

Original Research Article

Knowledge, attitude and practices of upright birthing positions in women from semi-urban and rural areas of Raigad district, Maharashtra: a cross-sectional study

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ABSTRACT

Background: Maternal-mobility and choice of birthing-position are important components of respectful maternity-care that influence labor-experience and birth-outcomes. Despite growing evidence supporting the use of upright-birthing positions, gap exists about women's awareness and actual use of different-positions during childbirth. This study aimed to assess the knowledge, attitudes, and practices related to birthing-positions among women of Raigad-district, Maharashtra.

Methods: A community-based cross-sectional-study was conducted among 786 women aged 15-49 years from rural and semi-urban-areas. Data were collected using validated-structured-questionnaire. A standardized-information-booklet containing pictorial-representations of various birthing-positions was used solely to facilitate uniform identification of positions during interviews. Descriptive-statistics were used to summarize participant's knowledge, perceptions and reported practices.

Results: Awareness of both upright and horizontal birthing-positions was reported by 91% of women in semi-urban areas and 67% of women in rural-areas. However, participants across both settings indicated that they were not offered a choice of birthing-position during labour. During first-stage of labour, dorsal-supine-position was most commonly reported in semi-urban (49%) and rural (32%) women. In the second stage, dorsal-supine remained the predominant-position reported by 54% of semi-urban and 60% of rural-participants. Squatting was the most frequently reported upright-position during second-stage (19% semi-urban and 35% rural women). Dorsal-supine, lithotomy and squatting-positions were commonly perceived as safe-options for childbirth.

Conclusions: Although knowledge of various birthing positions was relatively high, women reported limited-autonomy in choosing their preferred-position during labour. The findings highlight a gap between awareness and practice hence emphasize the need for greater promotion of informed-choice, provider-education and woman-centred maternity care to support the safe use of multiple-birthing positions.

Keywords: Birthing position, Labour outcomes, Maternal health, Perinatal care, Upright posture

INTRODUCTION

Pregnancy and childbirth are the major events in a woman's life that represent intense vulnerability over a time period commencing from conception to the postnatal state. Safe motherhood encompasses the spectrum of morbidity and mortality, where respectful maternity care is a universal right of every pregnant woman around the world. In India, maternal mortality remains a major public health problem, although the majority of these preventable maternal deaths, about 94% occur in resource-constrained settings.^{1,2} However, it is being noticed that the rate of mortality and morbidity is greater than 10-15% in developed countries, corresponding to approximately 20% of cesarean sections performed.³ One of the major reasons is obstructed labor, which may be due to an inappropriate childbirth position. This highlights the need for the adoption of optimal birthing positions to align the birth canal and the fetus. Most often, healthcare professionals suggest birthing postures based on experience, although they may not always have strong scientific evidence.⁴

Maternal birthing postures are the positions that the female adopts during labor for childbirth. The ideal maternal position remains controversial, with each position offering certain biomechanical advantages. Traditionally, childbirth was performed at home by midwives or 'dais' where the mother adopted any comfortable position during stages I and II of labor.⁴ Till the mid-seventeenth century, a French obstetrician, Francois Mauriceau advocated the semi-recumbent position for women in labor as it has easy access for forceps delivery. Over time, this posture has been popularized to many developed and developing countries around the globe, gradually evolving into semi-recumbent or lithotomy positions or supine positions. Lithotomy posture has an advantage over upright positions as it enables the health care professional to have better visibility of the procedure during childbirth and thus aiding a safe delivery.⁵

In contrast, many international organizations like the National Institute for Health and Care Excellence, Queensland Health, Royal College of Midwives, and World Health Organization (WHO) suggest that the mother should be allowed to choose any comfortable position during labor for a positive birth experience, better maternal-neonatal outcomes like reduced duration during first and second stage of labour, reduced rate of episiotomy and abnormal foetal heart rate patterns requiring intervention, a sense of accomplishment, and well-being.⁶ The World Health Organization has specified comprehensive guidelines for respectful intrapartum care for mothers by encouraging the adoption of mobility and upright position during labor.⁷ The American College of Obstetricians and Gynecologists also recommends that adopting different birthing positions in labor should be practiced, as no one position has proven best for childbirth. In accordance with the global evidence and

guidelines, maternal health initiatives in India recommend adaptation of alternative childbirth positions as a vital component of respectful maternity care through the Surakshit Matritva Aashwasan (SUMAN) program.⁸

The upright positions, namely sitting on an obstetric chair/stool, half sitting, ambulating, kneeling, squatting unaided or using squatting bars, deep squatting, or a supported standing position, can be safely adopted during the first and second stages of labor.⁹ When a woman in labor is in an upright position, there is less risk of compressing the mother's inferior vena cava and aorta, which means there is a better oxygen supply to the baby. Upright position aids the uterus to contract more strongly and efficiently, thus resulting baby's descent in a shorter duration. Also, radiological evidence has revealed that upright positions result in larger anteroposterior and transverse pelvic outlet diameters.

