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Women's experiences of membrane sweeping for labour induction: a phenomenological qualitative study

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Abstract

Background. Membrane sweeping is a common but still invasive procedure offered to hasten labour in prolonged pregnancy. Rising labour induction rates have increased the use of interventions like membrane sweeping, though its impact on women's experiences remains unclear.

Aim. To explore women lived experiences of membrane sweeping in a tertiary Italian maternity unit and identify their informational needs.

Methods. Twenty women ≥40+0 to 41+6 weeks' gestation who underwent membrane sweeping were interviewed in-hospital 24-48 h postpartum. Semi-structured interviews (mean 18 min) were analysed with combined inductive-deductive content analysis.

Findings. Three themes emerged i) clarity and timing of information ii) baseline knowledge and information-seeking behaviour iii) physical and emotional experience of the procedure in relation to the onset of labour. In addition, some women reported the procedure as painful or required further pharmacological induction of labour, adding a layer of dissatisfaction in their narrations. However, most women stated that they would undergo membrane sweeping again in a future pregnancy.

Conclusions. When embedded in shared decision-making, membrane sweeping can be a well-accepted initial induction option. Moreover, structured antenatal education could be recommended.

Key words

- induction of labour
- informed consent
- membrane sweeping
- women's experiences

INTRODUCTION

Labour induction is the iatrogenic stimulation of uterine contractions before the onset of spontaneous labor, when maternal or fetal well-being is threatened by medical or obstetric complications [1]. Over the past decade, global induction rates have risen to about 25 percent, affecting both low- and high-risk pregnancies [1]. Available techniques span from pharmacological methods – such as oxytocin or prostaglandins – to mechanical or procedural approaches, including artificial rupture of membranes, double-balloon catheterisation, and membrane sweeping [2]. Several guidelines [3, 4] recommend membrane sweeping to reduce the need for formal pharmacological induction in post-term pregnancies.

Membrane sweeping is a procedure in which a clinician inserts a gloved finger through the cervix and gently detaches the lower pole of the membranes from the uterine wall [5]. This manoeuvre is intended to stimulate local prostaglandin release, promoting cervical ripening. Thus, this simple, low-cost intervention that can be done in the outpatient setting, increases the likelihood of spontaneous labour within 48 hours by roughly 20 percent and therefore diminishes reliance on pharmacological agents [6]. A Cochrane systematic review and other studies confirm that membrane sweeping does not significantly heighten maternal or perinatal risk compared with drug-based induction [6, 7], explaining its widespread adoption in everyday obstetric practice. If serious complication are rare, common side effects are mild vaginal bleeding, irregular uterine contractions and discomfort during procedure. In fact, membrane sweeping can be uncomfortable and may feel intrusive to some women [6].

Understanding women's subjective experiences is essential regardless of broader debates about obstetric violence [8, 9], yet most research focuses on timing and efficacy [10, 11], largely overlooking women's informational needs, psychological responses, and personal narratives. A recent qualitative systematic review

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identified only one study that explored the procedure from women's perspectives [12]. This knowledge gap is concerning considering the rising global induction rates [6, 13] and the potential role of membrane sweeping in reducing pharmacological inductions. Because experiences are likely to differ across organisational and cultural settings, additional qualitative research is needed to refine clinical practice in line with women's preferences and expectations.

Thus, we aim to explore the experiences of women undergoing membrane sweeping at the Obstetric and Obstetric Pathology Unit of the Agostino Gemelli University Hospital-IRCCS, aiming to inform clinical practice and advance a more woman-centred model of care.

MATERIALS AND METHODS

We conducted a descriptive phenomenological study, reported following COREQ (Consolidated criteria for reporting qualitative research) [14]. A phenomenological lens is appropriate when the goal is to illuminate participants lived experiences, particularly in fields with limited prior evidence [15]. The study was approved by our local Ethical Committee (Protocol ID 7350 of February 10, 2025).

Participants

Eligible women were recruited between 10 February and 25 March 2025 through the post-term pregnancy outpatient clinic of the Obstetric and Obstetric Pathology Unit at Agostino Gemelli University Hospital IRCCS. Inclusion criteria were age >18, BMI 18-30 kg/m^2, singleton uncomplicated pregnancy, fluent Italian, no previous attempt at membrane sweeping in the current pregnancy. Gestational age was determined according to crown-rump length in the first trimester. Participation was voluntary, and all women were assured of data confidentiality and of their right to withdraw at any time without affecting their care. Exclusion criteria were maternal age <18; inadequate proficiency in Italian; or no clinical indication for membrane sweeping.

