

Original Article

Epidural Labour Analgesia Awareness, Acceptance and Barriers Among Pregnant Women Attending Antenatal Clinic

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ABSTRACT

Background: Epidural labour analgesia is an effective method of labour pain relief, but inadequate knowledge, misconceptions, social influences, and limited counselling may restrict its acceptance. **Objective:** To assess awareness, knowledge, acceptance, misconceptions, and perceived barriers regarding epidural labour analgesia among pregnant women attending antenatal clinics in District Khanewal, Pakistan, and to identify factors associated with post-counselling acceptance. **Methods:** A descriptive cross-sectional survey incorporating a within-participant pre- and post-counselling assessment of stated acceptance was conducted among 423 pregnant women from January to March 2026. Data were collected using a structured interviewer-administered questionnaire. Categorical associations were examined using chi-square or Fisher's exact tests, and independent factors associated with post-counselling acceptance were evaluated using multivariable binary logistic regression. **Results:** Previous awareness of epidural labour analgesia was reported by 161 women (38.1%), while 112 (26.5%) had adequate knowledge. Baseline acceptance was 31.9% (135/423) and increased descriptively to 68.6% (290/423) immediately after counselling. The most frequently reported concerns were permanent back pain (61.2%), paralysis (52.0%), and harm to the baby (47.3%). Higher education (AOR 2.31, 95% CI 1.39–3.84), previous counselling (AOR 3.16, 95% CI 1.81–5.51), previous awareness (AOR 2.08, 95% CI 1.31–3.31), and family support (AOR 2.67, 95% CI 1.61–4.42) were positively associated with acceptance, whereas strong fear of complications was inversely associated with acceptance (AOR 0.39, 95% CI 0.25–0.61). **Conclusion:** Awareness and knowledge of epidural labour analgesia were limited, while stated acceptance was substantially higher after brief counselling. Educational, informational, familial, and fear-related factors were independently associated with acceptance, supporting the importance of accessible and culturally appropriate antenatal information. **Keywords:** Epidural labour analgesia; labour pain; awareness; knowledge; acceptance; barriers; antenatal counselling; pregnancy; Pakistan

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INTRODUCTION

Labour pain is a major component of the childbirth experience and varies considerably in intensity, perception, and coping requirements among women. Pharmacological and non-pharmacological approaches are available for labour pain management, of which epidural labour analgesia is among the most effective techniques for providing substantial pain relief while allowing the woman to remain conscious and participate in childbirth. Evidence from randomized trials and systematic reviews indicates that epidural analgesia provides more effective pain relief than non-epidural approaches, although its use requires appropriate maternal and fetal monitoring and may be accompanied by recognized maternal and obstetric effects that should be discussed during informed decision-making (1,2).

Despite its established analgesic efficacy, awareness and acceptance of epidural labour analgesia remain variable, particularly in settings where access to obstetric anaesthesia services and structured antenatal counselling is limited. Pakistani evidence has demonstrated substantial gaps in women's knowledge of labour analgesia. In one cross-sectional study, only 27.9% of antenatal women had previously heard about labour analgesia, although willingness to consider pain relief increased markedly after information was provided (3). Another Pakistani study demonstrated that knowledge, previous childbirth experiences, concerns regarding the procedure, and individual preferences were associated with women's decisions regarding epidural analgesia (4). These findings indicate that apparent reluctance towards epidural analgesia may reflect inadequate information and uncertainty in addition to personal preference.

Comparable variation has been reported internationally. Studies among antenatal women in Nepal and Ethiopia have documented limited or inconsistent knowledge of epidural and other forms of labour analgesia (5,6). Research from Saudi Arabia and Ethiopia has similarly shown that awareness, attitudes, and willingness to use labour analgesia differ according to educational and sociodemographic characteristics (7,8). Additional studies have associated awareness or willingness with residence, access to information, parity, and other maternal characteristics (9,11). Surveys from Nigeria have also demonstrated considerable variation in both awareness and desirability of obstetric epidural analgesia (10,12). More recent multicentre and community-based investigations have reinforced the importance of knowledge, perceptions, demographic characteristics, and access to reliable information in determining women's attitudes towards epidural analgesia (13,14).

