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Relationship between social support, family functioning, sociodemographic and gynecological-obstetric characteristics in pregnant women who attend prenatal care

Relación entre apoyo social, funcionamiento familiar, características sociodemográficas y ginecobstétricas en gestantes que asisten a cuidado prenatal

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Abstract:
Introduction: Social support is an important aspect during pregnancy as it facilitates favorable coping with stressful situations that may arise during this stage of a woman's life. Likewise, family support is a protective factor by reducing the risk of neonatal complications, facilitating the coping of the pregnant woman and the transition to motherhood.
Objective: To establish the relationship between social support, family functioning, sociodemographic and gynecological-obstetric characteristics in pregnant women who attend prenatal care in a Primary Care Health Institution.
Methods: Quantitative study of comparative and cross-sectional design. The information was collected by applying a sociodemographic survey and gynecological-obstetric variables. In addition, the Functional Social Support and Family APGAR questionnaires were used. 357 participants were selected. The data were analyzed using the Chi square test; statistical significance was established with p-value <0.05, and a Multiple Correspondence Analysis (MCA) was performed.
Results: There is a significant relationship between social support and socioeconomic status (p-value: 0.041). Occupation is another category that is also related to functional social support (p-value: 0.033); pregnant women who work have a normal perception, contrary to those who do household chores.
Conclusions: Health services must provide comprehensive care to pregnant women, given the physical and emotional changes that occur during this period, hence the importance of social support as a mechanism to promote the physical and mental health of the pregnant woman and her unborn child.

Key words: Pregnant women; social support; family support; mental health.

Resumen:

Introducción: El apoyo social es un aspecto importante durante la gestación, facilita un afrontamiento favorable ante situaciones estresantes en esta etapa de la vida de la mujer, de igual manera, el apoyo familiar es un factor protector al reducir el riesgo de complicaciones neonatales, facilita el afrontamiento de la gestante y la transición a la maternidad.

Objetivo: Establecer la relación entre apoyo social, funcionamiento familiar, características sociodemográficas y ginecobstétricas, en gestantes que asisten a cuidado prenatal en una Institución de Salud de Primer Nivel de Atención.

Métodos: Estudio cuantitativo de diseño comparativo y transversal. La información fue recolectada mediante la aplicación de una encuesta sociodemográfica y variables ginecobstétricas. Además, se utilizaron los cuestionarios de Apoyo Social Funcional y APGAR familiar. Se seleccionaron 357 participantes. Los datos se analizaron utilizando la prueba de Chi cuadrado; la significancia estadística se estableció con p-valor <0.05, y se realizó un Análisis de Correspondencias Múltiples (MCA).

Resultados: Existe relación significativa entre el apoyo social y el estrato socioeconómico (p-valor: 0,041). La ocupación es otra categoría que también está relacionada con el apoyo social funcional (p-valor: 0,033); las gestantes que trabajan tienen una percepción normal, contrario a las que se dedican a los oficios en el hogar.

Conclusiones: Los servicios de salud deben brindar una atención integral a la gestante, dadas las alteraciones físicas y emocionales que se presentan durante este periodo, de ahí la importancia del apoyo social como mecanismo promotor de la salud física y mental de la gestante y su hijo por nacer.

Palabras clave: Mujer embarazada; apoyo social; apoyo familiar; salud mental.

INTRODUCTION

Due to the physiological changes that occur during pregnancy [1], women experience adjustments in their physical, psychological, behavioral, and emotional states to adapt to the demands of supporting the development of the new life. These changes may or may not be evident and are influenced by multiple factors that affect the normal functioning of all organs.

Psychological manifestations associated with pregnancy are related to sociodemographic, cultural, and gynecological-obstetric factors, as well as partnership dynamics, emotional stability, social support, psychological history, among others [2]. The literature shows that emotions are more intense during pregnancy, which has a direct impact on the physical and mental health of the mother [3].

Some authors suggest [4] that during this stage, it is necessary to make adjustments in the structure and functioning of the family group, as well as in relationships with significant others, to provide adequate family and social support. Thus, social support is considered an important aspect during pregnancy [2] as it promotes positive coping with stressful situations that may arise during this period [5,6].

