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Spousal Support for Maternal Health Service Access and Spousal Abuse among Expectant and Nursing Mothers in Idemili South L.G.A, Anambra State, Nigeria

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Abstract

This paper has investigated the relationship between spousal support for maternal access to health care and spousal abuse experiences of expectant and nursing mothers in the Idemili South Local Government Area, Anambra State, Nigeria. Using the AGIL Model, the Structural Violence Theory (SVT), and the Social Support Theory (SST), the study examined the nature of interactions between structural, institutional and relational factors to influence health experiences among the study population. A descriptive-correlational survey design was adopted for the study and the data were collected using face-to-face questionnaire to as sample of 232 participants in eight primary healthcare facilities, who were selected using the proportionate convenience sampling technique. Descriptive - frequency count and percentage and inferential statistics (t-test), were used to analyse the data. Findings revealed that while financial support from spouses was relatively high, emotional and practical support were moderate to low. Overall, 69% of respondents reported occasional experiences of spousal abuse, whereas 16.6% had never experienced abuse. Statistical analysis indicated a significant negative interrelationship between spousal support and spousal abuse ($t = 7.84$, $p = .001$), which meant that higher levels of spousal support were associated with lower incidences of spousal abuse. The study also found that male low participation in maternal care due to patriarchal orientation, financial strains, and poor institutional mobilization leads to stress and experiences of spousal abuse. The study therefore recommends that institutional support on maternal health should be enhanced, that males should be engaged in other areas other than money and that sensitisation of communities should be done to encourage equitable gender relations. Such interventions are relevant in enhancing the health of expectant and nursing mothers, as well as minimising the chances of spousal abuse in the rural Nigerian setting.

Keywords: maternal health access, spousal support, spousal abuse, Idemili South, Nigeria

Introduction

One of the most urgent health problems of the 21st century globally, is maternal health. It is a common fact that not only maternal outcomes are defined by the health of women during pregnancy and after delivery, but the survival and development of infants and children is also affected by it (World Health Organisation [WHO], 2017). Mothers who have access to

quality healthcare have higher chances to undergo good parturition and there are long-term effects of maternal well-being on family and societal success. On the other hand, maternal health impairs the morbidity and mortality of mothers and subsequently, infant and child mortality (Ajayi & Akpan, 2020).

Realising this, the Sustainable Development Goals (SDGs) have put maternal health at the forefront of the global development agenda. In particular, Goal 3 presupposes the reduction of the maternal mortality rate (target 3.1), provision of universal access to sexual and reproductive health services (target 3.7), and universal health coverage (target 3.8) (United Nations, 2015). These goals highlight the point that maternal health is not a personal problem but a public health concern that is needed in sustainable developments. Locally, this perspective resonates with cultural beliefs in south-eastern Nigeria, such as the Igbo adage, "*ahara ndu kpa aku, onye iro erie*", which literally implies that health is wealth—suggesting that health is foundational to individual and collective prosperity.

The issues of maternal health still prevail in most developing nations even although efforts to curb the problem are being intensified through national and international commitments, particularly in Sub-Saharan Africa. In Nigeria, the maternal mortality ratio is ranked among the highest globally with the estimated level standing at 512 deaths per 100,000 live births (National Population Commission [NPC] & ICF, 2019). Mothers receive varied access to health services, and rural women are the most disadvantaged group as they suffer due to poor infrastructure, lack of adequate health service staff, expensive health services, and socio-cultural orientation (Mahumud *et al.*, 2019; Doctor *et al.*, 2018). Those access disparities tend to put expectant and nursing mothers at disadvantaged status, compelling them to strike a trade-off between their health care requirements and household economic constraints.

Immediate health outcomes are not the only effects of limited access to maternal healthcare as it also has social and relational implications. There is empirical support that, lack of access to the necessary maternal health services for women, increased tension and spousal abuse in their marriages, particularly in socio-economic conditions where it remains common that men are expected to support the household needs (Fawole, 2018; Okenwa-Emegwa, 2016). This linkage of healthcare with spousal abuse is a dimension that

little has been well-explored in recent empirical literature, but remains critical as far as maternal health studies are concerned. Financial stress, power relations affected by gender and cultural expectations in most Nigerian families converge, leading to conflicts when women's maternal health needs are not met. These conflicts can further escalate into marital abuse, by verbal, physical or neglect.

From the criminological perspective, spousal abuse is critically important since it may turn into intimate partner violence (IPV) - a kind of gender-related violence that has physical and psychological outcomes (Jewkes and Morrell, 2018). IPV and the factors affecting maternal health may be especially destructive, as expectant and nursing mothers are already vulnerable to a greater extent since they encounter physical trauma, hormonal changes, and the obligation to take care of a child. Spousal abuse connected to maternal healthcare demands may at the very least result in serious physical abuse and even homicide, which is why its importance is even more relevant in the field of criminology as it is not only a domestic issue but a violation of human rights (Heise *et al.*, 2019).

This intersection is also complicated by the patriarchal structure of the Nigerian socio-cultural environment and as such the men are expected to be the decision makers in the home including the use of healthcare by their wives. Studies have shown that rural women are generally expected to obtain the approval of their husbands to utilise maternal healthcare services, and rejection by the husband (either due to lack of financial capacity or opposition of culture) can build resentment and animosity into marital union (Isiugo-Abanihe, 2017; Akin-Akintayo, 2020). This situation is often worsened by the economic challenges faced by most households in Nigeria, particularly rural households. As such, men who are unable to meet the healthcare needs of their wives may face hostility or dissatisfaction, while women may experience frustration that can lead to verbal or physical confrontations between the spouses.