In accordance with our institutional protocol, all women with an otherwise uncomplicated singleton pregnancy reaching 40 weeks' gestation undergo ultrasonographic assessment of amniotic fluid volume and a non-stress fetal test. Immediate induction of labour is typically indicated if anhydramnios is detected on ultrasound (single deepest vertical pocket <2 cm) [16] or if cardiotocography criteria for normality are not met. Otherwise, routine induction of labour is scheduled no later than 41+0/3 weeks' gestation. When clinically indicated, membrane sweeping may be offered during these visits as part of the standard care pathway, but never portraited as mandatory. When membrane sweeping was clinical indicated, the study procedures were explained in detail by an obstetrician and a research midwife. Women who expressed interest were provided with additional information regarding the study's aims and methodology and subsequently gave written informed consent.

Data collection and analysis

Women who gave written consent were interviewed 24-48 hours after birth, while still hospitalised in the Obstetrics Unit. Interviews took place in the women's single rooms, in accordance with the current clinical practice, and always in the presence of the newborn. In most cases, a support person (typically the partner) was also present during the interview.

A PhD research midwife and young research midwife with no clinical role in their care carried out face-to-face, semi-structured interviews of roughly half an hour, guided by a flexible topic schedule (8 domains; *File 1S available online as Supplementary Material*) designed to explore women's views on membrane sweeping.

After the interview, each participant completed an anonymous questionnaire capturing socio-demographic and obstetric details. All conversations were audio-recorded, then the verbatim were transcribed and anonymised. Immediately afterwards, the interviewer added contextual observations and reflexive notes to a field diary to enrich subsequent analysis. All data were stored and managed in compliance with the General Data Protection Regulation (GDPR), ensuring confidentiality, anonymity, and secure handling of participants' information.

Data analysis

We analysed the transcripts with qualitative content analysis that blended deductive and inductive coding [17, 18]. Two researchers independently (ER, research midwife and JP, PhD midwife) read each transcript line by line, identified meaning units – words or passages that reflected the women's experiences – and assigned initial codes. Deductive codes stemmed from the study questions, whereas inductive codes emerged directly from the data, capturing unexpected insights. The coders compared their work and resolved differences through discussion; when consensus was elusive, a third researcher (GA, PhD midwife) was consulted to reach and agreement [19]. Codes were analysed with the support of dedicated sheets in Microsoft Excel. Data collection and analysis proceeded concurrently, allowing iterative refinement of the coding frame and progressively deeper interpretation [20]. Recruitment ceased when theoretical saturation was reached and no new codes or categories appeared [21].

RESULTS

Between February and March 2025, 20 women were interviewed. Their principal sociodemographic and obstetric characteristics are summarised in *Table 1*. The median age of the participants was 33 years (IQR: 29.5;36). All first sweeps occurred at 40+1 (IQR: 40+0 - 40+2) weeks of gestation. Four women received a second sweep at 40+3 weeks of gestation. Five (25%) subsequently required pharmacological induction; the remaining 15 (75%) entered spontaneous labour within 48 h.

The analysis categorized women's narratives into three overarching themes, each with its own layers of meaning (*Figure 1*): i) clarity and timing of information, encompassing two sub-themes that captured how and when details were provided; ii) baseline knowledge and information-seeking behaviour, articulated through three sub-themes reflecting women's prior understand-

Table 1
Sociodemographic and obstetric characteristics

Participants	Value
Women, n (%)	20 (100%)
Age, years-median (IQR)	33 (29.5-36)
Italian citizenship, n (%)	19 (95%)
Nulliparous, n (%)	10 (50%)
Repeated membrane sweep, n (%)	4 (20%)
Gestational age at first membrane sweeping, weeks-median (IQR)	40+1 (40+0 - 40+2)
Pharmacological induction required, n (%)	8 (40%)

IQR: Interquartile range; %: percentage; n: number of women.

ing, misconceptions, and sources of learning; and iii) physical and emotional experience of the procedure, described across four sub-themes that ranged from physical sensations to emotional responses. Together, these themes sketch a comprehensive picture of how women perceived, understood, and lived through membrane sweeping.

