

The Role of Family Support on Maternal Well Being During Pregnancy in Disaster-Prone Areas

ABSTRACT

Background: Pregnancy is a complex period associated with stress, anxiety, and depression in disaster-prone areas with limited healthcare. The role of family support in maternal well-being in disaster-prone contexts is still underexplored. This study aimed to analyze the role of family support in the maternal well-being of pregnant women in disaster-prone areas. **Methods:** This study used a retrospective cohort design with 124 pregnant women, selected through high-risk cluster random sampling in four villages affected by floods, landslides, and tornadoes. Data were collected through observations and interviews regarding family support (financial, practical, informational, and emotional) and maternal well-being (readiness for motherhood, emotional closeness with the fetus, involvement, self-care, and attitudes toward health). Analysis was performed using logistic regression. **Results:** The results show that most pregnant women receive positive family support, with the majority reporting happiness during pregnancy. Most of them were in good maternal health condition. Regression tests show that family support has a significant effect on happiness ($p=0.000$; $OR=0.044$) and maternal health ($p=0.015$; $OR=2.539$). Family support explained 48.7% of the variance in happiness and 6.4% of the variance in maternal health. Family support has a more dominant influence on maternal happiness than on maternal health. **Conclusion:** These findings underscore the importance of family-based health interventions to strengthen emotional, practical, financial, and informational support, particularly in disaster-prone areas. The study's contribution lies in maintaining the perspective of maternal happiness as an indicator of positive well-being, as well as providing a basis for developing promotive-preventive programs that are adaptive to disaster risk.

Keywords: Pregnancy, family support, maternal well-being, disaster

INTRODUCTION

Pregnancy are complex adaptation periods, marked by biological, psychological, and social changes. During this period, mothers are vulnerable to stress, and anxiety, especially when faced with stressful environmental conditions such as natural disasters [1]. Previous research suggests that pregnant women living in areas exposed to disasters are more vulnerable to psychological distress than those in non-disaster settings. Disasters as complex events that affect pregnancy through multiple pathways, including psychological strain, breakdown of healthcare systems, environmental disruption, and increased social fragility [2]. Studies conducted in post-disaster environments provide supporting evidence for these mechanisms. Elevated rates of prenatal depression among women exposed to the Lushan earthquake, while also identifying social support and coping mechanisms as important buffers against psychological symptoms. In a similar vein, research reported that earthquake exposure in Nepal contributed to adverse pregnancy outcomes indirectly through its impact on antenatal mental health conditions [3].

Maternal well-being in disaster-prone regions can be understood as the result of a complex interaction between exposure to disaster events, psychological responses, healthcare access, and the availability of social and family support. In the broader maternal health literature, consistent evidence indicates that social and family support plays a crucial role in protecting psychological well-being during pregnancy. The higher levels of perceived social support are associated with lower levels of depression, anxiety, loneliness, and repetitive negative thinking among pregnant women [4]. During periods of crisis, support from partners, family members, and social networks tends to decline, while maternal stress increases significantly [5]. These findings suggest that family support operates as a key protective factor rather than a peripheral variable in maintaining maternal emotional stability under stressful conditions. However, there is still a noticeable gap in the literature regarding the specific role of family support in shaping maternal well-being in disaster-prone areas, particularly in low- and middle-income countries such as Indonesia.

Mojokerto Regency is prone to hydrometeorological disasters, including floods, landslides, and strong winds. These conditions can disrupt pregnant women's access to antenatal care (ANC)

