

Relationship Between Husband's Support and Anxiety Among Third-Trimester Pregnant Women at UPT Puskesmas Rawa Buntu, Serpong

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ARTICLE HISTORY

Received: June 22, 2025
Revised: September 10, 2026
Accepted: October 14, 2026

DOI

<https://doi.org/10.52970/grdis.v6i4.1433>

ABSTRACT

Husband's support may play an important role in the psychological well-being of pregnant women, particularly in relation to anxiety during the third trimester. This study aimed to examine the relationship between husband's support and anxiety among third-trimester pregnant women at UPT Puskesmas Rawa Buntu, South Tangerang City. A descriptive correlational design with a cross-sectional approach was used, and total sampling included 30 respondents. Data were collected using a husband's support questionnaire and the Perinatal Anxiety Screening Scale (PASS). The findings showed that 16 respondents (88.9%) who received support from their husbands experienced low anxiety, whereas 11 respondents (91.7%) who did not receive such support experienced high anxiety. The Chi-square test indicated a statistically significant association between husband's support and anxiety (reported $p = 0.000$, appropriately expressed as $p < 0.001$). These findings suggest that husband's support is associated with anxiety levels among third-trimester pregnant women in the study setting. Further research involving larger samples and appropriate analytical methods is needed to confirm this association.

Keywords: Husband's Support, Anxiety, Third Trimester.

I. Introduction

Maternal mental health is an important component of maternal and child health because pregnancy involves not only physiological changes but also psychological and social adjustments. Although pregnancy is often associated with positive expectations, women may experience emotional distress related to fetal well-being, childbirth, changes in family responsibilities, and uncertainty about the delivery process. The World Health Organization (WHO, 2022) emphasizes the importance of integrating mental health promotion, early identification, and appropriate support into maternal and child health services. This perspective highlights the need to understand psychological difficulties during pregnancy as part of comprehensive antenatal care rather than treating maternal health exclusively as a physical concern. Anxiety during pregnancy deserves particular attention because persistent symptoms may be associated with adverse maternal and perinatal outcomes. A systematic review and meta-analysis by Grigoriadis et al. (2018) found that antenatal anxiety was associated with increased odds of preterm birth and low birth weight, although these associations do not establish that anxiety directly causes such outcomes. Anxiety may also affect women's psychological well-being during the transition to motherhood. Consequently, recognizing factors associated with maternal anxiety is important for improving psychosocial assessment and identifying women who may benefit from

additional support. The third trimester is a particularly relevant period to investigate because childbirth is approaching and concerns about labor, pain, complications, and the baby's condition may become more immediate.

Anxiety during pregnancy is influenced by multiple factors, including previous reproductive experiences, perceived health risks, socioeconomic circumstances, and the availability of social support. Among these factors, support from a husband or partner is especially relevant because it may provide emotional reassurance, practical assistance, and information during pregnancy. Support can include listening to concerns, accompanying a wife to antenatal appointments, helping with daily activities, discussing childbirth preparations, and participating in decisions concerning maternal and infant health. These forms of involvement may help pregnant women feel understood and better prepared to face childbirth. Nevertheless, the extent to which support is available and perceived as adequate may vary across individuals and family circumstances. Evidence from broader research supports the relevance of social support to maternal psychological well-being. Bedaso et al. (2021), in a systematic review and meta-analysis, found that social support was associated with mental health problems during pregnancy, including anxiety and depression. Dennis et al. (2022) similarly reported that insufficient support from partners, family members, and friends was associated with a greater risk of depressive and anxiety symptoms during the perinatal period. These findings suggest that social support is a relevant psychosocial factor, although support from different sources should not automatically be considered equivalent to support specifically provided by a husband. Examining husband's support separately can therefore provide more focused evidence about its relationship with anxiety among pregnant women.

