

Research Article

## Knowledge, Attitudes, and Support of Partners in Preparation for Motherhood and Maternal Satisfaction with Partner Support: A Hospital-Based Cross-Sectional Study in the Galle District

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### Abstract

**Introduction:** In Sri Lanka, male partners play a critical role in maternal health, necessitating their knowledge, support, and involvement during pregnancy to enhance outcomes. This study assessed the knowledge, attitudes, and support of husbands regarding preparation for motherhood (PFM) and evaluated women's satisfaction with their husband's support.

**Methods:** A cross-sectional study was conducted among 310 married couples attending antenatal clinics at Teaching Hospital Mahamodara in May 2023. Husbands completed a pre-tested, self-administered questionnaire assessing knowledge (good, average, poor), attitudes (positive, negative), and support (highly supportive, moderately supportive, passively supportive). Women evaluated their satisfaction with their husband's support (highly, moderately, poorly satisfied). Data were analyzed using SPSS 26, employing descriptive statistics and inferential tests

**Results:** The mean age of husbands and women was 30.59 (SD = 6.32) and 26.68 (SD = 6.28) years, respectively. Good knowledge was observed in 57.4% of husbands, though gaps in nutritional supplementation, sexual activities, and minor complications were noted. All husbands demonstrated positive attitudes, and 98.7% provided high support. Among women, 99.4% reported high satisfaction with their husband's support.

**Conclusion:** Most husbands exhibited good knowledge, positive attitudes, and high support, contributing to improved PFM and maternal satisfaction. Targeted interventions are necessary to address knowledge gaps in specific areas, further enhancing pregnancy outcomes.

**Keywords:** *Attitude, Knowledge, Motherhood, Partner preparation, Partner support*

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## **Introduction**

Pregnancy is a joyous experience for a mother anticipating the arrival of her baby. Despite the challenges and pain experienced during pregnancy, childbirth marks the long-awaited birth and the beginning of a new journey in life (WHO, 1998). During pregnancy, a mother undergoes a multitude of changes, both physiological and psychological. Hormonal changes that occur during this period can significantly affect emotions, leading to reactions such as happiness, heightened sensitivity, mood swings, sadness, disappointment, hurt, anxiety, and even stress (Rumaseuw et al., 2018). Under these circumstances, preparation for motherhood (PFM) becomes extremely important, and the support of the husband or partner is crucial in ensuring a positive and healthy experience for the mother (Diani & Susilawati, 2013). PFM during pregnancy is defined as "an ongoing process of active, conscious, and positive participation that supports the transition toward motherhood" (Osorio et al., 2017).

When the partner or husband is actively involved during pregnancy, maternal negative health behaviours decrease, and the risks of pre-term birth, low birth weight, and fetal growth restriction are significantly reduced (Ilska & Przybyła, 2020). Partners should be encouraged to actively participate in household chores and infant care activities to help prevent overwhelming the pregnant mother and ensure a balanced support system during this crucial time (Dennis & Ross, 2006). Lack of social support from the husband is one of the factors that can contribute to antenatal depression.

Conversely, partners who welcome the pregnancy positively and provide encouragement play a key role in uplifting the pregnant mother's mental and emotional health, as has been proven in various studies (Zegeye et al., 2018).

Since husbands are often the primary decision-makers regarding healthcare in families, a change in their attitude can make a significant difference, positively impacting both the mother's and the baby's health. The support provided by husbands, such as ensuring regular antenatal check-ups, fulfilling the mother's wishes, reminding her to take vitamin supplements, and helping with household chores, may seem like small tasks. However, these actions carry great importance in improving the mother's psychological health and her satisfaction with the support from her partner, ultimately leading to a healthier pregnancy and delivery (Mamuroh & Nurhakim, 2019).

Therefore, the partner's involvement in PFM is a crucial aspect that health authorities should address, as it leads to positive outcomes during pregnancy and childbirth, and can also impact the later stages of the child's development (Diani & Susilawati, 2013). This area needs to be studied systematically, especially in countries like Sri Lanka, where male dominance in society often results in men taking on authoritative roles rather than supportive ones. However, this dynamic may have shifted in the past decade, as a significant demographic transition has occurred, with younger generations becoming increasingly exposed to Western influences. This topic remains underexplored globally. Therefore, this study

was conducted to assess the knowledge, attitudes, and support of husbands and assess the factors affecting knowledge, attitude and support of husbands regarding PFM as well as to evaluate maternal satisfaction with the extent of the husband's support for PFM.

## **Materials and methods**

### **Study design, participants, setting**

A descriptive study was conducted at the antenatal clinics of Teaching Hospital Mahamodara (THM). A convenience sample of married couples seeking maternity care services in the 2<sup>nd</sup> and 3<sup>rd</sup> trimesters who attended the antenatal clinics during May 2023 were invited to participate in the study. A total of 310 couples were included in the study. The sample size was calculated according to Lewanga and Lemshow equation (Lachenbruch et al., 1991).