services, increasing the risk of declining maternal well-being [6]. The novelty of this research lies in its integration of family support, maternal well-being, and the context of disaster-prone areas, which are rarely studied simultaneously in existing literature. Unlike previous studies that primarily focus on how family support reduces stress, anxiety, or depression during pregnancy. This study emphasizes maternal happiness as a positive indicator of subjective well-being. Furthermore, the inclusion of a disaster-prone area added a unique perspective by considering how environmental uncertainties impact maternal mental health and access to healthcare. By combining these elements, this study not only expands and deepens theoretical understanding but also provides valuable insights for developing family-based maternal health interventions tailored to disaster risk regions. Maternal well-being during pregnancy is essential to study because it is closely related to mental and physical health and child development. Recent studies have shown that maternal subjective well-being can be a protective factor against perinatal depression and anxiety, while also improving mothers' ability to adopt healthy behaviors during pregnancy, such as maintaining a healthy diet and attending with antenatal checkups [7]. Furthermore, maternal well-being affects the birth experience, breastfeeding success, the quality of the mother-child bond, and the infant's early-life emotional development [8]. Interventional research also shows that social support and digital-based programs can increase maternal well-being, which in turn can strengthen family resilience and reduce the risk of perinatal mental disorders [9]. Therefore, researching maternal well-being during pregnancy provides an essential basis for designing promotive and preventive interventions, improving maternal health services, and reducing social disparities in reproductive health.

Family support plays a central role in maintaining maternal mental health during pregnancy. This support can be emotional, instrumental, or informational, and is a protective factor against pregnancy stress [10]. Specifically, husband's support, as part of the nuclear family, has been shown to reduce negative psychological symptoms significantly. Systematic studies report that husbands' involvement in prenatal care is closely associated with improved maternal psychological well-being [1].

Quantitative research in Indonesia found that husbands' support and maternal emotional maturity significantly contributed to reduced anxiety during childbirth [11]. This suggests that family support not only provides comfort but also enhances maternal emotional preparedness. Furthermore, research on the happiness of housewives indicates that positive perceptions of social support provided by husbands contribute to increased happiness, particularly when facing the pressures of parenting [12]. These findings are relevant to understanding the mechanisms of happiness in pregnant women. In the context of disasters, phenomenological research on pregnant women in evacuation centers indicates urgent needs, such as comprehensive health checks, material assistance, and a desire to remain at home due to discomfort in evacuation centers [6]. This situation highlights the dual challenges faced by mothers in disaster-prone areas.

Research on postpartum depression reveals that social support and family functioning significantly reduce the risk of postpartum depression. This support works both directly and indirectly on maternal mental health [13]. Preventive efforts emphasising the "Happy Mom" pillar have been developed as part of public health education. This program emphasises maternal mental health as a crucial component in strengthening families and promoting child well-being [14]. In terms of measurement, research on maternal happiness in Indonesia emphasises the need for a contextual construct that is culturally appropriate. This is crucial so that the maternal happiness index used truly reflects the unique experiences of Indonesian women, not simply Western theories [13].

Disasters often disrupt maternal health services, making family-based strategies an alternative solution. Family support is reliable because it is easily accessible, quickly implemented, and does not rely entirely on formal services, which may be hampered [15]. Considering the disaster-prone context of Mojokerto Regency and empirical evidence regarding the role of family support in maternal well-being, this research is crucial. The results are expected to provide a basis for planning family-based interventions that are adaptive to disaster risk and support maternal well-being. Therefore, the main hypothesis tested in this study is family support has a significant positive effect on maternal well-being during pregnancy in disaster-prone areas.

MATERIALS AND METHODS

Study Design

This study used a retrospective cohort design. The primary data sources were pregnant woman, while secondary data were obtained from maternal health records provided by midwife coordinators at community health centres (*Puskesmas*) in Mojokerto Regency

Population and Sample

The study population consisted of pregnant mothers living in disaster-prone areas of Mojokerto Regency. The inferential sample included 124 respondents selected from this population using a high-risk cluster random sampling technique. Four villages were chosen as clusters: Gayaman (28 respondents), Kemlagi (26 respondents), Mojojebang (24 respondents), and Pacet (46 respondents). These areas experienced natural disasters such as floods, landslides, and whirlwinds during 2024–2025. Data on pregnant mothers were obtained from the midwife coordinators at the community health centres serving these four villages.