Studies from Asia and Africa reveal that women adopt squatting as one of the most attainable postures to perform activities of daily living, thus permitting ease to adopt during labor. In contrast, literature indicates that women in the West find it difficult to maintain a squat position for a considerable time due to a lack of muscular fitness and stamina, thereby increasing the rate of perineal trauma. Biomechanically squatting with feet flat leads to approaching an optimal lumbar curvature and the plane of the pelvic inlet closer to being perpendicular to the lumbar spine. Thus, squatting position with feet flat "naturally" approached the optimal conditions and can have a real impact on supporting birth as an alternative position. It has been noted that birthing in squatting increases the pelvic outlet by 20% and also decreases the duration of the first and second stages of labor by 9 minutes.¹⁰ Besides the merits, the major drawback is that the women may not have appropriate muscular fitness and stamina to maintain the squatting position for a considerable time.

Birthing in dorsal positions is now used as standard practice around the globe. Several recent national surveys indicate that, despite national and international guidance and professional recommendations, a substantial proportion of women worldwide continue to give birth in supine or lithotomy positions. The proportion of births occurring in a lying-down position has been reported as approximately 50% in England and Wales, 47.9% in Canada, 68% in the United States, and as high as 92% in Brazil.¹¹ In addition, a significant number of women report restricted freedom to move or change position during some or all of labour, affecting around 30% of women in England and Wales, 55% in Brazil, and 57% in the United States. Thus, this finding underscored the importance of voluntary choice of birthing position and noted negative association between the supine birthing position and satisfaction with childbirth.¹²

Although the dorsal position ensures ease for the birth attendant during childbirth, it poses a biomechanical

disadvantage to the mother thus necessitating excessive effort during labor. Previous studies have reported that health care professionals fail to promote and encourage mothers to adopt upright postures. Studies have also suggested that health care professionals lack knowledge on respectful practices of maternal care, where giving a choice for birthing position is one of the crucial aspects.¹³ Thus, the study aimed to understand the level of knowledge, attitude and practices of birthing positions adopted during various stages of labor by women in rural and semi-urban areas of Raigad district of Maharashtra.

METHODS

Study site and design

A cross-sectional study was conducted among women in rural and semi-urban areas of the Raigad district. Institutional ethical committee clearance IEC MGMDCH IN/SOP/76/02/2024 was sought, and informed consent as per the Declaration of Helsinki was obtained from all participants. 786 women from Raigad district (semi-urban- 384, rural- 384) in the reproductive age group 18-49 years, with history of natural or planned conception, spontaneous birth of at least one foetus by normal vaginal mode of delivery with or without episiotomy, were recruited for the study. Nulliparous, women with medical conditions leading to infertility like polycystic ovary syndrome, primary ovarian insufficiency, endometriosis, uterine fibroids, implantation failure, endocrine disorders, cervical lesions caused by human papillomavirus infection, autoimmune disorders, gonorrhoea, and chlamydia, were excluded. The study data was based on the recall of information by the mothers during their perinatal period.

The women from rural areas of the Raigad district, namely Dodhani, Dhamani, Tawarwadi, Waghachiwadi, and Dherang, and semi-urban areas from Kalamboli and Panvel were interviewed from May 2024 to July 2024. The women were interviewed at their residential setting in rural areas or when they visited the hospitals or accompanied family members in the hospitals.

These rural areas rely on government PHCs, sub-centres, and grassroot health workers (ASHAs and ANMs) for public health services. Access to specialized maternity care is limited in rural areas, requiring women to travel to a nearby tertiary hospital for advanced obstetric services. Deliveries in rural settings are often conducted in PHCs or at home with the assistance of traditional birth attendants. The semi-urban areas have access to primary health centers (PHCs), private clinics, and a multispecialty hospital for maternal healthcare services. The selected study settings were covered by the tertiary care medical teaching hospital through the program of Unnat Bharat Abhiyan, scheme of Government of India to enable higher educational institutions to work in rural areas for sustainable growth of both public and the private sectors.