### **Data collection tool**

A pre-tested, self-administered questionnaire with two sections that included closed-ended questions based on World Health Organization (WHO) recommendations on antenatal preparation (WHO, 2016) and the maternal care package from the family health bureau, Minister of Health, Sri Lanka (Hemachandra, 2011) was used. Section 1 was administered to the husbands to assess their knowledge, attitude and support for PFM. Section two was administered to the women.

### **Section 1 – Questionnaire for husband**

**Knowledge:** 35 questions assessing the partner's knowledge on PFM were included. These questions used a three-point scale: True, False, and No Idea. Correct answers

scored 1 mark, while false or "no idea" answers scored 0. The total possible score for knowledge was 35 marks. Marks were allocated as 25-35 marks for being good knowledge, 13-24 marks for being average knowledge, and 0-12 marks for being poor knowledge. (Table 1)

**Attitude:** 8 statements assessing the partner's attitude toward PFM were included using a five-point Likert scale: Strongly agree, Agree, Neutral, Disagree, and Strongly disagree. Marks were allocated as follows: Strongly agree (4 marks), Agree (3 marks), Neutral (2 marks), Disagree (1 mark), and Strongly disagree (0 marks). The maximum possible score for attitude was 32 marks. Marks were allocated as 16-32 marks for being positive attitudes, and 0-15 marks for being negative attitudes (Table 1).

**Support:** Support for PFM was evaluated with 14 statements on a five-point scale: Always, Often, Sometimes, Rarely, and Never. Marks were allocated as follows: Always (4 marks), Often (3 marks), Sometimes (2 marks), Rarely (1 mark), and Never (0 marks). The maximum possible score for support was 56 marks. Marks were allocated as 38-56 marks for being highly supportive, 19-37 marks for being moderately supportive, and 0-18 marks for being passively supportive (Table 1).

### **Section 2 – Questionnaire for women**

**Satisfaction:** 11 statements were included to assess the woman's satisfaction with her husband's support for PFM. These statements used a five-point scale: Highly satisfied, Satisfied, Neutral, Dissatisfied, and Very dissatisfied. Marks were allocated as

follows: Highly satisfied (4 marks), Satisfied (3 marks), Neutral (2 marks), Dissatisfied (1 mark), and Highly dissatisfied (0 marks). The maximum possible score for satisfaction was 44 marks. Marks were allocated as 31-44 marks for being highly satisfied, 15-30 marks for being moderately satisfied and 0-14 marks for being poorly satisfied (Table 1).

### Statistical analysis

Data were analysed using the Statistical Package for the Social Sciences (SPSS) version 26.0. Descriptive statistics were used to present the data.

The levels of knowledge, attitude, support, and satisfaction were determined using pre-determined cut-off values (3 equal ranges for variables with three categories and 2 equal ranges for variables with two categories) and based on the total score obtained as shown in Table 1. Independent sample t-tests were applied to examine significant differences between two variables, while one-way ANOVA tests were used to assess significant differences between three variables. Statistical significance was set at a p-value of <0.05.

### Ethical clearance

Ethical clearance for this study was obtained from the Ethics Review Committee, Faculty of Allied Health Sciences, University of Ruhuna, Sri Lanka (Reference no - 149.11.2022).

Informed consent was obtained before data collection. The data collection was conducted while participants were waiting to meet the medical officer at the clinic, ensuring minimal disruption to the clinic's routines. All methods were carried out in accordance with relevant ethical guidelines and regulations.

## Results

### Socio-demographic characteristics

The majority of the husbands were in the below 30 years age group, representing 51.3% (n=159). A large proportion identified as Sinhala (94.2%, n=292), had completed Ordinary Level education (50.9%, n=158), and lived in a nuclear family structure (69.4%, n=215). Most were employed in the private sector (35.2%, n=109), with 73.2% (n=227) being the primary breadwinner of the family. Over half (57.7%, n=179) did not have children, and the majority had a monthly income ranging from 26,000 LKR to 45,000 LKR (42.9%, n=133) (Table 2).

The majority of the women were below 30 years old (74.2%, n=230). A large proportion (93.5%, n=292) identified as Sinhalese, and 68.4% (n=212) were housewives. Approximately 42.3% (n=131) had completed education up to Ordinary Level. Regarding age at marriage, 76.5% (n=237) of participants were married between 20 to 30 years of age. Furthermore, 85.5% (n=265) of the pregnancies were planned and expected, with 71.7% (n=223) in the 2nd trimester. Nearly half of the sample (51.6%, n=160) were expecting their first child (Table 3).