The rural communities in south-eastern Nigeria are not immune from these realities. Expectant and nursing mothers in communities such as Idemili South Local Government Area (LGA) of Anambra State often face multiple layers of disadvantage: poor access to healthcare facilities, socio-economic hardship, and entrenched gender norms that limit women's autonomy in health-related decision-making. Most women in these settings still

engage in physically demanding activities during pregnancy and the postpartum phase, a circumstance that does not only jeopardize their health but also introduces other stressors in their marital unions (Owoo & Lambon-Quayefio, 2018).

Although available literature on maternal health in Nigeria have been on the increase, only a handful of researchers have examined the association between spousal support for maternal healthcare access and spousal abuse. A large part of the research has been on either the health outcomes of mothers (NPC & ICF, 2019; Mahumud *et al.*, 2019) or on the general topic of intimate partner violence (Fawole, 2018; Okenwa-Emegwa, 2016). The overlap of the two aspects, including the role of spousal support for access to maternal healthcare and its effects on violence against expectant and nursing mothers as spouses, has not been properly explored. Such an omission is of great significance especially in the rural areas, where the issue of maternal health is being complicated by that of the marriage and both problems are prone to intersect.

This article thus, finds itself as a cross point between medical sociology and criminology. In terms of medical sociology, it investigates ways structural disparities of access to healthcare influence the experiences of expectant and nursing mothers. Criminological, it examines the ways in which these experiences can lead to spousal abuse in homes, which then contextualizes maternal access to health as a social problem, as well as something that contributes to household stability and social harm. By focusing on Idemili South LGA in Anambra State, this research provides a contextualised analysis of how spousal support for maternal health access interacts with marital dynamics, contributing both to academic debates and to policy discussions on women's health and safety in Nigeria.

Objectives of the Study

1. To assess the level and forms of spousal support received by expectant and nursing mothers in accessing maternal health services in Idemili South L.G.A, in Anambra State.
2. To examine the relationship between spousal support for maternal health service access and the occurrence of spousal abuse among expectant and nursing mothers in Idemili South L.G.A, in Anambra State.

Literature Review

Concept of Maternal Health/Maternal Health Services

Maternal health is a central concern in public health because it directly affects the wellbeing of women and their children. The World Health Organization (WHO, 2017) defines maternal health as the health condition of women prior to and throughout pregnancy, at the birth of the child, and during the postpartum. It is important to highlight that it is not simply the lack of disease or infirmity but a condition of total physical, mental, and social well-being in all issues concerning women of childbearing age. Maternal health, in this case, is a comprehensive perspective of the wellbeing of the women in their reproductive life course.

This conceptualisation has been further increased by scholars. According to Olonade *et al.* (2019), maternal healthcare involves providing education, social, and nutritional services in addition to medical care during and after pregnancy. Likewise, Okeke *et al.* (2016) believe that in the African context, maternal health can also be seen as the possibility of women to exercise reproductive rights, i.e. family planning and access to focused antenatal care without a sense of constraint by patriarchy, financial constraints or geographical barriers. The expanded lenses also place maternal health in a wider context, which is not limited to biomedical care but also in socio-cultural and structural determinants.

Maternal healthcare services are, consequently, the scope of health and support services offered to women prior to conception, during pregnancy, throughout delivery, and in the postnatal phase (Olonade *et al.*, 2019). There has been an increased concern regarding the access of these services globally, given that maternal healthcare is one of the strongest interventions that can help lower maternal and childhood mortality, especially in underdeveloped nations like Nigeria (Kifle *et al.*, 2017). The availability of quality maternal health services is also part of the realization of the Sustainable Development Goals (SDGs), particularly Goal 3, which emphasizes on the provision of healthy living and happiness to everyone.

Such services are not limited to clinical care, but also sexual and reproductive health, nutrition information, screening and control of communicable and non-communicable

illnesses, prevention and response of gender-based violence, and early warning and management of pregnancy-related risks (Olonade *et al.*, 2019). As a conceptual construct, therefore, maternal healthcare services is defined in this study as an overall package of programmes aimed at ensuring that women at reproductive age not only stay in optimal health, but also make informed decisions about their health throughout their reproductive life period.

Access to Maternal Health Services

Access refers to the ability of individuals to obtain, use, and benefit from essential services when needed (Penchansky & Thomas, 1981). Contemporary frameworks extend this idea by emphasising not only availability and affordability but also approachability, appropriateness, and acceptability of services (Levesque *et al.*, as reviewed in Cu *et al.*, 2021). In practice, access thus covers aspects of service provision, physical proximity, affordability, cultural acceptability and technical sufficiency of care.

Recent findings have also substantiated that regular access to high-quality maternal care, in terms of timely antenatal contacts, skilled birth care, and postpartum care, is linked to reduced maternal morbidity and mortality and improved neonatal outcomes (Albarqi, 2025). In Nigeria particularly, facility-based and national survey research has shown that women with stable access to maternal health services are more likely to receive early antenatal care, skilled childbirth, and post-partum care which results in the reduction of complications and maternal confidence in the perinatal period (National Population Commission & ICF, 2019; Bello, 2022).