Several studies indicate that the positive influence of social support during pregnancy is associated with reduced anxiety, increased sense of self-control, and lower rates of postpartum depression [7], which are recognized as mental health risk factors during the perinatal period [8]. Similarly, low levels of stress and anxiety have been observed in response to obstetric complications. In this regard, conditions of stress, anxiety [6,9], and inadequate family support during pregnancy [7], increase the likelihood of obstetric and neonatal complications, and unfavorable perinatal outcomes[10].

Therefore, the interdisciplinary healthcare team's comprehensive support also plays an essential role by reducing uncertainty, enhancing knowledge related to pregnancy, and providing resources to facilitate a positive childbirth experience [11].

With respect to family support, authors such as Pérez, Cruz & Arriaga [7] indicate that it serves as a protective factor during pregnancy by reducing the risk of adverse neonatal complications, supporting women in adapting to changes and facilitating the transition to motherhood [9]. It also promotes mother-child attachment during breastfeeding[11], enhances self-efficacy, and improves subjective well-being. Additionally, a positive perception of support from a partner or spouse is associated with a better quality of life and a lower risk of experiencing depression, anxiety, and generalized stress[7].

The findings of this study will contribute to developing mental health interventions that promote the well-being of pregnant women, their families, and communities, with the goal of providing comprehensive prenatal care. Additionally, the study will offer critical insights into understanding the phenomenon under study and effectively addressing social support and family functioning during pregnancy, thereby improving maternal-perinatal healthcare in the region.

The objective of this study is to establish the relationship between social support, family functioning, sociodemographic, and gynecological-obstetric characteristics in pregnant women who attend prenatal care at a primary healthcare facility.

MATERIAL AND METHOD

Quantitative study with a comparative and cross-sectional design. The population consisted of 679 pregnant women who attended prenatal care at a Primary Care Health Institution located in a municipality in the department of Córdoba, Colombia. From the total population (N=679), a sample of 357 pregnant women was calculated with a 95% confidence level (Z=0.975), a 3% margin of error (confidence interval) (d=0.03), and a probability of 0.5 (p=0.5 q=0.5), using the established mathematical formula for calculating sample size for finite populations.

Participants in the study were selected through convenience sampling, with inclusion criteria being that they were of legal age, had normal physical and psychological conditions, attended prenatal care during the study period, and voluntarily agreed to participate.

Data collection was conducted through a survey that provided sociodemographic data and gynecological-obstetric variables. Additionally, the Functional Social Support Questionnaire (Duke UNC), which quantitatively measures perceived social support, was used. This questionnaire assesses two dimensions: confidential social support (availability of information, advice, or guidance, or people to share problems with) and affective social support (love, affection, esteem, sympathy, and belonging to groups).

This self-administered questionnaire consists of 11 items and uses a Likert-type response scale offering five response options, with scores ranging from 1 to 5, where 1 means "much less than I desire" and 5 means "as much as I desire." The score range is between 11 and 55 points. To classify perceived functional social support, a cutoff at the 15th percentile was chosen, corresponding to a score below 32. A score of 32 or above indicates normal support, while below 32 indicates perceived low social support.

Another instrument used was the Family Function (APGAR) questionnaire, which measures the perception of care and support that an individual receives from their family in relation to five elements: adaptation, participation, resource gradient, affection, and problem-solving capacity. These components are evaluated through five closed-ended questions constructed on a Likert scale with five options, scored between 0 (Almost never), 1 (Sometimes), and 2 (Almost always), with a maximum possible score of 10. To assess the pregnant women's perception of family function, the cutoff points were chosen as follows: normal function: 7-10 points; mild dysfunction: 3-6; and severe dysfunction: 0-2 points.

The data obtained from the different instruments were analyzed using descriptive statistics to explain the sociodemographic and gynecological-obstetric variables.
Results were presented in frequency tables to show the distribution of frequencies and percentages of the categories present in the study's various variables of interest. The Chi-square test was used to determine the significant relationship between categorical variables resulting from the classification of the Family APGAR and Functional Social Support (Duke) questionnaires.

This test is based on comparing presented frequencies while considering the null hypothesis of independence between the variables, offering insight into the influence of these factors on the psychosocial well-being of pregnant women. Statistical significance was established with a p-value < 0.05.

Finally, a Multiple Correspondence Analysis (MCA) was conducted to evaluate the relationships among the various variables; those with low frequencies were excluded in advance to reduce result bias. All analyses were performed using the Statistical Package for the Social Sciences (SPSS) version 26.0.

