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ORIGINAL RESEARCH

Motivations for and experience with labor induction at 39 weeks in women with obesity—A qualitative study

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Abstract

Introduction: Timing of induction of labor (IOL) at term has been investigated in multiple settings. In Denmark, the 'When to INDuce for OverWeight' (WINDOW) study compares IOL at 39 weeks of gestation versus expectant management in low-risk women with obesity. However, knowledge on women's expectations of and experience with IOL is sparse. The aim of this study was to explore women's motivation to join the WINDOW study and their experience when randomized to IOL at 39 gestational weeks.

Material and Methods: A qualitative interview study of 25 pregnant women with obesity randomized in the WINDOW study to IOL at 39 weeks of gestation was conducted. Participants were recruited from four hospitals in Central Denmark Region and were interviewed four to six weeks after giving birth. A thematic analysis was performed using a phenomenological approach.

Results: The analysis resulted in three main themes, (1) Motivation for IOL, (2) The IOL process, and (3) IOL in recollection and in the future. Participants perceived inclusion into the WINDOW study as a "great opportunity," as they hoped to be randomized to IOL at 39 weeks of gestation. Their main motivation for participating was physical discomfort in late pregnancy and a wish for "knowing" the timing of the birth. BMI-related risk factors were mentioned by few as a motivating factor. Some participants described the IOL process as a team effort between the couple and the midwives and were positive towards future IOL. Others associated the IOL process with prolonged labor or described the body as "reluctant" to respond to the induction regime. A desire to experience spontaneous onset of labor in a future pregnancy was mentioned.

Conclusions: Physical discomfort and wanting to "control" the onset of labor were main motivations for women's decision to participate in the WINDOW study, hoping they would be allocated for IOL. Comprehensive information and being supported by midwives through the IOL process was crucial for a positive IOL experience. Some

Abbreviations: BMI, body mass index; WINDOW, When to INDuce for OverWeight; IOL, induction of labor.

participants were positive towards a future IOL. Others speculated if their body was not ready for birth in 39 weeks of gestation and/or associated the IOL process with a challenging labor.

KEYWORDS
induction of labor, obesity, outpatients, pregnancy, qualitative research

1 | INTRODUCTION

The timing of and indications for induction of labor (IOL) are being investigated in multiple settings.[1–3] In addition to addressing the clinical effects of IOL, in-depth knowledge about women's expectations and experience of IOL is central for future development of induction guidelines. Previous studies indicate that pregnant women's participation in clinical trials is motivated (among other factors) by perceived risk status and the potential to minimize the risk.[4–6] Existing research on women's experience of IOL is limited and findings have shown diverse results[7,8] Some studies report a high satisfaction among women who have had IOL, both with the IOL process and with the childbirth experience,[7,9] while other studies find that some women consider the IOL process to negatively affect the birthing experience.[10–13] These results reflect that induced labor, both as a physiological process and an individual experience, is a complex process influenced by a variety of factors. Therefore, more focused studies of selected groups of pregnant women's experience of IOL are necessary to understand women's perspectives in the situations where IOL is offered.

In Denmark, a large randomized multicenter study, When to Induce for OverWeight (WINDOW),[3] is currently investigating whether IOL at 39 gestational weeks compared to expectant management results in more vaginal deliveries in low-risk women with obesity. According to the national surveillance of deliveries provided by the Danish Health Authorities, approximately 15% of pregnant women in Denmark have a pre-pregnancy BMI of 30 kg/m^2 or more,[14] which is associated to an increased risk of complications during pregnancy and birth,[15–17] and the risk of cesarean section is particularly high.[18,19] The WINDOW study offers an opportunity to study a specific group of women having labor induced at 39 weeks.

Such insights are of the utmost importance to the overall assessment of the potential implications of the WINDOW study. Therefore, the aim of this study was to explore the motivations and experiences of IOL at 39 weeks gestation among the subgroup of low-risk women with obesity, being randomized to the intervention arm in the WINDOW study.

Key Message

Physical discomfort and a desire to "control" the onset of labor was prominent motivations for the 25 women, who were randomized to IOL. Some participants were positive towards a future IOL. Others associated the IOL process with a challenging labor.

