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Original Article

Factors Associated With Partner Support During Pregnancy Among Pregnant Women in a Tertiary Hospital in Ibadan, Nigeria

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Abstract

Introduction: The significance of support during pregnancy cannot be overestimated, as it contributes to improved maternal health and birth outcomes. This study assessed the magnitude of partner support and its associated factors among women attending a tertiary antenatal clinic in Ibadan, Nigeria.

Methods: In this cross-sectional study, 394 pregnant women were recruited using a two-stage mixed sampling technique. A 31-item questionnaire was administered to assess self-reported partner support. Scores were dichotomized as "inadequate" (<24.7) or "adequate" (≥24.7) partner support. Odds ratios (ORs) and 95% confidence intervals (CIs) were estimated using logistic regression models to identify factors associated with partner support at a two-sided $P<0.05$.

Results: The mean age of respondents was 30.1 ± 5.6 years, and 284 (72.1%) reported receiving adequate partner support during pregnancy. Most respondents were primiparous (194, 50.3%), practised Islam (217, 55.2%), were married (353, 92.2%), had a tertiary education (187, 48.2%), and were involved in trading and business (146, 38.1%). Being Christian (OR: 2.23; 95% CI: 1.27-3.91) was the only factor significantly associated with adequate partner support during pregnancy. Women with tertiary education (OR: 2.23; 95% CI: 1.00- 5.23; $P=0.050$) were more likely to receive adequate partner support, but this association was attenuated (OR: 1.8l; 95% CI: 0.19, 5.12; $P=0.218$) in the final multivariable-adjusted model that included both respondents' and partners' characteristics.

Conclusion: Culturally appropriate interventions that account for religious beliefs may help improve partner support during pregnancy and, in turn, maternal health and birth outcomes in this setting.

Keywords: Pregnancy, Partner, Support, Maternal health, Women

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Introduction

Pregnancy is a vulnerable period for women and places multiple emotional, psychological, and physical pressures on them.[1] The complex perception and approach to pregnancy management in low- and middle-income countries (LMICs), where pregnancy is often treated as a strictly feminine problem and deprived of essential support, predispose women to the risk of maternal mortality and poor pregnancy outcomes.[2,3] This is also the case in Nigeria; it is often described as the maternal mortality capital of the world, where nearly 20% of all global maternal deaths occur.[4,5]

Adverse pregnancy outcomes are complications or negative health events that affect the mother, foetus, or newborn during pregnancy, delivery, or shortly after birth.[6] Partner support is a determinant of maternal health with the potential to reduce adverse pregnancy outcomes by promoting timely antenatal care, improving maternal mental health, and facilitating decision-making during emergencies. In contrast, inadequate partner support can delay healthcare seeking, increase stress, and reduce access to resources, thereby contributing to adverse outcomes.[7]

Additionally, several other factors (e.g., low socioeconomic status, lack of formal education, poor utilization of antenatal services, poor nutrition, maternal infection, and clinical complications)[2,8] have been linked to adverse pregnancy outcomes, including poor labour progression, low birth weight, preterm labour, anxiety, depression, neural tube defects, and maternal mortality.[7,9,10] However, despite the established importance of partner support in improving clinical care and maternal outcomes, little is known about the overall magnitude of

this support, and its associated factors remain poorly understood. Some studies [11-15] have explored partner involvement during pregnancy, but empirical data among women from LMICs remain scarce. Similarly, few studies have evaluated the prevalence and determinants of partner support during pregnancy, particularly among women in sub-Saharan Africa, where maternal mortality remains very high. The extent to which pregnant women receive support from their partners, as well as the factors that promote or hinder such support, is still not well understood. The magnitude of partner support and its associated factors needs to be studied to determine whether pregnant women receive adequate support from their partners. This will provide evidence to inform the design of interventions that improve the health and well-being of women during pregnancy. Assessing partner support is essential for identifying gaps and developing interventions to improve maternal health outcomes.[16] It also helps to understand its impact on maternal behaviours and pregnancy outcomes, guiding strategies to enhance male involvement in maternal care.[17]