Research conducted in Indonesia also provides a basis for examining this relationship. Abidah et al. (2021) reported that husband's support was associated with psychosocial stress among pregnant women approaching childbirth. In another Indonesian study, Avifurohmah et al. (2024) examined husband's support, adversity quotient, and anxiety among primigravida women in the third trimester, highlighting the relevance of examining partner support alongside other psychological factors. However, findings from other settings and populations cannot automatically be generalized to every antenatal care facility. Differences in reproductive history, socioeconomic circumstances, family relationships, and local healthcare contexts may influence how pregnant women experience support and anxiety. Therefore, further context-specific investigation remains relevant. Reliable assessment is also essential when examining maternal anxiety. Somerville et al. (2014) developed and preliminarily validated the Perinatal Anxiety Screening Scale (PASS) to identify a broad range of anxiety symptoms during the perinatal period. In Indonesia, Yuliani et al. (2024) evaluated the Indonesian version of PASS and reported evidence supporting its validity and reliability among pregnant women. The availability of a contextually adapted screening instrument provides a methodological basis for assessing anxiety, although its suitability and scoring procedures must be considered carefully in each study. Distinguishing between screening results and clinical diagnoses is equally important when interpreting the level of anxiety reported by respondents.

Despite the growing evidence concerning social support and maternal anxiety, the relationship between husband's support and anxiety needs to be examined within specific healthcare settings. The present study focuses on third-trimester pregnant women attending UPT Puskesmas Rawa Buntu, Serpong, South Tangerang City. The study addresses a contextual evidence gap by examining whether differences in reported husband's support are associated with differences in anxiety levels among women receiving antenatal care at this facility. The rationale is not that the relationship has never been studied elsewhere, but that findings from other populations do not necessarily describe the circumstances of women in this particular setting. Local evidence may help healthcare providers better understand the psychosocial circumstances of pregnant women and inform discussions about partner involvement during antenatal care.

Accordingly, this study aimed to examine the relationship between husband's support and anxiety among third-trimester pregnant women at UPT Puskesmas Rawa Buntu, Serpong, South Tangerang City. Using a descriptive correlational design with a cross-sectional approach, the study investigated the association between the two variables in the participating sample. The findings are intended to contribute

context-specific evidence for maternal healthcare practice and future research on psychosocial support during pregnancy. Because the design is cross-sectional, the study can identify an association but cannot establish a causal effect of husband's support on anxiety.

II. Literature Review

2.1. Anxiety Among Third-Trimester Pregnant Women

Anxiety during pregnancy is a psychological response that may involve excessive worry, apprehension, and uncertainty about maternal health, fetal well-being, childbirth, and the transition to parenthood. Although some concern is expected during pregnancy, persistent or intense anxiety warrants attention because it may affect psychological well-being and the experience of pregnancy. The World Health Organization (WHO, 2022) emphasizes the integration of mental health promotion, identification, and appropriate responses into maternal and child health services. This approach recognizes psychological well-being as an essential component of antenatal care rather than a secondary concern. The third trimester is particularly relevant to the study of maternal anxiety because childbirth becomes more immediate and concerns about labor pain, complications, and the infant's health may intensify. Grigoriadis et al. (2018), in a systematic review and meta-analysis, reported associations between antenatal anxiety and adverse perinatal outcomes, including preterm birth and low birth weight. These findings support the importance of recognizing anxiety during pregnancy, although observational associations should not be interpreted as proof of causation. Anxiety may also vary according to maternal age, parity, educational attainment, employment, financial circumstances, previous pregnancy experiences, and perceived social support. Research on risk factors for perinatal anxiety has similarly highlighted the importance of considering both individual and psychosocial circumstances (Biaggi et al., 2016). Anxiety should not be understood as a uniform experience among all pregnant women. Primigravidas may face uncertainty because they have not experienced childbirth previously, whereas multigravidas may experience anxiety associated with previous difficult pregnancies or deliveries. Economic concerns, physical discomfort, perceived obstetric risks, and limited access to reliable information may also contribute to worry. Consequently, assessing anxiety requires attention to the broader circumstances of pregnant women rather than attributing their psychological experiences to a single factor.