### Knowledge on PFM among partners

Among the husbands, 89.4% (n=227) were aware that the public health midwife (PHM) visits should be done before the 12th week of pregnancy. A similar percentage (89.4%, n=277) had good knowledge about folic acid supplementation. However, knowledge about calcium (47.7%, n=148), vitamin C (42.3%, n=131), and iron supplementation was lower compared to folic acid. Regarding nutritional requirements during pregnancy, 89% (n=276) of participants were aware of the high nutritional demands during this period. Furthermore, 57.1% (n=177) knew that sexual activity during pregnancy is generally

**Table 1: Score ranges of levels of variables**

<b>Variable</b>	<b>Levels/Categories</b>	<b>Marks range</b>
Knowledge of partner	Good knowledge	25-35marks
	Average knowledge	13-24marks
	Poor knowledge	0 -12marks
Attitude of partner	Positive attitude	16-32marks
	Negative attitude	0-15marks
Extent of support from partner	Highly supportive	38-56marks
	Moderately supportive	19-37marks
	Passively supportive	0-18marks
Satisfaction of women on partner's support	Highly satisfied	31-44marks
	Moderately satisfied	15-30marks
	Poorly satisfied	0-14marks

**Table 2: Socio-demographic characteristics of husbands (n=310)**

<b>Socio-demographic factors</b>	<b>Subgroups</b>	<b>n (%)</b>
Age (years)	≤ 30	159(51.3%)
	31-40	136(43.9%)
	≥ 41	15(4.8%)
Ethnicity	Sinhala	292(94.2%)
	Non-Sinhala	18(5.8%)
Education level	Up to grade 8	62(20%)
	Pass Ordinary Level	158(50.9%)
	Pass Advanced Level	41(13.2%)
	Diploma education	20(6.5%)
	University education	29(9.4%)
Occupation	Government	98(31.6%)
	Private	109(35.2%)

	Business	53(17.1%)
	Self-employment	35(11.3%)
	Unemployed	15(4.8%)
Family type	Nuclear	215(69.4%)
	Extended	95(30.6%)
Number of earning members	Partner is the breadwinner	227(73.2%)
	> 1 member	83(26.8%)
Monthly household income from all source	25000 LKR or less (81.USD)	39(12.6%)
	26000-45000LKR (84-46USD)	133(42.9%)
	46000-100000LKR (149-325USD)	110(35.5%)
	Above 100,000 LKR (325USD)	28(9%)
Marriage duration (Years)	>1	67(21.6%)
	1-6	165(53.2%)
	7 -11	53(17.1%)
	≥ 12	25(8.1%)
Number of children	No children	181(58.4%)
	1 child	91(29.4%)
	≥2 children	38(12.2%)

safe. Almost all (99.4%, n=308) knew the importance of rest during pregnancy. Awareness of danger signs like vaginal bleeding, dribbling, and fever was 99% (n=307), and most partners were knowledgeable about supporting the mother's mental well-being by allowing participation in religious activities (98.4%, n=305) and visits to their parent's house (98.4%, n=305). Half of the participants (50%, n=155) knew about all nutritional supplements, while 69.4% (n=215) were informed about exercises during pregnancy. Most (99%, n=307) were aware of danger signs, and

nearly half (51.3%, n=159) had knowledge of minor complications (Table 4).

The mean score of knowledge of the husbands was 25.38 (SD =4.88; 57.4% (n=178) demonstrated a good level of knowledge, while 41.3% (n=128) had an average level of knowledge.

Only 1.3% (n=4) had a poor level of knowledge. Factors influencing knowledge were significantly associated with the number of children in the family ( $p=0.018$ ) and the trimester of the pregnancy ( $p<0.001$ ).



**Table 3: Socio-demographic characteristics of pregnant women (n=310)**

<b>Socio-demographic factors of the women</b>	<b>Subgroup</b>	<b>n (%)</b>
Age (years)	≤ 30	230(74.2%)
	30 -40	78(25.2%)
	≥ 41	2(0.6%)
Occupation	Government	46(17.7%)
	Private sector	31(10%)
	Self-employment	10(3.2%)
	Business	11(3.5%)
	House wife	212(68.4%)
Nationality	Sinhala	290(93.5%)
	Non-Sinhala	20(6.5%)
Education	Up to grade 8	14(4.5%)
	Pass Ordinary Level	131(42.3%)
	Pass Advanced Level	118(38.1%)
	Diploma education	21(6.8%)
	University education	26(8.4%)
Age at married (years)	≤ 20	55(17.7%)
	21 - 30	237(76.5%)
	31 - 40	18(5.8%)
Expectation of current pregnancy	Expected	265(85.5%)
	Unexpected	45(14.5%)
Period of Amenorrhea	2 <sup>nd</sup> trimester	223(71.7%)
	3 <sup>rd</sup> trimester	87(28%)

Husbands from families with more children and those with wives in the third trimester exhibited higher mean knowledge scores on PFM (Table 7).

#### **Attitude towards PFM among husbands**

The majority strongly agreed or agreed that antenatal preparation should be included as part of a strategy for ensuring a healthy

pregnancy outcome (Table 5).