It is crucial to evaluate the level of support pregnant women receive from their partners and to identify the associated factors. Such research is essential for understanding the distal and proximal determinants of pregnancy management and for designing appropriate interventions that promote supportive environments for women during pregnancy and help reduce the burden of maternal mortality. We postulate that adequate partner support during pregnancy facilitates a proper continuum of care, thereby improving the psychological and emotional well-being of pregnant women. Therefore, this study evaluated the level of partner support and its associated factors among pregnant women attending the antenatal clinic at a tertiary hospital in Ibadan, Nigeria. This study will provide valuable local evidence by addressing the existing gap in sub-Saharan Africa, particularly southwestern Nigeria.

Materials and Methods

Study Design, Target Population, and Sampling Procedure

This cross-sectional study was conducted over four months (September to December 2020) among pregnant women attending the antenatal clinic at Adeoyo Maternity Teaching Hospital (AMTH), Ibadan, Oyo State, Nigeria. The target population comprised pregnant women of reproductive age (18 to 49 years) attending the antenatal clinic at AMTH, Ibadan, Oyo State, Nigeria. The minimum sample size (n) was estimated using the Kish formula:

$$n = \{Z^2pq\}/d^2$$ [18]

where n is the minimum sample size, Z is the standard normal deviation (1.96), p is the estimated proportion of women with partner support (assumed to be 50% due to insufficient prior data), $q = 1\text{-}p$, and d is the level of precision or maximum allowable error (0.05). This yielded a minimum sample size of 380.

The inclusion criteria for pregnant women were: 1) age ≥ 18 years, 2) gestational age (GA) ≥ 13 weeks and no pre-existing medical complications, 3) regular attendance at AMTH at the time of recruitment, 4) provision of informed consent. Pregnant women were excluded from the study if they were currently ill or receiving medical treatment, had aGA < 13 weeks, or refused to participate. In total, 398 pregnant women consented to participate and were recruited, of whom 394 were included in the final analysis. Four respondents were excluded due to missing data on partner support.

Eligible pregnant women were selected using a two-stage mixed sampling technique. In the first stage, AMTH was purposively selected as the study site because it is the most patronized health facility for maternal health services, particularly routine antenatal care. In the second stage, pregnant women in the second and third trimesters were systematically sampled from the antenatal clinic register of pregnant women attending the facility for routine antenatal care. The first pregnant woman in the second and third trimesters was randomly selected from the sampling frame, and subsequent respondents were selected using the k^{th} interval, calculated as the ratio of the total number of pregnant women listed in the antenatal register to the sample size.[19]

Data Collection

Partner Support

A 31-item partner support instrument, designed by maternal health promotion experts and pretested for validity, was administered to assess the adequacy of support received by pregnant women from their partners. The instrument was systematically designed to measure partner support for the study. First, experts in health promotion clarified the definitions and reviewed the theory and prior literature on partner support during pregnancy, identifying validated instruments and their dimensions/subscales from other settings. Second, the identified tools were contextualized for relevance to our study setting, using clear and simple language, while avoiding leading or ambiguous questions in developing the current instrument. Third, the instrument was pretested among a small purposively selected group of pregnant women, after which experts reviewed the items for relevance and clarity. The instrument comprised four domains: acceptance and affirmation support, financial support, physical support, and social support. Responses to all items were summed, yielding minimum and maximum scores of 0 and 31, respectively. The overall partner support scores were dichotomized based on the mean distribution of the total partner score: "inadequate" if the score was < 24.7, and "adequate" if the score was at least 24.7, as described elsewhere.[20]

Respondents' Characteristics

A standard instrument was used to assess the respondents' sociodemographic characteristics. Age (in years) was

categorized as 18-30, 31-35, and ≥36. Respondents' education levels were self-reported as none, primary, secondary, or tertiary. Respondents' pregnancy experience was classified as 'primiparous' or 'multiparous'. Religion was reported as 'Christianity' or 'Islam', and marital status as 'never married,' 'cohabiting/married,' or 'divorced'. Formal education was categorized as 'none' (no formal education), 'primary' (completed primary school), 'secondary' (completed secondary school degree), or 'tertiary' (completed a tertiary degree). Occupation was reported as 'none,' 'health worker,' 'banking and finance,' 'trading/business,' 'self-employed /artisan,' 'civil servant,' or 'other.' Partner characteristics (age, formal education, and occupation) were classified using the same criteria. The type of marriage was reported as 'monogamy' or 'polygamy'.