2.2. Husband's Support During Pregnancy

Husband's support refers to assistance, care, and involvement provided by a husband to his pregnant wife. Conceptually, this support can include emotional reassurance, practical assistance, information, and expressions of appreciation or respect. Emotional support involves listening to concerns and providing reassurance; instrumental support includes helping with daily activities and accompanying the wife to antenatal appointments; informational support involves discussing pregnancy-related information and preparations for childbirth. These dimensions provide a useful framework for understanding how partner involvement may be relevant to maternal psychological well-being. Social support is widely recognized as a relevant factor in mental health during pregnancy. Bedaso et al. (2021) synthesized evidence from 67 studies involving 64,449 pregnant women and found that low social support was associated with antenatal mental health problems, including anxiety. However, social support is a broader construct than husband's support because it may also originate from relatives, friends, and other social relationships. Therefore, evidence concerning general social support provides a theoretical foundation for investigating husband's support, but the two constructs should not be treated as interchangeable.

The role of husbands is particularly relevant in settings where partners participate in family decisions and provide practical and emotional assistance throughout pregnancy. In Indonesia, Abidah et al. (2021) examined the relationship between husband's support and anxiety among third-trimester pregnant women.

Avifurohmah et al. (2024) also investigated husband's support and anxiety among third-trimester primigravidas, alongside adversity quotient. These studies provide context-specific evidence that partner support is a relevant variable in maternal anxiety research. Nevertheless, their findings should be interpreted within the populations and settings examined rather than assumed to apply identically to all healthcare facilities. Husband's support may be associated with anxiety through several plausible pathways. Reassurance and responsive communication may help women feel understood, while practical assistance may reduce everyday demands and perceived burdens. Information sharing may also help women prepare for childbirth and clarify concerns that could otherwise remain unresolved. These pathways offer a conceptual explanation for the expected association between husband's support and anxiety; they do not, by themselves, establish that support directly causes anxiety to decrease.

2.3. The Relationship Between Husband's Support and Maternal Anxiety

Evidence from Indonesian studies generally supports examining the relationship between husband's support and anxiety among pregnant women. Abidah et al. (2021) reported an association between husband's support and anxiety during the third trimester. Avifurohmah et al. (2024) found a negative relationship between husband's support and anxiety among third-trimester primigravidas, indicating that greater support was associated with lower anxiety in their sample. Harto and Sulistyoningtyas (2024) also reported a statistically significant relationship between husband's support and anxiety among third-trimester pregnant women attending a community health center in Sleman, Yogyakarta. Indonesian literature reviews have likewise discussed the potential role of husbands in reducing anxiety as childbirth approaches. Wirabakti and Septiyono (2022) reviewed literature concerning husbands' roles in relation to anxiety among third-trimester pregnant women. Although such reviews can help identify recurring findings, conclusions depend on the quality, comparability, and scope of the studies included. Differences in sampling, measurement instruments, anxiety categories, and statistical procedures may limit direct comparisons across studies.

The interpretation of this relationship also requires methodological care. Studies using cross-sectional designs assess support and anxiety at a particular point in time. Such designs can identify statistical associations but cannot determine whether limited support precedes anxiety, whether anxiety affects perceptions of support, or whether both are influenced by other factors. Maternal age, parity, socioeconomic circumstances, and previous reproductive experiences may therefore need to be considered when interpreting findings. A statistically significant association should not automatically be interpreted as evidence of a causal or protective effect.