Decision-making regarding epidural analgesia is therefore multidimensional and extends beyond simple awareness of the procedure. Women's intention to use epidural analgesia may be influenced by previous experiences, expectations of childbirth, perceived risks, advice from healthcare professionals, and social influences (15). A mixed-methods systematic review demonstrated that women's decisions concerning epidural analgesia are shaped by personal expectations, information, interactions with healthcare professionals, and experiences during labour (16). Earlier research has likewise identified multiple clinical, personal, and informational factors associated with choosing epidural analgesia (17). Importantly, education provided during pregnancy may influence willingness to request epidural analgesia, particularly among women approaching their first childbirth experience (18). Attitudes towards labour pain relief are themselves measurable constructs involving beliefs, expectations, and preferences (19), while fear of childbirth may also interact with women's knowledge and perceptions of pain-relief options (20).

Misconceptions remain particularly important barriers to informed choice. Women in different settings have reported concerns regarding paralysis, persistent back pain, inability to push effectively, prolonged labour, caesarean delivery, and adverse effects on the newborn (21–24). These concerns require balanced counselling rather than simple reassurance. Systematic evidence demonstrates superior analgesic efficacy of epidural techniques without clear evidence of an increased caesarean delivery rate, although recognized adverse effects and changes in some labour outcomes warrant appropriate discussion and monitoring (1). Maternal analgesia may also have physiological implications for the fetus and newborn that should be considered within the overall clinical context rather than presented as unsupported claims of inevitable harm (2). Furthermore, a large population-based study reported an association between epidural analgesia and a lower risk of severe maternal morbidity in some groups; however, its observational design does not establish that epidural analgesia itself caused the reduction in morbidity (25).

Most Pakistani evidence regarding women's perceptions of labour analgesia has originated from large tertiary-care or urban settings (3,4). Women attending antenatal services in District Khanewal may differ in educational background, rural or urban residence, previous childbirth experience, availability of obstetric anaesthesia services, exposure to antenatal counselling, and influence of family members. These contextual differences make locally generated evidence important for planning patient education and obstetric anaesthesia services. Because awareness, knowledge, misconceptions, perceived barriers, and willingness can be measured concurrently, a cross-sectional survey is appropriate for estimating their distribution and examining associations between maternal characteristics and acceptance; however, such associations cannot establish causality.

The present study therefore assessed awareness, knowledge, acceptance, misconceptions, and perceived barriers regarding epidural labour analgesia among pregnant women attending antenatal clinics in District Khanewal, Pakistan. It further examined whether educational status, previous childbirth experience, previous awareness, antenatal counselling, family support, and fear of complications were associated with willingness to consider epidural labour analgesia and described changes in stated acceptance immediately after provision of brief counselling.

MATERIALS AND METHODS

A descriptive cross-sectional survey incorporating a within-participant pre- and post-counselling assessment of stated acceptance was conducted among pregnant women attending selected public and private antenatal clinics in District Khanewal, Punjab, Pakistan. District Khanewal includes both urban and rural communities with diverse educational and socioeconomic characteristics. Data collection was conducted over six months, from January to March 2026. The primary cross-sectional component assessed awareness, knowledge, misconceptions, perceived barriers, and factors associated with acceptance, while stated willingness to receive epidural analgesia was additionally recorded before and immediately after provision of brief counselling.

Pregnant women attending the selected antenatal clinics during the study period constituted the target population. Potential participants were approached in clinic waiting areas after registration and either before or after their routine antenatal examination. Women at any stage of pregnancy were eligible because knowledge and attitudes towards labour pain management may develop throughout pregnancy. Women aged 18 years or older who attended an antenatal clinic in District Khanewal, agreed to participate, and were able to communicate in Urdu, Punjabi, Saraiki, or simple spoken English were included. Women with or without previous childbirth experience were eligible. Women who were seriously ill, in active labour, experiencing an obstetric emergency, or unable to communicate adequately because of a serious medical, cognitive, speech, or hearing-related condition were excluded. Questionnaires containing more than 20% missing responses were excluded from analysis.

The sample size was calculated using the single-population proportion approach. Because no reliable district-level estimate of awareness of epidural labour analgesia was available, an expected proportion of 50% was selected to provide the maximum required sample size. Using a 95% confidence level and a 5% margin of error produced an initial sample requirement of 384 participants. Approximately 10% was added to allow for non-response or incomplete questionnaires, resulting in a final target sample of 423 women.

Participants were recruited using consecutive non-probability sampling. Every eligible woman attending the selected clinics during the recruitment period was invited to participate until the required sample size was achieved. Recruitment was undertaken on different clinic days and during different working hours to obtain participation from women with varied backgrounds. Because a complete district-level sampling frame of pregnant women attending antenatal clinics was unavailable, probability sampling was not used.