Besides, a recent study showed that access to maternal healthcare services can counter household stress: when services are secure, women report less care-related anxiety and less reliance on male partners on emergency decisions - aspects that minimize one possible cause of marital stress and spousal abuse (Chol *et al.*, 2019). Innovations that increase access — for example, telehealth antenatal models and facility-level quality improvements — also demonstrate promise for maintaining continuity of care and improving outcomes, especially where physical access is constrained (Cottrell *et al.*, 2023; Tijani *et al.*, 2025). Taken together, these findings indicate that access is not only a matter of clinical provision

but also a social determinant that can influence household relations and, by extension, the risk environment for spousal abuse among expectant and nursing mothers.

Maternal Health Access and Spousal Abuse

The relationship between maternal health access and spousal abuse has gained growing attention, though it remains underexplored in both medical sociology and criminology. Existing literature demonstrates that spousal abuse—commonly operationalised in global research as intimate partner violence (IPV)—negatively affects women's maternal health outcomes by constraining their ability to seek or continue care (Jewkes, 2002; Fawole, 2008). In Nigeria, large-scale analyses of the Demographic and Health Surveys have provided robust evidence of this relationship. For example, Adewuyi and Awaworyi Churchill (2021) found that women who experienced spousal abuse were less likely to utilise antenatal, delivery, and postnatal services. Similarly, Adewoyin *et al.* (2022) identified spatial variations, showing that violence further entrenches existing regional disparities in maternal health access. These studies highlight the structural significance of spousal abuse in shaping health inequalities.

It has been criticized however that the relationship is one-sided in the literature since violence results in poor access but little consideration has been made to examine how poor access may be a further cause of spousal abuse. Campbell (2002) and Okenwa-Emegwa (2016) suggest that an inability to access the necessary services may increase the intensity of marital conflicts in the instance of expectant or nursing mothers who display dissatisfaction and men who feel that their failure to fulfil the healthcare requirements are a challenge to their power. This implies that the relationship between the two is cyclical or reciprocal but there are few empirical studies examining such a reciprocity especially in Nigeria.

The external validity of the evidence base of the region is also doubtful. The study of sub-Saharan Africa (Aboagye *et al.*, 2022) and Ethiopian (Ousman *et al.*, 2022) can prove the existence of the reduction in maternal access to health because of IPV, yet because the community level of the country has health funding, the attitudes of women, and available resources, the study cannot be generalized to the situation in Nigeria. Moreover, most studies rely on cross-sectional survey data, which establish associations but not causality,

leaving unanswered whether improved maternal hea lth access can directly reduce the prevalence of spousal abuse.

Nigerian studies in the recent past have however widened the area of research. The results of a study by Olubodun *et al.* (2023) revealed that IPV in pregnancy and postpartum lowered compliance with the best breastfeeding practices, which means that violence impacts not only the service usage but also the maternal behaviours influencing the child health. Such findings reveal a broader chain of consequences, yet they also expose a gap: few studies interrogate the protective role of maternal health access against domestic violence, despite theoretical claims that improved access reduces household stressors (Imam & Igbokwe, 2020).

In sum, while the literature establishes a strong association between spousal abuse and poor maternal health outcomes, it is weakened by conceptual ambiguities (e.g., the conflation of spousal abuse and IPV), reliance on self-reported data, and a lack of longitudinal evidence. There is, therefore, a pressing need for context-specific, interdisciplinary studies that examine not only how spousal abuse limits maternal health access, but also whether expanded access itself can act as a deterrent to abuse. This crucial gap puts the current study in the realm of the public health discourse as well as in the discourse of criminology, which renders it exceptionally applicable to the problem of maternal health in Nigeria.

Theoretical Frameworks

This study adopts an integrated theoretical perspective through the combination of the Parsons AGIL Model (1951, 1971), Galtung Structural Violence Theory (1969) and Social Support Theory (Cohen and Wills, 1985) to explain the multidimensional relation between spousal support for maternal health access and spousal abuse among expectant and nursing mothers in Idemili South, Anambra State. Collectively, these theories provide information on the relationship between the macro-level structures, institutional coordination, and interpersonal dynamics to determine the health-seeking behaviour and vulnerability of women to spousal abuse.

Parsons' AGIL Model provides a systemic view of how societies maintain stability through four functions: Adaptation, Goal Attainment, Integration, and Latency. In Nigeria, failures in

adaptation - manifested in weak health infrastructure, high service costs, and urban-rural disparities (Doctor *et al.*, 2018), limit women's access to quality care and heighten their dependence on spousal support. Unmet national goals on maternal health and weak institutional coordination further generate stress and marital discords (Okedo-Alex *et al.*, 2020). Patriarchal norms also erode the aspects of integration, making the healthcare choices of women dependent on the consent of husbands (Isiugo-Abanihe, 2017), whereas latency upholds the gender norms according to which male dominance is acceptable and the autonomy of women is limited (Jewkes *et al.*, 2017). Thus, the AGIL model links poor maternal health access and spousal abuse to systemic dysfunctions in societal roles and value maintenance.

This is supplemented by the Structural Violence Theory that illustrates how structural and social realities indirectly create harm by being in the form of inequality and exclusion (Galtung, 1969; Farmer, 2004). Women are limited to their own independence due to inadequate health infrastructure, gendered hierarchies of power, and poverty (Okenwa-Emegwa, 2016; Yaya *et al.*, 2019). Such inequalities usually exacerbate marital conflicts of power where men can be frustrated by their inability to control the structural situation and may direct their anger towards coercive control or abuse towards women in their household (Fawole, 2008). This means that poor maternal health access, as well as spousal abuse, are the outcome of the same imbalance in the system. It has been indicated that structural inequities can be reduced by both enacting gender-responsive policy changes and by equally financing health, which can simultaneously lead to a reduction in maternal outcomes and a reduction in spousal abuse (Garcia-Moreno *et al.*, 2022; Watts *et al.*, 2021).