2 | MATERIAL AND METHODS

2.1 | Design

To answer the study aim, a qualitative research design based on semi-structured interviews was chosen. It is a well-established scientific method for exploring complex, subjective experiences and involves the systematic collection, organization and analysis of data material obtained from conversation and/or observations.[20] Qualitative research allows for an in-depth and contextual understanding the meanings and interpretations that people themselves ascribe to their experiences,[21] for example, women's experience of IOL.

2.2 | Setting

In Denmark, all pregnant women are offered comprehensive maternity care, free of charge. Generally, low-risk maternity care and birth are midwifery-led, and midwives are responsible for initiating, monitoring, and supporting women throughout the IOL process. If any complications arise, the midwives are responsible for involving an obstetrician. Outpatient induction where oral misoprostol is self-administered at home by the women is standard procedure in Danish low-risk pregnancies.[22,23] A typically IOL process includes a daily check up at the hospital including abdominal palpation, vaginal examination to estimate Bishop score and cardiotocography (CTG) monitoring. Written and oral information about the procedures of IOL is provided. At each visit, midwives assesses whether the outpatient regimen can continue or whether the woman should continue the IOL in-hospital. Women without a uterine scar are given misoprostol tablets (25 μg) to be self-administered at home every 2 h with a maximum daily dose of 200 μg for up to 3 days. If the tablets do not initiate labor, rupture of membranes or a balloon catheter is the next step. Women in our study received the same examinations, information, and follow-up as are routinely offered to all women with IOL.

2.3 | Participants

Recruitment for this study took place in the Central Region Denmark, at three regional maternity departments and one

University hospital (October 2022 through October 2023). Women were recruited consecutively by midwives already recruiting participants for the WINDOW study (See Figure 1). The inclusion criteria for the WINDOW study[3] are presented in Table 1. Women who were randomized to the intervention arm (IOL) were eligible for this qualitative study and received written information and a consent form. If they agreed to participate, they were contacted by JH by telephone three to five weeks postpartum and given additional information about the study. Recruitment continued until sufficient information power was obtained as defined by Malterud et al.[24] A total of 25 women were recruited, there were no drop-outs.

2.4 | Data collection

The interview guide was developed by scrutiny of the literature[25] and by thorough discussions among the authors. The interview questions were intended to provide space for women's reflections and descriptions. Open-ended questions and follow-up questions were asked to promote this process. Topics and examples of questions are presented in Table 2.

Twenty women were interviewed by phone, three via video, and two in person in their homes. All interviews were conducted by JH, who is a midwife and experienced in qualitative interviewing.

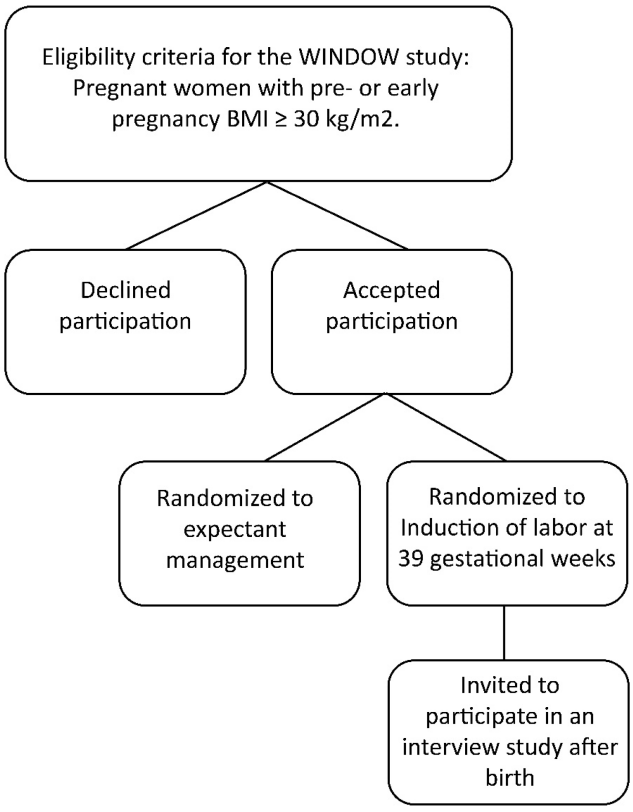

FIGURE 1 WINDOW Study recruitment. The participants are a subset of the WINDOW study participants.