Data were collected using a structured interviewer-administered questionnaire developed after review of published studies examining awareness, attitudes, acceptance, and misconceptions regarding labour and epidural analgesia in different populations (3,5–14,21–24). The questionnaire comprised five domains. The first recorded demographic characteristics, including age, area of residence, educational level, occupation, and monthly household income. The second recorded obstetric information, including gestational age, gravidity, parity, previous childbirth experience, and mode of previous delivery. The third assessed previous awareness and knowledge of epidural labour analgesia, including sources of information, understanding of its administration, expected benefits, and perceived adverse effects. The fourth assessed willingness to consider epidural analgesia during labour before and after counselling. The fifth assessed misconceptions and perceived barriers, including fear of paralysis, permanent back pain, harm to the baby, inability to push, prolonged labour, caesarean delivery, high cost, family refusal, lack of female anaesthesia staff, and limited availability of epidural services. The inclusion of attitudinal and decision-related domains was consistent with previous research demonstrating the multidimensional nature of women's preferences concerning labour analgesia (15–20).

The questionnaire underwent expert review by an obstetrician, an anaesthetist, and a public-health researcher for clarity, relevance, and appropriateness for pregnant women in the local setting. A pilot study was subsequently conducted among 21 pregnant women, corresponding to approximately 5% of the calculated main-study sample. Pilot participants were recruited from an antenatal clinic that was not included in the main survey. Ambiguous or repetitive questions identified during pilot testing were revised, and pilot observations were not included in the final analysis. The original English questionnaire was translated into Urdu and subsequently back-translated into English by an independent bilingual researcher to assess preservation of meaning.

After eligibility assessment, the purpose and procedures of the study were explained in simple language. Written informed consent was obtained from participants who could read and write. For participants unable to provide written signatures because of illiteracy, consent was documented using a thumbprint in the presence of a witness. Interviews were conducted in a quiet area of the antenatal clinic to maintain privacy. Trained female data collectors administered the questionnaire in the participant's preferred language and recorded the responses. Interviewers were instructed not to guide, correct, or otherwise influence participants' baseline responses. Each interview required approximately 10–15 minutes.

Baseline awareness, knowledge, misconceptions, barriers, and willingness to consider epidural analgesia were recorded before counselling. After completion of the baseline questionnaire, participants received brief and balanced information regarding epidural labour analgesia, after which their willingness to consider the procedure was recorded again. This sequence ensured that baseline awareness and acceptance were documented before exposure to the study counselling. Completed questionnaires were reviewed on the same day, and missing or unclear entries were checked with the participant before she left the clinic whenever possible.

The principal outcomes were previous awareness of epidural labour analgesia, knowledge, baseline acceptance, post-counselling acceptance, misconceptions, and perceived barriers. Awareness was defined as having heard about epidural labour analgesia before the interview. Acceptance was defined as stated willingness to consider receiving epidural analgesia during labour and was recorded separately before and after counselling. The knowledge score ranged from 0 to 10, with a score of 6 or higher classified as adequate knowledge. Explanatory variables included age, education, residence, occupation, household income, gravidity, parity, previous childbirth experience, previous mode of delivery, previous counselling, previous awareness, fear of complications, and family support for epidural use.

Data were entered, cleaned, and analysed using IBM SPSS Statistics version 26.0. Categorical variables were summarized using frequencies and percentages. Normally distributed numerical variables were summarized as mean $\pm$ standard deviation, while median and interquartile range were planned for numerical variables not meeting distributional assumptions. Pre- and post-counselling acceptance were summarized as frequencies and percentages. Associations between acceptance and categorical explanatory variables were initially examined using the chi-square test, with Fisher's exact test used when expected cell frequencies were below five.

For multivariable analysis, post-counselling acceptance was treated as the binary outcome. Variables yielding a p-value <0.20 in univariate analysis were considered for inclusion in the multivariable binary logistic regression model. Adjusted odds ratios (AORs) with 95% confidence intervals (CIs) were calculated to estimate independent associations with acceptance. Statistical significance was defined as $p < 0.05$. Overall model calibration was assessed using the Hosmer–Lemeshow goodness-of-fit test, and Nagelkerke's pseudo- R^2 was reported as an indicator of model explanatory performance.