2.4. Measurement of Perinatal Anxiety

Appropriate measurement is important when examining anxiety during pregnancy. Somerville et al. (2014) developed and preliminarily validated the Perinatal Anxiety Screening Scale (PASS) to identify a broad range of anxiety symptoms relevant to the perinatal period. The instrument was designed to support screening in clinical and maternity care settings. Its use can provide a structured approach to assessing anxiety symptoms, but screening results should not be equated with a clinical diagnosis. The interpretation of PASS scores depends on the version administered, the scoring procedure, and the criteria used to classify anxiety levels. Researchers should report these details clearly and establish that the instrument is appropriate for the population being studied. Similarly, husband's support should be measured using a clearly described instrument with documented scoring and evidence of reliability and validity. Transparent measurement procedures are essential for interpreting the relationship between the two variables and comparing findings across studies.

III. Research Method

This study used a descriptive correlational design with a cross-sectional approach and a total sampling technique. The sample consisted of 30 respondents. Husband's support was the independent variable, while anxiety among pregnant women was the dependent variable. The instruments used were a husband's support questionnaire and the Perinatal Anxiety Screening Scale (PASS). Data were analyzed using Spearman's rank correlation.

IV. Result and Discussion

4.1. Results

a. Respondent Characteristics

A total of 30 third-trimester pregnant women participated in this study. Table 1 presents their demographic and obstetric characteristics.

Table 1. Characteristics of the Respondents (n = 30)

Characteristic	Category	Frequency (n)	Percentage (%)
Maternal age	<20 years	2	6.7
	20–35 years	24	80.0
	>35 years	4	13.3
Educational attainment	Basic education	2	6.7
	Secondary education	22	73.3
	Higher education	6	20.0
Employment status	Employed	2	6.7
	Not employed	28	93.3
Income	Below the regional minimum wage	17	56.7
	At the regional minimum wage	8	26.7
	Above the regional minimum wage	5	16.7
Parity	Primigravida	18	60.0
	Multigravida	12	40.0

As shown in Table 1, most respondents were aged 20–35 years (24; 80.0%). Secondary education was the most common educational category, reported by 22 respondents (73.3%). Most respondents were not employed (28; 93.3%), and 17 respondents (56.7%) reported incomes below the regional minimum wage. Regarding parity, 18 respondents (60.0%) were primigravidas, while 12 (40.0%) were multigravidas.

b. Distribution of Husband's Support

Table 2. Distribution of Husband's Support (n = 30)

Husband's support	Frequency (n)	Percentage (%)
Supportive	18	60.0
Not supportive	12	40.0
Total	30	100.0

Table 2 shows that 18 respondents (60.0%) reported receiving support from their husbands, whereas 12 (40.0%) reported that their husbands were not supportive. Thus, the majority of respondents reported receiving support, although a substantial proportion reported insufficient support.

c. Distribution of Anxiety Levels

Table 3. Anxiety Levels Among Third-Trimester Pregnant Women (n = 30)

Anxiety level	Frequency (n)	Percentage (%)
Low anxiety	17	56.7
High anxiety	13	43.3
Total	30	100.0

As presented in Table 3, 17 respondents (56.7%) were classified as having low anxiety, while 13 (43.3%) were classified as having high anxiety. Although low anxiety was more common, the proportion of respondents classified as having high anxiety was substantial.

d. Association Between Husband's Support and Anxiety

Table 4. Association Between Husband's Support and Anxiety Levels (n = 30)

Husband's support	Low anxiety, n (%)	High anxiety, n (%)	Total, n (%)
Supportive	16 (88.9)	2 (11.1)	18 (100.0)
Not supportive	1 (8.3)	11 (91.7)	12 (100.0)
Total	17 (56.7)	13 (43.3)	30 (100.0)

Among respondents who reported receiving support from their husbands, 16 (88.9%) had low anxiety and 2 (11.1%) had high anxiety. In contrast, among respondents who reported not receiving support, 1 (8.3%) had low anxiety and 11 (91.7%) had high anxiety. The original manuscript reported an odds ratio (OR) of 0.011 and a Chi-square test p-value of 0.000. The reported p-value indicates statistical significance when expressed as $p < .001$, provided that the original statistical output confirms this result. The OR requires verification against the original coding and reference categories before its direction and magnitude can be interpreted definitively. Overall, the cross-tabulation shows a marked difference in anxiety categories between respondents who reported receiving support and those who did not. However, this descriptive pattern should be interpreted alongside the verified statistical analysis and the limitations of the study design.