Approval from the Central Bioethics Committee of the University of Córdoba was necessary for this study. Voluntary consent from participants was obtained through signed informed consent, and confidentiality and anonymity were guaranteed.

RESULTS

Initially, a descriptive analysis of sociodemographic characteristics was conducted. Among the 357 participants, the largest percentage were aged between 25 and 34 years (61.6%); of mixed race (99.2%); and in socioeconomic stratum one (91.3%). About 64.1% had completed secondary education; 73.9% lived in a common-law partnership; 76.8% resided in urban areas; and 97.2% were enrolled in the General System of Social Security in Health (GSSSH) under the subsidized regime.

About 51.8% of participants lived with their spouse or partner, while 46.2% lived with their parents and/or siblings; 78.4% were dedicated to household chores, and 56.3% had family income below the minimum wage. (Table 1).

Table 1. Sociodemographic Characterization.

Variable	Category	Frequency (N°)	Percentage (%)
Age range	18 to 24 years	103	28,9
	25 a 34 years	220	61,6
	35 to 44 years	34	9,5
Area of origin	Rural area	41	11,5
	Rural dispersed area	42	11,8
	Urban area	274	76,8
Marital status	Married	39	10,9
	Divorced	6	1,7
	Single	48	13,4
	Common-law partner	264	73,9
Socioeconomic status (SES)	1	326	91,3
	2	31	8,7
Educational level	No education	3	0,8
	Elementary	47	13,2
	High school	229	64,1
	Technical	56	15,7
	Undergraduate	22	6,2
Occupation	Student	10	2,8
	Domestic duties	280	78,4
	Worker	67	18,8
Household members	Friends	3	0,8
	Shelter	4	1,1
	Married partner	185	51,8
	Parents and/or siblings	165	46,2
Enrollment in GSSSH	Special regime	10	2,8
	Subsidized regime	347	97,2
Economic income	Below minimum wage	201	56,3
	Minimum wage	119	33,3
	Above minimum wage	37	10,4

Sourse: Survery results.

of therelation to the gynecological and obstetric variables, it was observed that 1.1% of the participants were primigravida, 95.5% had between 1 and 4 pregnancies, while 3.4% were multiparous with 5 or more pregnancies. Regarding pregnancy planning, only 9.2% were planned; 8.7% were desired, and 95.5% were accepted.

Table 2. Gynecological and Obstetric Variables

Variable	Category	Frequency (N°)	Percentage (%)
Pregnancy Trimester	1° Trimester	121	33,9
	2° Trimester	167	46,8
	3° Trimester	69	19,3
Previous pregnancies	0	4	1,1
	1 to 4	341	95,5
	5 or more	12	3,4

Sourse: Survery results

Results of the Duke Questionnaire

The results demonstrate that the majority of pregnant women reported having normal levels of emotional and confidential support, represented by 85.7% and 88.8%, respectively.

When relating the variables of functional social support and the dimensions of emotional and confidential support from the Duke Questionnaire, the results obtained show that there is no significant relationship between these. Regarding functional social support, 89.1% of pregnant women indicated having normal social support.

When relating the results of the Duke Questionnaire with sociodemographic variables, it was evident that functional social support does not vary with age, origin, marital status, affiliation with the SGSSS, level of education, people with whom they live, or level of economic income.

Regarding socioeconomic status, the results show a p-value of 0.041, indicating that pregnant women living in the first stratum mostly perceive low functional social support, in contrast to those residing in the second stratum, who perceive normal functional social support. Occupation is another category that is also related to the perception of functional social support (p-value: 0.033); pregnant women who work have a normal perception, unlike those who are engaged in household tasks, who mostly report a low perception. (Table 3).

Table 3. Associations between perceived functional social support and sociodemographic characteristics, p-value less than 0.05 (5%).

