HEALTHCARE PROVIDER, ROMANTIC PARTNER, AND FAMILY SUPPORT AS PREDICTORS OF FEAR OF CHILDBIRTH IN OSUN STATE, NIGERIA

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Abstract

Studies have established the relationship between social support and fear of childbirth, however, the distinct contribution of different sources of social support on the domains of fear of childbirth has not been thoroughly assessed. This study examined the relationship between perceived social support from healthcare providers, partners, family, friends and four domains maternal fear of childbirth (fear of pain, mistreatment, baby safety, and loss of control) among pregnant women in Osun State. A cross-sectional study was conducted involving 210 antenatal attendees in selected public and private healthcare facilities situated in rural and urban areas from July to August, 2024. Data were gathered using standardized instruments which are; The Fear of Childbirth Questionnaire (FCQ), Measure of Perceived healthcare providers scale and the Multidimensional Scale of Perceived Social Support. Descriptive and inferential statistics, including logistic regression analysis, were conducted using IBM SPSS Statistics, version 25. Result revealed that younger women were more likely to report fear of mistreatment/trust (AOR = 1.56, p = .044) compared to older women. Single/divorced women showed higher odds of fear across the four dimensions of fear, losing control/coping (AOR = 2.17, p = .028) and mistreatment/trust (AOR = 2.05, p = .031) than married women. Pregnant women who perceived low family support were 3.4 times likely to experience fear of losing control/coping (AOR = 3.38, p = .002), 3.3 times likely to experience fear of mistreatment/trust **(**AOR = 3.25, p **=** .003), 2.9 times experience fear of pain (AOR = 2.87, p = .006), and 2 times have fear of baby's safety (AOR = 2.01, p = .045) than those who perceived high family support. Based on these findings**,** partner and family- inclusive models should be incorporated in antenatal care to enhance maternal mental health.

Keywords: **Fear of childbirth, Social support, pregnant women, healthcare provider, partner, family**

Introduction

Fear of childbirth (FoC), also known as tokophobia, is increasingly recognized as a significant psychological and public health concern with far-reaching implications for maternal wellbeing. It is characterized by excessive anxiety or dread regarding labour and delivery, beyond typical apprehension, and may interfere with antenatal participation, birthing decisions, or postpartum health outcomes (Webb *et al.,* 2021). Pregnancy and childbirth are major unforgettable events in a woman's life. Most times, when women are faced with reality of pregnancy, childbirth, and motherhood, they doubt their ability to cope with these big events most especially the child delivery process.

Globally, clinical FoC is estimated to affect 6–14% of pregnant women, while subclinical levels often unrecognized impact as many as 80% (Yin *et al.,* 2024). In low- and middle-income countries (LMICs), the burden is more severe due to poor maternal health infrastructure, high obstetric risk, and sociocultural constraints. Prevalence studies have shown FoC rates of 15% in Tanzania (Massaae *et al.,* 2021) and up to 25.3% in Ethiopia (Gelaw *et al.,* 2020). Nigeria lacks comprehensive national data on FoC,

but regional studies suggest high prevalence. A study done in Lagos by Esan et al (2021) documented that over half of surveyed primigravidas reported moderate to severe childbirth fear, linked to distrust in healthcare systems, prior obstetric trauma, and poor communication from providers. In Ekiti State, Ali et al (2022) revealed that fear stemmed from unpredictability, pain, lack of support, and unfavourable delivery experiences. In Rivers State, Amesi *et al.* (2023) reported 15%. These findings reflect a broader concern that FoC in Nigeria is often compounded by inadequate emotional and institutional support (Chijioke *et al.*, 2024; Fadele *et al.*, 2024).

It is worthy to note that unaddressed FoC has wide-ranging consequences. Women with intense fear may opt for unnecessary caesarean sections, avoid skilled birth attendants, or develop postpartum depression and PTSD (Ertan *et al.*, 2021; Orovou *et al.*, 2025). Moreover, it could also contribute to reduced satisfaction with the birthing process and in some cases, it drives women toward unsafe alternatives such as home births or untrained traditional attendants, often due to heightened anxiety and lack of institutional trust reinforced by socio-environmental stressors. FOC is said to have impact on the physical and mental health of pregnant women (Yan *et al.*, 2022) ranging from sleep disturbances, nervousness, stomach cramps, prolonged labour (Serçekuş, *et al.*, 2020), infant growth (Huang, *et al.*, 2021) to postpartum anxiety and depression (Räisänen *et al.*, 2014).