4.2. Discussion

a. Respondent Characteristics and Maternal Anxiety

Most respondents were aged 20–35 years (80.0%). This age group represented the largest proportion of the sample, but the study did not directly test whether maternal age was associated with anxiety. Therefore, the age distribution should be interpreted as a descriptive characteristic rather than evidence that age influenced anxiety in this sample. Permatasari et al. (2020) discussed maternal characteristics in relation to pregnancy-related anxiety, providing a basis for considering age in future analyses. Regarding education, 73.3% of respondents had secondary education. Educational attainment may be relevant to how pregnant women access, understand, and use health information. Suyani (2020) reported an association between educational level and anxiety among third-trimester pregnant women. Nevertheless, the present study did not report a separate statistical test of educational attainment against anxiety. Consequently, the relationship between education and anxiety cannot be established from the descriptive data alone.

Most respondents were not employed (93.3%). Employment may influence daily activities, social interactions, access to information, and financial circumstances. Gary et al. (2020) examined maternal characteristics in relation to anxiety before spontaneous childbirth, while Murdayah et al. (2021) discussed factors associated with anxiety during childbirth. These studies provide context for considering employment status in maternal anxiety research. However, the high proportion of respondents who were not employed in the present sample does not demonstrate that unemployment was associated with high anxiety. More than half of the respondents (56.7%) reported incomes below the regional minimum wage. Financial circumstances may be relevant because pregnancy involves costs associated with antenatal care, nutrition, childbirth, and infant care. Damanik and Zuiatna (2021) examined factors associated with anxiety among pregnant women preparing for childbirth. Although financial concerns may be a plausible source of worry, the present study

did not directly test the association between income and anxiety. Further analysis would be required to determine whether income was related to anxiety in this population.

Primigravidas accounted for 60.0% of the respondents. Women experiencing pregnancy for the first time may face uncertainty about labor and childbirth because they lack previous childbirth experience. Setiawan and Nurfaiza (2021) examined the relationship between parity and anxiety during normal childbirth. However, the current study did not report a separate analysis of parity and anxiety. The observed proportion of primigravidas therefore provides important sample context but does not establish that primigravidity contributed to anxiety in this study.

b. Husband's Support During Pregnancy

The results showed that 18 respondents (60.0%) reported receiving support from their husbands, whereas 12 (40.0%) reported not receiving support. This distribution indicates that support was reported by the majority, although four out of every ten respondents were classified in the unsupported category. Husband's support may include emotional reassurance, practical assistance, attention, and involvement in pregnancy-related preparations. Examples discussed in the original manuscript include helping with daily needs, offering comfort, and showing concern for the pregnant woman's well-being. Such behaviors may help women feel supported as they prepare for childbirth. Nevertheless, the present study measured reported support and did not evaluate a specific support intervention. Its findings therefore cannot establish that any particular supportive behavior reduces anxiety. The proportion of respondents reporting insufficient support also suggests the relevance of asking about partner involvement during antenatal visits. Health professionals may consider discussing emotional well-being and available family support with pregnant women, while respecting individual circumstances and preferences. This is a practical implication of the observed distribution rather than evidence that an intervention has been proven effective by this study.

c. Anxiety Among Third-Trimester Pregnant Women

Low anxiety was reported by 17 respondents (56.7%), while high anxiety was reported by 13 (43.3%). Although low anxiety was slightly more prevalent, the high-anxiety category represented a considerable proportion of the sample. These findings indicate that anxiety assessment remains relevant among third-trimester pregnant women attending the study site. Potential concerns during the third trimester include anticipated labor pain, uncertainty about childbirth, maternal and fetal health, physical discomfort, and preparation for parenthood. Previous reproductive experiences and socioeconomic circumstances may also be relevant. However, the study did not report separate tests of these factors against anxiety, and the observed anxiety categories cannot be attributed to any single cause. The distribution also highlights the importance of interpreting anxiety screening results appropriately. The manuscript reports low and high anxiety categories based on the Perinatal Anxiety Screening Scale (PASS), but the thresholds used to define these categories are not fully documented in the Methods section. These cutoffs should be verified before the findings are compared with those of other studies or used to guide clinical interpretation.