The mean attitudes score was 28.43 (SD =3.53). All of the husbands had a positive attitude towards partner involvement in maternal PFM. Significant associations were observed between the attitude of the partner on PFM and ethnicity ( $p < 0.001$ ), monthly income ( $p = 0.016$ ), and marriage duration ( $p = 0.016$ ). Partners who were non-Sinhalese,

**Table 4: Assessment of knowledge of partner on PFM (n=310)**

No	Statement	Correct answers n(%)	Incorrect answers n(%)
<b>Antenatal clinics</b>			
01	Pregnant women should visit the PHM (public health midwife) before the 12 <sup>th</sup> week of pregnancy.	277(89.4%)	33(10.6%)
02	Booking visit (1 <sup>st</sup> clinic visit) should be done before the 8 <sup>th</sup> week.	240(77.4%)	70(22.6%)
03	Pregnant women should attend the ANC once a month	267(86.1%)	43(13.9%)
04	Worm treatment should be done in 2 <sup>nd</sup> trimester	113(36.5%)	197(63.5%)
05	Tetanus vaccine should be given during 2 <sup>nd</sup> trimester	167(53.9%)	143(46.1%)
06	Anomaly scan done at 20 <sup>th</sup> week of pregnancy	205(66.1%)	105(33.9%)
<b>Investigation and monitoring</b>			
07	In every visit, blood pressure monitoring is done	256(82.6%)	54(17.4%)
08	Weight monitoring and BMI calculation are done at the ANC	277(89.4%)	33(10.6%)
09	Screening for HIV, anaemia, syphilis and testing for blood group and Rh done at antenatal clinics	231(74.5%)	79(25.5%)
10	TSH (thyroxine) blood tests should done at clinics	150(48.4%)	160(51.6%)
11	Fetal movement can be identified by marking KCC (kick counter chart) in the 36 <sup>th</sup> week	202(65.2%)	108(34.8%)
<b>Nutritional supplementation</b>			
12	Folic acid should be taken from pre-pregnant period	277(89.4%)	33(10.6%)
13	Iron and calcium should not get at the same time	146(47.1%)	164(52.9%)
14	Calcium tablets should get in the morning to increase the absorption	148(47.7%)	162(52.3%)
15	Iron with vitamin C tablets enhances the iron absorption	131(42.3%)	179(57.7%)
16	Iron tablets should get at night to reduce the discomfort due to nausea	133(42.9%)	177(57.1%)
<b>Nutrition</b>			
17	A pregnant mother should take 2 additional small meals should take with 3 main meals	276(89%)	34(11%)
18	Pregnant women should consume a variety of locally available foods	251(81%)	59(19%)
19	Caffeine intake is better restricted for pregnant mothers	212(68.4%)	98(31.6%)



### **Rest and sleep**

20	Pregnant mothers need rest periods	308(99.4%)	2(0.6%)
21	Pregnant women need more sleep than non-pregnant period	223(71.9%)	87(28.1%)

### **Exercises**

22	Kegel exercises should be practiced by the pregnant mother	191(38.4%)	119(61.6%)
23	Moderate exercises lower pregnancy complication	199(64.2%)	111(35.8%)
24	She should engage in normal house hold activities	269(86.8%)	41(13.2%)

### **Breastfeeding**

25	Breasts (nipple) should be adequately prepared for breastfeeding	216(69.7%)	94(30.3%)
26	Clothing arrangements is important for breast preparation	248(80%)	62(20%)
27	There are various types of breast-feeding positions	220(71%)	90(29%)

### **Sexual activities**

28	Sexual activities during pregnancy period is safe	177(57.1%)	133(42.9%)
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### **Transportation**

29	Rough ride can harm to the pregnant mother and the baby	287(92.6%)	23(7.4%)
30	Long rides are risk for pregnant mother	288(92.9%)	22(7.1%)

### **Danger signs**

31	Vaginal bleeding, dribbling, fever are the signs that should immediately seek medical advices	307(99%)	3(1%)
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### **Mental wellbeing**

32	Pregnant mother should participate religious activities	305(98.4%)	5(1.6%)
33	Allow her to meet parent and friends will improve her mental health	305(98.4%)	5(1.6%)

### **Minor complication**

34	Allow her to eat some soft food on bed after wakeup to reduce vomiting	187(60.3%)	123(39.7%)
35	Heat application is good for leg cramping	250(50.6%)	60(19.4%)

**Table 5: Assessment of the attitude of the husband on PFM (n=310)**

N o	Statement	Strongly agree n(%)	Agree n(%)	Neutral n(%)	Disagree n(%)	Strongly disagree n(%)
01	Antenatal preparation is essential for a healthy pregnancy	165 (53.2%)	127 (41.0%)	16 (5.2%)	2 (0.6%)	0 (0%)
02	Regular attending antenatal clinic is compulsory	171 (55.2%)	110 (35.5%)	20 (6.5%)	9 (2.9%)	0 (0%)
03	Calcium, iron, folic vitamin supplements are necessary for fetal growth	197 (63.5%)	101 (32.6%)	10 (3.2%)	2 (0.6%)	0 (0%)
04	I will allow the doctor to examine my wife	195 (62.9%)	111 (35.8%)	4 (1.3%)	0 (0%)	0 (0%)
05	It is necessary for a partner to prepare for the birth of a child while his wife is pregnant	206 (66.5%)	97 (31.3%)	2 (0.6%)	5 (1.6%)	0 (0%)
06	A partner should plan ahead of time how his wife will get to the health facility for childbirth	213 (68.7%)	92 (29.7%)	4 (1.3%)	1 (0.3%)	0 (0%)
07	It is necessary for a partner to discuss his partner's pregnancy with a skilled care provider	202 (65.2%)	86 (27.7%)	15 (4.88%)	7 (2.3%)	0 (0%)
08	A partner should make joint decisions with his wife regarding pregnancy and childbirth	191 (61.6%)	94 (30.3%)	10 (3.2%)	12 (3.9%)	3(1%)

had a higher monthly income, and couples married 12 years ago had higher mean attitude scores towards PFM (Table 7).