Statistical Analysis

The distribution of respondents' characteristics was presented as the mean ± standard deviation (SD) for continuous variables and frequencies (proportions) for categorical variables. The chi-square test was used to compare proportions of categorical variables by partner support status ("adequate" or "inadequate"). In addition, the distribution of age as a continuous variable was visually inspected for normality using histograms. An independent-samples t-test was used to compare the means of constant data by partner support status ("adequate" or "inadequate"). Multivariable non-automated stepwise logistic regression models were fitted to estimate the odds ratio (OR) and 95% confidence interval (CI) for the association between respondent characteristics and partner support status, with inadequate partner support as the reference category, taking into account respondents' or partners' characteristics with a *P*-value < 0.20 in the bivariate analyses reported in Tables 1 and 2, respectively. The stepwise regression models were as follows: an unadjusted model was first fitted without any covariates to

Table 1. Characteristics of Pregnant Women Attending AMTH

	All Respondents			
Characteristics	**(N = 394)**	**Partner Support**		
		Adequate (n = 284)	**Inadequate (n = 110)**	***P*-value***
Age (years), mean ± SD	30.1 ± 5.6	30.1 ± 5.2	30.2 ± 6.5	0.884
18 – 30	223 (56.6)	162 (72.6)	61 (27.4)	
31 – 35	103 (26.1)	79 (76.7)	24 (23.3)	0.152
≥36	68 (17.3)	43 (63.2)	25 (36.8)	
Pregnancy Experience, n (%)				
Primiparous	194 (50.3)	147 (75.8)	47 (24.2)	0.099
Multiparous	192 (49.7)	131 (68.2)	61 (31.8)	
Religion, n (%)				
Christianity	176 (44.8)	139 (79.0)	37 (21.0)	0.006
Islam	217 (55.2)	144 (66.4)	73 (33.6)	
Marital Status, n (%)				
Never Married	29 (7.6)	17 (58.6)	12 (41.4)	
Cohabiting/Married	353 (92.2)	259 (73.4)	94 (26.6)	0.170
Divorced	1 (0.3)	1 (1.0)	0 (0.0)	
Formal Education, n (%)				
None	3 (0.8)	0 (0.0)	3 (1.0)	
Primary	34 (8.8)	20 (58.8)	14 (41.2)	0.003
Secondary	164 (42.3)	113 (68.9)	51 (31.1)	
Tertiary	187 (48.2)	145 (77.5)	42 (22.5)	
Occupation, n (%)				
None	6 (1.6)	4 (66.7)	2 (33.3)	
Health Worker	23 (6.0)	14 (60.9)	9 (39.1)	
Teacher	63 (16.4)	49 (77.8)	14 (22.2)	
Banking & Finance	2 (0.5)	2 (1.0)	0 (0.0)	0.073
Trading & Business	146 (38.1)	114 (78.1)	32 (21.9)	
Self-employed/Artisan	119 (31.1)	76 (63.9)	43 (36.1)	
Civil Servants	9 (2.3)	7 (77.8)	2 (22.2)	
Others	15 (3.9)	8 (53.3)	7 (46.7)	

Note. AMTH: Adeoyo maternity teaching hospital; SD: Standard deviation; **P*-values correspond to an independent samples t-test for continuous variables and a chi-square test for categorical variables. Fisher's exact test was used when n was < 5.