Development of a semi-structured questionnaire

A structured questionnaire was prepared to address the research question after reviewing studies on birthing positions during labor. The tool was validated by three experts in women's health from physiotherapy, community medicine, and obstetrics and gynecology departments with over ten years of experience. The questionnaire included sections on demographic details, socioeconomic information, antenatal, perinatal, postnatal history, neonatal history, level of knowledge, attitude, and practices of birthing positions.

Data were collected using a structured information booklet containing pictorial representations of birthing positions across different stages of labour. The booklet was used solely as a visual standardization tool to ensure uniform understanding of the positions during the interview process and did not constitute an educational or interventional component. The illustrated positions included sitting, standing, squatting, kneeling, walking, side-lying, dorsal supine, and lithotomy. Each position was labelled, and a brief description was provided to clarify identification. The content was available in English, and local languages (Marathi, and Hindi) to facilitate comprehension among participants. No counselling, recommendation, or guidance regarding preferred or recommended positions was provided. Following exposure to the pictorial booklet, participants were interviewed using a structured questionnaire to assess their knowledge, attitudes, and self-reported practices related to birthing positions.

Knowledge of birthing position

The knowledge domain consisted of seven items, which assessed participants' familiarity with different birthing positions, their perceived role during labour, and women's preference for adopting specific postures. Most questions required dichotomous responses (Yes/No), while certain items included multiple-choice options allowing participants to identify specific birthing positions they were aware of or would prefer to adopt. The response options included lithotomy, side-lying, supine, squatting, kneeling, walking, and other positions. Participants who answered "yes" were further asked about the safe and helpful positions for better labor outcomes.

Attitude on alternative birthing positions

Participants' attitudes toward birthing positions were assessed using four items that explored their perceptions regarding women's autonomy in choosing birthing posture and their beliefs about the usefulness of upright positions during labour. The items included questions on whether women should be allowed to choose their preferred birthing position, the participant's preferred birthing posture if given an option, and their perceptions regarding the effectiveness of squatting and upright

positions during labour. Responses for perception-based items were recorded using three response options (yes/no/don't know). For the preference-related question, participants selected their preferred birthing position from a list that included lithotomy, supine, squatting, kneeling, walking, side-lying, other, or none.

Practices of birthing position

It was assessed by asking participants about various birthing positions that were adopted at the time of their labour, the choice of position offered, and their level of satisfaction with the adopted position during labor. Data were collected through face-to-face interviews using the validated questionnaire. The interview was completed in 20-25 minutes. All interviews were conducted either in English, Marathi, or Hindi, depending on the language both the researcher and participants were fluent in and understood well.

RESULTS

Socio-demographic characteristics of respondents

The average age of women from semi-urban areas was 28.1 ± 6.3 years, while the corresponding mean age for those in rural settings was 30.07 ± 6.9 years. In terms of socio-economic status among semi-urban women, it was observed that 75% were classified as upper middle class, whereas 25% were in the lower middle-class category. Conversely, the rural female population exhibited a distribution of 10% in the upper middle class, 66% in the lower middle class, 7% in the upper lower class, and 7% identified as belonging to the lower class. With regard to educational attainment, 28% of semi-urban women were graduates, 31% possessed high school diplomas, and 40% held secondary school certificates. Among rural women, 29% were illiterate, 20% had completed primary education, 25% possessed secondary school certificates, 13% had middle school diplomas, 7% held high school certificates, and 6% were graduates.

In the semi-urban context, 85% of women were unemployed, while 15% were engaged in professional

occupations. In contrast, within the rural demographic, 78% were unemployed, 15% were professionals, 6% were classified as skilled workers, and 1% were employed in agricultural settings.

Practices of birthing positions

The place of delivery differed substantially between settings. In semi-urban areas, 82% of women reported giving birth in tertiary-level hospitals and 18% at primary health centres (PHCs). In rural areas, 57% delivered at tertiary facilities, 40% at PHCs, and 3% reported home births. All semi-urban births were attended by medical doctors, whereas in rural settings only 57% were medically supervised, with the remaining deliveries conducted by traditional birth attendants, nursing personnel, or ASHA workers.