### **Extent of support of partners on PFM**

Among the partners, 87.1% (n=270) of participants reported that they always buy food items for their pregnant wife. However, only 50.6% (n=157) of the study participants consistently support their pregnant women in doing exercises during pregnancy. Additionally, 51.6% (n=160) of partners reported taking care of domestic chores during their wife's pregnancy (Table 6).

The mean score of the extent of support of the

partners was 51.82 (SD =4.50). The majority of the partners, 98.7% (n=306), were highly supportive of PFM. A significant association was found between the wife's occupation ( $p = 0.017$ ) and the extent of support the partner provides in PFM (Table 7).

### **Satisfaction of pregnant women on partner's support on PFM**

Most of the pregnant women expressed satisfaction with their partners' support during pregnancy. However, they were less satisfied in certain areas, such as the partner's involvement in domestic chores and taking care of children and other family members. Specifically, 73.5% (n=228) of women were

satisfied with their partner's contribution to domestic chores, and 78.7% (n=244) were satisfied with their partner's involvement in caring for children and other family members during the pregnancy (Table 8).

The mean score of satisfaction of pregnant women regarding their partner's support during pregnancy was 42.02 (SD =3.33), indicating high levels of satisfaction. A remarkable, 99.4% (n=308) of the pregnant women were highly satisfied with the support provided by their partners during pregnancy. Only a small percentage, 0.06% (n=2),

reported being moderately satisfied with the support.

### Discussion

This study aimed to assess the knowledge, attitude, and support of partners of pregnant women attending the ANCs of a leading maternity hospital in Sri Lanka. The factors associated with the knowledge, attitude and support were also evaluated. Further, the satisfaction of pregnant women (maternal) with partner support was also assessed. The findings revealed that the majority

**Table 6: Assessment of partner support on PFM (n=310)**

No	Statement	Always n(%)	Often n(%)	Sometimes n(%)	Rarely n(%)	Never n(%)
01	As the partner, I participate in clinics with my wife	185(59.7%)	105(33.9%)	15(4.8%)	5(1.6%)	0(0%)
02	I buy food items that she wants	270(87.1%)	37(11.9%)	3(1%)	0(0%)	0 (0%)
03	I support her to do exercise during pregnancy	157(50.6%)	93(30%)	43(13.9%)	9(2.9%)	8(2.6%)
04	I purchase medicine, supplements to her	256(82.6%)	36(11.6%)	13(4.2%)	4(1.3%)	1(0.3%)
05	I remind her to get supplements during pregnancy	226(72.9%)	63(20.3%)	19(6.1%)	2(0.6%)	0(0%)
06	I saved money for her needs	267(86.1%)	34(11%)	7(2.3%)	2(0.6%)	1(0.3%)
07	I arranged the transport to visit the hospital	274(88.4%)	26(8.4%)	7(2.3%)	2(0.6%)	1(0.3%)
08	I take care of domestic chores when she is pregnant	160(51.6%)	106(34.2%)	37(11.9%)	6(1.9%)	1(0.3%)
09	I looked after the children and family members when she was pregnant	218(70.3%)	74(23.9%)	13(4.2%)	3(1%)	2(0.6%)

10	I help with preparation of clothing and comfort measures	237(76.5%)	62(20%)	10(3.2%)	1(0.3%)	0(0%)
11	I support my wife by providing comfort measures	267(86.1%)	40(12.9%)	3(1%)	0(0%)	0(0%)
12	I prepare a clean environment for the baby	288(92.9%)	17(5.5%)	2(0.6%)	3(1%)	0(0%)
13	I give her a chance to meet her relatives, and friends during pregnancy	248(80%)	51(16.5%)	9(2.9%)	1(0.3%)	1(0.3%)
14	I show her love and affection as usual and provide psychological wellbeing	296(95.5%)	11(3.5%)	1(0.3%)	1(0.3%)	1(0.3%)

partners had good knowledge regarding PFM, held positive attitudes toward their role in supporting their pregnant partner, and demonstrated a high level of support. Furthermore, pregnant women were highly satisfied with the support provided by their partners during pregnancy. These results underscore the importance of partner involvement in pregnancy, which positively influences maternal satisfaction and well-being.