Clarity and timing of information

The first theme that emerged from the data, relates to the information provided to women regarding the membrane sweeping procedure and the process through which verbal informed consent was obtained. This theme captures women's experiences of being informed – both in terms of clarity and timing – and how this influenced their sense of autonomy and involvement in the decision-making process.

Information received before and during the procedure

A recurrent, cross-cutting theme was the need to feel properly informed – not through technical minutiae, but via clear, straightforward explanations of the manoeuvre – because such communication anchored women's sense of agency and genuine informed consent. Most women described receiving simple, step-by-step guidance that they found reassuring: *"Before the procedure I was told exactly how it would be done… The gynaecologist said it might be a bit uncomfortable, but I could ask her to stop at any time"*. One woman, who had actively requested the sweep, echoed this sentiment: *"They explained every step very clearly, and that made me feel part of the decision"*. This

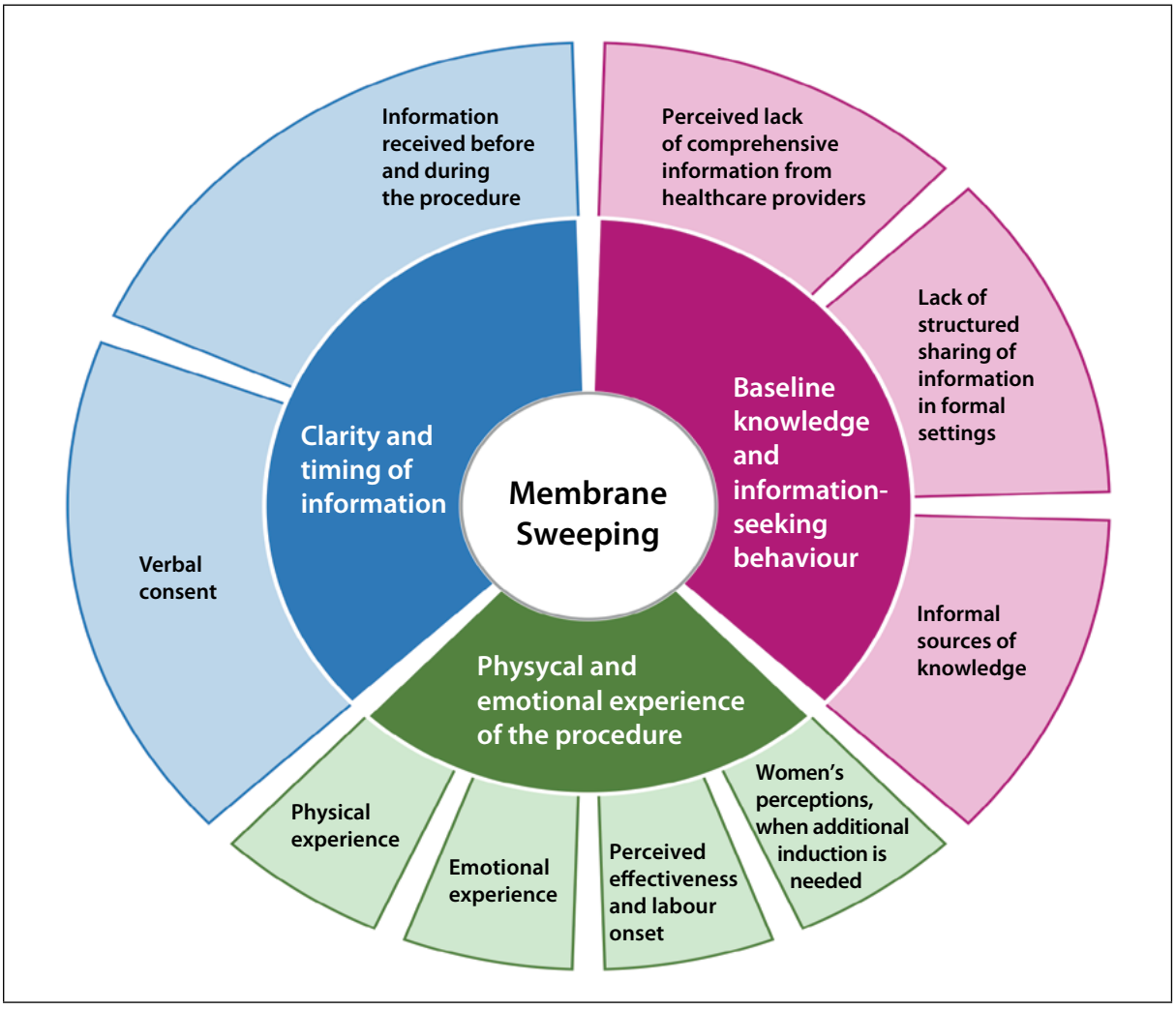

Figure 1
Emerging themes from women's perceptions of membrane sweeping.