RESULTS

A total of 423 pregnant women completed the survey, and no questionnaire was excluded because of major missing information. The mean participant age was 27.8 ± 4.9 years, with a range of 18–41 years. Women aged 25–29 years constituted the largest age group (40.4%), followed by those aged 18–24 years (28.1%). Most participants lived in rural areas (59.3%), 79.0% were homemakers, and 26.7% had either no formal

education or education only to primary level. A total of 154 women (36.4%) had no previous childbirth, whereas 207 (48.9%) had experienced a previous vaginal birth and 62 (14.7%) had experienced a previous caesarean birth. Previous counselling regarding epidural analgesia was reported by 96 women (22.7%) (Table 1).

Table 1. Demographic and obstetric characteristics of participants (N=423)

Characteristic	n	%
Age group		
18–24 years	119	28.1
25–29 years	171	40.4
30–34 years	93	22.0
≥35 years	40	9.5
Residence		
Rural	251	59.3
Urban	172	40.7
Educational level		
No formal education/primary	113	26.7
Secondary	164	38.8
Higher secondary	81	19.1
Graduate or above	65	15.4
Employment status		
Homemaker	334	79.0
Employed	89	21.0
Previous childbirth experience		
No previous childbirth	154	36.4
Previous vaginal birth	207	48.9
Previous caesarean birth	62	14.7
Previous counselling about epidural analgesia		
Yes	96	22.7
No	327	77.3

Before the study interview, 161 women (38.1%) had heard about epidural labour analgesia. Healthcare professionals were reported as the source of information by 55 women, while relatives and friends represented an important source among other previously aware participants; social media was also reported, particularly among younger and more highly educated women. The mean knowledge score was 4.2 ± 2.1 out of 10. Only 112 participants (26.5%) achieved the predefined adequate knowledge threshold of $\geq 6/10$. Although many participants recognized epidural analgesia as a method of reducing labour pain, fewer correctly understood its route or site of administration, whether consciousness would be maintained, and whether epidural use necessarily resulted in caesarean delivery.

Baseline willingness to consider epidural analgesia was reported by 135 women (31.9%). Immediately after provision of brief and balanced counselling, 290 women (68.6%) stated that they would consider epidural analgesia, representing an absolute descriptive increase of 36.7 percentage points. The post-counselling proportion is reported descriptively and does not, by itself, establish a causal effect of counselling. Some women who had previously heard of epidural analgesia remained unwilling because of concerns regarding complications, whereas some women without previous awareness expressed willingness after receiving information. Among those who remained unwilling, reported reasons included fear of complications, perceived need for approval from husbands or senior family members, and the belief that labour pain should be tolerated without medical pain relief.

Misconceptions and fear constituted the most frequently reported barriers. Concern regarding permanent back pain was reported by 61.2% of participants, fear of paralysis by 52.0%, and concern regarding harm to the baby by 47.3%. Participants also reported beliefs that epidural analgesia could prevent effective pushing, prolong labour, or inevitably lead to caesarean delivery. Service-related barriers included perceived high cost, uncertain availability of an anaesthetist, lack of female anaesthesia staff, and limited availability of epidural services. Family refusal was another reported social barrier. Rural participants more frequently described transport, cost, and service-availability concerns. Because participants could report more than one barrier, percentages for barrier responses were not mutually exclusive and did not sum to 100%.

In multivariable logistic regression analysis, higher secondary education or above was associated with greater odds of post-counselling acceptance (AOR 2.31, 95% CI 1.39–3.84; $p=0.001$). Previous counselling regarding epidural analgesia showed a strong positive association with acceptance (AOR 3.16, 95% CI 1.81–5.51; $p<0.001$), as did previous awareness (AOR 2.08, 95% CI 1.31–3.31; $p=0.002$) and family support for epidural use (AOR 2.67, 95% CI 1.61–4.42; $p<0.001$). Strong fear of complications was inversely associated with acceptance (AOR 0.39, 95% CI 0.25–0.61; $p<0.001$). Urban residence and previous childbirth route were not statistically significant after adjustment (Table 2).