Variable	Category	Support received				P-value
		Low		Normal		
		(N°)	(%)	(N°)	(%)	
Age	18 to 24 years	13	33,3%	90	28,3%	0,770
	25 to 34 years	22	56,4%	198	62,3%	
	35 to 44 years	4	10,3%	30	9,4%	
Area of origin	Urban area	33	84,6%	241	75,8%	0,372
	Rural area	2	5,1%	39	12,3%	
	Rural dispersed area	4	10,3%	38	11,9%	
Marital status	Single	6	15,4%	42	13,2%	0,097
	Commom-law partner	33	84,6%	231	72,6%	
	Married	0	0,0%	39	12,3%	
	Divorced	0	0,0%	6	1,9%	
Enrollment in GSSSH	Subsidized regime	39	100,0%	308	96,9%	0,261
	Special regime	0	0,0%	10	3,1%	
Socioeconomic status (SES)	One	39	100,0%	287	90,3%	0,041
	Two	0	0,0%	31	9,7%	
Educational level	No education	0	0,0%	3	0,9%	0,296
	Elementary	3	7,7%	44	13,8%	
	High School	29	74,4%	200	62,9%	
	Technical	7	17,9%	49	15,4%	
	Undergraduate	0	0,0%	22	6,9%	
Household members	Parents and/or siblings	19	48,7%	146	45,9%	0,821
	Married partner	20	51,3%	165	51,9%	

Variable	Category	Support received				P-value
		Low		Normal		
		(N°)	(%)	(N°)	(%)	
	Friends	0	0,0%	3	0,9%	
	Relatives	0	0,0%	4	1,3%	
Occupation	Student	3	7,7%	7	2,2%	0,033
	Domestic duties	33	84,6%	247	77,7%	
	Worker	3	7,7%	64	20,1%	
Economic income	Below minimum wage	27	69,2%	174	54,7%	0,502
	Minimum wage	12	30,8%	107	33,6%	
	Above minimum wage	0	0,0%	37	11,6%	

Source: Duke Questionnaire Results

When correlating the results of the perception of functional social support with gynecological and obstetric variables (number of pregnancies, births, abortions, cesarean sections, live-births, pregnancy interruptions, and acceptance of pregnancy), it was found that there is no significant relationship between these variables.

The gynecological category of trimester of pregnancy, showed a significant relationship (p-value: 0,012) with functional social support; pregnant women in their first trimester reported a normal perception in higher proportion, whereas for the second and third trimesters, a higher percentage of pregnant women perceived low social support.

Regarding the category of desired pregnancy, the results indicate that there is a higher proportion of normal functional social support perception when the pregnancy is undesired; a similar behavior is observed in cases of unplanned pregnancies.

Table 4. Associations between perceived functional social support and gynecological-obstetric characteristics, p-value less than 0.05 (5%).

Variable	Category	Self-perceived support				P-value
		Low		Normal		
		(N°)	(%)	(N°)	(%)	
Trimester	1° Trimester	5	12,8%	116	36,5%	0,012
	2° Trimester	25	64,1%	142	44,7%	
	3° Trimester	9	23,1%	60	18,9%	
Desired pregnancy	Yes	7	17,9%	24	7,5%	0,029
	No	32	82,1%	294	92,5%	
Planned pregnancy	Yes	7	17,9%	26	8,2%	0,047
	No	32	82,1%	292	91,8%	
Accepted pregnancy	Yes	38	97,4%	303	95,3%	0,540
	No	1	2,6%	15	4,7%	

Source: Duke Questionnaire Results.

Results of the Family APGAR Questionnaire

It was evident that the majority of participants perceived normal family functionality (59.4%), followed by mild family dysfunction (38.7%). The study results did not show a significant relationship between family functionality and the sociodemographic variables of the participants. Regarding gynecological and obstetric variables, a

significant relationship was observed between the categories of number of births and live-born children. When there are no previous pregnancies, it is more likely that participants' perceptions are classified as normo-functional, followed by mild dysfunction; whereas when there are 5 or more births, there is a higher likelihood of experiencing severe family dysfunction, similar to what occurs with the variable number of live births. (Table 5).

Table 5. Associations between perceptions of family functionality and gynecological-obstetric characteristics, p-value less than 0.05 (5%)

Variable	Category	Normo-functional		Mildly dysfunctional		Severely disfunctional		P-value
		(N°)	(%)	(N°)	(%)	(N°)	(%)	
Births	0	154	72,6%	93	67,4%	4	57,1%	0,000
	From 1 to 4	57	26,9%	45	32,6%	2	28,6%	
	5 or more	1	0,5%	0	0,0%	1	14,3%	
live-born	0	119	56,1%	79	57,2%	3	42,9%	0,000
	From 1 to 4	92	43,4%	59	42,8%	3	42,9%	
	5 or more	1	0,5%	0	0,0%	1	14,3%	
Desired pregnancy	Yes	15	7,1%	16	11,6%	0	0,0%	0,243
	No	197	92,9%	122	88,4%	7	100,0%	
Planned pregnancy	Yes	17	8,0%	16	11,6%	0	0,0%	0,368
	No	195	92,0%	122	88,4%	7	100,0%	
Accepted pregnancy	Yes	205	96,7%	129	93,5%	7	100,0%	0,307
	No	7	3,3%	9	6,5%	0	0,0%	

Source: Results of the Family APGAR Questionnaire.