Social support could be regarded as interpersonal relationship which provides individuals with emotional help, support and information when required. This help is often provided by family members, neighbours, colleagues, relatives, and the treatment team. As regards healthcare provider, contributing factors to fear of childbirth include structural and interpersonal dynamics. Ilesanmi *et al.* (2023) noted that many public maternity facilities in Nigeria remain under-resourced, overcrowded, and marked by poor pain management, lack of privacy, and dismissive provider behaviour all of which intensify anxiety. Empirical evidence shows that the presence or absence of respectful communication from healthcare providers strongly influences a woman's confidence and fear level (Bohren *et al.*, 2015; Gebeyehu *et al.*, 2023).
Moreover, the role of healthcare providers is central in shaping women's perceptions of childbirth. The quality of antenatal care, communication styles, and the degree of empathy demonstrated by healthcare professionals significantly influence maternal confidence and emotional well-being (Akcay & Alan, 2025). Positive interactions with skilled birth attendants can foster a sense of safety and trust, thereby reducing fear. Conversely, negative experiences, such as perceived neglect, verbal abuse, or lack of informed consent, have been associated with heightened anxiety and traumatic childbirth experience (Ganisia & A'zdom, 2025). In many healthcare settings, particularly in resource-constrained environments, systemic issues such as overcrowding, understaffing, and inadequate training may hinder the delivery of respectful maternity care, thereby contributing to women's fears.

Consequently, family dynamics play a dual role. In supportive environments, partners and relatives help alleviate fear by offering encouragement, financial support, and accompaniment to antenatal visits. However, in other cases, they increase anxiety through fear-laden stories, traditional pressure, or absence of tangible help (Nordin-Remberger *et al.*, 2024). In patriarchal settings, women may also lack decision-making power about their own care, further amplifying fear during antenatal period. On the other hand, researchers (Demšar *et al.*, 2018; O'Connell *et al.*, 2019; Nath *et al.*, 2021) have identified sociodemographic characteristics such as history of abuse, young maternal age, unscheduled pregnancy, unemployed, single motherhood and psychological characteristics such as history of mental illness, current depression as risk factors for FOC.

Statement of Problem

Fear of childbirth has emerged as a significant public health and psychosocial concern affecting pregnant women globally, with growing implications for maternal health outcomes, healthcare utilization,

and overall well-being (Elsharkawy *et al.,* 2024). Childbirth is often socially construed as a natural and expected life event, many women experience varying degrees of fear, anxiety, and psychological distress related to the anticipation of labour and delivery. In severe cases, this fear may lead to avoidance of pregnancy, increased preference for elective caesarean sections, prolonged labour, or negative birth experiences. Despite advances in maternal healthcare, fear of childbirth continues to persist, suggesting that biomedical improvements alone are insufficient to address the psychological and sociocultural dimensions of childbirth (Alizadeh-Dibazari *et al.,* 2024).

In Nigeria, and particularly in states such as Osun State, maternal health indicators reveal both progress and persistent challenges. Although there is relatively high utilization of healthcare facilities for childbirth in some areas, a substantial proportion of women still experience anxiety and fear associated with delivery. This fear is shaped not only by concerns about pain, complications, and safety but also by sociocultural narratives, previous birth experiences, and perceived quality of care (Ali *et al.,* 2022; Navarrete *et al.,* 2023). Furthermore, the coexistence of modern healthcare systems and traditional birth practices introduces complexities that may heighten uncertainty and fear among expectant mothers.

Despite the clear significance of social support, very few studies in Nigeria particularly in Osun State have comprehensively examined the combined influence of healthcare provider, partner family and friend support on FoC. Most existing research focuses narrowly on provider attitudes or demographic predictors, without exploring the interplay between institutional and interpersonal systems. Furthermore, few studies are grounded in a theoretical framework that situates fear within a broader socio-behavioural context.

This gap in knowledge presents a significant problem for maternal health interventions and policy development. Without a comprehensive understanding of how different forms of support influence fear of childbirth, efforts to reduce maternal anxiety and improve childbirth experiences may remain fragmented and ineffective. Moreover, failure to address fear of childbirth may contribute to adverse maternal outcomes, including increased medical interventions, poor psychological wellbeing, and reduced satisfaction with care.

Moreover, the present study aligns closely with the Sustainable Development Goals (SDGs), particularly Goal 3 (Good Health and Well-being) as it contributes to understanding protective factors that reduce fear and improve maternal outcomes. Such understanding directly supports Target 3.1, which seeks to reduce global maternal mortality, as well as Target 3.4, which emphasizes the promotion of mental health and Target 3.8 on universal health coverage by examining the value of respectful, supportive, and patient-centered maternal care as an essential dimension of quality health services. This study therefore examined the association between perceived social support from healthcare providers, partner, family, friends and maternal fear of childbirth among pregnant women attending selected health facilities in Osun State. The study also assessed the influence of the sociodemographic variables of pregnant mothers on fear of childbirth.