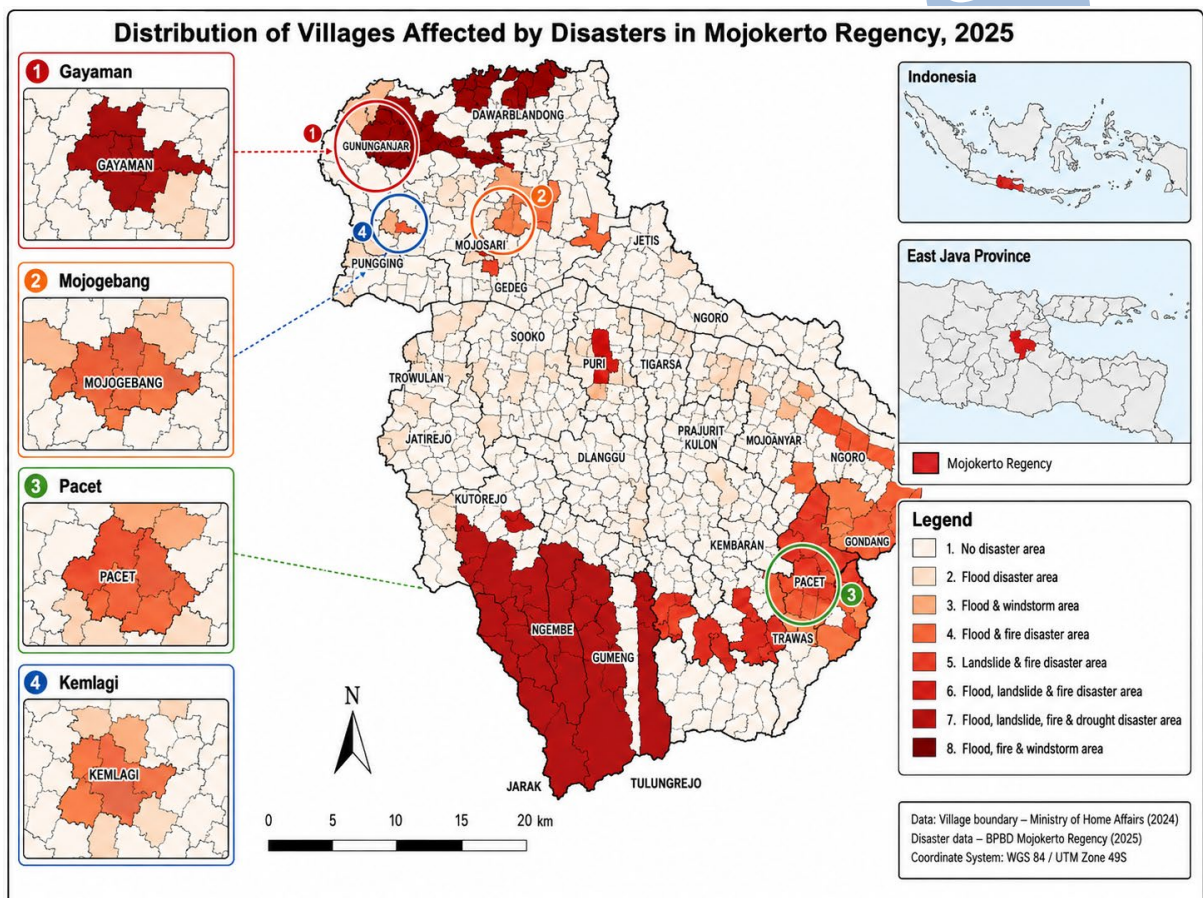


Figure 1. Study locations (four villages) in Mojokerto Regency, East Java, Indonesia