Multiple Correspondence Analysis (MCA)

In the Multiple Correspondence Analysis, the variables with the greatest influence on each dimension were identified using the coefficient of determination R^2 along with its associated p-value. For the first dimension, the variables with the highest values were: economic income, marital status, socioeconomic stratum, and educational level, with results of 0.8730, 0.8096, 0.7884, and 0.36957, respectively. In relation to dimension 2, the variables number of living children, number of births, educational level, and area of residence had values of 0.5153, 0.5060, 0.4857, and 0.3781, respectively (Table 6).

**Table 6.** Correlation Level Between Variables and Dimensions

Variable	Dimension 1		Dimension 2	
	R2	p-value	R2	p-value
Economic income	0,8730	2,24E-159	0,2127	4,18E-19
Marital status	0,8096	9,51E-127	0,0866	5,16E-07
Socioeconomic status	0,7884	8,96E-122	0,0740	1,79E-07
Educational level	0,6957	1,39E-89	0,4857	1,29E-49
Occupation	0,5092	1,94E-55		
Household members	0,2377	1,16E-20	0,0385	3,09E-03
Area of origins	0,1110	8,96E-10	0,3781	3,07E-37
Age	0,0977	1,25E-08	0,1485	4,42E-13

Variable	Dimension 1		Dimension 2	
	R2	p-value	R2	p-value
Desired pregnancy	0,0834	2,78E-08	0,0502	1,91E-05
Planned pregnancy	0,0726	2,35E-07	0,0477	3,16E-05
Live-borns	0,0413	5,70E-04	0,5153	2,13E-56
Perceived functional social support	0,0225	4,47E-03		
Births	0,0267	8,37E-03	0,5060	6,17E-55
Pregnancies	0,0255	1,03E-02	0,2289	1,03E-20
Family functioning perception			0,0364	1,41E-03

Source: Applied questionnaires results

In Figure 1, it is observed that the variables number of living children, number of births, and area of residence showed a stronger correlation in dimension 2; whereas the variables economic income, marital status, socioeconomic stratum, and occupation were more correlated in dimension 1. The perception of family functionality and functional social support did not contribute significant information to these dimensions; however, they were used as auxiliary variables to explain certain behaviors.

Figure 1. Correlation Between Variables.
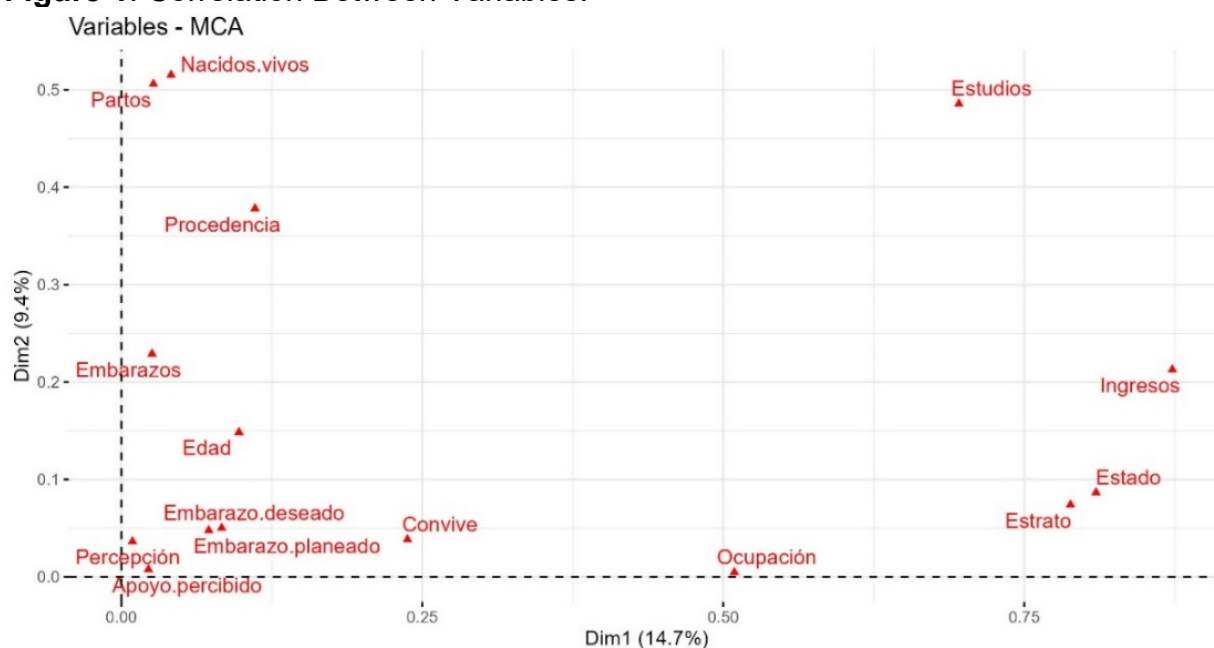
Source: Applied questionnaires results