Theoretical Framework

This study draws upon two foundational sociological theories: Symbolic Interactionism Blumer (1969) and Social Capital Theory by Bourdieu (1986). Symbolic Interactionism, was developed by Mead (1900) and advanced by Blumer (Blumer, 1969) explains how individuals construct and negotiate meanings through social interactions. In the context of this study, maternal fear of childbirth (FoC) is understood not merely as an internal emotional reaction but as a dynamic outcome of interpersonal and symbolic exchanges. Women's fears may arise from conversations with peers, narratives passed through families, or interpretations of health provider behaviours. These meanings are shaped and reshaped through repeated social contact, influencing how women emotionally prepare for childbirth (Al-Mutawtah *et al.,* 2023).

In this context, Symbolic interactionism reveals that meanings about childbirth are socially constructed through daily interactions, language, and shared cultural symbols. These meanings are deeply embedded in cultural practices and maternal traditions (Toper *et al.,* 2023). In Osun State, cultural norms surrounding childbirth is often framed as a spiritual battle where women confront forces beyond human control. Proverbs like *"*ikoko ti o maa jo, kii fo lori adiro*"* (the pot destined to boil won't break on the fire) reinforce the idea that childbirth is fated and dangerous. Women are socialized to believe that childbirth is both a test of womanhood and a moment of potential death. Thus, cultural norms and meaning of childbirth Another concept is symbolic exchange which is the communication processes and the inter-*exchanges* of significant symbols that are central to childbirth. Older women recount stories of maternal deaths, obstructed labour, and "battle with witches" during childbirth. These narratives are passed from mother to daughter, amplifying fear as a collective memory (Aynlem *et al.,* 2023). Religious leaders (Christian, Muslim, or traditional) often interpret childbirth as needing divine protection, further framing it as a spiritually perilous event. Conversely, some interactions present childbirth as an initiation into motherhood a source of honor and respect if successfully endured.

Consequently, issues of identity and stigma are closely tied to the birthing process (Rugumisa, 2024). For instance, in some communities, opting for caesarean section (CS) is stigmatized as a sign of weakness. Symbolically, "real women" are those who endure labour pains naturally. This symbolic expectation produces fear: women fear not only death and pain but also social shame if women "fail" to deliver naturally. Hence, the cultural-symbolic framework, "real women" are those who endure the pains of labour and successfully deliver vaginally. Such symbolic expectations shape women's childbirth experiences by generating dual fears: not only the fear of physical pain and the risk of mortality, but also the fear of social disapproval and shame associated with perceived inability to give birth naturally. On the other hand, Social Capital Theory, as theorized by Bourdieu (1986) focuses on the resources embedded within social networks such as trust, support, and emotional reciprocity that individuals can draw upon for well-being. In maternal health, the presence of supportive partners, family members, and empathetic healthcare providers constitutes a form of social capital that can buffer against anxiety and improve birth preparedness. Conversely, the absence of such support can erode psychological resilience and increase vulnerability to FoC (Andrushko & Lanza, 2024).

Social capital explains how networks of relationships (family, peers, professionals, institutions) circulate and reinforce the socially constructed meanings associated with childbirth. Bonding Social Capital have significant influence on emotional feelings attached to childbirth. For instance, in Osun state where family and kinship ties are very strong, pregnant women rely heavily on mothers, mothers-in-law, aunties, and female elders for advice. These networks often transmit fear-based meanings, warnings of maternal mortality, stories of obstructed labour, and emphasis on pain endurance. But bonding ties can also provide practical help such as companionship during labour, traditional herbs that ease anxiety (Ali *et al.,* 2022). Moreover, bridging Social Capital through community and peer groups may help mitigate fear of childbirth. Women's groups in churches, mosques, and local associations create spaces where alternative birth narratives circulate. For instance, testimonies of "safe delivery by God's grace" may reduce fear by replacing danger narratives with hope. Antenatal classes, online pregnancy forums and support groups expose women to diverse peers and shared experiences, which can normalize fears and offer coping strategies.

On the other hand, as regards linking with social capital such as healthcare institutions and providers, pregnant women's trust in skilled birth attendants, midwives, and hospitals vary. In states in Nigeria and some Osun communities, distrust in hospitals (due to high costs, disrespectful maternity care, or previous deaths in facilities) reinforces fear. Women with strong linking capital (good rapport with

midwives, access to empathetic healthcare providers) are more likely to view childbirth as safe and manageable (Nwafor *et al.,* 2022; Oche *et al.,* 2024). Conversely, weak linking capital (poor health communication, negative staff attitudes and medical dominance) amplifies symbolic meanings of childbirth as dangerous.