Interviews were recorded digitally and transcribed verbatim by an anthropology student with experience in transcription. The quality of the transcripts was evaluated by JH by comparing them to the audio files systematically. The audio files and the transcribed material were stored in a secure database according to Danish legislation.

2.5 | Data analyses

The analyses were performed by JH and SL. To present key elements of participants' statements, the material was read and re-read to generate the initial codes. Three interviews were test-coded independently by JH and SL and discrepancies in coding were discussed and resolved. All interviews were coded using NVIVO 10.0 (QSR international, Melbourne, Australia).

The codes were assessed and sorted into main themes and sub-themes to generate a thematic map of the content and topics across the data and to summarize the variation and regularities within. The thematic map was discussed by all authors and refined. Concurrently, a table of quotes that illustrated the findings of each theme was developed (Table 3), which is referenced throughout the Results section.

TABLE 1 Eligibility criteria for the WINDOW study.

Inclusion criteria	• Pregnant women with pre- or early pregnancy BMI ≥ 30 kg/m^2
Exclusion criteria	• Legal or ethical considerations: maternal age <18 years, language difficulties requiring an interpreter • Multiple pregnancy • Previous cesarean section • Uncertain gestational age, defined as gestational age not determined by Crown-Rump-Length • Planned elective cesarean section at time of randomization • Known fetal contraindications to IOL at time of randomization: eg, non-cephalic presentation, or other fetal conditions contraindicating vaginal delivery • Known fetal contraindications to expectant management at time of randomization: eg, fetal conditions* • Known maternal contraindications to IOL at time of randomization: eg, placenta previa/accreta, vasa previa • Maternal contraindications to expectant management at time of randomization: eg, maternal medical conditions**, ultrasonically diagnosed oligohydramnios (DVP< 2 cm), signs of labor including pre-labor rupture of membranes (PROM)

*Fetal conditions: Fetal demise, history of continuously abnormal or pathologic CTG, FGR or macrosomia diagnosed by ultrasound, or major malformations. All conditions are considered from an individual clinical perspective. **Maternal medical conditions: Insulin treated diabetes mellitus, any hypertensive disorder with blood pressure >140/90, cardiac disease, renal insufficiency, other medical or psychological conditions with indicated delivery <41 gestational week and 0 days.

TABLE 2 Topics and examples of questions.

Topics	*Examples of questions*
Pregnancy	Please tell me a bit about how you experienced being pregnant? How did you feel in the late stages of pregnancy?
Consideration about accepting to join the WINDOW-study	What was your motivations for participating in WINDOW? What were your experiences and expectations of IOL prior to participation in WINDOW? Where there anything weighing against participation?
IOL	How did you experience the information about IOL procedures? Is there something that you would have liked to know more about? How did you experience the induction process?
Birth	How did your labor proceed? How did you experience it? Do you think that IOL had an impact on your childbirth experience?

3 | RESULTS

Participant characteristics are shown in Table 4. Approximately half of the respondents were women who gave birth for the first time, and three of the 25 respondents had a cesarean section. From the respondent answers, we identified three main themes and 2–4 subthemes:

Theme (1) Motivation for IOL at 39 gestational weeks, with subthemes (1.1) The perceived Risks of BMI≥30, (1.2) Burdened by pregnancy and eager for birth, (1.3) A sense of control, and 1.4) Previous positive experiences with IOL and birth.

Theme (2) The IOL process, with subthemes (2.1) Waiting for labor, and (2.2) Team spirit.

Theme (3) IOL in recollection and in the future, with subthemes (3.1) Open to future IOL, and (3.2) Hesitant towards future IOL.

3.1 | Theme 1: Motivations for IOL at 39 gestational weeks

All participants described the possibility to participate in the WINDOW study as a "great opportunity" as they felt "ready for birth." They described "relief" when realizing that they had been randomized to the intervention arm. This theme describes their motivations for participating in the overall randomized study in the above mentioned four subthemes: The perceived risks of BMI ≥30 kg/m^2, burdened by pregnancy and eager for birth, a sense of control, and previous positive experiences with IOL and birth.