transparency fostered respect and inclusion: *"I didn't feel pressured; I felt at ease"*, another noted. Yet not all accounts were positive. One participant suspected the sweep had been performed without her fully grasping it: *"The gynaecologist told me it just 'a little help, not a membrane sweep"*. Her experience highlights how even subtle lapses in communication can erode trust and leave women uncertain about the care they had received.

Verbal consent

Nearly all women recalled that clinicians explicitly sought their verbal consent before proceeding with the manoeuvre, a gesture they consistently interpreted as both respectful and collaborative. This practice reinforced their sense of emotional safety and personal autonomy: *"The doctor told me that if the conditions were right, they could proceed, but only with my consent"*. Another echoed, *"(…) and they asked for my consent"*, while a third reflected, *"I felt included in the decision to perform the procedure proposed by the doctor"*.

Baseline knowledge and information-seeking behaviour

The second theme dealt with women's grasp of the procedure itself, meaning the extent to which they possessed a conscious, accurate understanding of what membrane sweeping entails and why it is offered.

Perceived lack of comprehensive comprehension of the procedure

Although every woman recalled receiving a brief explanation of membrane sweeping, many acknowledged that they still did not grasp its full meaning or implications. One woman noted, *"They told me it was a manoeuvre to help release hormones and start labour, but I couldn't picture what would actually happen."* Another remarked, *"I understood it might speed things up, yet I had no idea about possible downsides or alternatives"*. Those who were familiar with the topic reported having done further research on it, stating: *"I was aware of the various induction methods, both mechanical and otherwise, but before consenting, I made sure to look deeper online, even with images, into the membrane sweeping procedure"*. Several reported the medical explanation of the procedure as *"quick"* or *"lacking depth"*, leaving them feeling under-briefed: *"When the doctor suggested it, I said yes – but only afterwards did I realise I hadn't really understood what I'd agreed to"*. A few had learned of the technique for the first time in that very moment: *"Before they mentioned it, I didn't even know membrane sweeping existed"*. Consequently, although the consent was formally requested, many women felt they lacked genuine comprehension of the procedure and its broader consequences.

Lack of structured sharing of knowledge in formal settings

Several women noted that membrane sweeping had never been addressed in their antenatal classes or other structured education sessions, so they first encountered the concept only when it was offered late in pregnancy. One woman reflected, *"I was poorly informed at the time it was proposed. Going forward, I would have liked to know more during pre-birth classes"*.

Informal sources of knowledge

For the women who approached the outpatient visit already aware of membrane sweeping, that knowledge almost always came from informal sources rather than from healthcare professionals. They mentioned browsing websites and forums: *"I was already somewhat informed from reading on the internet"* or consulting popular pregnancy books: *"During my first pregnancy, I read a book about it"*. Personal networks were equally influential: *"I knew about the manoeuvre because my cousin had it two months ago"*. Social media stood out as a particularly powerful channel, shaping both awareness and expectations: *"I got information from social media and friends, mainly people online who had already given birth"*.

Physical and emotional experience of the procedure

This theme encompasses women's physical sensations and emotional reactions to membrane sweeping, along with their views on how it influenced labour. Most women recalled the procedure favourably, highlighting both its tolerability and its perceived effectiveness: *"Overall, I would repeat the manoeuvre; it was a positive and effective experience"*.

Physical experience

Most women depicted membrane sweeping as *"uncomfortable but bearable*," underscoring its brief duration and the clinicians' considerate technique. One participant noted, *"They let me feel with my fingers the maximum pressure they would apply, so I understood exactly what was happening"*. Only one woman described the manoeuvre as distinctly painful, yet even they emphasised that the short time it took helped to offset the discomfort: *"It was painful at times. Painful, especially when they touch your cervix. You know you have to do it, and that it doesn't l last long, but it is painful"*.