Together, these theories provide a robust framework for analysing maternal fear as a socially mediated phenomenon. Symbolic Interactionism explains how meanings around childbirth are constructed through cultural narratives and care experiences, while Social Capital Theory highlights the protective or exacerbating role of relational networks. Fear of childbirth emerges when symbolic exchanges in bonding networks circulate meanings of pain, risk, or loss of control, without balancing inputs from bridging or linking networks (Seto *et al.,* 2024). Conversely, when diverse social capital gives women access to supportive, empowering narratives (bridging and linking), fear can be mitigated This dual-theoretical approach enables the study to explore how social meaning-making and relational capital interact to shape women's experiences and responses to childbirth fear in Osun state.

Methods

Research Design

A cross-sectional design was adopted to assess the relationship between perceived social support and maternal fear of childbirth among pregnant women attending antenatal clinic in two public and two private health facilities in Osun state.

Study Setting

Osun State is one of the 36 states of the Federal Republic of Nigeria, located in the southwestern geopolitical zone. It was created on August 27, 1991, with Osogbo as the state capital. The state is predominantly inhabited by the Yoruba ethnic group, with sub-ethnic identities such as the Ijesa, Ibolo, Ife, and Igbomina. The major languages spoken are Yoruba and English. Christianity and Islam are also widely practiced, often interwoven with traditional beliefs. Due to trade, education, and urbanization (especially in Osogbo and Ile-Ife), the state also includes: Hausa, Igbo, Other Nigerian minorities (Tiv, Ebira, Urhobo) and West African migrants (Benin Republic, Togo, Ghana). Summarily, Osun State is Yoruba-dominated but culturally pluralistic, especially in urban centres. These cultural and religious orientations play a significant role in shaping perceptions of health, illness, and childbirth. Administratively, Osun State has 30 Local Government Areas (LGAs) distributed across urban, semi-urban, and rural settings, making it suitable for studies that require stratified sampling across different facility types (public vs. private; rural vs. urban).

Osun State, with an estimated population of about 4.4 million**,** is predominantly Yoruba but hosts diverse Nigerian and West African populations. The healthcare system is structured into primary, secondary, and tertiary levels, with increasing government investment in maternal and child health. While facility-based childbirth is relatively high, significant challenges persist, including early childbirth, reliance on traditional birth attendants, and disparities in quality of care. These factors collectively shape maternal and neonatal health outcomes in the state. About 94.8% of women deliver in healthcare facilities in some areas (Egbewale & Bamidele, 2009; Afolabi *et al.,* 2025). This is an indication of relatively high utilization of skilled birth services compared to other regions in Nigeria

Sample Size Determination

The minimum sample size was calculated using Cochran's formula for a single proportion, assuming a 95% confidence level ($Z = 1.96$), a conservative prevalence of 50% ($p = 0.5$), and a precision of 5% ($d = 0.05$), which yielded 196 participants (Cochran, 1977; Lwanga & Lemeshow, 1991). Using the above formula, the study is to recruit 196 participants but to account for a potential 10% non-response rate, the required sample size was adjusted to 218. A total of 218 pregnant women were successfully recruited

for the study. However, 8 questionnaires were excluded due to incomplete responses, resulting in a final analysable sample of 210 participants**,** which remained above the minimum required size of 196.

Sampling Procedure

The recruitment of participants followed a multistage stratified random sampling approach. In the first stage, all registered antenatal care facilities in Osun State were first grouped into four strata based on ownership type (public vs. private) and location (urban vs. rural)**.** This produced four distinct categories namely; Public-urban facilities, Public-rural facilities, Private-urban facilities and Private-rural facilities. From each of the four strata, health facilities were randomly selected using a simple random sampling method (balloting). This ensured that each facility had an equal chance of being chosen, while also guaranteeing representation of both public and private, as well as urban and rural, contexts. The total sample size of 210 pregnant women was then proportionately distributed across the selected facilities based on the average number of women attending antenatal clinics in each stratum. That is, facilities with higher antenatal attendance were allocated a larger number of participants compared to those with fewer attendees within each selected facility, a systematic random sampling procedure was used to recruit participants. Attendance registers were used as the sampling frame, and every 4^{th} eligible woman was approached for participation after the first respondent was randomly chosen. Recruitment continued until the predetermined quota for each facility was reached. This procedure yielded a final sample of 210 pregnant women, ensuring representativeness across different facility types and geographic settings in Osun State. These facilities include; Catholic Hospital, Osogbo (60 participants), General Hospital, Iwo (65 participants), State Hospital, Ila Orangun (50 participants), Ogo-Oluwa Hospital, Okuku (35 participants). Only pregnant women who were registered for antenatal care, aged 18 years and above, in their second or third trimester and willing to give informed consent were included in the study. Women who had severe medical complications were excluded from the study. Recruitment of the pregnant women who participated in the study was done between July and August, 2024.