Maternal positioning varied by labour stage and location. During the first stage of labour, semi-urban women most frequently adopted a dorsal-supine position (49%), followed by squatting (18%), standing (9%), walking (8%), and side-lying (5%). Rural participants also showed a preference for dorsal-supine (32%), but reported greater diversity in positioning, including sitting (22%), squatting (26%), walking (10%), side-lying (6%), and standing (4%).

In the second stage of labour, semi-urban women again predominantly used the dorsal-supine posture (54%), supplemented by lithotomy (27%) and squatting (19%). Among rural women, dorsal-supine (60%) and squatting (35%) were the most common postures, with lithotomy reported by only 5%.

Positioning during the third stage of labour showed minimal variation. In semi-urban settings, 93% of women adopted a dorsal-supine posture, while 7% engaged in ambulatory movement, particularly following normal vaginal birth. Rural findings were comparable, with 91% in dorsal-supine and 9% walking during expulsion of the placenta.

Table 1: Practises of birthday positions adopted by women during perinatal period.

Practices: Birthing position adopted by women during the perinatal period	Stage 1 (%)		Stage 2 (%)		Stage 3 (%)	
	Semi-urban (n=384)	Rural (n=384)	Semi-urban (n=384)	Rural (n=384)	Semi-urban (n=384)	Rural (n=384)
Sitting	11	22	0	0	0	0
Standing	9	4	0	0	0	0
Squatting	18	26	19	35	0	0
Kneeling	0	0	0	0	0	0
Dorsal supine	49	32	54	60	93	91
Walking	8	10	0	0	0	0
Lithotomy	0	0	27	5	7	9
Side Lying	5	6	0	0	0	0

Overall, the data indicate continued reliance on conventional supine positioning across labour stages, with limited utilization of other alternative upright positions (Table 1).

Knowledge of birthing positions

Overall awareness of labour positioning was high across both settings. Nearly all participants acknowledged potential benefits of upright postures during labour, with 94% of semi-urban women and 91% of rural women reporting perceived advantages. Only a small proportion remained unaware of specific positional benefits, as 6% of semi-urban and 5% of rural respondents reported no

knowledge of the benefits of upright positions, such as squatting, during labour. Knowledge of squatting as a birthing option was consistently reported across both groups, indicating that this posture may be better integrated into community perceptions of childbirth than other upright positions.

Patterns of routine physical activity also varied by setting. More than half of semi-urban participants 55% and 40% of rural participants reported low habitual activity levels. Despite this, 49% of semi-urban women and 64% of rural women routinely performed squatting in daily tasks, suggesting familiarity with the physical mechanics of the posture irrespective of structured physical activity.

Table 2: Knowledge of birthing-positions that can be adopted during perinatal period among women.

Knowledge (%)	Semi-urban (n=384)	Rural (n=384)
Awareness of different labor positions	67	91
Are you aware of upright positions that can be adopted during labor?		
Yes	94	91
No	0	1
Don't know	6	8
Do you feel that an upright posture will help during labor?		
Yes	77	65
No	0	0
Don't know	23	35
Which birthing positions do you feel are helpful for normal vaginal delivery?		
Lithotomy	47	40
Sidelying	14	5
Supine	29	30
Squatting	25	25
Kneeling	10	9
Do you think lithotomy/supine position are the safest position for labor?		
Yes	98	61
No	2	39
Are you willing to adopt any other birthing positions other than traditional ones?		
Yes	98	70
No	2	30
Would you recommend new or experienced mothers to consider alternative/vertical birthing positions?		
Yes	92	32
No	8	68

Collectively, these findings indicate substantial awareness of upright birthing positions, with persistent urban-rural disparities in breadth of knowledge and exposure (Table 2)

Attitude of birthing positions

Attitudinal assessment revealed strong support for maternal autonomy in childbirth. All women in semi-urban settings (100%) and the majority in rural areas

(94%) believed that women should have the freedom to choose their birthing posture. Uncertainty regarding choice was minimal, reported by 5.5% of rural women. No participants in either group selected walking, kneeling positions, or reported having no preference. Overall, the findings indicate a favourable attitude toward choice and upright squat birthing position in both settings, with semi-urban women demonstrating slightly stronger endorsement and clarity compared with rural counterparts (Table 3).

Table 3: Attitude of women to adopt birthing-positions during perinatal period.