The Social Support Theory adds additional layer to the analysis by providing the micro-level approach to stress alleviation with emotional, informational, and instrumental support that enhances health outcomes (Cohen & Wills, 1985). Empathy of spouses and common decision-making and communication in the context of maternal health contribute to the confidence and access to services, and the absence or conditional support results in tension and exposure to abuse (Ng, 2023; Kim & Lee, 2020). Social support therefore serves as a relative process that mediates the impacts of structural and institutional pressure.

Integrating these perspectives provides a comprehensive model that connects structure, system, and relationship. The AGIL Model describes functional failures in the societal systems; Structural Violence Theory reveals that these failures are converted into institutionalised harm; and Social Support Theory shows the interpersonal pathways that would either mitigate or enhance these effects. Collectively, they demonstrate that maternal health access and spousal abuse are intertwined processes shaped by the intersection of social systems, institutional structures, and relational support networks.

This integrated framework therefore, advocates a multilevel approach to women's health and safety. On the macro level, the structural and policy changes have to decrease the unfairness in both healthcare and gender norms. Better coordination is required between the communities and health institutions at a meso level. On the micro level, the stresses generated by structural constraints may be mitigated by promoting emotional and practical spousal support. This framework provides a holistic explanation of the role of both the societal organisation and intimate relationships in that systemic, structural and psychosocial understanding of how the interaction of these factors leads to maternal health outcomes and spousal abuse.

METHODS

Research Design

The study design used in the present research was descriptive-correlational which, as Creswell and Creswell (2018) and Polit and Beck (2021) state, enables describing and analyzing the relationship between variables in a given population and not interfering with them. The reason why this design was deemed fitting was due to the fact that it enabled the measurement of not only the level of spousal support for maternal healthcare access, but also its relationship with spousal abuse among about among expectant and nursing mothers, hence offering objective and generalizable data that can be used to inform specific maternal health interventions and policies (Bryman, 2016; Garcia-Moreno and Pallitto, 2013).

Area and Population

The research was carried out the study in eight Primary Health Care (PHC) centers offering postnatal and antenatal care in Idemili South Local Government Area (L.G.A.), Anambra

State, Nigeria. The choice of PHCs was influenced by their strategic position as the first line of contact of majority of women in rural and semi-urban areas since they offer great services in maternal and child health. PHCs are set to provide community-based, preventive, and affordable care, which would more equally provide access to health services. This makes them ideal for capturing a representative picture of maternal health service utilisation and experiences of spousal abuse during pregnancy and postpartum (World Health Organization [WHO], 2018; Federal Ministry of Health [FMOH], 2019; Adebayo et al., 2020).

Idemili South L.G.A. is one of the 21 L.G.As in Anambra State, located in South-East Nigeria. It lies between Latitude 6°20′60″ North and Longitude 7°00′ East of Nigeria. The area comprises seven major Igbo-speaking towns: Akwaukwu, Alor, Awka-Etiti, Nnobi, Nnokwa, Oba, and Ojoto, with Ojoto serving as the administrative headquarters. Idemili South is predominantly rural, with agriculture as the major occupation of the people (Unegbu *et al.,* 2018). However, ongoing urbanisation across Anambra State has introduced diverse socio-economic activities, including small-scale commerce, education, light industries, and public administration, particularly in the semi-urban parts of the area.

The target population was comprised of expectant and nursing mothers undergoing antenatal and postnatal services in the targeted PHCs. According to the Anambra State Ministry of Health (2024) reports, about 2,000 women access the services of maternal healthcare in 25 PHCs of the L.G.A. For the purpose of this study, eight facilities were purposively selected, representing both rural and semi-urban settings, with a combined accessible population of 625 women attending maternal health services at the time of the study.

Sample and Sample Techniques

The sample size for this study was determined using Yamane's (1967) formula for finite populations at a 5% margin of error: The formula is given as: $n = \frac{\mathrm{N}}{1+ N\,(e)^2}$

Where:

- n = sample size
- N = population size (625)
- e = level of precision (margin of error)

$$n = \frac{(625)}{1+ 625\ (0.05)^2} = \frac{(625)}{1+ 625\ (0.0025)} = \frac{(625)}{1+ 1.5625} = \frac{(625)}{2.5625} = 240$$

A sample size of 240 respondents was obtained. This sample size was proportionally allocated among the eight facilities and done depending on the proportion of the number of the users of maternal health services in each of the facilities. Given the practical realities of health facility attendance, the study adopted a proportionate convenience sampling strategy, where women were selected based on their availability and willingness to participate during the periods of data collection. To ensure that the required sample from each facility was attained, the researcher made repeated visits to the selected facilities until the proportionate number of respondents for each facility was achieved.

Inclusion criteria were: women aged 18 years and above, currently pregnant (≥ 32 weeks gestation) or nursing, and residing within the catchment area of the selected facilities. Women with severe obstetric complications or those unable to participate in interviews were excluded.