Research Instruments

Data were collected using a structured questionnaire utilizing the 20-item Fear of Childbirth Questionnaire, Multidimensional Scale of Perceived Social Support (MSPSS) and Perceived Social Support – Healthcare Provider (PSS-HCP) questionnaire.

Fear of Childbirth Questionnaire was developed by Slade *et al*. (2021). It has 20 self-report items and each item is rated on a 4-point Likert scale (“strongly disagree" to "strongly agree"). On the scale, there are 8 items which are reverse-scored to ensure consistency (Syed *et al.,* 2024). The total score of the questionnaire ranges approximately from 0 to 60**.** Consequently, the scale includes three extra Likert-scale items to evaluate the frequency and distress impact of the fears, and whether the woman desires support (Carraher *et al.,* 2024). Scoring of the scale is classified as 0–20 low fear**,** 21–39, moderate fear while 40–60 is classified as high fear. The reliability of the scale $\alpha = .84$ **(**Hoseini *et al.,* 2024**)** while the reliability coefficient obtained from a pilot study in the present research is $\alpha = .79$.

The MSPSS instrument was used to evaluate the social support received by pregnant women from family and friends. A-12 item scale by Zimet *et al.* (1988) measured on a 7-point Likert scale ranging from very strongly disagree to very strongly agree. The level of social support is determined by calculating the mean of the total item scores. Social support received from friends and significant others is the sum of items 1,2, 5, 6, 7, 9, 10 and 12 divided by 8, and family is the sum of items 3, 4, 8, and 11 divided by 4. Scoring of the scale is done as follows mean score ranging from 1 to 2.9 is low support; a mean score of 3 to 5 is moderate support; a mean score of 5.1 to 7 is high support. Olabisi *et al.* (2020) reported the internal

consistency and reliability to be good with a Cronbach alpha of 0.82. The present study obtained Cronbach alpha of 0.79 from a pilot study.

The PSS-HCP, a subscale of perceived social support for Adolescents and young adults (AYAs developed by Son *et al.,* in 2023 was adopted to measure healthcare provider social support. It consists of 15 items rated on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). Scores range from 15 to 75, with higher scores indicating greater perceived social support from healthcare providers as follows; low support = 15–34, moderate support = 35–54, high support= 55–75. A Cronbach's α = 0.73 was reported by Son *et al.* (2023) while the present study after a pilot study obtained Cronbach alpha of 0.70.

Method of Data Collection

Pregnant women attending antenatal clinic of each health facility were informed about the study. Participants were provided with clear information about the purpose, procedures and potential benefits of the study before giving written informed consent. Participation was entirely voluntary, with the right to refuse or withdraw at any time without penalty or loss of benefits. Ethical approval was obtained from the Health Research Ethics Committees of Osun State**.** Permission to collect data was received from the Director/Head of each of the facility used in the study**.** Data collection was facilitated by two trained research assistants fluent in English and Yoruba languages who administered the questionnaire on site at each facility in participants' preferred language. All data collected were treated with strict confidentiality; personal identifiers were not recorded, and responses were coded to ensure anonymity. Information was stored securely in password-protected files accessible only to the research team, and findings was reported in aggregate form without disclosing individual identities

Results

The data analysis was carried out using Statistical Packages for Social Sciences version 25 (SPSS 25). Descriptive statistics were presented with frequency and percentages. Logistic regression was used to predict the influence of sociodemographic characteristics and social support on maternal fear of childbirth. The inferential analyses were considered significant at P-value .05.

Table 1: Socio-Demographic Characteristics of Respondents (N = 210)

Variable	Frequency (n)	Percentage (%)
Age Group		
20–24 years	59	28.1
25–34 years	110	52.4
35 and above	41	19.5
Marital Status		
Married	161	76.7
Single/Divorced	49	23.3
Educational Status		
Primary Education	42	20.0
Secondary Education	88	41.9
Tertiary Education	80	38.1
Occupation		
Trader	81	38.6
Civil Servant	53	25.2
Artisan/Skilled Labour	32	15.2
Unemployed/Housewife	44	21.0
Religion		
Christian	143	68.1

Muslim	67	31.9
Location		
Urban	125	59.5
Rural	85	40.5

A total of 210 pregnant women participated in the study. The majority (52.4%) were aged between 25 and 34 years, followed by 28.1% who were between 20 and 24 years. Most respondents (76.7%) were married, and in terms of educational attainment, 41.9% had completed secondary school while 38.1% had tertiary education. Occupation-wise, 38.6% were traders, 25.2% were civil servants. Notably, 78.6% reported no history of mental health issues. Most participants were Christians (68.1%) and 87.1% reported regular attendance at antenatal clinics.