3.1.1 | Subtheme 1.1: The perceived risks of BMI ≥30 kg/m^2

Only a few women mentioned the desire to minimize the potential risk factors associated with a BMI ≥30 kg/m^2 as one (but never solely) reason for accepting IOL at 39 gestational weeks (Table 3, #1, #2, #3) For most women, previous information about BMI-related risk factors did not notably influence their decision to participate in the overall randomized trial. BMI was described as "an inaccurate measure" by the women because it did not consider individual variations, such as 'being petite' or "having more muscle mass." Rather than BMI, these women relied on a personal and more holistic sense of being healthy and used this feeling as their compass (Table 3, #2, #3). Several women did not perceive themselves as particularly obese, and they did not perceive themselves to be "at risk." Many emphasized their belief in their body's capacity to manage pregnancy and childbirth (Table 3, #3). As such, their decision to participate in WINDOW was not driven by risks or concerns related to potential obesity-related adverse pregnancy outcomes. Some women felt vulnerable when labeled as obese and some expressed how getting aware of BMI-related risks caused feelings as annoyance, embarrassment, and shame (Table 3, #4). Many women felt well-informed about obesity related risks, yet some expressed a desire for receiving more comprehensive information earlier in pregnancy. While recognizing that such information might not necessarily have changed their health behavior, they emphasized the importance of knowing and being prepared for the risks associated with obesity in various ways.

3.1.2 | Subtheme 1.2: Burdened by pregnancy and eager for birth

In late pregnancy, many women experienced major physical discomfort and exhaustion, including fatigue, pain, and edema, which motivated them for participating in the randomized study, as daily activities and routines, such as grocery shopping or finding comfortable positions to rest, seemed insurmountable (Table 3, #5, #6). Some expressed a "desire to not share their body with the baby" anymore, while others had experienced serious pain and discomfort in a previous, late pregnancy and wanted to avoid reaching that point again. One woman highlighted the compounding effects of obesity during pregnancy, stating, "In the beginning, the body is already stressed, and it only worsens as the pregnancy progresses." Mentally, some women struggled with feelings of sadness, irritability, and guilt for not being able to be a 'good' mother to older children and for relying on their partner for practical and emotional support. Some women simply

TABLE 3 Themes and supporting quotes.