Data Collection

Data were collected using a structured, interviewer-administered questionnaire, designed to obtain comprehensive information relevant to the study objectives. It consisted of three sections: i) Socio-demographic and economic characteristics, including motherhood status, age, marital status, educational attainment, income level, occupation, and religious affiliation; ii) Maternal health service access indicators, such as sexual and reproductive health educational services, nutritional advice, antenatal care, postnatal care, risk detection and management, among others; iii) Experiences of spousal abuse – focusing on physical, emotional, and economic abuse experienced during pregnancy and postpartum.

Data Analysis

Data collected from the survey were coded into the Statistical Package for Social Sciences (SPSS) software version 27, which was used in processing all the relevant statistical data. To ensure data quality and integrity, double data entry was performed by the researcher. Thereafter, data were analyzed using descriptive statistics (frequencies, percentages, and cross-tabulations) to summarise the characteristics of the study population and key study variables. The t-test statistic ($p < 0.05$) was used to compare the difference in experience of

spousal abuse in relation to the level of spousal support for maternal healthcare access among the respondents.

Results

Table 1.

Distribution of Respondents' Socio-Demographic Characteristics

Variables		Frequency	Percent (%)
Motherhood Status			
Expectant Mother		167	52.1
Nursing Mother		65	47.9
Total		**232**	**100.0**
Age Category			
18-27 Years		51	21.9
28-37 Years		124	53.6
38-47 Years		57	24.5
Total		**232**	**100.0**
Educational Qualification			
None		10	4.2
Primary		29	12.4
Secondary		99	42.8
Tertiary (Diploma/NCE/Equivalents)		56	24.3
Tertiary (Graduate)		33	14.1
Tertiary (Post-Graduate)		5	2.2
Total		**232**	**100.0**
Average Monthly Household Income			
< 10,000.00		27	11.5
N11,000.00 – 30,000.00		87	37.5
N31,000.00 – 50,000.00		74	31.7
N51,000.00 – 70,000.00		33	14.1
> 70,000.00		12	5.2
Total		**232**	**100.0**
Occupational Status			
Unemployed		57	24.5
Formal	Private Service	36	15.6
	Government/Public Service	29	12.5
Informal	Petty Trading/Self-Employed	44	18.8
	Business Farming/Agriculture	39	16.6
	Skilled labour	28	12.0
Total		**232**	**100.0**

Religious Affiliation		
Christianity	209	90.6
Islam	4	1.7
Traditional Religion	19	8.2
Total	**232**	**100**

Table 1 contains the summary of analysis conducted on socio-demographic characteristics of the respondents as articulated in this present study. Data analysis showed that 72.1% of the respondents were expectant mothers, while 27.9% of them were nursing mothers. It was discovered that the respondents aged between the minimum age of 18 years to the maximum age of 47 years. Consequently, a majority (53.6%) of the respondents were mothers who aged between 28 – 37 years. 24.5% of them aged between 38 – 47 years; while the smallest proportion (21.9%) of them was young mothers who aged between 18 – 27 years.

With regard to educational qualification, a majority (42.8%) of the respondents completed the secondary level of education. Approximately 40.6% of the respondents attended up to the tertiary level of education, of which 24.3% of them only completed the Diploma level, 14.1% of them completed up to the first degree level and only a very lower proportion (2.2%) of them completed up to the post-graduate level. This finding showed that female education in the present study area was impressive, even though about half proportion of them could not attend up to the higher education.

Data analysis equally indicated that the average household income for the majority (37.5%) of the respondents was ₦11, 000.00 – ₦30, 000.00. This implied that majority of the mothers in the study area live in households that earn within or below the current minimum wage level. This is also not surprising since a majority of them only completed the secondary school educational level, including the fact that the area is rural where opportunities for social mobility is often low.

Data analysis equally showed that the respondents varied in their occupations. However, a majority (24.5%) of them were unemployed. Among those who were employed, 15.6% of them were employed within the private sector, 12.5% of them were employed within

government/public sector. This entails that only about 28.1% of mothers in the study area were employed within the formal sector. Furthermore, those who were informally employed were approximately majority (47.4%) – comprising of 18.8% of them that were engaged in petty trading/small businesses, 16.7% of them that were engaged in skilled labour, and 12.0% of them that were engaged in farming/agricultural activities.

With respect to religious affiliation, data analysis showed that almost all the respondents (90.6%) were Christians, with the exception of a lower proportion (9.4%) of them who were affiliated with traditional religion, while a very insignificant proportion (1.7%) of them was affiliated with Islam. This is not surprising since the study area was a Christian dominated environment.

Level of Spousal Support for Maternal Healthcare Services Access

Table 2 shows the descriptive statistics for the forms of spousal support given to expectant and nursing mothers in Idemili South L.G.A., Anambra State. Generally, the mean scores reveal a mixed pattern of support, in which the financial support showed relatively higher means, the practical support had lower mean values, and emotional/psychological support showed a moderate though uneven pattern.

In regard to financial support, the respondents reported that their spouses were supportive in providing money for antenatal registration and visits, paying for delivery and postpartum care costs, and providing money for medications, supplements, or investigations with means of 3.42 ± 0.96, 3.43 ± 0.50, and 3.35 ± 0.48, respectively. However, transportation support recorded a low mean score (M = 1.43, SD = 0.51), indicating that many spouses rarely or never provided transportation funds.