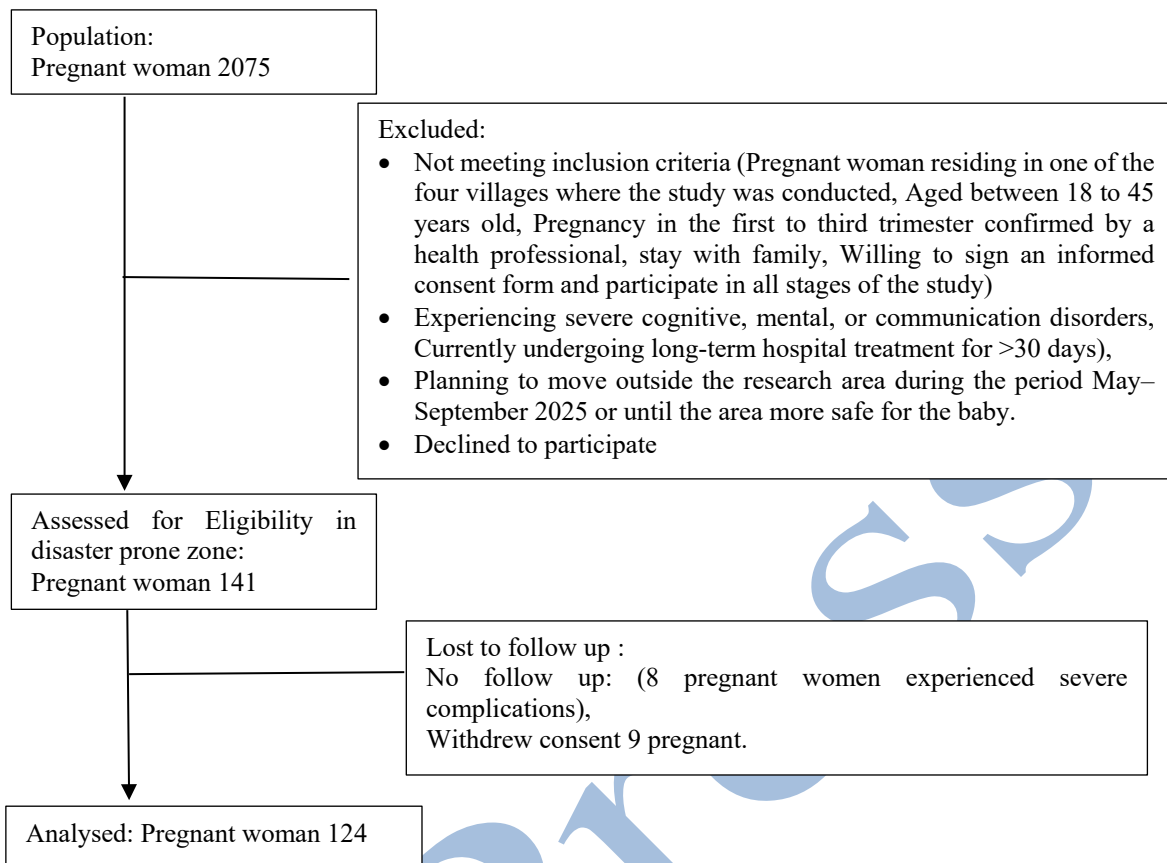


Figure 2. STROBE flow diagram for the study population of this study

Sample Criteria

Inclusion criteria were: (1) pregnant residing in one of the four study villages and live with family; (2) aged between 18 and 45 years; (3) pregnancy confirmed by a qualified health professional (any trimester); and (4) willingness to sign an informed consent form and participate in all stages of the study. Exclusion criteria included: (1) severe cognitive, mental, or communication disorders; (2) long-term hospitalisation for more than 30 days; (3) plans to relocate outside the study area during May–September 2025 or until the area becomes safer for the baby; and (4) refusal to participate. The study was conducted from May 4 to June 5, 2025. Selected participants were observed and interviewed over a month.

Potential Bias

The researchers acknowledged several potential sources of bias in this study. The use of high-risk cluster random sampling was intended to maintain homogeneity in sociodemographic characteristics and healthcare access within the study population. Restricting participant age to 18–45 years may have introduced exclusion bias by omitting adolescent and older mothers, who often face distinct obstetric and psychological risks. Pregnancies occurring at very young or advanced maternal ages are generally considered high-risk and require closer monitoring and specialized care. Consequently, the findings may primarily reflect the experiences of relatively healthier mothers with better access to healthcare services and should therefore be interpreted with caution. Selection bias could also have arisen if mothers who were not living with their families had been included in the sample. However, this possibility was minimized through the inclusion criteria, which specified that only respondents residing with their families were eligible to participate.