Table 2. Characteristics of Partners of Pregnant Women Attending AMTH

	All Respondent			
Characteristics	**(N = 394)**	**Partner Support**		***P*-value***
		Adequate (n = 284)	**Inadequate (n = 110)**	
Age of partner (years), mean ± SD	36.7 ± 6.5	36.6 ± 6.0	37.2 ± 7.8	0.403
18 – 30	75 (19.8)	50 (66.7)	25 (33.3)	0.009
31 – 35	100 (26.4)	84 (84.0)	16 (16.0)	
≥ 36	204 (53.8)	140 (68.6)	64 (31.4)	
Partner's Formal Education, n (%)				
None	3 (0.8)	2 (66.7)	1 (33.3)	0.094
Primary	6 (1.6)	4 (66.7)	2 (33.3)	
Secondary	125 (32.8)	82 (65.6)	43 (34.4)	
Tertiary	247 (64.8)	189 (76.5)	58 (23.5)	
Partner's Occupation, n (%)				
None	0 (0.0)	0 (0.0)	0 (0.0)	0.066
Health worker	2 (0.5)	1 (0.5)	1 (0.5)	
Teacher	22 (6.0)	12 (54.5)	10 (45.5)	
Banking & Finance	14 (3.8)	13 (92.9)	1 (7.1)	
Trading & Business	140 (38.4)	96 (68.6)	44 (31.4)	
Self-employed Artisan	113 (31.0)	86 (76.1)	27 (23.9)	
Civil Servant	18 (4.9)	16 (88.9)	2 (11.1)	
Others	56 (15.3)	41 (73.2)	15 (26.8)	
Type of Marriage, n (%)				
Monogamy	291 (85.1)	220 (75.6)	71 (24.4)	0.054
Polygamy	51 (14.9)	32 (62.7)	19 (37.3)	

Note. AMTH: Adeoyo maternity teaching hospital; SD: Standard deviation; **P*-values correspond to an independent sample t-test for continuous variables and a chi-square test for categorical variables.

assess the association between respondent characteristics and partner support. Model I was adjusted for participants' characteristics only and included age (18-30 as reference vs 31-35 or ≥ 36), religion (Islam as reference vs Christianity), marital status (never married as reference vs cohabiting/married/divorced), formal education (none/primary as reference vs secondary or tertiary), occupation (none as reference vs self-employed/artisan or civil/private workers), and pregnancy experience (primiparous vs multiparous). Model II was adjusted for respondents' partner characteristics only; this included partner's age (18-30 as reference vs 31-35 or ≥ 36), partner's formal education (none/primary as reference vs secondary or tertiary), and type of marriage (monogamy as reference vs polygamy). The final model (model III) included covariates from models I and II. All reported *P*-values were two-sided, and IBM SPSS Statistics version 25 was used for the statistical analysis, with a two-sided *P*-value threshold of < 0.05.

Results

Respondents Characteristics

Overall, the mean age of the respondents was 30.1 ± 5.6 years. A total of 110 (27.9%) respondents reported inadequate partner support, while 284 (72.1%) reported adequate partner support. The majority of respondents were primiparous (194, 50.3%), practiced Islam (217, 55.2%), were married (353, 92.2%), had tertiary education (187, 48.2%), and were involved in trading and business (146, 38.1%). Regarding partner support status (Table 1), a higher proportion of women with primiparous pregnancy experiences (147, 75.8%) reported adequate partner support compared with those with multiparous pregnancy experiences (131, 68.2%, $P = 0.099$). Moreover, pregnant women who practiced Christianity reported a higher proportion of adequate partner support (139, 79.0%) than their Muslim counterparts (144, 66.4%, $P = 0.006$). Furthermore, pregnant women with tertiary education reported a higher proportion of adequate partner support during pregnancy (145, 77.5%) than those with secondary education (113, 68.9%) or primary education (20, 58.8%, $P = 0.003$).

The overall mean age of pregnant women's partners was 36.7 ± 6.5 years, and by age category, 66.7%, 84.0%, and 68.6% of pregnant women whose partners were aged 18-30 years, 31-35 years, and ≥ 36 years, respectively, experienced adequate partner support ($P = 0.009$).

Respondents' partners were mostly aged at least 36 years old (204, 53.8%), had tertiary education (247, 64.8%), and were in monogamous relationships (291, 85.1%). Additionally, pregnant women in polygamous relationships reported a lower proportion of adequate partner support (32, 62.7%) than those in monogamous unions (220, 75.6%, $P = 0.054$).