Regarding emotional/psychological support, the findings showed moderate levels of encouragement to seek care early and regularly (M = 2.69, SD = 0.90), provision of comfort during labour or postpartum recovery (M = 2.62, SD = 0.83), and help in reducing stress and avoiding emotional neglect (M = 2.76, SD = 0.89). Showing concern and empathy during pregnancy/postpartum (M = 2.28, SD = 0.88) and avoiding verbal abuse when maternal health decisions are made (M = 2.25, SD = 0.82) scored lower, reflecting inadequate emotional support in this setting.

For practical support, the items that showed particularly low mean scores included accompanying the respondent to antenatal, delivery, or postnatal visits (M = 1.38, SD = 0.51) and taking responsibility for household chores or childcare during clinic visits (M = 1.41, SD = 0.52). Arranging or providing transport to health facilities had a high, uniform mean (M = 3.00, SD = 0.00), as did ensuring timely attendance at appointments (M = 2.99, SD = 0.13). These results suggest that whereas financial support is relatively strong, emotional support is moderate but inconsistent, and practical support is largely low, particularly in areas of physical accompaniment and household assistance. This mixed pattern suggests that whereas spouses are often financially involved, other important aspects of support during pregnancy and postpartum periods are less consistently provided.

Table 2.
***Descriptive Statistics of Spousal Support for Maternal Healthcare Access* (N = 232)**

Form of Support	Item	M	SD
Financial Support	Provides funds for antenatal registration and visits	3.42	.959
	Pays for delivery and postpartum care costs	3.43	.496
	Provides money for transportation to health facilities	1.43	.505
	Provides money for medications, supplements, or investigations	3.35	.479
Emotional/Psychological Support	Encourages me to seek care early and regularly	2.69	.896
	Shows concern and empathy during pregnancy/postpartum	2.28	.884
	Helps me reduce stress and avoids emotional neglect	2.76	.889
	Offers me comfort during labour or postpartum recovery	2.62	.833
	Avoids the use of verbal abuse when maternal health decisions are made	2.25	.820
Practical Support	Accompanies me to antenatal, delivery, or postnatal visits	1.38	.513
	Arranges or provides transport to health facilities	3.00	.000
	Takes responsibility for household chores or childcare during clinic visits	1.41	.518
	Ensures timely attendance of appointments	2.99	.131

The overall mean scores for spousal abuse was further used to describe the clustering of these patterns. As shown in Figure 1, 43.1% of respondents fell into the Low–Moderate spousal support category, while 56.9% were classified under High–Very High spousal support. This distribution indicates that although financial support is consistently strong, emotional and practical dimensions are comparatively weaker, resulting in a moderate but meaningful proportion of women experiencing lower overall spousal support. Nonetheless, the majority of respondents (56.9%) reported high to very high levels of spousal support, underscoring the critical role that spousal involvement—especially financial—plays in facilitating maternal healthcare access.

Figure 1.

Level of spousal support for maternal health access

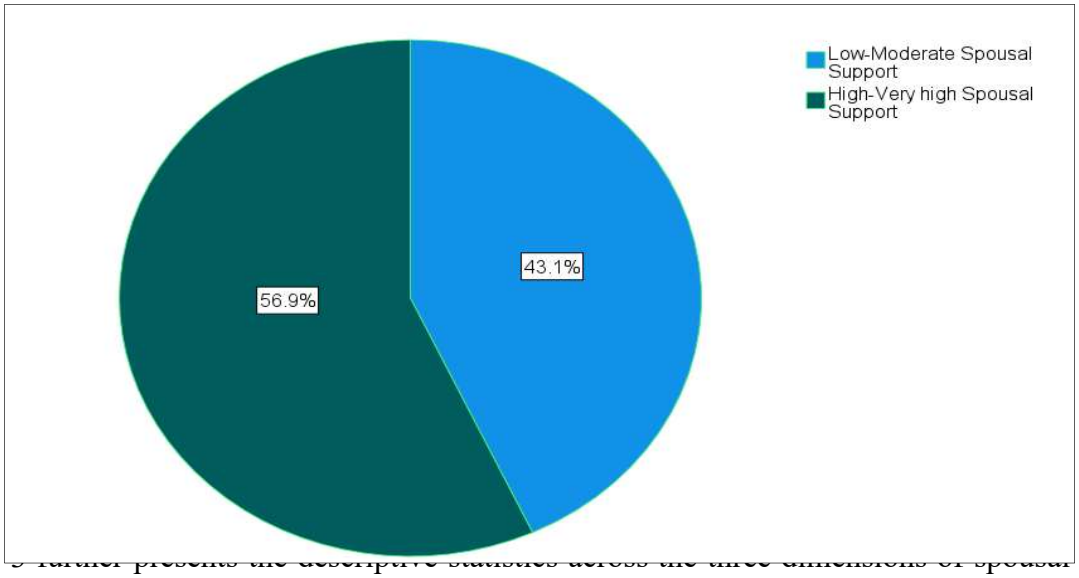


Table 3 further presents the descriptive statistics across the three dimensions of spousal support for maternal health care access among expectant and nursing mothers in Idemili South L.G.A, Anambra State. The results indicate that financial support had the highest mean ratings across the two groups, with a mean of 2.90 (SD = 0.33) for expectant mothers and 2.93 (SD = 0.29) for nursing mothers. This suggests that, generally, both groups of mothers receive a high level of financial support from their husbands, perhaps by way of payment of antenatal and delivery costs, transportation, and so on, which are all linked to maternal healthcare.