### Knowledge on PFM among partners

In this study population, the majority of partners demonstrated good knowledge regarding PFM, with 57.4% falling into the good knowledge category and 41.3% in the average knowledge category. Only 1.3% were in the poor knowledge category. Factors contributing to this high level of knowledge likely include previous experiences with children, antenatal sessions conducted at the clinics, exposure to social media, and a strong desire to prepare for and welcome a new child. The study also found that partners whose pregnant women were in the 3<sup>rd</sup> trimester and those with more children at

home were more likely to have a higher level of knowledge, highlighting the influence of experience and the pregnancy stage. Furthermore, the education level of the partner and their increased concern for their wife's well-being likely played a role in enhancing their knowledge. Welcoming a new family member is a significant life event for couples, whether it's the first or subsequent pregnancy. Partners with average or poor knowledge might have missed antenatal sessions or relied on inaccurate information from social media, which could have contributed to the knowledge gaps observed.

This finding aligns with the study conducted by Younas and colleagues, which revealed that 52% of partners in Pakistan demonstrated good knowledge of antenatal care for their pregnant wife (Younas et al., 2020). Similarly, an Indian study found that while the majority of partners had good knowledge of antenatal care, many lacked an understanding of its importance (Pruthi et al., 2016). In contrast, a study in Kenya on the knowledge and perception of partners regarding antenatal care found that 57.6% of partners had a low level of knowledge

**Table 7: Difference of knowledge, attitude, and extent of support of partners on PFM among different variables (n=310)**

Variable	Subgroup	Mean (SD)	P value
Knowledge of partners on PFM			
Number of children	No children	24.72(5.05)	0.018
	1 child	26.22(4.69)	
	2 or above 2	26.50(3.97)	
Trimesters	2 <sup>nd</sup> trimester	24.79(4.915)	<0.001
	3 <sup>rd</sup> trimester	26.87(4.487)	**
Attitude of partners on PFM			
Ethnicity	Sinhala	28.30(3.56)	<0.001
	Non-Sinhala	30.56(2.09)	**
Monthly household income from all source	25000 LKR or less (81.USD)	29(2.84)	0.016
	26000-45000LKR (84-46USD)	27.72(3.65)	
	46000-100000LKR (149-325USD)	28.82(3.57)	
	Above 100,000 LKR (325USD)	29.50(3.08)	
Marriage duration (Years)	>1	29.19(3.01)	0.016
	1-6	27.85(3.86)	
	7 -11	28.83(2.92)	
	Above 12	29.40(3.09)	
The extent of support of partners for PFM			
Wife occupation	Government	50.67(4.71)	0.017
	Private sector	53.74(2.43)	
	Self-employment	54.30(1.76)	
	Business	51.73(3.92)	
	House wife	51.67(4.70)	
*Only the variables that show significant differences are shown here.			
**Independent sample t-test			
*** One-way ANOVA test			

(Kinoti & Fava, 2022). These regional differences could be attributed to varying educational backgrounds, cultural and religious influences, and limited widespread maternal preparation education. Such findings support the conclusion by Hanapi et al., who noted that a partner's knowledge is often linked to the number of children they have, suggesting that greater experience may

lead to better knowledge (Hanapi et al., 2019). Although the majority of partners demonstrated good overall knowledge, the current study identified several knowledge gaps in areas such as worm treatments, tetanus toxoid immunization, anomaly scans, vitamin supplements, Kegel and other exercises, sexual activities during pregnancy, and managing complications like vomiting.

**Table 8 : Assessment of satisfaction of women about partner's support on PFM**

No	Statement	Highly Satisfied n(%)	Satisfied n(%)	Neutral n(%)	Dissatisfied n(%)	Very dissatisfied n(%)
01	My partner participates in antenatal clinics with me	245(79%)	58(18.7%)	7(2.3%)	0(0%)	0(0%)
02	He allows me to go to antenatal clinics and participate with me	254(81.9%)	55(17.7%)	1(0.3%)	0(0%)	0(0%)
03	He buys medication and supplements	263(84.8%)	41(13.2%)	5(1.6%)	1(0.3%)	0(0%)
04	He reminds me to get supplements	261(84.2%)	44(14.2%)	5(1.6%)	0(0%)	0(0%)
05	He arranges a safe transport method to travel	277(89.4%)	28(9%)	4(1.3%)	1(0.3%)	0(0%)
06	He saves money for my needs and spends it for me	264(85.2%)	42(13.5%)	4(1.3%)	0(0%)	0(0%)
07	He took care of domestic chores after I got pregnant	228(73.5%)	68(21.9%)	14(4.5%)	0(0%)	0(0%)
08	He looked after the children and other family members after I got pregnant	244(78.7%)	57(18.4%)	9(2.9%)	0(0%)	0(0%)
09	He supports my daily day today activities	258(83.2%)	44(14.2%)	8(2.6%)	0(0%)	0(0%)
10	He considers buying nutritious food good for pregnancy	284(91.6%)	21(6.8%)	5(1.6%)	0(0%)	0(0%)
11	He shows me love and affection as usual and makes my psychological wellbeing	287(92.6%)	21(6.8%)	2(0.6%)	0(0%)	0(0%)



These areas may not have been sufficiently covered during antenatal education sessions, and some partners may perceive them as less significant during pregnancy. However, for an optimal pregnancy outcome, it is essential to address all aspects of maternal care equally. Hence, future maternal care programs should prioritize filling these knowledge gaps to ensure comprehensive support for both partners and a healthier pregnancy experience.