Factors Associated with Adequate Partner Support

Table 3 presents the ORs and 95% CIs for factors associated with adequate partner support. In the unadjusted analysis, although the result was not statistically significant, respondents aged 31-35 years were 1.24 times more likely to receive adequate partner support (OR: 1.24, 95% CI: 0.72- 2.13; $P=0.439$) than those aged 18–30. Christian women were 1.9 times more likely to receive adequate partner support than women practicing Islam (OR: 1.90, 95% CI: 1.20-3.01; $P=0.006$). In addition, the odds of receiving partner support increased with educational attainment; women with a tertiary level of education were significantly more likely to receive partner support than those with primary education or less (OR: 2.94, 95% CI:

Table 3. Factors Associated With Inadequate Partner Support Among Pregnant Women Attending AMTH

	Unadjusted	*P*-value	Adjusted	*P*-value	Adjusted	*P*-value
Respondent Characteristics	**OR (95% CI)**		**OR (95% CI)**		**OR (95% CI)**	
			Model I		**Model III (Final Model)**	
Age (years)						
18 – 30	1		1			
31 – 35	1.24 (0.72, 2.13)	0.439	1.31 (0.72, 2.37)	0.377	1.30 (0.63, 2.69)	0.473
≥36	0.65 (0.37, 1.15)	0.139	0.74 (0.38, 1.43)	0.368	0.94 (0.41, 2.16)	0.881
Religion						
Christianity (Islam as reference)	1.90 (1.20, 3.01)	0.006	2.24 (1.32, 3.77)	0.003	2.23 (1.27, 3.91)	0.005
Marital Status						
Cohabiting/Married/Divorced (never married as reference)	1.95 (0.90, 4.24)	0.091	2.34 (0.95, 5.67)	0.064	1.16 (0.39, 3.43)	0.791
Formal Education						
None/Primary	1		1		1	
Secondary	1.88 (0.91, 3.89)	0.088	1.58 (0.71, 3.52)	0.267	1.66 (0.69, 4.01)	0.260
Tertiary	2.94 (1.41, 6.10)	0.004	2.23 (1.00, 5.23)	0.050	1.88 (0.69, 5.12)	0.218
Occupation						
None	1		1		1	
Self-employed/Artisan	1.90 (0.77, 4.70)	0.164	2.58 (0.93, 7.16)	0.068	1.13 (0.30, 4.28)	0.853
Civil/Private Workers	2.16 (0.81, 5.74)	0.122	2.22 (0.74, 6.64)	0.155	0.95 (0.24, 3.75)	0.940
Pregnancy Experience						
Primiparous	1		1		1	
Multiparous	0.69 (0.44, 1.07)	0.100	0.66 (0.40, 1.08)	0.100	0.60 (0.34, 1.04)	0.067
			Model II			
Partner Characteristics						
Partner's Age (years)						
18-30	1		1			
31-35	2.63 (1.28, 5.39)	0.008	1.47 (0.63, 3.43)	0.377	2.46 (1.06, 5.73)	0.037
≥36	1.09 (0.62, 1.92)	0.755	0.63 (0.31, 1.30)	0.215	1.18 (0.50, 2.79)	0.701
Partner's Formal Education						
None/Primary	1		1			
Secondary	0.95 (0.23, 4.00)	0.948	1.18 (0.17, 8.25)	0.865	0.99 (0.21, 4.70)	0.991
Tertiary	1.63 (0.40, 6.72)	0.499	2.05 (0.30, 13.99)	0.464	1.34 (0.28, 6.45)	0.716
Partner's Occupation						
None	1		1			
Self-employed/Artisan	0.94 (0.49, 1.80)	0.948	1.42 (0.67, 3.02)	0.363	1.43 (0.68, 3.02)	0.344
Civil/Private Worker	1.10 (0.47, 2.56)	0.499	1.12 (0.43, 2.90)	0.813	1.50 (0.57, 3.96)	0.412
Type of Marriage†						
Monogamy	1		1			
Polygamy	0.54 (0.29, 1.02)	0.057	0.69 (0.35, 1.36)	0.277		

Note. AMTH: Adeoyo maternity teaching hospital; OR: Odds ratio; CI: Confidence interval.
Model I: Adjusted for pregnant women's characteristics only.
Model II: Adjusted for partner's characteristics only.
Model III: Adjusted for both pregnant women's and partners' characteristics.
†-The variable was identified as a confounder (conceptually overlapping with marital status) and was excluded from the final adjusted Model III.