Figure 2 shows that the categories with the greatest importance in the first dimension were: marital status, educational level, socioeconomic stratum, number of living children, number of births, area of residence, and occupation. It is also evident that variables such as university-level education, married marital status, socioeconomic stratum two, and income above the minimum wage did not contribute significantly to dimension 2.

Figure 2. Association Between Category Results and Dimensions of the Applied Questionnaires.
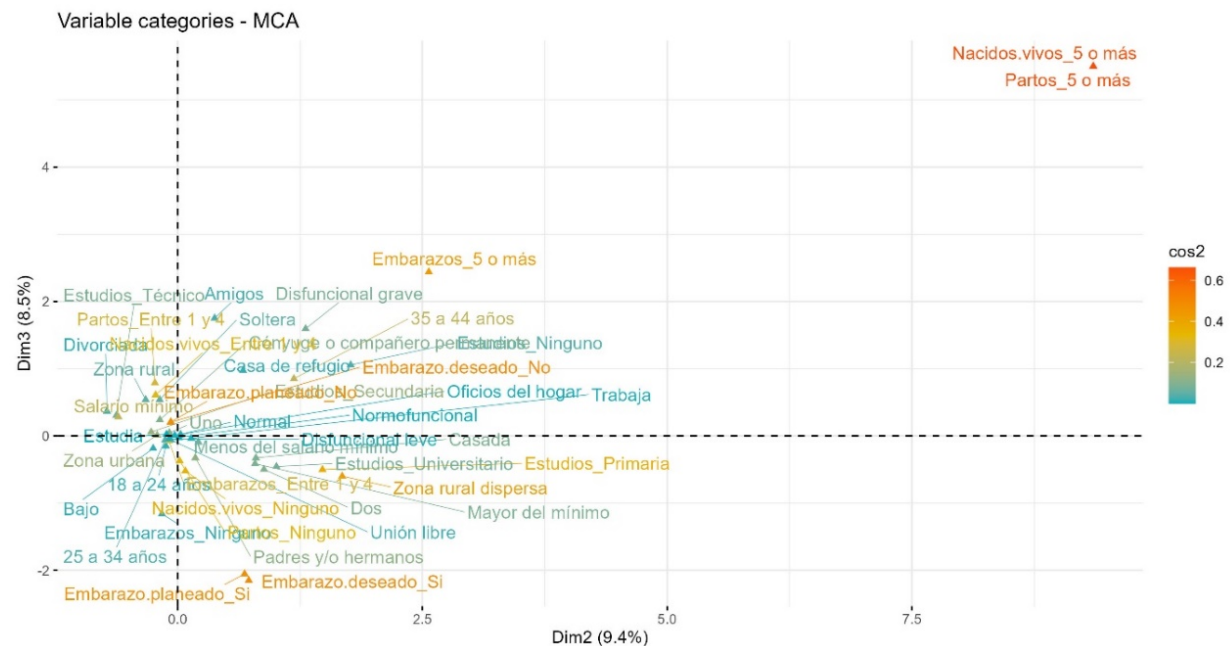
Source: Applied questionnaires results

Regarding the perception of low social support, the variables with the strongest correlation were pregnant women residing in remote rural areas, with an education level of primary school or less, engaged in household tasks, and with family income below the minimum wage (Figure 3).