### **Attitude towards PFM among partners**

In this study, the partners exhibited 100% positive attitudes, which is a promising trend, particularly in developing countries. Several factors may contribute to this positive outlook, including the relatively young age of many partners, their higher level of education, cultural differences, and the quality of their relationships with their pregnant women. Furthermore, their exposure to global or Western perspectives on prenatal care might have shaped their attitudes, fostering a more engaged and supportive approach to pregnancy. This trend highlights the potential for cultural shifts and educational interventions to further improve the attitudes of partners toward prenatal care in similar settings.

The findings from this study are consistent with previous research on partners' attitudes toward antenatal care. For example, a study done in Iran by Soltani and colleagues (Soltani et al., 2018) indicated that 65.3% of partners had a positive attitude regarding antenatal care. Similarly, an Indonesian study showed that 67.4% of partners had a positive attitude toward their involvement in antenatal care (Dahake & Shinde, 2020). In contrast, a study conducted in Kenya found that only 51.5% of partners held a positive attitude toward antenatal care, with the remaining participants displaying less engagement or support (Kinoti & Fava, 2022).

These differences in attitudes may be influenced by varying cultural norms, education levels, and access to prenatal care across different regions, emphasizing the importance of targeted interventions to foster positive attitudes in populations with lower levels of support for antenatal care. This variation may also be attributed to the impact of community health programs and public awareness initiatives that have helped partners become more knowledgeable and mindful of the importance of supporting healthy pregnancy outcomes in some regions. These programs likely encourage positive behaviors and attitudes toward antenatal care.

Although some African communities have shown more negative aspects in partner involvement during pregnancy, it is encouraging that the majority of individuals still maintain positive attitudes, which is a hopeful sign for the future of paternal involvement in PFM. Unfortunately, studies examining the factors associated with partners' attitudes toward PFM are relatively scarce in the literature, highlighting the need for further research in this area to identify the influences that shape these attitudes and how to improve them globally.

### **Extent of support of partners on PFM**

It is encouraging to see that partners in Sri Lanka were highly supportive of their pregnant women during the antenatal period, particularly in a traditionally male-dominated society where involvement in such activities could sometimes be viewed negatively. The fact that only 1.3% of participants were moderately supportive and none were unsupportive reflects a positive trend in paternal involvement in pregnancy care.

The majority of participants were expecting their first child, which likely contributed to their eagerness to participate in their wife's antenatal care. This first-time experience often leads to heightened excitement and

involvement, as partners seek to support their pregnant women through the process of expecting a child. The affection toward the wife and the unborn child, as well as the changing attitudes of the younger generation, may be key factors behind this positive involvement.

However, it is important to note the 1.3% of participants who were only moderately supportive. Factors such as alcoholism, neglect, or domestic violence could be potential reasons for this less-than-ideal support. These issues are critical to address, as they can severely affect the well-being of both the mother and the child. Raising awareness and providing targeted interventions at the community level to address these problems is crucial for improving overall support from partners during the antenatal period. Focusing on these aspects in future research and community programs can help ensure that all partners are fully engaged in supporting their pregnant women throughout pregnancy.

The findings from the study conducted by Younas and colleagues in Pakistan (Younas, Parpio et al., 2020), which found that 84% of partners were highly supportive during pregnancy, align with the shift in cultural trends and norms, demonstrating increased partner involvement in antenatal care. This shift is encouraging, as it highlights growing awareness and a more active role for fathers in the care and support of their pregnant wives.

In contrast, the study from India, which reported that only 20% of partners supported and accompanied their pregnant women for check-ups, reflects a different reality. The reasons cited for this lack of support such as busy schedules, time constraints, and family pressure are common barriers in many regions (Pruthi et al., 2016). These factors, alongside economic pressures, can significantly impact the level of support

partners provide during pregnancy.

Sri Lanka, like India, is currently facing significant economic challenges. While the positive trend observed in the current study suggests an improvement in partner involvement, the broader economic situation could limit this support in certain communities. In particular, economic hardship may lead to increased work hours for both partners, reducing their ability to attend antenatal visits and other pregnancy-related activities. This creates a disparity between those who can afford time and resources to participate actively in pregnancy care and those who cannot, potentially limiting maternal health outcomes for some.

While the overall trend in Sri Lanka appears positive, it is crucial to consider the economic context in which maternal and paternal involvement is taking place. Addressing the socio-economic factors that hinder full participation in maternal care could improve the overall experience and outcomes for both mothers and fathers in the antenatal period.

The findings of the current study align with those of Rumaseuw and colleagues (Rumaseuw et al., 2018), who highlighted that the working status of a wife significantly influences her partner's involvement in antenatal care. In the study, partners were found to provide higher levels of support to working women during pregnancy, as working mothers often require additional help due to the physical and emotional demands of balancing work and pregnancy.

This trend suggests that many partners are aware of the need for increased support for working pregnant women, particularly during pregnancy. It reflects a positive shift towards more balanced and supportive relationships, where partners recognize the importance of shared responsibility in maternal health. As more couples embrace this dynamic, it may contribute to better outcomes for mothers and

their children.