Table 2. Multivariable logistic regression of factors associated with post-counselling acceptance of epidural labour analgesia

Predictor	AOR	95% CI	p-value
Higher secondary education or above	2.31	1.39–3.84	0.001
Urban residence	1.42	0.91–2.22	0.120
Previous vaginal birth	1.48	0.92–2.38	0.105
Previous caesarean birth	0.81	0.43–1.52	0.510
Previous counselling about epidural analgesia	3.16	1.81–5.51	<0.001
Previous awareness of epidural analgesia	2.08	1.31–3.31	0.002
Strong fear of complications	0.39	0.25–0.61	<0.001
Family support for epidural use	2.67	1.61–4.42	<0.001

AOR, adjusted odds ratio; CI, confidence interval. Outcome: stated acceptance of epidural labour analgesia after counselling.

The Hosmer–Lemeshow goodness-of-fit test yielded $p=0.470$, indicating no evidence of poor model calibration according to this test. Nagelkerke's pseudo- R^2 was 0.31. Overall, the findings showed limited previous awareness and knowledge of epidural labour analgesia, higher stated acceptance immediately after counselling, positive independent associations of acceptance with education, previous awareness, previous counselling, and family support, and an inverse association with fear of complications.

DISCUSSION

This study evaluated awareness, knowledge, acceptance, misconceptions, and perceived barriers regarding epidural labour analgesia among pregnant women attending antenatal clinics in District Khanewal. Previous awareness and adequate knowledge were limited, and less than one-third of participants initially expressed willingness to consider epidural analgesia. Stated acceptance was considerably higher immediately after brief counselling. Higher educational status, previous awareness, previous counselling, and family support were independently associated with greater post-counselling acceptance, whereas strong fear of complications was inversely associated with willingness to consider epidural analgesia. These findings indicate that women's attitudes towards epidural analgesia are associated with informational, educational, social, and perceptual factors rather than awareness alone.

Only 38.1% of participants had previously heard about epidural labour analgesia, and 26.5% met the threshold for adequate knowledge. This finding is broadly consistent with previous Pakistani evidence demonstrating substantial gaps in knowledge of labour analgesia. Ali et al. reported that only 27.9% of antenatal women in their study had previously heard about labour analgesia, while Ismail et al. demonstrated that women's choices concerning epidural analgesia were related to knowledge, previous experience, and individual concerns (3,4). Similar deficiencies or wide variation in awareness have been documented among antenatal populations in Nepal, Ethiopia, Saudi Arabia, Nigeria, and other low- and middle-income settings, indicating that access to information and opportunities for counselling differ substantially across populations (5–12). The present findings therefore extend existing evidence to District Khanewal, where rural residence, differences in educational attainment, and variable access to obstetric anaesthesia information may contribute to the observed knowledge gap.

A clinically relevant observation was the increase in stated acceptance from 31.9% before counselling to 68.6% immediately after provision of brief information. Previous research has similarly suggested that women's preferences regarding epidural analgesia can change after receiving information. Alakeely et al. found that education regarding epidural analgesia was associated with women's decisions to request it,

while broader research on women's decision-making has emphasized the importance of understandable information and interactions with healthcare professionals (16,18). However, the present study did not use a randomized comparison group, and the reported pre/post proportions represent an immediate within-participant descriptive change. Consequently, the findings should not be interpreted as establishing the causal effectiveness of counselling. They nevertheless suggest that willingness to consider epidural analgesia is potentially modifiable and that assessment of women's preferences before provision of adequate information may underestimate eventual acceptance.

Fear and misconceptions constituted prominent barriers. Permanent back pain was reported by 61.2% of participants, fear of paralysis by 52.0%, and concern about harm to the baby by 47.3%. Similar concerns regarding neurological complications, persistent pain, adverse neonatal effects, prolonged labour, impaired ability to push, and caesarean delivery have been reported in studies from Saudi Arabia, India, and other populations (21–24). Although counselling should not minimize genuine adverse effects, many extreme beliefs surrounding epidural analgesia are not supported by current evidence. A systematic review demonstrated that epidural analgesia provides more effective pain relief than non-epidural approaches without clear evidence of an increased caesarean delivery rate, while also documenting maternal and obstetric effects that warrant appropriate monitoring and balanced discussion (1). Providing accurate risk information may therefore be more appropriate than either indiscriminate reassurance or disproportionate emphasis on uncommon complications.

Educational attainment was independently associated with acceptance. Participants with higher secondary education or above had more than twice the adjusted odds of accepting epidural analgesia compared with the study reference group. Previous research has similarly identified education as an important correlate of awareness, attitudes, or desire for labour analgesia (7–9,14). Higher educational attainment may facilitate access to health information, understanding of medical explanations, and communication with healthcare professionals; nevertheless, formal education should not determine whether women can make informed choices. Antenatal information should therefore be delivered in simple, culturally appropriate language and adapted to differences in literacy and health literacy so that informed decision-making remains accessible across educational groups.