Subtheme	Quote #	Quotes to illustrate the results
Theme 1: Motivation for IOL at 39 gestationel week		
1.1: The perceived Risks of BMI≥30	1	I guess, if having the birth induced earlier could make things safer for both the baby and me, then it was definitely the right choice. So, it wasn't a tough decision at all" (ID22).
	2	"Giving birth is natural, and I think we have to be careful that… just because we can know all these things scientifically, we should be cautious about it. BMI for example, is such an odd measure. Because you can be muscular and be super strong without any fat, and still, the BMI might say otherwise. What really matters to me is that I am well-functioning and feel healthy" (ID19).
	3	"I haven't thought too much about these risks and potential complications. Honestly, throughout my pregnancy, I felt really good about the pregnancy and the baby, and there were no signs to indicate otherwise" (ID 20).
	4	"I became irritated and also a bit embarrassed (when receiving information about BMI and risk). And…it was awkward. Perhaps that's too strong of a word, but you do get annoyed with yourself for putting yourself in a situation where you could potentially create complications for yourself and your child."
1.2: Burdened by pregnancy and eager for birth	5	"I was done with being pregnant. I felt so exhausted and sore. So, it was really a comfort to think, "It won't be long now." No more struggling with swollen legs and fingers, not being able to pick up stuff from the floor or find a comfortable position in bed. To be honest, I'm not one of those persons who romanticizes pregnancy, thinking, "Oh, it's a wonderful experience!" (ID1).
	6	"I was super desperate. So, I think that at that point in my pregnancy, I would have done anything to give birth. I mean, they could have asked me anything, and I would have almost certainly said yes, as long as it meant getting the baby out" (ID14).
1.3: A sense of control	7	"I'm a control freak, and it was comforting for me to know, 'Okay, it's happening tomorrow.' That way, we had something to aim for, or should I say, something to plan around. It was nice in a way. We had a schedule to follow, which was reassuring for me, rather than not knowing if it's day or night when it happens" (ID17).
1.4: Previous positive experiences with IOL and birth.	8	"It motivated me that I had been induced before and it was a good experience. I was sure it would go as smoothly this time, that my body would just respond to the hormones…" (ID3).
Theme 2: The IOL process		
2.1: Waiting for labor	9	"My partner was at home, with me, and it was just cozy. We watched TV series, relaxed on the couch, holding hands, cleaned up, got everything ready at home, – all the things we knew we wouldn't have time for later, when the baby would arrive" (ID13).
	10	"So, you're inside this bubble for days. And when the contractions seem to intensify, you get really excited, and when they disappear again, you feel so disappointed. So, I used a lot of strength and energy waiting when perhaps it would have been better to focus on relaxing" (ID 12).
	11	"… and then we're told that nothing has happened yet. So, you start thinking, 'What's wrong with this body?' You feel a bit disappointed with your own body, like, 'Why can't you just get things moving? After all, this is my third time giving birth."(ID 1).
2.2: Team spirit	12	"We could call the midwives anytime and were offered check-ups when needed, and…well, it was just open arms, you know, it was a joint project, almost. It was just good teamwork" (ID2).
	13	"I was actually nervous about the prejudices one might encounter due to one's weight and such, but that was proven wrong. I have been met by some really skilled and professional people, who were good at communicating and involving me throughout the process" (ID5).
	14	"Because previously, when my labor started, I must say, it has been somewhat chaotic and unsettling, because one is left to oneself. In those situations, you stay at home and wait for something to happen for a long time. However, this time when induced, I wasn't alone. I felt that I had some professionals close to me who could help, especially because I tend to panic during my labors. I truly felt a sense of reassurance, because people kept an eye on me and the baby" (ID 7).
Theme 3: IOL in retrospect and in the future		
3.1: Open to future IOL	15	"Of course, it's hard to tell, but I really don't think IOL made a difference. I think that my body would have needed assistance in the birthing process anyway. So, I don't believe it made a difference" (ID 17).

(Continues)

TABLE 3 (Continued)

Subtheme	Quote #	Quotes to illustrate the results
3.2: Hesitant towards future IOL	16	"I still believe that we were induced before my body was ready, and that's why the IOL process took so long. The birth was so intense and traumatic, and that's why I don't want to go through it again (be induced)" (ID2).
	17	"…it was so intense, and I blame the pills. It was immediate and hard-hitting. I was at my limits from the very first contraction, I felt completely powerless and didn't recognize myself in that situation. I haven't experienced it like that before" (ID14).

TABLE 4 Characteristics of study participants.

Characteristics	Total ($N = 25$)
Maternal age (years)	
24–29	14
30–39	11
Mean maternal age (years)	29
Parity	
Nullipara	12
Multipara	13
Educational level[a]	
Low	6
Middle	17
High	2
Duration of induction, Mean (range) days	3 (1–8)
Interventions for IOL	
Misoprostol tablet	24
Balloon catheter	7
Artificial rupture of membranes	12
Epidural analgesia during birth	14
Vaginal birth	21
Instrumental vaginal birth	1
Cesarean section	3

Note: All data are self-reported.

[a]Using the educational nomenclature (ISCED) from Statistics Denmark, educational level was grouped into three categories; low (1–10 years), medium (11–14 years) and high (>15 years).

described themselves as individuals who did not enjoy pregnancy, even referring to it as a "pregnancy hell." Thus, many women felt impatient and that every additional week of pregnancy was unbearably long. The prospect of IOL offered them relief from their discomfort and marked the beginning of their transition from pregnancy to motherhood.

3.1.3 | Subtheme 1.3: A sense of control

Several women described IOL as a source of control, which was crucial for their decision to participate in WINDOW, as they hoped to be randomized to IOL. Whereas the unpredictability of spontaneous labor was perceived as "uncontrollable", the certainty of the IOL date was emphasized as providing mental comfort and stress release (Table 3, #7). Knowing the IOL date allowed the women to relax, savor the final days of pregnancy, and make practical arrangements such as ensure care for older children and pets. IOL gave the women a clear "finishing line" to work towards. A few women who all had mental health challenges mentioned their diagnoses as factors influencing their need for control and desire for IOL.