Emotional/psychological support by a spouse recorded a moderate mean score of 2.53 (SD = 0.34) and 2.50 (SD = 0.32) for expectant and nursing mothers, respectively. This means that even

though spouses offer some level of encouragement and psychological support during pregnancy and after birth, this may not be at the same level or consistency as financial support.

It can be observed that, throughout the three dimensions, the mean scores for practical support are the lowest: the expectant mothers mean score was 2.10 (SD = 0.26), and for nursing mothers, it was slightly higher, at 2.19 (SD = 0.27). It means that spouses provide relatively minimal hands-on assistance, such as accompanying their partner to health facilities, assisting them with domestic chores, or directly engaging themselves in maternal care activities.

Across all domains, nursing mothers consistently reported a little higher levels of support than expectant mothers, although the differences are modest. These patterns suggest that while financial support is relatively strong, emotional and especially practical support are areas where spousal involvement could be strengthened to improve maternal health care access in the study area.

Table 3.

Descriptive statistics of spousal support for maternal health care access by motherhood category

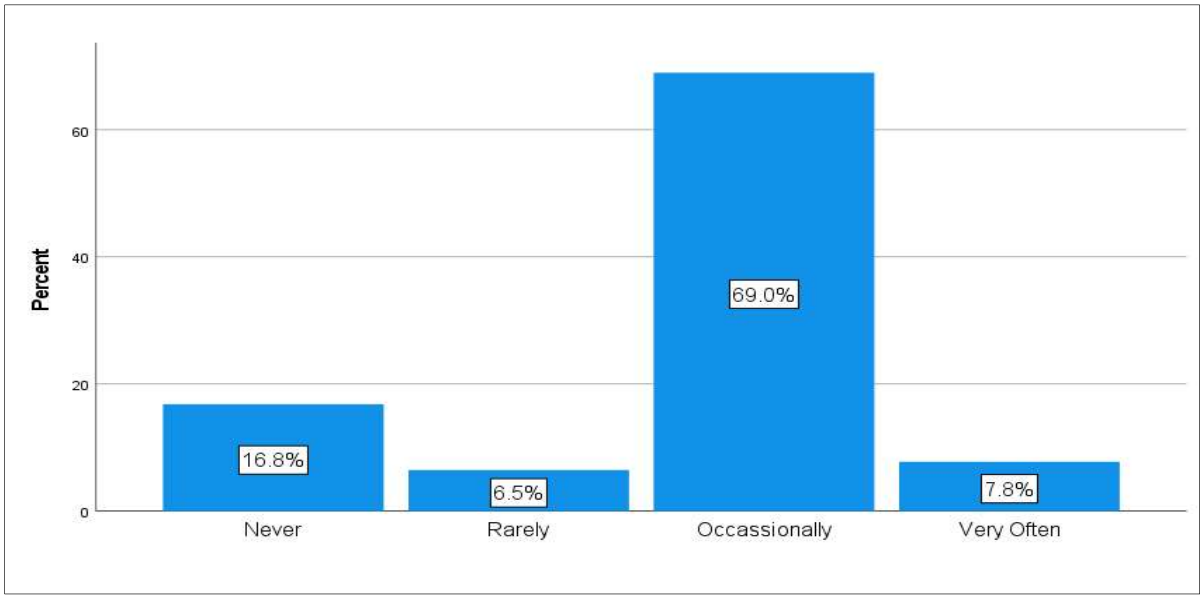
Motherhood Category	**N**	**Financial Support *M (SD)***	**Emotional/Psychological Support *M (SD)***	**Practical Support *M (SD)***
Expectant Mothers	165	2.90 (0.33)	2.53 (0.34)	2.10 (0.26)
Nursing Mothers	67	2.93 (0.29)	2.50 (0.32)	2.19 (0.27)
Total	**232**	**2.91 (0.32)**	**2.52 (0.33)**	**2.13 (0.27)**

Relationship between Spousal Support for Maternal Health Access and Spousal Abuse

Effort was made to determine whether the level of spousal support for maternal health care access was associated with spousal abuse among expectant and nursing mothers in the study area. To do this, data collected on spousal abuse were cross tabulated with data on spousal support for maternal health access. First, the data analysis presented in Figure 2 indicates that the majority of respondents (69.0%) reported experiencing spousal abuse occasionally, compared to smaller proportions who reported never (16.6%), rarely (6.5%), or very often (7.8%) experiencing it.

Figure 2.

Distribution of respondents regarding experience of spousal abuse



Hypothesis: Respondents with lower spousal supports for maternal health care access are more likely to experience spousal abuse compared to those with higher spousal supports.

An independent samples t-test revealed a significant difference in spousal abuse scores between participants with low–moderate spousal support (M = 3.09, SD = 0.43) and those with high–very high spousal support (M = 2.36, SD = 0.94), $t(193.17) = 7.84$, $p < .001$, 95% CI [0.54, 0.91]. This indicates that expectant and nursing mothers with higher spousal support for maternal healthcare access reported significantly lower levels of spousal abuse compared to those with lower spousal support. This further implies that the stated alternate hypothesis is accepted. Results of the test are shown in Tables 4 and 5.

Table 4.

Group statistics for median spousal abuse by level of spousal support

Level of Spousal Support	N	Mean	Std. Deviation	Std. Error Mean
Low-Moderate Spousal Support	100	3.0900	.42865	.04286
High-Very high Spousal Support	132	2.3636	.94322	.08210

Table 5.