Emotional experience

Women's emotional reactions spanned a spectrum from relief, particularly among those eager to avoid pharmacological induction, to anxiety about *"interfering"* with a natural childbirth process. One woman admitted, *"I was scared at the idea of intervening in something that might have happened naturally on its own"*. Another described the procedure as *"annoying but tolerable"*, adding that she *"hoped it would work, especially because I wanted to avoid pharmacological induction"*. Women also reported the possibility of undergoing membrane sweeping again in subsequent pregnancies. *"If I were to have another pregnancy, I would undergo membrane sweeping again because it's not painful and it increases the chances that labour will start naturally, without needing other induction methods"*. The clinical team was often tempered as *"someone to trusts a lot"*, so women *"felt relieved doing it since completely relied on the doctors' clinical experience"*.

Perceived effectiveness and labour onset

Many women attributed the onset of labour to the sweep itself, citing early physical signs, such as contractions, loss of the mucus plug, or spontaneous rupture of membranes, within 24-48 hours from the procedure: *"Right after I went home, I began feeling the uterine con-*

tractions; the next morning I lost the mucus plug, and that evening my waters broke". For these women, the procedure offered a welcome sense of momentum: "*I think it worked, because labor started within 48 hours*". Others valued the sweep as a middle ground between passive waiting and pharmacological induction, giving them a measure of control: "*I felt ready for the manoeuvre and saw it as a more thorough check-up*", and "*It's good that it's done and then you can go home. Being at home longer helps me cope with contractions*". This perceived labour progress was emotionally reassuring: "*I had a good experience and believe it triggered labour*". Yet a few women were ambivalent, feeling uneasy about initiating labor artificially even while recognising its potential benefits: "*I felt weird, really anxious, even if I knew this manoeuvre could help me*". Together, these accounts show how membrane sweeping can simultaneously foster empowerment, relief, and lingering uncertainty, depending on individual women expectations and values.

Women's perceptions, when additional induction is needed

Despite largely favourable reports, a subset of women still required pharmacological induction or caesarean section, underscoring the wide variation in clinical trajectories. One woman reflected, *"The sweep wasn't effective for me. I needed a pharmacological induction for my vaginal birth after caesarean section, and ultimately, I had a caesarean section"*. Another woman recalled, *"They performed an additional sweep while I was already on misoprostol; a few hours later my waters finally broke"*. Such experiences highlight the need for flexible, individualised care plans and acknowledge that membrane sweeping may not work for everyone.

DISCUSSION

This qualitative study is one of the few published articles to explore women's perceptions of membrane sweeping, focusing on their informational needs, decision-making processes and lived experience of the procedure. Women valued transparent, step-by-step explanations and the opportunity to provide their consent; however, the depth of counselling received, and women's baseline knowledge of the procedure varied widely. Physical discomfort was generally described as tolerable, and many participants framed membrane sweeping as an acceptable "*middle ground*" between passive waiting and pharmacological induction. A minority of women experienced information on membrane sweeping as cursory and remained uncertain about possible risks and alternatives, underscoring persistent gaps in antenatal education.

All women reported receiving verbal explanations and feeling genuinely involved in the decision-making process. This a finding contrasts with previous studies in which many women reported to be inadequately informed and felt excluded from the clinical decisions process [22, 23]. Previous work linked this lack of involvement to heightened anxiety and a loss of control, whereas respectful, well-informed, shared care was shown to enhance the childbirth experience [23]. Although most women in our sample considered the information received as "*adequate*", several still would have received a deeper explanation of the procedure's purpose, risks, and benefits. This echoes prior researches [23, 24], that underscored the need for comprehensive, anticipatory information as a foundation for truly shared decision-making.

Baseline understanding of membrane sweeping differed widely across women. Some arrived at the outpatient clinic with prior knowledge gleaned from the internet or their personal networks, while others first encountered the concept of "membrane sweeping" at the moment of the visit. These accounts underline how digital media and peer communities now shape maternity-related health literacy. Some women said that they would have welcomed structured, anticipatory information on membrane sweeping in their antenatal classes, suggesting a broader unmet educational need. This finding echoes calls for more comprehensive childbirth preparation to support truly informed choices [24]. Rather than postponing discussion until an induction is clinically indicated, introducing the risks and benefits of induction, membrane sweeping included, during routine antenatal classes may be beneficial, given evidence that course attendees feel significantly better prepared than non-attendees [25].