3.1.4 | Subtheme 1.4: Previous positive experiences with IOL and birth

When choosing to participate in the WINDOW study, all parous women leaned on their past experiences with IOL or childbirth. Some had responded well to IOL in the past (Table 3, #8), while others considered their previous positive birth experiences to be a sign that their bodies would respond well to IOL. Some parous women had never experienced spontaneous onset of labor, which made IOL an obvious choice. Most women had no reservations about being induced in gestational week 39, primarily because they trusted the healthcare system's recommendations. A few women had initial concerns about forgoing spontaneous labor and interfering with the "natural birth process," however the above-mentioned perceived benefits of IOL outweighed this concern.

3.2 | Theme 2: The IOL process

Overall, the women felt safe initiating the induction process. They reported receiving a high level of information from healthcare staff regarding both the positive and negative effects of IOL. This theme describes their experiences with the IOL process in two subthemes: Waiting for labor and Team spirit.

3.2.1 | Subtheme 2.1 Waiting for labor

For all but one woman (who had artificial rupture of membranes), the IOL process started with misoprostol tablets. A few women were hospitalized during IOL, primarily due to a history of rapid childbirth. While these women acknowledged the necessity of hospitalization as recommended by the healthcare system, they described missing their families at home and having to adapt to the hospital environment. All other women self-administered misoprostol at home, which they all described as "safe" and "preferable." Initially,

the women described feeling joy and excitement about the upcoming labor and delivery, "meeting the baby," and becoming parents. While at home, the women appreciated their daily routines, making relaxation a priority, and spending time with their children (Table 3, #9). However, the women who did not go into labor during the first days at home described feelings of frustration and extreme attention to any bodily sign that would indicate contractions were about to begin (Table 3, #10, #11). Some felt disappointed by their body and described how they started to worry if something would "go wrong" For some women, the practicalities of daily trips to the hospital for check-ups combined with the impatience caused by "no progress" left them feeling exhausted even before labor began.

3.2.2 | Subtheme 2.2 team spirit

Despite some frustrations, all women reported receiving ample support from their obstetrical clinic during outpatient IOL. They felt encouraged to call the labor ward around the clock in case of any doubt or questions, eg regarding contractions or administration of the tablets. They described the midwives at the IOL clinic as accessible, welcoming, and competent (Table 3, #12). Despite some practical issues, the daily check-ups were viewed positively, as they provided reassurance about the well-being of both the mother and child. Women described how the physical examinations were performed in a respectful and careful manner. The women felt no prejudice against them due to obesity (Table 3, #13). Some women referred to the outpatient IOL process as a "teamwork or joint venture" involving both the couples and the midwives (Table 3, #14). Two women compared the experienced collaborative nature of the IOL process to the more individualized experience of going into spontaneous labor, which they had experienced as unpredictable and overwhelming in their previous births.

3.3 | Theme 3: IOL in retrospect and in the future

As can be inferred from Table 4, the women went on to have very different processes of IOL, labor and delivery. However, the analyses showed no clear relation with the women's 'type' of birth and their evaluation of their decision to participate in the randomized study and the allocated IOL at 39 gestational weeks. The material was then analyzed based on the women's willingness to undergo IOL in a future pregnancy which is described in two subthemes: Open to future IOL and Hesitant towards future IOL.

3.3.1 | Subtheme 3.1 Open to future IOL

Most of the participating women were inclined to choose IOL again if relevant (any indication) in a future pregnancy. This group consisted of both nulliparous and parous women. Common to this group was that they did not associate the IOL process with subsequent negative experiences during birth, even though some of them recounted a lengthy and draining labor process. Their post-rationalization was that the birth experience likely would have been the same with spontaneous labor (Table 3, #15). They viewed IOL as beneficial and valuable, with one woman even expressing fear of waiting for spontaneous labor.