Independent samples t-test comparing median spousal abuse by level of spousal support

	Levene's Test for Equality of Variances		t-test for Equality of Means						
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Equal variances assumed	156.069	.000	7.158	230	.000	.72636	.10147	.52644	.92629
Equal variances not assumed			7.843	193.165	.000	.72636	.09261	.54370	.90903

Discussions

This study examined the relationship between spousal support for maternal health access and spousal abuse among expectant and nursing mothers in the Idemili South Local Government Area, Anambra State. The spousal support level analysis revealed that although most of the women were getting some assistance in one way or another in terms of emotional, financial, or practical support, the rate of support was moderate. This is an indication of an inherent gender imbalance in reproduction roles whereby the participation of men is mostly on the financial aspect as opposed to decision making and physical involvement in maternal health. Within the AGIL Model, this finding highlights a weakness in the Integration construct (i.e., the coordination of family and institutional roles). Cultural norms that confine maternal health to women's domain (Isiugo-Abanihe, 2017; Olanrewaju *et al.*, 2022) impede full male engagement, signaling inadequate Adaptation of societal structures to contemporary maternal health needs.

In terms of Structural Violence theory, it can be said that moderate spousal support is a reflection of the limitations of systemic inequities. The inadequate healthcare status, economic suffering, and power inequalities between genders (Doctor *et al.,* 2018; Yaya *et al.*, 2019) limit the ability to act freely by both spouses. These form of structural constraints tend to take the form of dominating the health choices of women where the men restrict access by way of exercising authority (Fawole, 2008). In such a situation, low spousal

support cannot be regarded as a mere behavioural problem but as a manifestation of structural damage underlying the system of social and institutional organisations.

This study equally found out that spousal support and spousal abuse have a major negative correlation, whereby an increase in spousal support correlates with a decrease in spousal abuse ($t(193.17) = 7.84$, $p < .001$). This finding is supported by the buffering effect postulation of Social Support Theory (Cohen & Wills, 1985), which proposes that the supportive partnering soothes stress and conflict. Emotional and instrumental support contribute to the increase of marital stability and empathy which was also consistent with the results of Ng (2023) and Kim and Lee (2020) who discovered that the risk of violence was reduced through the communicative exchange between couples and emotional responsiveness. Nevertheless, the standard deviation of the high-support group indicates that not every support comes in the form of protection - conditional or controlling support will support dependency and continue to maintain power asymmetries. This suggests the quality and intent of support determine whether it functions as empowerment or control, judging from the perspective of the Structural Violence Theory.

When considered collectively in the AGIL Model, the results signify how the issues in the Adaptation dysfunction, Goal Attainment, and Integration continue to promote limited maternal health access and spousal abuse. The lack of proper healthcare adaptation and governance increases the stress levels in the household, whereas the perpetual cycle of inequity is supported by deeply rooted Latency values, the patriarchal norms that justify the subjugation of women (Jewkes *et al.*, 2017). Spousal support in this context is a micro level coping process that can either mitigate or enhance the impacts of these structural pressures. These results hence reiterate the argument put forward by Galtung (1969) that interpersonal violence can in most instances be a collateral effect of structural inequalities.

The Social Support Theory was also integrated to put in a psychosocial dimension which revealed that emotional validation and shared responsibility are capable of overcoming systemic and cultural stressors. On the contrary, the lack of this support is increasing the vulnerability and spousal abuse. Thus, the spousal support works as an intermediary between structure and behaviour-the existence of which counteracts the negative influence of structural violence and systemic dysfunction.

Conclusion/Recommendations

This study investigated the relationship between spousal support and access to maternal healthcare services, and how these factors influence spousal abuse among expectant and nursing mothers in Idemili South Local Government Area of Anambra State, Nigeria. Guided by the AGIL Model, Structural Violence Theory, and Social Support Theory, the study found that access to maternal healthcare is not merely a function of individual behaviour but is deeply embedded in social structures, cultural norms, and systemic inequalities. Indeed, the results showed that while most women received some form of spousal support, the general level of spousal support remained moderate and reflected both the persistence of gendered power relations and a limited male involvement in maternal health. Such findings point to the strong negative association between spousal support and spousal abuse; supportive relationships may thus offer protection against domestic violence.

These findings emphasize the interconnectedness of structural inequities with interpersonal relationships in shaping maternal health outcomes. The deficit in healthcare infrastructure, coupled with conditions of economic deprivation and patriarchal norms, restricts women's access to care and generates environments where stress and dependency increase the risk of abuse. Conversely, where spouses provide emotional and financial support, household harmony and women's healthcare utilisation improve. Therefore, the strengthening of institutional capacity, as well as relational support systems, becomes of utmost importance to improve maternal health and reduce gender-based violence.

Based on these results, the research recommends the following:

1. To increase access to skilled maternal care, the relevant government health ministries need rehabilitate and adequately equip primary health centres, maintain regular staffing and transport networks so as to reduce the reliance of women on the financial support of their spouses.
2. There is equally need for policymakers to provide access to community-based health insurance and subsidised or free maternal healthcare programmes, to eradicate the cost-based obstacles and facilitate equal access to the necessary maternal healthcare services among expectant and nursing mothers.

3. Programmes should sensitise men on the importance of emotional, practical, and financial support, encouraging shared decision-making and empathy to strengthen marital harmony and reduce spousal abuse.
4. Traditional, religious, and women's leaders should partner with government and health agencies to promote equitable gender relations, discourage domestic violence, and normalise male participation in maternal healthcare.

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