Most women described membrane sweeping as "*uncomfortable but bearable*"; only a few found it distinctly painful, while emphasising that the short duration of the manoeuvre and their trust in the clinical team kept the pain manageable. Emotionally, reactions ranged from relief, especially among women keen to avoid pharmacological induction, to anxiety about intervening in what they perceived as a natural process. Nevertheless, many viewed the sweep favourably because it either appeared to hasten labour or allowed them to remain at home longer before admission. Nearly all women reported feeling "*relieved*" once the procedure was over, and they were convinced that it might help initiate labour. Although the knowledge of the study could have heightened clinicians' attentiveness, a potential source of positive-response bias, our data suggest that thorough counselling and clear information women's understanding and overall experience are substantially improved. No negative experiences were reported, and several women said they would readily choose membrane sweeping in a future pregnancy because they did not find it traumatic. Taken together, these findings reinforce the perception of membrane sweeping as a generally tolerable first-line option for induction. By offering a low-intervention alternative and potentially averting more invasive, and often less satisfactory, methods, membrane sweeping may enhance both clinical outcomes and maternal satisfaction [22].

Overall, our findings highlight the pivotal role of trust between women and their care providers in shaping childbirth experiences. One woman valued being able to return home after the sweep, noting that the familiar environment made the onset of labour feel more manageable. This aspect echoed in studies reporting women's higher maternal satisfaction with outpatient, rather than in-hospital, induction [26]. This evidence aligns with others reporting that high-quality support, from clinicians and personal companions alike, helps

women cope with labor and birth pain [27, 28]. Clear, timely communication and shared decision-making not only enhance women's experience of membrane sweeping but also promote a more positive childbirth journey as a whole. To that end, healthcare professionals should remain attentive to women's preferences, offer personalised counselling, and provide psychologically supportive care throughout the induction process.

Study limitations

First, all membrane sweeps were performed exclusively by obstetricians, so the study does not capture potential differences in technique or counselling that midwives might bring; this limits the transferability of our findings across different professional groups. Moreover, since our research was conducted in a single maternity unit in Italy, its applicability to settings with different resources, protocols, or populations may be limited.

CONCLUSIONS

To our knowledge, this is the first qualitative study to examine women's subjective experiences of membrane sweeping rather than its clinical success alone in Italy. Given that most women described the procedure positively, membrane sweeping merits consideration as a first-line induction option before escalating to pharmacological methods. Mixed-methods studies could be particularly valuable for exploring the phenomenon in greater depth, offering a more comprehensive understanding of both clinical outcomes and personal narratives.

Authors' contributions

JP, GA, SS: contributed to the study design, data interpretation, literature search, and manuscript writing; SB, ER, JP, SF, SM: were involved in data collection; ER, JP, GA: contributed to data analysis and figure generation; SS, SF, SB, MD, EC, FR: contributed to the revision of the manuscript. All Authors read and approved the final version of the paper.

Conflict of interest statement

The Authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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REFERENCES