Levels of Fear of Childbirth and Perceived Social Support

Table 2 presents the categorized distribution of respondents based on four dimensions of fear of childbirth (FoC) and perceived levels of social support. The data indicates a high prevalence of childbirth-related fear among pregnant women in Osun State. Among fear dimensions, fear of losing control and coping during labour was the most pronounced, with 80.0% of respondents reporting fear in this dimension. This suggests widespread anxiety about managing the physical and emotional demands of childbirth, likely shaped by prior birth experiences, cultural expectations, or inadequate antenatal preparation. Fear of pain and complications was also highly prevalent, affecting 71.9% of participants pointing to anticipatory anxiety surrounding labour pain and obstetric risks. Furthermore, fear of mistreatment and trust in care was indicated by 65.7%, indicating apprehension about disrespect, lack of autonomy, or poor health provider conduct during childbirth. Fear for baby's safety was reported by 55.7%, reflecting concern over neonatal outcomes, particularly in contexts of high infant mortality.

Social support showed variation across sources. Partner support was relatively strong: 45.2% of respondents reported high support, and 39.5% moderate support. This affirms the central role of male partners in maternal decision-making and emotional preparedness in Nigerian households. Similarly, family support was perceived as high by 38.1%, and moderate by 43.3%, showing familial involvement as a significant source of reassurance. However, 18.6% reported low family support indicating potential vulnerability due to strained relationships or absence of caregiving roles.

Healthcare provider support was notably low: nearly half of participants (49.5%) rated it as low, and only 14.3% perceived it as high. This signals a significant deficiency in interpersonal care quality, possibly linked to provider attitudes, lack of continuity in care, or systemic constraints such as understaffing and limited privacy. Given that provider-related support is a key determinant of maternal trust and reduced FoC. Friend support was the least reported, with 70.5% indicating low level of support possibly due to cultural preferences for family-based support or limited peer involvement during pregnancy.

Table 2: Categorized Levels of Fear of Childbirth and Perceived Social Support (N = 210)

Measure	Categories	Frequency (n)	Percentage (%)
Fear of Pain and Complications	Yes	151	71.9
	No	59	28.1
Fear of Mistreatment & Trust in Care	Yes	138	65.7
	No	72	34.3
Fear for Baby Safety	Yes	117	55.7
	No	93	44.3
Fear of Losing Control & Coping	Yes	168	80.0
	No	42	20.0
Partner Support	Low (1.0–2.9)	32	15.2
	Moderate (3.0–5.0)	83	39.5
	High (5.1–7.0)	95	45.2

Family Support	Low	39	18.6
	Moderate	91	43.3
	High	80	38.1
Healthcare Provider Support	Low	104	49.5
	Moderate	76	36.2
	High	30	14.3
Friend Support	Low	148	70.5
	Moderate	49	23.3
	High	13	6.2

Notes: Fear variables are dichotomized based on mean cut-off scores (Mean ≥ 3.0 = Yes;< 3.0=no

The logistic regression analysis in table 3 revealed distinct predictors for each dimension of maternal fear of childbirth (FoC), integrating sociodemographic factors and different sources of perceived social support. Findings revealed that younger women (20–24 years) were more likely to report fear of mistreatment/trust (AOR = 1.56, p = .044) compared to those aged 25–34. Also, single/divorced women consistently showed higher odds of fear across several domains, particularly losing control/coping (AOR = 2.17, p = .028) and mistreatment/trust (AOR = 2.05, p = .031). Consequently, women with only secondary education had significantly higher odds of fear of pain (AOR = 1.65, p = .046) and losing control/coping (AOR = 1.76, p = .041).

Moreover, findings of the study revealed that low partner support raised odds of fear of losing control/coping (AOR = 2.94, p = .004), fear of mistreatment/trust (AOR = 2.88, p = .005), and fear of pain (AOR = 2.43, p = .008) as compared with high support. Moderate partner support also increased odds, though to a lesser extent (e.g., losing control/coping, AOR = 1.76, p = .046). Low family support substantially increased odds of losing control/coping (AOR = 3.38, p = .002), mistreatment/trust (AOR = 3.25, p = .003), pain (AOR = 2.87, p = .006), and baby's safety (AOR = 2.01, p = .045). Moderate family support also raised odds, such as losing control/coping (AOR = 2.01, p = .033).Low provider support increased the odds of fear of losing control/coping (AOR = 2.88, p = .005) and mistreatment/trust (AOR = 2.94, p = .007). Moderate provider support (pain, AOR = 1.41, p = .084). Consequently, low friend support independently predicted higher odds of fear of mistreatment/trust (AOR = 2.20, p = .038), fear of losing control/coping (AOR = 2.34, p = .029), and fear for baby's safety (AOR = 2.12, p = .041). Moderate friend support showed decreased odds for fear of mistreatment/trust (AOR = 1.58, p = .067, borderline).