1.41-6.10; $P=0.004$).

In the multivariable-adjusted Model I (Table 3), which included only respondents' characteristics, religion remained significantly associated with adequate partner support. Women practicing Christianity were 2.24 times more likely to receive adequate partner support (OR: 2.24, 95% CI: 1.32-3.77; $P=0.003$) than those practising Islam. Similarly, women with tertiary education (OR: 2.23, 95% CI: 1.00-5.23; $P=0.050$) were more likely to receive adequate partner support. In the multivariable-adjusted Model II (Table 3), which evaluated only partner-related characteristics, no statistically significant factors were associated with adequate partner support.

The odds of having adequate partner support among women with tertiary education were attenuated (OR: 1.88, 95% CI: 0.19-5.12; $P=0.218$). However, the observed association between Christianity and adequate partner support remained significant in the final multivariable-adjusted Model III (Table 3), which included both respondents' and their partners' characteristics. Women who practiced Christianity were more likely to receive adequate partner support than those who practiced Islam (OR: 2.23, 95% CI: 1.27–3.91; $P=0.005$).

Discussion

This study explored factors associated with adequate partner support during pregnancy among pregnant women. Our findings indicate that a notable proportion of pregnant women still receive inadequate support from their partners. Religion and formal education were identified as the most significant predictors of adequate partner support in this sample. Aside from contributing significantly to the existing literature and extending the understanding of this subject, these findings serve as a viable resource for designing targeted interventions to enhance partner support during pregnancy, thereby improving maternal and child health outcomes.

The proportion of women who received adequate partner support in this study was lower than that reported among pregnant women in rural communities in Nigeria (93.2%)[12] and among expectant women in the Boston area of the United States (93.6%).[21] This disparity may be explained by several factors. First, the current study was hospital-based, while the comparative Nigerian study was community-based and conducted among rural women. The setting of data collection can influence respondents' perceptions and reporting of partner support, as women attending health care facilities may differ from those in rural communities in terms of exposure, expectations, and health-seeking behaviour. Additionally, differences in the methods used to assess adequate partner support may have contributed to the disparity, as differences in question structure and scoring approaches can yield different estimates. While the current study quantified partner support using a composite measurement approach based on responses to multiple questions, Arisukwu et al assessed partner support by directly asking whether it was received.[12] Although the study by Cheng et al in the United States was also health care-based, the proportion of women with adequate partner support was still higher than that observed in the current study.[21] However, the proportion of women with adequate partner support in this study is similar to that observed among women in the comparative study with lower socioeconomic status.

Additionally, while this study reported the proportion of pregnant women with adequate partner support, other studies[14,15,22] reported mean support scores, thereby limiting direct comparison due to differences in measurement scales and reporting formats. Nevertheless, the reported mean partner support scores (66.06 ± 19.82,[15] 73.84 ± 11.22,[14] and 62.1 ± 28.7)[22] suggest moderate to high levels of partner support, which are broadly consistent with the relatively high proportion of adequate partner support observed in this study. Although one of the studies[15] was not hospital-based, the similarities may reflect respondents' perceptions of partner support, as reflected in their affirmation of antenatal care.

Partner support is crucial in shaping the overall social support system, as partners are the primary providers of such support.[23] One study reported that partner support was a strong predictor of higher levels of postpartum functioning among women.[13] Additionally, research indicates that factors such as age, education, and marital status influence male partner involvement during pregnancy.[24-26] Consistent with previous reports, our study identified two key factors associated with adequate partner support: religion and education status. Although marital status was not statistically significant in our study, the point estimates suggest that pregnant women who were married or in committed relationships had approximately twice the odds of receiving adequate partner support during pregnancy compared with those who were not married or in a committed relationship.