Figure 3. Distribution of Individuals, Grouped by Phase in Confidence Ellipses for Perceived Support.
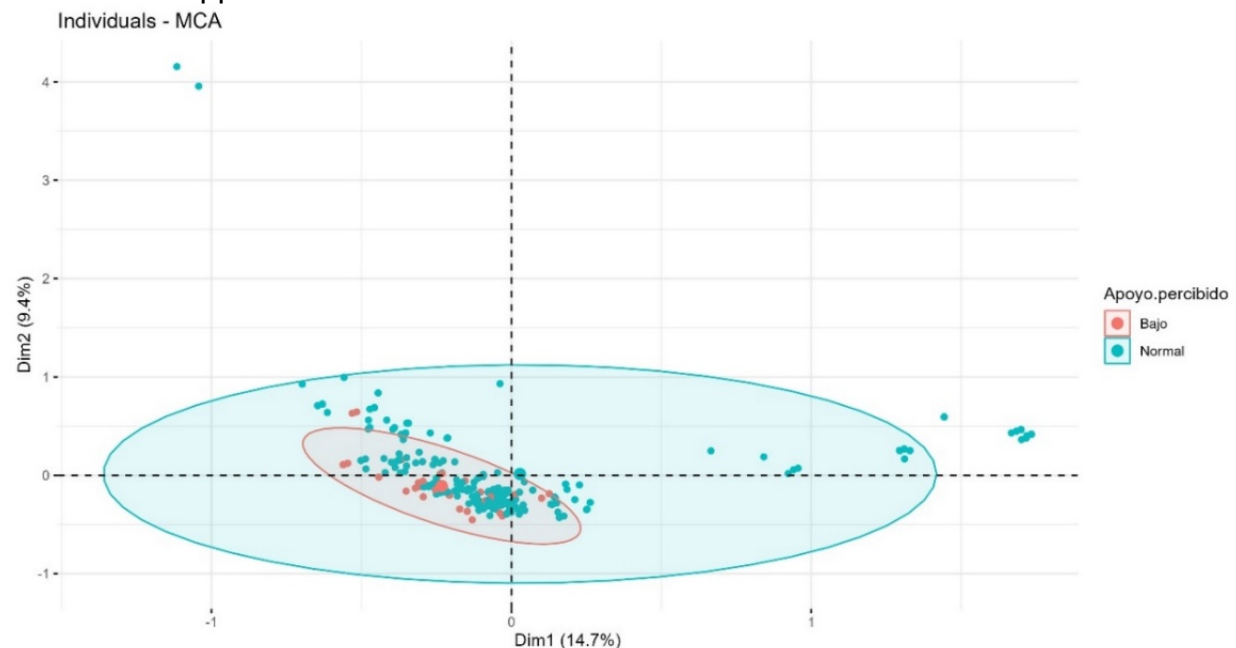
Source: Applied questionnaires results

DISCUSSION

Various authors state that during pregnancy, emotions are more intense [3] and can disrupt the normal functioning of a woman's organs and systems [1], resulting in unfavorable consequences for both the mother and her unborn child. In this context, social and family support during this stage is essential due to its positive influence on health, well-being, and the normal development of pregnancy [3].

The results of this study showed that most participants were between 25 and 34 years old, lived in urban areas, had completed secondary education, were housewives, and were in common-law unions with their partner. These findings align with the results of a study by Thomas-Hilarión et al [11], conducted in another Colombian city.

Another significant finding relates to family incomes below the minimum wage (US$384). The literature shows the negative impact of poverty on health, education, and family environment [12,13], and pregnancy is no exception to this reality. Some authors indicate a positive relationship between maternal morbidity and the multidimensional poverty index [14]. Santos & Patricio [15], in a study conducted in the Dominican Republic, found a 2.2-fold increase in maternal mortality in regions with high multidimensional poverty compared to those with lower poverty levels.

Regarding gynecological-obstetric variables, most participants were multigravid. Findings from other studies indicate that parity increases the likelihood of pregnant women experiencing anxiety and depression [16]. This situation may be due to potential negative experiences with previous pregnancies and/or interpersonal issues with other children and the partner resulting from the arrival of a new family member [17]. Similarly, Steen & Francisco [18] note that during the stages of pregnancy, childbirth, and postpartum, there is a high probability of increased anxiety, stress, or other mental health issues in women.