The awareness shown by partners in this study regarding the unique needs of working women during pregnancy points to the potential for further improvements in maternal care. This recognition can play a crucial role in fostering healthier, more supportive environments for expectant mothers, contributing to the well-being of future generations in the country. As this trend continues, it may lead to broader societal changes, where shared responsibilities in parenting and pregnancy are more widely accepted, ensuring better health outcomes for both parents and children.

### **Satisfaction of pregnant women on partner's support on PFM**

The high level of satisfaction among pregnant women regarding their partner's support in this study is a promising indicator for better pregnancy outcomes in the future. The affection and strong relationship between partners likely play a significant role in the high satisfaction levels observed. This suggests that emotional support and the partner's involvement in pregnancy-related tasks contribute positively to the mother's well-being, potentially improving both physical and mental health during pregnancy.

In the current study, the fact that only a very small percentage (0.06%) of participants was moderately satisfied with their partner's support emphasizes the generally high levels of involvement and care provided by the partners, which further strengthens the findings of positive partner support.

This study fills a gap in the literature, as there appears to be limited research specifically on maternal satisfaction with partner support during pregnancy, especially in the Sri Lankan context. As a result, the findings of this study provide valuable insights that can

be used to inform future healthcare practices and policies. Understanding the factors that lead to high satisfaction with partner support can guide interventions and public health programs to encourage greater partner involvement in antenatal care, ultimately contributing to improve maternal and child health outcomes.

### **Applications of study findings and recommendations**

Childbearing and rearing are indeed shared responsibilities, and the study findings highlight the crucial role of partner involvement in antenatal care sessions. The geographical area of the study, which is more exposed to knowledge dissemination, and awareness sessions, and has a relatively educated population, likely contributed to the positive results observed. However, as noted, rural areas may face challenges in accessing such information, despite having an educated population. This underscores the need for ground-level assessments to better understand regional disparities and take targeted actions to address knowledge gaps.

The identified deficiencies in certain areas of knowledge and partner support provide an opportunity to enhance educational interventions. More focused attention on practical aspects such as nutrition, supplementation, danger signs, and sexual activities during antenatal care can significantly improve partner involvement and support. These topics should be emphasized in educational sessions to reinforce positive behaviors and encourage greater engagement from both partners.

Furthermore, the involvement of both partners in antenatal care not only enhances their relationship but also leads to improved satisfaction for the pregnant woman and can help alleviate depressive symptoms. This finding suggests that when both partners

attend sessions together, it fosters a supportive and cooperative environment that benefits the overall well-being of the family.

Future research should consider exploring the knowledge, attitude, and support of partners who do not attend clinics, particularly in rural or underserved areas. This would provide a more comprehensive understanding of the barriers to partner involvement and guide interventions aimed at improving access to information and participation.

Encouraging both partners to actively participate in antenatal clinics, particularly those facilitated by nurses and public health midwives, should be a key focus of health education and promotion efforts. By promoting active partner involvement, Sri Lanka can achieve a more positive perinatal experience for families and improve maternal and child health outcomes on a national level.

### **Strengths and limitations of the study**

Although several studies have addressed antenatal care in the Sri Lankan context, this study appears to be one of the first to specifically explore the role of partners in PFM. This makes a valuable contribution to the existing literature, providing insights that can inform future research and policymaking in the field.

However, the crowded clinical environment during data collection posed challenges in maintaining participant privacy, which may have affected the accuracy of the responses. To mitigate this issue in future studies, extra precautions should be taken, such as extending the data collection period or organizing it in a less congested setting to ensure privacy and reduce potential biases.

Data collection was limited to participants attending clinics, meaning the sample may not accurately represent the full spectrum of partners within the community. To enhance

the inclusivity of future research, it would be beneficial to conduct studies across multiple centers or in community-based settings.

Finally, the presence of language barriers particularly for Muslim and Tamil individuals may have led to underrepresentation of these demographic groups. Efforts to provide translations or offer culturally sensitive data collection methods in future studies could help address this issue and ensure a more diverse and representative sample. By overcoming these limitations, future research can build on the current study's findings and provide more comprehensive insights into the role of partners in antenatal care.

### **Conclusions**

The knowledge, attitude, and support of partners regarding PFM in this study were found to be satisfactory, with most partners demonstrating high or moderate levels of knowledge regarding pre-pregnancy care and awareness about the wife and unborn baby. However, there were areas where knowledge gaps were observed, particularly regarding nutritional supplementation, sexual activities, and minor complications, which were unsatisfactory. Despite these gaps, mothers reported high satisfaction with their partner's support, highlighting a positive influence on the overall pregnancy experience.

These positive findings reinforce the importance of partner involvement and support during pregnancy, contributing to better maternal and child outcomes. Such support is a critical factor in promoting healthier pregnancies and, ultimately, a healthier future generation. Addressing the identified knowledge gaps in specific areas through targeted education and awareness programs for partners could further enhance the quality of prenatal care and the overall

pregnancy experience for both mothers and fathers.

### Conflicts of interest

The authors declare that they have no conflicts of interest.

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