3.3.2 | Subtheme 3.2 Hesitant towards future IOL

Some women were hesitant and a few even against IOL in a future pregnancy. The women in this group linked the IOL process to subsequent negative experiences during the birth process (Table 3; #16). For example, the experience of a prolonged and challenging labor process that ended in cesarean section led women to ponder whether it could have unfolded differently after spontaneous labor. In hindsight, some women also felt that their body was maybe "not ready" for birth at 39 gestational weeks and described the body as "reluctant" to respond to the induction methods, which made them hesitant towards accepting a future IOL. A few parous women in this group experienced extremely intense contractions from the outset, unlike any of their previous experiences (Table 3, #17). They found it difficult to cope with these contractions and felt overwhelmed and powerless. They attributed the intensity of these contractions to the induction. For a few women, the hesitancy towards future IOL was not founded in negative birthing experiences, but simply a strong desire to experience spontaneous labor in a future pregnancy.

4 | DISCUSSION

The aim of this study was to explore the motivations and experiences of IOL at 39 weeks gestation among the small subgroup of low-risk women with obesity, being randomized to the intervention arm in the WINDOW study. Participants perceived inclusion into the WINDOW study as a "great opportunity," as they hoped to be randomized to IOL at 39 weeks of gestation. When randomized to IOL, all women held a positive attitude towards IOL. Comprehensive information and available, supportive midwives through the outpatient IOL process was central to a positive experience. The women's main motivation for participating stemmed from physical discomfort in late pregnancy and a desire to "know" the timing of the birth. BMI-related risk factors were mentioned by few as a motivating factor. Some participants described the IOL process as a team effort between the couple and the midwives and were positive towards future IOL. Others associated the IOL process with prolonged labor or described the body as "reluctant" to respond to the induction regime. A desire to experience spontaneous onset of labor in a future pregnancy was mentioned.

Our findings reveal areas of attention. First, we found that women's primary motivations for participation were that they hoped that earlier childbirth would relieve physical and mental discomfort,

and that IOL would provide a sense of control over timing of the birth. Contrarily, previous studies indicate that pregnant women's participation in clinical trials is motivated (among other factors) by perceived risk status.[4–6] Notably, in the present study, BMI-related risks for mother and child were only mentioned by a few. Rather, the women did not perceive themselves as 'particularly' obese or at risk. Robinson and Kersberger[26,27] consider this perception as a consequence of the global surge in obesity. They argue that the obesity epidemic may have shifted societal and personal perception of body weight, making larger bodies seem more common and acceptable. This normalization of a larger body size may contribute to the women's (from a medical point of view) 'underestimation' of consequences of their weight[27] with potential negative personal and public health implications. It has been suggested that making individuals more aware of their obesity could enforce their weight reduction efforts and reduce risk.[28] However, research indicate that individuals identifying as "overweight" are paradoxically more prone to gaining weight.[27] Robinson and Kersberger highlight how recognizing the label of 'obesity' also entails identifying with a widely stigmatized social group, likely causing stress, damaging self-esteem, and increasing the risk of depression.[29,30] Similarly, some women in our study described feeling sensitive about being obese and that being reminded of BMI-related risks caused feelings of irritation and shame. Several women in our study emphasized instead their belief in their body's capacity to manage pregnancy and childbirth. Rather than BMI, these women relied on a personal and more holistic sense of being healthy and used this feeling as their compass. Healthcare professionals may feel the challenge of providing information and guidance according to current evidence on the negative effects of obesity on pregnancy while simultaneously involving and respecting individual understandings and preferences, which are essential to maintaining women's self-efficacy, understood as confidence in one's own potential to handle various situations and tasks.