It is notable that a high percentage of participants reported that their current pregnancy was unplanned and undesired. Various authors point out that unplanned pregnancies are associated with low social support from partners, which negatively affects family relationships [6]. The United Nations Population Fund (UNFPA) [19] reports that globally, around 80 million women have had an unwanted pregnancy, of which one in four has been terminated, endangering the woman's life.

Likewise, the World Health Organization (WHO) [20] indicates that unwanted pregnancies pose numerous risks to the physical and mental health of both the pregnant woman and her child, including malnutrition, abuse, neglect, and even death. Unplanned pregnancies also lead to multiple births, reduced educational and employment opportunities for women, and contribute to poverty—situations that can persist for generations. Legarra et al [21] state that factors such as lack of social support, an unplanned or unwanted pregnancy, and complications in previous pregnancies [22] are considered risk factors associated with depression and anxiety during pregnancy.

When analyzing the perception of social support among pregnant women, the results were consistent with those observed by Osma-Zambrano et al [23], who found that the participants in their study perceived normal social support. In this context, it is

important to note that social support is a protective factor for the mental health of pregnant women because it helps reduce levels of stress and anxiety, improves self-esteem, and reinforces feelings of security, especially when the perceived support comes from a partner[24].

This study analyzed the significant relationship between perceived social support in pregnant women and sociodemographic and gynecological-obstetric variables. Regarding sociodemographic variables, there was a relationship between socioeconomic status and the occupation of the participants. The results showed that pregnant women in socioeconomic stratum one mostly perceived low functional social support, while those in stratum two perceived normal functional social support. These findings are similar to those observed by Thomas-Hilarión et al [11], who noted that pregnant women from middle-high socioeconomic backgrounds perceive higher social support compared to those from lower socioeconomic strata.

A significant relationship was also found between occupation and the perception of functional social support. Pregnant women who worked had a normal perception of social support, while those who were housewives mostly perceived low functional social support. Similar results were reported by Velascos & Álvarez [24], who observed that having a job had a slight positive effect on the perception of social support, while unemployment and socioeconomic problems were negatively associated with perceived social support. Similarly, Ginja et al [25], in a study conducted in England, found a significant relationship between social support and participants' employment status.

Regarding the family support perceived by pregnant women, the results indicate no relationship with sociodemographic variables; however, gynecological-obstetric variables such as the number of births and living children show a significant relationship. Primigravida participants in the study reported perceiving normal family support, while multigravida women were more likely to perceive severe family dysfunction, findings that align with those reported by Thomas-Hilarión et al[11].

These results require thorough evaluation due to potential limitations in the study. The use of convenience sampling may limit the generalizability of the findings to a broader population of pregnant women attending prenatal care at a Primary Care Health Institution. Additionally, self-administered questionnaires may be influenced by response biases and social desirability effects.

CONCLUSIONS

One of the most important challenges faced by healthcare services is providing comprehensive care to pregnant women, given the physical and emotional changes that women experience during this period. This highlights the importance of social support as a mechanism that promotes the physical and mental health of both the pregnant woman and her unborn child.

There is a significant relationship between socioeconomic status and the perception of social support among pregnant women. Those in socioeconomic stratum one mostly perceives low functional social support, in contrast to those in stratum two, who perceive normal functional social support. The occupation or type of work performed

by the pregnant woman also influences the perception of functional social support. Women who work perceive normal functional social support, whereas those who perform household tasks mostly report low perceptions of social support.

There is a significant relationship between the pregnancy trimester and functional social support. The majority of participants in their first trimester perceived normal functional social support, whereas those in their second and third trimesters had lower perceptions of social support.

Most participants stated that their current pregnancy was unplanned and unwanted but accepted. This situation is unfavorable for the health of the pregnant woman, as unplanned pregnancies are associated with low social support from partners, negatively impacting family relationships and putting safe motherhood at risk.

There is a significant relationship between family functionality and gynecological-obstetric variables, such as the number of births and living children. When there are no previous pregnancies, it is more likely that participants will perceive normal family functionality, followed by mild family dysfunction. However, when there is a history of five or more births, the likelihood of severe family dysfunction increases, as seen with the variable of living children. In general, it was found that most pregnant women in the study perceived normal family functionality, functional social support, and both affective and confidential support.

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