Attitude (%)	Semi-urban (n=384)	Rural (n=384)
Do you think women should have the choice of birthing posture?		
Yes	100	94
No	0	0.5
Don't know	0	5.5
If given an option, which birthing position would you choose?		
Lithotomy	23	25
Supine	23	24
Squatting	31	24
Kneeling	0	24
Walking	0	0
Side Lying	14	4
Other	0	0
None	0	0
Do you think squatting activities helped during labour?		
Yes	94	90
No	0	5
Don't know	6	5
Do you feel that an upright posture will help during labour?		
Yes	94	91
No	0	1
Don't know	6	8

DISCUSSION

The study revealed that women from both semi-urban and rural areas had high knowledge of upright and horizontal birthing positions. However, females of both settings reported that no choice to adopt any preferred birthing position was offered during labor by the healthcare professional. The disparity between rural environments profoundly impacts the choices available to women due to limited access to healthcare facilities, relying primarily on local healthcare providers, and traditional knowledge passed down within communities. In addition, lower socioeconomic status and lower education level among rural women contributed to disparities in the utilization of healthcare services and access to appropriate resources. In contrast, semi-urban women benefit from a plethora of healthcare facilities and advanced medical services, providing a broad spectrum of choices through modern technologies and medical advancements. Over the last 10 years, the mean percentile value of vacuum delivery was 78.47%, while that of forceps was 21.52 % showing how instrumental and advanced technologies have been more preferred over natural birthing positions over the years.^{14,15}

The delivery in a semi-urban setting was conducted by obstetrics and gynecologists at the tertiary hospital and primary health care centre, whereas in rural areas, apart from qualified doctors, traditional birth attendants (TBA), and health care workers, also conducted childbirth at the hospital, primary health care centre, and home-based

delivery. Home-based births were considered to be traditional, natural, and culturally appropriate among rural women. Rural women believed that higher rates of caesarean section were conducted in private hospitals, resulting in hesitation or avoidance of hospital-based deliveries.

During the first stage of labor, most women adopted a dorsal-supine position, followed by standing, sitting, walking, side-lying, and squatting. Women in both settings reported that they were not given any choice of position during labor but were asked by healthcare providers to assume a dorsal-supine position. The findings of our study are also consistent with those of a study conducted in Tanzania, where women in the hospital assume a supine position as it offers convenient accessibility to healthcare providers and improved visibility of the perineum.¹⁶ Few women in both settings assumed upright positions, such as sitting, standing, squatting, and walking, as encouraged by health care providers. Upright positions significantly shorten labor duration, reduce the rate of instrumental vaginal birth and episiotomy, and assist by utilizing gravity-assisted fetal descent, increasing pelvic outlet dimensions through sacral nutation and pelvic mobility, optimizing lumbopelvic alignment, enhancing uterine-abdominal force coupling, and reducing aortocaval compression, thereby promoting efficient fetal rotation and descent. Biomechanical analysis by Borges et al demonstrated that flexible sacrum birthing positions (upright postures) allowed significantly greater coccygeal rotation (~15.7°)

with reduced pubic symphysis widening (~3 mm), whereas non-flexible sacrum positions (supine/lithotomy) restricted coccygeal rotation (~3.6°) and showed increased diastasis symphysis pubis (~6 mm) during vaginal delivery.¹²

In stage 2 of labor, it was observed that women from both settings adopted the dorsal supine and lithotomy positions following squatting, standing, and walking. Most rural women assumed upright positions as involved in ground-level activities for ADLs and influenced adherence to traditional birthing methods rooted in familial and cultural practices, emphasizing continuity with ancestral wisdom rather than contemporary medical interventions. Biomechanical analyses demonstrated distinct differences among upright birthing positions. Squatting was characterized by marked hip flexion in the sagittal plane, increased hip abduction in the coronal plane, and greater external rotation in the transverse plane, a combination that maximizes pelvic outlet dimensions and supports efficient fetal descent and labour progression.¹⁷ In contrast, positions involved increased trunk flexion, such as elbows-and-knees or bent-knee postures, promote anterior weight redistribution and a forward-leaning alignment, which was beneficial during specific phases of labour. Use of a birthing ball is associated with pronounced anterior pelvic tilt in the sagittal plane, potentially increasing pelvic inlet space and facilitating engagement of the fetal head in the early stages of labour. Conversely, the all-fours position produces the greatest posterior pelvic tilt, resulting in a more neutral lumbar posture, which may offer advantages in the later stages of labour by enhancing maternal comfort and pain modulation.¹⁸

