. So we were both discouraged and wondered what to do next. (Eri et al., 2010b)

#### *'Stay home as long as possible'*

Women said that the message 'stay home as long as possible' was strongly communicated antenatally. This backdrop was very evident in women's experiences during early labour, but they did not always understand why it had to be like that. The message added to the feelings of uncertainty, because it was difficult to know how long 'as long as possible' actually was when they had not experienced labour before:

I tried to prepare myself by reading about the different phases, but I couldn't understand why you have to stay home for so long—after all, it's the beginning of labour and the moment when you are most unsure. It seems like you are supposed to come in as late as possible and leave again as soon as possible. (Eri et al., 2010b)

#### *Being the perfect patient*

Women were much occupied with doing the right thing. They were concerned about arriving at the intended place of birth at the right time, and there was an underlying stress of needing to be right about the timing. They felt that they had to be 'ready' when they arrived, and not go in 'too soon':

The only thing I worried about was going to the hospital maybe too soon. You have that fear of getting there and...then having

the doctor tell me that I could come in tomorrow, and kind of going over him and making that decision [to go in sooner], and worrying about it being wrong...I just thought it would be bad if we get there only to be told to go back home. It would be discouraging. (Beebe and Humphreys, 2006)

Some women described that they were praised for coming in late, and felt that going through early labour at home was a test they had to pass in order to be admitted to the labour ward. If they attended the hospital at the 'right' time they were called 'the perfect patient':

And when we arrived they said that 'you're perfect and came exactly in the appropriate time' and, yes, 'you are a perfect patient' (Nyman et al., 2011)

#### *Seeking permission to come in*

Many women described feeling that they had to seek and wait for permission to come in. They perceived that they were asked to identify the 'right' timing, but eventually the decision was taken by the midwifery staff based on the dilatation of the cervix. Some women felt that they had to negotiate in order to gain admittance to the labour ward:

I wasn't dilated as much as one is supposed to...but I was permitted to stay, which I thought was good, not having to return home again. (Nyman et al., 2011)

Several of the studies reported the immense importance women assigned to the task of properly diagnosing labour at home. Women felt that they should be able to recognise the signs in order to know when to go to the intended place of birth. The feeling of uncertainty could be diminished for some time by contacting the birthing unit to get feedback on how to interpret the possible signs of labour. On the other hand, the contact could also lead to even more insecurity:

...by that stage I didn't know when I should go in, when I shouldn't...I certainly wasn't sure about what stage I should have been there. I just didn't know. (Cheyne et al., 2007)

### There is always a risk of being sent home

#### *Being sent home from the labour ward is distressing*

Many women said that they were afraid of being sent home if they arrived 'too soon' at the labour ward, but they knew that this was always a risk. Even women presenting in advanced labour were concerned about being sent home until the midwife had made an evaluation of labour progress. In most of the papers the women described the distress of being sent home from the labour ward. This was expressed as discouraging, disappointing and embarrassing and leading to increased anxiety. They also expressed concern and uncertainty about how to know when to contact the hospital the next time if they were sent back home:

...they said that there was nothing really they could do, just to take cocodamol... for some reason when I seemed to be in the hospital it didn't seem to be as bad, but then the minute I came home it just seemed to get worse, every time I came home it got worse and worse. (Beebe and Humphreys, 2006)

#### *Feeling safe in the hospital*

Some women described how the labour ward felt like the safe sheltered place they needed to give birth to their baby, and for some this was linked to fear of giving birth at home. This was

described as a wish to hand over responsibility to professional caregivers. Women were scared and afraid that they had to go home to renewed uncertainty:

'As for me and my soul it was like honey. Yes, now I was here (at the labour ward) and they kept me safe in their hands all the time.' 'I'm very thankful for being allowed to be admitted, as I was giving birth for the first time, I didn't know what this meant for me or for my child.' (Carlsson et al., 2009)

## Encountering health professionals arouses strong emotions

### *Caring and uncaring midwives*

Encounters with health professionals during early labour were sometimes perceived as caring and sometimes not. Whether on the phone or in person, women were very sensitive to the way the midwives spoke or treated them, and they described feeling exposed and 'naked'. The way they were met gave rise to a variety of emotions, and could make the situation turn in either a positive or a negative way. There was a feeling that care had to be earned by being sufficiently far advanced in the labour process when they arrived. The condition for earning the care was cervical dilatation of at least 3–4 cm:

'They do kind of make you feel a bit silly phoning' '... she just said 'well if you are that teary then come up to be monitored but there's nothing to worry about' '...when I made the third [call] I thought, all I could think of was them thinking 'Oh god, it's this girl on the phone again' (Green et al., 2011)

A midwife who was impersonal and indifferent or who did not explain anything could be experienced as uninterested and thus uncaring. A willingness to listen and show interest in their needs was perceived as caring:

The second time I came in, it wasn't like I dreaded the next time, if it was still too early, because she said that it was impossible to know how it is the first time or how advanced you are. She also told me that she came in too early with all four children herself. (Eri et al., 2010b)

### *Being seen as an individual*

The women felt that there was one set plan for everyone and that the advice they were given was not always tailored to them. In one paper, this was expressed as being subjected to a professional agenda to keep women at home which was applied uniformly, with little consideration for the distress of the individual women:

It has to do with the people you talk to, how you feel you're getting on, if they are listening and that. A little more humility from those I talked to would've been positive. I mean, when you're in pain, you can't take so much and you're more irritable. It could have been my hormones of course, but it didn't feel like that. They, of all people, should know how that can influence [the experience]. But of course, I know it wasn't that regular, but it was my first time and it progressed quickly. They have a plan that says 'slowly, and stay at home'. But that is wrong, because when there's no set recipe, they can't give any advice on that matter. (Eri et al., 2010b)

It was the same sort of, you know 'the stay at home blah, you know how it is' (Nolan and Smith, 2010)

To be seen as an individual was also about being treated with respect. Women appreciated reassurance, confidence, information, friendliness and encouragement from the midwife:

I was particularly impressed... When I had the contraction on the phone, ... the midwife was very much saying 'Look, you don't need to talk, I won't put the phone down, just get through it and then start talking again'. (Green et al., 2011)

### *Making a mistake*

The feeling of making a mistake or making a wrong judgement about the onset of labour or the appropriate time to seek contact with the intended place of birth was experienced as embarrassing by several women. Attending the labour ward 'too early' led to feeling 'stupid', 'silly', 'daft' and 'being a wimp'. The women reported that even the thought of coming in too early could release these kinds of emotions, and this made some of them delay the contact to avoid an embarrassing situation. For women who were sent home from the hospital, the feeling of making a mistake could be even stronger:

I had one contraction right after the other right there in the lobby and another one getting out of the elevator. It was really funny because the receptionist who was waiting in the triage area sort of looked out and saw me there and thought, 'Labor! We're not sending her home.' And I was thinking, you know, I hope they do not send me home 'cause, I don't know, maybe it would be like failing somehow to show up at the hospital and think you're in labor and you're not. (Low and Moffat, 2006)

### *Being believed*

Women expressed a sense of being in an inferior position on arrival, and could feel challenged if they sensed that the midwives did not fully understand their situation and appeared not to trust the symptoms reported. This could lead to feelings of loneliness, helplessness and sadness. Women were sensitive to cues that their concerns were seen as invalid:

They did not understand that it hurt really badly and that I ought to be more open. Rather... 'what are you doing here, you could be at home instead' (Carlsson et al., 2009)

Some papers report that women did not feel welcome at the labour ward when they lacked the objective and measurable cues of established labour: regular contraction pattern and cervical dilatation. A feeling of not being taken seriously about their individual experiences in early labour could release strong emotions:

Maybe she thought we had decided to go home, but then she probably realized that I had been crying. I was very emotional at that point and couldn't bear much before I started to cry. It was like she just had to say one wrong word and I'd burst out in tears, I was so emotional. It meant a lot to me to feel welcomed in that phase, I was very sensitive, and didn't know what was lying ahead of me. But I didn't feel well received. I felt that she didn't believe me. It was really important for me to feel believed because it was my body, and I was the one who experienced it. That was the bad thing about it. But when she realized that I really had contractions, she was fantastic. (Eri et al., 2010b)