Table 3: Logistic Regression Showing Predictors of Dimensions of Fear of Childbirth among Pregnant Women in Osun State

Predictors	**Fear of Pain & Complications** (AOR, p-value)	**Fear of Mistreatment & Trust** (AOR, p-value)	**Fear for Baby's Safety** (AOR, p-value)	**Fear of Losing Control & Coping** (AOR, p-value)
Age (25–34 ref.)				
20–24 years	1.42 (.086)	1.56 (.044)	1.21 (.172)	1.38 (.091)
35+ years	1.31 (.119)	1.22 (.213)	0.98 (.812)	1.47 (.077)
Marital Status (Married ref.)				
Single/Divorced	1.89 (.039)	2.05 (.031)	1.42 (.093)	2.17 (.028)
Education (Tertiary ref.)				
Secondary	1.65 (.046)	1.48 (.081)	1.20 (.215)	1.76 (.041)
Perceived Social Support – Partner (High ref.)				
Moderate	1.52 (.059)	1.71 (.048)	1.40 (.077)	1.76 (.046)
Low	2.43 (.008)	2.88 (.005)	1.85 (.052)	2.94 (.004)
Perceived Social Support – Family (High ref.)				
Moderate	1.68 (.041)	1.95 (.038)	1.62 (.062)	2.01 (.033)

Low	2.87 (.006)	3.25 (.003)	2.01 (.045)	3.38 (.002)
Perceived Social Support – Healthcare Providers (High ref.)				
Moderate	1.41 (.084)	1.56 (.072)	1.28 (.123)	1.62 (.066)
Low	2.65 (.009)	2.94 (.007)	1.77 (.058)	2.88 (.005)
Perceived Social Support – Friends (High ref.)				
Moderate	1.49 (.068)	1.62 (.052)	1.33 (.098)	1.72 (.047)
Low	2.31 (.012)	2.58 (.009)	1.74 (.049)	2.66 (.006)

Discussion

This research revealed that women with low social support from healthcare providers, partner, family and friends also have high level of fear of childbirth across the dimensions of fear. Among the sources of social support, women who reported low family support experienced high level of fear of childbirth in the four dimensions (fear of losing control/coping, fear of mistreatment/trust, fear of pain**,** fear of baby's safety) than those who perceived high family support. This research also found that younger women were more likely to report fear of mistreatment/trust than older women. Moreover, single/divorced women showed higher odds of fear across the four dimensions of fear than married women. Furthermore, women with only secondary education had significantly higher odds of fear of pain and losing control/coping as compared to those with higher level of education.

Perceived Social support and Fear of Childbirth

Maternal FoC remains a significant concern with serious implications for maternal outcomes, including increased risk of cesarean section, prolonged labour, and postnatal disorders. In this study, a notable proportion of women experienced fear of childbirth corroborating the findings of Elsharkawy *et al.,* (2024) that 70.4% of women who participated in their study have some degree of fear and 11.3% exhibited severe FOC. Also, Li et al, (2025) documented that 24% of pregnant women experienced a high level of FoC and 7% experienced severe FoC in their study.

Researchers have documented that perceived social support reduce psychological distress (Azimi et al, 2018; Harrison *et al.,* 2022). This study found that perceived social support from family, partner, healthcare provider and friends is associated with fear of childbirth. This is consistent with the findings of Mohammdi *et al.,* (2025) who documented that spouse's support, family's support, and support of spouse's family and friends' support influences fear of childbirth among women. Also, Massae et al (2021) noted that those who did not receive any social support from male partners in previous childbirths were more likely to have fear of childbirth. Moreover, Zamani et al (2019) found that friend support is associated with childbirth fear. On the other hand, Al-Mutawtah et al (2023) reported that female network connections, care and affection from the husband, dissatisfaction with relationships, financial support from the husband and family, practical support from family and friends and health information support have significant relationship with fear of childbirth among women.

Result obtained from the study further revealed that among the sources of social support, family support is most associated with fear of childbirth. The possible reason for this finding could be that since pregnancy is socially embedded in the Nigerian setting, women rely heavily on family and communal ties for emotional and practical support during childbearing. Such networks offer reassurance, reduce uncertainty, and provide advocacy in healthcare encounters, thereby alleviating childbirth fear. From a symbolic interactionist perspective, the meaning attributed to support reinforces women's sense of competence and belonging, while social capital theory emphasizes how trust and reciprocity within

networks buffer against maternal fear. This finding justify the need for strengthening supportive interventions in maternal healthcare.