Respondents who practiced Christianity had higher odds of receiving adequate partner support than those who practiced Islam. However, limited research has specifically evaluated the influence of religion on partner support during pregnancy. This finding may partly explain differences in religious practices and the social support frameworks embedded within them. For example, previous research suggests that Christian women may experience greater partner involvement reinforced by social networks.[27]

Higher levels of maternal education were associated with a greater likelihood of receiving adequate partner support in this study, although this association was attenuated in multivariable models. This finding aligns with previous literature demonstrating similar associations between maternal education and partner support during pregnancy. Studies from Ethiopia and Turkey have shown that women with higher education are more likely to receive greater partner support.[23,28] Similarly, a systematic review by Xue et al found consistently higher father involvement among women with higher levels of education.[28] We hypothesize that the more educated a woman is, the greater her likelihood of effectively communicating her needs and

encouraging her partner to provide adequate support. This supports the view that education correlates with greater awareness of the demands and complexities of pregnancy, thereby fostering a more supportive environment. It may also reflect the impact of socioeconomic status on a partner's willingness and ability to provide support during pregnancy.

Furthermore, the relationship between maternal education and partner support may be explained by educational assortative mating, whereby educated women are more likely to be engaged with educated men who may be more health-conscious and supportive during pregnancy. Although this study found no significant association between partners' education and support, most respondents' partners had secondary or tertiary education. Xue et al also highlighted the role of paternal education in fostering partner support.[28]

This study indicates that religion and maternal education significantly influence the likelihood of receiving adequate partner support during pregnancy. Hence, public health programs should consider strategies that promote partner engagement, target religious communities, and strengthen health literacy among both women and men in order to improve adequate partner support during pregnancy.

Limitations of the Study

This study has several limitations. First, it reflects only the perspectives of pregnant women and does not include the views of their partners, whose insights could have provided additional insight into the subject. Some women were reluctant to disclose information about their partners, possibly for cultural reasons. Additionally, women attending a tertiary hospital may differ in socioeconomic status and health care-seeking behaviour from those attending other types of health facilities, which could have influenced their perception of partner support.

Strengths of the Study

Despite these limitations, this study has notable strengths. First, it provides valuable data on the factors influencing adequate partner support during pregnancy in a Nigerian tertiary hospital, offering insights from a socio-demographically diverse population. In addition, assessing the associated factors provides a clearer understanding of the determinants of adequate partner support. Second, this study helps fill an evidence gap in sub-Saharan Africa, particularly in South-west Nigeria, by contributing context-specific evidence from a local setting such as Ibadan. Finally, the identified associated factors can inform the design of interventions to improve antenatal care programs, health education, and policies aimed at strengthening partner support and, ultimately, maternal and child health outcomes.

Conclusion

In conclusion, this study highlights the interplay of religion and educational attainment as factors influencing partner support during pregnancy. These findings provide a basis for targeted interventions to improve adequate partner support for pregnant women, which is essential for enhancing maternal and child health in this setting. Educative and informative, couple-friendly counselling on pregnancy and maternal wellness that promotes partner engagement while safeguarding maternal autonomy may be adopted in antenatal clinics. In addition, inclusive and flexible ante-natal clinic hours to accommodate partners' work schedules could also improve partner support during pregnancy. Culturally tailored educational interventions, combined with community engagement to raise societal awareness of the importance of partner support, may also be promising in shaping knowledge, social norms, and self-efficacy to promote partner support during pregnancy. Future studies should further examine the norms and cultural barriers that hinder partner support during pregnancy.

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Competing Interests

The authors declare that there is no conflict of interests.

Consent to Participate

Informed consent was obtained from all individual participants included in the study.

Data Availability Statement

The datasets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

Ethical Approval

The study was approved by the Research Ethics Review Committee of the Department of Planning, Research and Statistics Division, Ministry of Health, Oyo State Government, Nigeria (Approval number: AD13/479/4229B). Permission to recruit respondents was also obtained from the hospital management team at Adeoyo Maternity Teaching Hospital. All pregnant women participated voluntarily and provided written informed consent before enrollment. Participants were allowed to withdraw at any time without any loss of benefits. All questionnaires were self-administered privately, with support from a trained research assistant when needed.

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