### *Synthesis*

First-time mothers' experiences in early labour can be described as a 'balancing act' in an unknown territory where they have to navigate either on their own or together with anxious companions and with inadequate knowledge about the way ahead. To reach the final destination women have to perform tasks and to



pass obstacles. The 'unknown territory' has a double meaning; as the personal experience of going into labour for the first time and as encountering the maternity care system. On both levels women have to make significant decisions; if labour really has started and subsequently when to go to the hospital. Most women are surrounded by family during this time and have to balance those people's needs and wishes against their own. This will lead some to contact the labour ward earlier than they feel is right. For women, the task of properly diagnosing labour at home takes a lot of energy and involves turning in different directions for knowledge and confirmation. A key challenge is to balance the arrival on the labour ward at the 'right' time; not too early and not too late. However, it is not clear to the women what criteria have to be met to be 'right', nor whether they can have any impact on the decision to admit them. Arriving at the 'right' time leads to a positive path, which encompasses affirmation, acknowledgement, and positive encounters with the health care providers on the labour ward. Arriving 'too soon' might lead to a cascade of negative experiences, emotions and, potentially, encounters with uncaring midwives.

## Discussion

This metasynthesis provides qualitative evidence that first-time mothers' experiences of early labour are a complex balancing act. However, it has to be taken into consideration that all the included studies were performed in a context of hospital based maternity care. This is not surprising, because in the geographical areas of the included papers the vast majority of women give birth in institutionalised settings. No articles were identified exploring women's experiences in other contexts. Experiences of early labour at home for women planning a home birth might have influenced the results. Furthermore, no papers were identified concerning women with special needs or minority groups, for example migrant women or women with medical disorders.

Our study highlights aspects of early labour experiences that are important to women planning a hospital birth. Our findings are echoed in those reported in a study of British midwives' perceptions of their telephone contacts with women in early labour (Spiby et al., 2014). This found that midwives were trying to reconcile the conflicting priorities of responding to women's needs and trying to prevent inappropriate admissions to labour wards and, in so doing, recognised that they may be marginalising women's needs. Similarly, a Norwegian study of midwives' strategies to manage women in early labour concluded that the priority of keeping women out of hospital as long as possible might not meet women's needs in early labour (Eri et al., 2011). In Finnish studies (Bondas, 2002, 2005) pregnant women hoped for intrapartum care from a midwife who was already known and trusted. They had mixed feelings and worries about going into labour and felt safeguarded through the midwife's scientifically based and humane surveillance during pregnancy. The same need and wish thus continues into early labour, as the findings in this metasynthesis illuminate.

Women's sense of security when admitted to the hospital stands in contrast to research showing that admittance in early labour increases the likelihood of receiving oxytocin and giving birth via caesarean section (Bailit et al., 2005; Neal et al., 2014). It is thus questionable if a hospital ward is the optimal place for first-time women in early labour. A priority may therefore be to focus on support and care during pregnancy to identify and strengthen factors that can enhance a woman's own ability to cope with early labour out of hospital (Escott et al., 2004, 2005; Carlsson et al., 2014).

The studies included in the metasynthesis were published in a variety of countries, with different qualitative analytical

techniques, utilising both convenience and purposive sampling and recruiting women at a variety of stages in the childbearing period. Finfgeld-Connett (2010) emphasises that the sample in a metasynthesis must be homogenous enough to confirm the findings, and at the same time heterogeneous enough to ensure abstraction but not too abstract to be meaningless. This is potentially both a limitation and strength, and thus the reader needs to place the findings within such a diverse context. Given that this is the first meta-synthesis of women's experiences of early labour, an analysis in depth was warranted. Further refinement of salient issues may warrant restrictions in study selection in future syntheses.

## Conclusion

Our metasynthesis has broadened the understanding of first-time mothers' experiences of early labour, and suggests that women's needs when planning a hospital birth are not being adequately met at this stage in the labour process. A tool to evaluate women's experience of early labour has recently been developed (Janssen and Desmarais, 2013a, 2013b), and may be useful in extending our knowledge of how best to assist women. On the basis of the results of the metasynthesis, we suggest three important areas of future research. Ways of supporting and strengthening women during pregnancy in order to cope with early labour will be an important area, as will women's experiences of early labour when planning a birth in contexts other than hospital. Finally, it is important to continue to investigate new ways of giving care during early labour. This metasynthesis will be an aid to tailoring new ways of giving care directly to the aspects that are most important for women in early labour. Early labour has received little attention to date in the empirical literature. Our metasynthesis underlines the importance of this critical stage in women's experience of labour and outlines gaps in care related to imparting knowledge, providing support, and negotiating individualised approaches.

## Conflict of interest

None.

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