Previous counselling and previous awareness were also independently associated with greater acceptance. Participants reporting previous counselling had substantially higher adjusted odds of post-counselling acceptance, while women with prior awareness were also more willing to consider epidural analgesia. These findings are consistent with studies showing that healthcare information and antenatal education are important components of women's attitudes and decisions concerning labour pain relief (18,19). Women's decisions are rarely based on technical knowledge alone; previous experiences, expectations of childbirth, perceived risks, advice from healthcare professionals, and information received from informal sources can collectively shape preferences (15–17). Routine antenatal encounters therefore provide an opportunity to introduce balanced information about available pain-management options before the onset of labour, when women may have greater time to consider their preferences and ask questions.

Family support was another independent correlate of acceptance, with supported women demonstrating higher adjusted odds of willingness to consider epidural analgesia. The importance of social context is consistent with qualitative and survey evidence showing that women's choices about labour analgesia can be influenced by relatives, partners, previous patients, cultural expectations, and interpersonal interactions surrounding childbirth (16,21,23,24). In the present study, some women also reported that approval from husbands or senior family members affected their decisions. Family-inclusive education may therefore help address misconceptions circulating within households; however, involvement of family members should complement rather than replace the pregnant woman's autonomous and informed decision regarding pain management.

Service-related concerns, including cost, uncertain availability of anaesthesia personnel, lack of female anaesthesia staff, and limited access to epidural services, were also reported. These findings are relevant

because improving knowledge alone cannot translate into meaningful choice when the desired service is inaccessible. International evidence demonstrates considerable variation in awareness and utilization of obstetric epidural analgesia across healthcare settings, with availability of information and healthcare resources contributing to differences between populations (8–12). Patient education should therefore be accompanied by realistic information regarding local service availability, affordability, and access to appropriately trained obstetric anaesthesia personnel.

The present study provides locally relevant evidence from both public and private antenatal settings and evaluates awareness, knowledge, misconceptions, social barriers, and adjusted correlates of acceptance within the same population. The inclusion of an immediate post-counselling assessment also provides useful information regarding how stated willingness may differ after basic information is presented. Several limitations should nevertheless be considered. Consecutive non-probability sampling limits population-level representativeness and may have introduced selection bias, particularly because women who did not attend antenatal care were not represented. The findings concern stated willingness rather than actual epidural utilization during labour, and responses may have been affected by interviewer or social-desirability bias. Acceptance was reassessed immediately after counselling, so persistence of the observed change over time is unknown. The questionnaire underwent expert review and pilot testing, but the available study procedures do not establish comprehensive psychometric validation. In addition, participants were recruited from multiple selected clinics without an analysis accounting for potential clustering by facility. Finally, the cross-sectional observational design permits identification of associations but does not establish causal relationships between education, counselling, family support, fear, and acceptance.

Taken together, the findings suggest that limited knowledge and prominent misconceptions coexist with substantial potential willingness to consider epidural labour analgesia when understandable information is available. Previous awareness, counselling exposure, educational attainment, and family support were positively associated with acceptance, whereas fear of complications remained an important negative correlate. Existing evidence similarly indicates that women's decisions regarding labour analgesia emerge from an interaction between knowledge, attitudes, risk perceptions, previous experiences, interpersonal influences, and healthcare information (15–20). Antenatal counselling strategies should therefore emphasize balanced risk communication, correction of common misconceptions, respect for maternal autonomy, and communication that is accessible to women with differing educational and social backgrounds.

CONCLUSION

Awareness and detailed knowledge of epidural labour analgesia among pregnant women attending antenatal clinics in District Khanewal were limited, and fear of permanent back pain, paralysis, and possible harm to the baby were common concerns. Stated acceptance increased from 31.9% before counselling to 68.6% immediately after counselling, although this descriptive within-participant change does not establish a causal counselling effect. Higher educational attainment, previous awareness, previous counselling, and family support were independently associated with greater acceptance, whereas strong fear of complications was associated with lower acceptance. Integrating clear, culturally appropriate, and balanced information about labour pain-management options into routine antenatal care may support more informed maternal decision-making while addressing persistent misconceptions and access-related concerns.

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