Second, our findings did not reveal a clear pattern between the number of interventions during IOL or the women's mode of delivery and their evaluation of the experience. This indicates the complexity of childbirth experience as a phenomenon encompassing physical, psychological, social, and existential dimensions.[31] Biomedical studies show that obstetric interventions and complications, such as induced labor, emergency cesarean section or instrumental vaginal delivery are associated with dissatisfaction with childbirth.[11] Research grounded in the humanities adds that factors such as stability in daily life, a sense of coherence, presence of close relatives, and empathetic caregivers during birth contribute to a positive birth experience.[31,32] Additionally, a sense of self-control emerges as an important factor in women's birth experiences,[31,33] such as managing labor pain. Rijnders et al.[34] showed how women who felt dissatisfied with their pain coping mechanisms experienced more negative emotions during birth. Moreover, external control over the birthing process, understanding care providers' actions, and having a say in decisions have been shown to impact women's birth experiences.[35] As such, childbirth experience goes beyond a simple comparison of spontaneous versus induced labor or vaginal versus cesarean delivery as it holds individual, relational and contextual factors such as expectations, personality, relationships, and communication. Women in our study had different views on spontaneous onset of labor and IOL. Some women harbored concerns about not experiencing spontaneous onset of labor, while others perceived spontaneous labor as unpredictable and overwhelming. For all, however, the perceived benefits of IOL outweighed the desire for spontaneous birth and other concerns. As the maternal childbirth experience may play a crucial role in later health and family planning, implementing factors influencing childbirth experience in decision-making is imperative.

Finally, our results point to how IOL may serve as a health-promoting factor for some women, as it promises physical and mental relief and a sense of control. A consequence of this finding could be a discussion about choice of management (i.e., IOL vs. spontaneous labor) not only for women with obesity but for women burdened by pregnancy in general. However, "maternal request" as IOL indication could also raise concerns. The potential benefits of IOL to women's mental health must be weighed against potential negative consequences such as higher demands for IOL, which can challenge the distribution of (sparse) resources, and the increased medicalization of pregnancy.[36] Under the current jurisdiction, patients (including pregnant women) have no legal claim to dictate their treatment, and healthcare professionals bear the responsibility for both (shared) decision-making and implementation. Thus, a decision-making process concerning IOL can be viewed as a delicate balancing act that calls for a professional dialogue that incorporate the woman's preferences as well as medical evidence and expert knowledge. To frame this discussion further research is needed outside the context of the WINDOW study.

This study gains strength from its highly targeted sample of women, all of whom were participants in the WINDOW study, were willing to accept IOL at 39 weeks and were randomized to the intervention arm. Therefore, the results should be considered in the context of this specific population and may not apply to women who accept induction for other indications. The applicability of the findings may also be limited to countries with similar maternity care and IOL guidelines to those in Denmark. The study was strengthened by its open and exploratory approach, which encouraged women to express both positive and negative experiences with IOL. The interviewer, JH, is a midwife who is also experienced in interview techniques. Through a sample of 25 women with mixed parity along with research triangulation, we aimed to establish methodological rigor and credibility. However, to fully represent the Danish context, non-Danish speaking residents would optimally also have been included in the study. In this study we chose to focus narrowly on a very specific subgroup of women in order to gain an in-depth understanding. Future research should explore the motivations and experiences among women who were randomized to the expectant management arm or who declined participation in the WINDOW study.

5 | CONCLUSION

The primary motivation for women, in this qualitative interview-study, to participate in the WINDOW study, that randomizes low-risk women with obesity to IOL at 39 weeks or expectant management, was the prospect of IOL, that could offer them physical and mental relief. However, the views of WINDOW participants who were randomized to expectant management remains unknown. Women experienced the outpatient IOL regimen as safe. Comprehensive information and readily accessible staff to support and guide through the outpatient IOL process were important. This study highlights how women's childbirth experiences as a phenomenon goes beyond a simple comparison of spontaneous onset of labor versus induced labor, but encompasses multiple individual, relational and contextual factors such as expectations and communication.

AUTHOR CONTRIBUTIONS

Lise Qvirin Krogh, Julie Glavind, Stina Lou and Joan Hansen conceived the study and wrote the study protocol with input from the entire group of authors. Joan Hansen collected the study data. Joan Hansen and Stina Lou analyzed and interpreted the data. Joan Hansen drafted the manuscript in corporation with SL and with input from the entire group of authors. All authors commented on the manuscript and approved the final version.

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CONFLICT OF INTEREST STATEMENT

None.

ETHICS STATEMENT

According to the Danish Research Ethics Committee Law, ethical approval is not required for qualitative interview studies. The study was registered on October 13, 2022 to the record of processing activities for research projects in Central Denmark Region (J. No. 1–16–02-377-22). To the women it was clearly stated that participation was voluntary, that they were free to opt out at any time or answer only some of the questions. All participants were de-identified.

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