1. World Health Organization. WHO recommendations for induction of labour. Geneva: WHO; 2011.
2. Alfirevic Z, Keeney E, Dowswell T, Welton N, Medley N, Dias S, et al. Which method is best for the induction of labour? A systematic review, network meta-analysis and cost-effectiveness analysis. Health Technol Assess. 2016;20(65):1-584.
3. National Institute for Health and Care Excellence. Inducing labour (NG207). London: NICE; 2021.
4. Società Italiana di Ginecologia e Ostetricia. Linee guida per l'induzione del travaglio di parto. Rome: SIGO; 2022. Available from: https://www.sigo.it/wp-content/uploads/2022/02/LG15_Induzione_Travaglio_Parto.pdf
5. Boulvain M, Stan C, Irion O. Membrane sweeping for induction of labour. Cochrane Database Syst Rev. 2005;2005(1):CD000451. doi: 10.1002/14651858.CD000451.pub2. Update in: Cochrane Database Syst Rev. 2020;2:CD000451. doi: 10.1002/14651858.CD000451.pub3
6. Finucane EM, Murphy DJ, Biesty LM, et al. Membrane sweeping for induction of labour. Cochrane Database Syst Rev. 2020;2(2):CD000451. doi:10.1002/14651858.CD000451.pub3
7. Ugezu CH, Corcoran P, Dunn EA, Burke C. Does membrane sweep work? Assessing obstetric outcomes and patient perception of cervical membrane sweeping at term in an Irish obstetric population: a prospective multi-centre cohort study. Ir J Med Sci. 2020;189(3):969-77. doi: 10.1007/s11845-020-02191-w
8. Lundh CØ, Øvrum AK, Dahl B. Women's experiences with unexpected induction of labor: a qualitative study. Eur J Midwifery. 2023;7:7. doi: 10.18332/ejm/161481
9. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. Geneva: WHO; 2014. Available from: https://iris.who.int/handle/10665/134588
10. Hassan AM. Membrane sweeping to induce labor in post-term pregnant women: success rate and outcomes. Cureus. 2023;15(3):e36942. doi: 10.7759/cureus.36942
11. Coates R, Cupples G, Scamell A, McCourt C. Women's experiences of induction of labour: qualitative systematic review and thematic synthesis. Midwifery. 2019;69:17-28. doi: 10.1016/j.midw.2018.10.013
12. Roberts J, Evans K, Spiby H, Evans C, Pallotti P, Eldridge J. Women's information needs, decision-making and experiences of membrane sweeping to promote spontaneous labour. Midwifery. 2020;83:102626. doi: 10.1016/j.midw.2019.102626
13. Vogel JP, Souza JP, Gülmezoglu AM. Patterns and outcomes of induction of labour in Africa and Asia: a secondary analysis of the WHO Global Survey on Maternal and Neonatal Health. PLoS One. 2013;8(6):e65612. doi: 10.1371/journal.pone.0065612
14. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-57. doi: 10.1093/intqhc/mzm042
15. Creswell JW, Poth CN. Qualitative inquiry and research design: choosing among five approaches (4th ed.). Thousand Oaks, CA: SAGE Publications; 2018.
16. Wax JR, Pinette MG. The amniotic fluid index and oligohydramnios: a deeper dive into the shallow end. Am J Obstet Gynecol. 2022;227(3):462-70. doi:10.1016/j.ajog.2022.04.016
17. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105-12.
18. Elo S, Kyngäs H. The qualitative content analysis process. J Adv Nurs. 2008;62(1):107-15. doi: 10.1111/j.1365-2648.2007.04569.x
19. Nowell LS, Norris JM, White DE, Moules NJ. The-

matic analysis: striving to meet the trustworthiness criteria. Int J Qual Methods. 2017;16(1):1-13. doi: 10.1177/1609406917733847

20. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101. doi: 10.1191/1478088706qp063oa
21. Fusch PI, Ness LR. Are we there yet? Data saturation in qualitative research. Qual Rep. 2015;20(9):1408-16. doi: 10.46743/2160-3715/2015.2281
22. Blanc-Petitjean P, Dupont C, Carbonne B, Salomé M, Goffinet F, Ray CL; MEDIP Study Group. Methods of induction of labor and women's experience: a population-based cohort study with mediation analyses. BMC Pregnancy Childbirth. 2021;21(1):621. doi: 10.1186/s12884-021-04076-x
23. Coates D, Donnolley N, Foureur M, Henry A. Women's experiences of decision-making and attitudes in relation to induction of labour: a survey study. Women Birth. 2021;34(2):e170-e177. doi: 10.1016/j.wombi.2020.02.020
24. Simpson KR, Newman G, Chirino OR. Patients' perspectives on the role of prepared childbirth education in decision making regarding elective labor induction. J Perinat Educ. 2010;19(3):21-32. doi: 10.1624/105812410X514396
25. Coates D, Goodfellow A, Sinclair L. Induction of labour: experiences of care and decision-making of women and clinicians. Women Birth. 2020;33(1):e1-e14. doi: 10.1016/j.wombi.2019.06.002
26. Sangskär H, Berglin L, Sengpiel V, Svanberg T, Svensson M, Berter B, Elden H, Sjögren P, Strandell A, Carlsson Y. Safety, effectiveness, women's experience, and economic costs of outpatient induction in women with uncomplicated pregnancies: a systematic review and meta-analyses. Int J Gynaecol Obstet. 2023;161(2):343-55. doi: 10.1002/ijgo.14625
27. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2017;7(7):CD003766. doi: 10.1002/14651858.CD003766.pub6
28. World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: WHO; 2018.