On the other hand, the finding of present study contradicts the findings of Vakilian (2017) and Alizadeh-Dibazari, et al (2025) that perceived social support from family, friends and others did not have relationship with fear of childbirth among women. The discrepancy between the present findings and those of Vakilian (2017) and Alizadeh-Dibazari *et al.* (2025) can be understood through the symbolic interactionism and social capital theoretical framework. Symbolic interactionism noted that the meaning of social support is context-specific: in Osun State, support from family and friends symbolizes trust, care, and collective responsibility, which could minimize fear of childbirth. Similarly, social capital theory explains that strong family and communal networks characteristic of Nigerian society provide resources, reassurance, and advocacy that reduce women's childbirth fear. In contrast, in other cultural contexts, the symbolic value of support or the strength of social capital may differ, which could explain the absence of a significant association in previous studies. These contrasting findings highlight the importance of situating maternal health research within its sociocultural environment.

Sociodemographic Variables and Fear of Childbirth

Fear of childbirth (FOC) is a multidimensional phenomenon which could be influenced by sociodemographic characteristics. Variables such as age, marital status and educational attainment was examined in the study in relation to maternal fears during pregnancy. These factors shape women's expectations of childbirth, their coping resources, and their access to supportive networks, thereby exerting a significant influence on their perception of childbirth as either a positive or threatening experience (Khwepeya *et al.*,2018; Lebni *et al.,* 2021; Davies *et al.,* 2024).

The present study showed that younger women were more likely to report fear of mistreatment/trust than older women. This finding is consistent with the findings of Elsharkawy *et al.,* (2024) and Massae *et al.* (2021) that younger women have greater fear of childbirth. Consequently, Lebni *et al.* (2021) reported that adolescent pregnant mothers have higher fear of childbirth. Moreover, this study found that single/divorced women showed higher odds of fear across the four dimensions of fear than married women. This corroborates the work of Massae *et al.* (2021) that discovered that single mothers experienced higher fear of childbirth than their married counterparts. Furthermore, women with only secondary education had significantly higher odds of fear of pain and losing control/coping as compared to those with higher level of education. This is in line with the discovery of Onchonga (2021) that women with lower level of education displayed greater fear than other participants with higher level of education.

The demographic variations discovered in the present study can be explained through symbolic interactionism and social capital theory. Younger women reported greater fear of mistreatment and trust, possibly because of their limited maternal experience and exposure to negative narratives. On the other hand, older women relied on their past experiences and established networks that reinforce trust. Similarly, single or divorced women exhibited higher odds of fear across all domains, which can be understood symbolically as a response to anticipated stigma and lack of social legitimacy in maternity contexts. From a social capital perspective, married women benefit from stronger spousal and family networks that provide both emotional and practical resources, thereby reducing childbirth fear. Furthermore, women with only secondary education showed greater fears of pain and coping, reflecting how educational level shapes the symbolic meaning of childbirth and influences coping strategies. Higher education expands women's bridging social capital, providing access to wider networks and health information that can reduce fear of childbirth.

Implications of the Study

The study revealed that age as a social category shapes health experiences and this calls for tailored interventions such as age-sensitive and respectful maternity care to address younger women's heightened fears of mistreatment. Also, the study discovered that social norms and symbolic meanings of marriage influence women's healthcare experiences. This is because single/divorced women show higher odds of fear across all domains. Consequent upon this, antenatal and delivery services should actively address stigma by ensuring non-judgmental, inclusive care for unmarried women. Moreover, women with only secondary education reported more fear of pain and coping in the present study. This finding reflects the role of social stratification and cultural capital (education) in shaping health behaviours and outcomes. Thus, maternity education programs are needed to build coping skills and reduce fear of childbirth among pregnant women.

Furthermore, this study found social support as a protective social capital against fear of childbirth among women. This is an indication that social networks, trust, and reciprocity shapes health outcomes. Based on this, interventions should mobilize and strengthen family and community support systems and encourage partner and family involvement in antenatal care. Summarily, this study reinforces that childbirth experiences are socially embedded, and interventions must move beyond biomedical approaches to incorporate the sociocultural and relational dimensions.

Conclusion

Perceived low family support increased level of fear of childbirth in the four dimensions (fear of losing control/coping, fear of mistreatment/trust., fear of pain**,** fear of baby's safety). Younger women was more likely than older women to report fear of mistreatment/trust. In addition, single or divorced women showed higher odds of fear across all four dimensions compared to married women. Furthermore, women with only secondary education had significantly higher odds of reporting fear of pain and fear of losing control/coping compared to those with higher levels of education**.** First, interventions should strengthen family and community support systems, consistent with SDG 3, to reduce maternal fears and promote well-being. Second, healthcare providers should adopt age-sensitive and respectful maternity care practices to address the heightened fears reported by younger women. Third, inclusive maternal care policies are required to protect unmarried and divorced women from stigma, and thereby reducing inequalities. Fourth, community-based maternal health education programs should be expanded to empower less-educated women with coping strategies and accurate knowledge of childbirth.

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