d. Association Between Husband's Support and Anxiety

The principal finding was the observed association between husband's support and anxiety. Among respondents who reported receiving support, 88.9% had low anxiety and 11.1% had high anxiety. In the group reporting no support, 8.3% had low anxiety and 91.7% had high anxiety. The distribution suggests that low anxiety was more common among respondents who reported receiving support, whereas high anxiety was more common among those who did not. This pattern is consistent with the relationship examined by Baroroh (2019), who investigated husband's support and anxiety among third-trimester pregnant women in the Srumbung Community Health Center area. Permatasari et al. (2020) also reported an association between husband's support and anxiety during pregnancy in Tijayan during the COVID-19 pandemic. In addition, Rosiana et al. (2022) examined husband's support in relation to anxiety among third-trimester pregnant women attending a clinic in Ngawi. These studies provide relevant Indonesian research contexts for interpreting the present findings, although differences in study populations, instruments, and analytical methods should be considered when comparing results.

Several mechanisms may plausibly explain the observed association. Emotional reassurance may help women communicate their concerns, practical assistance may reduce perceived daily burdens, and

involvement in childbirth preparation may increase feelings of security. However, these mechanisms were not directly tested in the present study. The results therefore support an association between reported husband's support and anxiety categories, not a conclusion that husband's support caused anxiety to decrease. The statistical findings also require careful verification. The Methods section identifies Spearman's rank correlation, whereas the Results section reports a Chi-square test. The final manuscript must specify the analysis that was actually performed. Furthermore, the reported OR of 0.011 depends on the coding and reference categories used. Its interpretation should be checked against the original statistical output, including the confidence interval where available. Finally, the study included only 30 respondents from one community health center and used a cross-sectional design. These characteristics limit the generalizability of the findings and prevent causal conclusions. Anxiety may influence how women perceive support, and other factors may be associated with both variables. Future studies with larger samples, clearly documented measurement procedures, and appropriate statistical analyses could examine these relationships more comprehensively.

V. Conclusion

This study found a statistically significant association between husband's support and anxiety among third-trimester pregnant women at UPT Puskesmas Rawa Buntu, South Tangerang City. Of the 30 respondents, 18 (60.0%) reported receiving support from their husbands, while 17 (56.7%) experienced low anxiety. Among women who received husband's support, 16 (88.9%) reported low anxiety, whereas 11 (91.7%) of those who did not receive adequate support reported high anxiety. These findings indicate that husband's support was associated with anxiety levels among the pregnant women included in this study.

The findings highlight the importance of involving husbands in antenatal care and promoting supportive family environments during pregnancy. Healthcare professionals, particularly midwives and nurses, may encourage husbands to provide emotional support, practical assistance, and active involvement in routine antenatal visits. In addition, maternal healthcare services should consider assessing psychological well-being alongside physical health during pregnancy. Such measures may help identify women who require additional psychological support, although the effectiveness of specific interventions was not evaluated in this study.

This study has several limitations. The sample consisted of only 30 respondents from a single community health center, which limits the generalizability of the findings. Furthermore, the cross-sectional design does not establish a causal relationship between husband's support and anxiety. Future research should involve larger and more diverse samples across multiple healthcare facilities and examine other potentially relevant factors, including parity, previous pregnancy experiences, socioeconomic conditions, and broader family support. Longitudinal studies or intervention-based research could also help clarify the relationship between husband's support and maternal anxiety over time.

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