Semi-urban women who are involved in sedentary lifestyles tend to adopt birthing practices influenced by modern medical trends and shared experiences among social groups. Women from both settings had no choice but to voluntarily choose the birthing position during first and second stage of labor and revealed a neutral satisfaction level during birth. Conversely, semi-urban women, despite access to education and facilities, often preferred positions recommended by healthcare professionals, highlighting their resistance to exploring alternative birthing methods. Evidence suggests that the supine position during second stage of labor is associated with certain outcomes, including urinary incontinence, abnormal fetal heart rate patterns, and potential injuries to the pelvic floor muscles and sphincters. Thus, healthcare team members should encourage mothers by reinforcing potential medical benefits associated with alternative positions.¹⁹ In third stage of labor, positions such as lithotomy and dorsal supine were adopted by the mothers in both settings. Adopting a horizontal position aids expulsion of the placenta, which requires minimal effort and energy expenditure by the mother.

Health-related education has also emerged as a critical determinant in shaping women's understanding of and

preferences for birthing positions. Women from both settings were aware of the dorsal and upright birthing positions that could be assumed during labor. Also, the mentioned choice should be provided as it enables flexibility and a supportive environment for a better birthing experience.^{17,20} Women stated that they would like to adopt squatting, side-lying, and sitting positions, given a choice. These positions would benefit them by having more control over their body during labor and being actively involved in shared decision-making. Semi-urban women presented higher literacy rates and access to educational resources through social media and female co-workers, fostering greater awareness among women about the physiological benefits of different birthing positions. This knowledge equipped semi-urban women with the ability to make informed decisions, based on medical evidence and personal preferences.

Rural women exhibited higher levels of overall physical activity, with squatting exposure being the most preferred position used for performing activities of daily living. Evidence suggests that women in semi-urban settings lack of adequate strength in lower extremity muscles may make it difficult for women to sustain upright postures such as squat during labour thus guiding the choice of non-weight bearing postures such as dorsal lying.²¹

The study portrays a complex interplay of socioeconomic, educational, occupational, and healthcare factors that influence women's choices of birthing positions in semi-urban and rural contexts. Addressing these disparities requires educational programs aimed at empowering women with comprehensive knowledge and access to diverse birth options. By bridging these gaps, healthcare providers can better support women in making informed decisions that prioritize both their health and personal preferences, irrespective of their geographic location or socioeconomic background. Thus, integrating culturally sensitive approaches that respect and incorporate traditional practices while promoting evidence-based birth options is essential. Environmental factors such as poor and limited transportation facilities, posing out of pocket expenditure to avail health services among women from rural areas. Future research could expand upon our findings by broadening the scope to include a larger and more diverse sample across various regions, to gain deeper insights into regional variations in birthing practices and preferences. Exploring the roles of healthcare providers in promoting and facilitating alternative birthing positions could inform targeted training programs aimed at enhancing their knowledge, attitudes, and practices. Finally, assessing the economic implications of different birthing positions and their impact on healthcare costs and maternal outcomes could provide insights to guide policymakers in prioritizing interventions that optimize health outcomes and resource utilization.

The study was conducted in selected semi-urban and rural settings, which may limit the generalizability of the

findings. As the data were collected through self-reported questionnaires, recall bias and response bias cannot be excluded. Furthermore, the cross-sectional design does not permit causal inferences, and healthcare providers' perspectives regarding the choice of birthing positions were not explored.

CONCLUSION

The study demonstrates that although awareness of upright birthing positions is high among women in both semi-urban and rural settings, conventional supine and lithotomy postures continue to dominate intrapartum practice. A clear disconnect persists between knowledge, attitudes, and actual implementation, largely influenced by institutional norms, provider practices, and limited autonomy in decision-making during labor. Rural women showed comparatively lower awareness and endorsement of alternative positions and had reduced access to medically supervised delivery. By promoting education, increasing awareness about different birthing positions, and improving healthcare facilities, we can empower women to make informed decisions and enhance their overall satisfaction with labor positions. Strengthening provider training, integrating counselling on positional choice into routine antenatal care, and promoting women's informed participation in labour decisions are essential to optimise maternal experience and clinical outcomes in resource-constrained settings.

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