Data Collection

The variables examined in this study included family support, which was measured through indicators of financial, practical, advisory, and emotional support provided by husbands or other family members during pregnancy. Maternal well-being was measured using two subvariables,

namely maternal happiness and maternal health. Maternal happiness was assessed based on readiness and enthusiasm for motherhood, emotional bonding with the fetus and baby, information-seeking behavior and active involvement, self-care and health maintenance, and negative attitudes toward personal health. The maternal happiness questionnaire consisted of 11 items, while the family support questionnaire consisted of 24 items measuring family support during pregnancy and 20 items measuring family support after childbirth. Data were collected using questionnaires that had been tested for validity and reliability. Instrument validity was assessed using the corrected item-total correlation (r for all item $>0,30$), while reliability was examined using Cronbach's alpha (Cronbach's Alpha= 0,952 for family support; Cronbach's Alpha=0.807 for maternal happiness; and Cronbach's Alpha=0.799 for maternal health). In addition, the measurement instruments for family support and maternal well-being were reviewed by three experts, namely the head of the district health office, a maternal and child health specialist, and a disaster emergency expert, to ensure content validity (average of V'Aikens for relevance rate=0,91 and clarity level = 0,89). The maternal health measurement instrument was developed from the screening questions contained in the Maternal and Child Health Handbook, locally known as the KIA book. This handbook is used by pregnant and postpartum women and has been routinely applied by healthcare providers to monitor the health status of pregnant and postpartum mothers.

Data Analysis

Maternal health status data were interpreted into two categories: at risk and not at risk. Family support received by pregnant women was analyzed using the T-score formula and categorized as positive when the T-score mean was ≥ 50 and negative when it was <50 . Maternal happiness was also analyzed using the T-score and classified as happy when the T-score mean was ≥ 50 and unhappy when the T-score mean was <50 . The results of the Kolmogorov–Smirnov test for normality showed that family support, maternal happiness, and maternal health data were not normally distributed, as indicated by p -values $< \alpha = 0.05$. The Variance Inflation Factor was 1.000, which is below the threshold of 10, indicating no multicollinearity in the model. Furthermore, the results of the Box–Tidwell test showed that the p -value for maternal happiness was 0.801, and that for maternal health was 0.551. Since all Box–Tidwell test values were greater than $\alpha = 0.05$, the assumption of linearity of the logit was considered satisfied. Therefore, to analyze the role of family support in maternal well-being, the researcher used the logistic regression test.

Ethical Practices

This study received ethical approval from the Health Research Ethics Committee (*Komisi Etik Penelitian Kesehatan* or KEPK) of Majapahit College of Health Sciences, Mojokerto, Indonesia (Ethical Approval No. 220/EC-SM/2025). Informed consent was obtained from all participants before the study commenced. Participants were informed of their rights to participate voluntarily and to withdraw from the study at any time without consequences.

RESULTS

Characteristics of Pregnant Women and Their Supporting Families

Table 1 shows that pregnant women in disaster-prone areas, predominantly women of healthy reproductive age (25–35 years), not employed outside the home, with parity two, and without a history of abortion. These characteristics generally reflect relatively safe pregnancy conditions. However, 12.9% of pregnant women are over 35 years of age, which is categorized as advanced maternal age and requires special attention due to the increased risk of obstetric complications. Occupational factors and physical workload also influence maternal health during pregnancy. Most pregnant women in the study area do not work outside the home, which may serve as a protective factor by reducing exposure to heavy physical activity, prolonged standing, heavy lifting, and long working hours.

Table 1. Characteristics of pregnant women in disaster-prone villages in Mojokerto Regency in 2025

No	Woman's Characteristic	Frequency (%)
a.	Age of pregnant mother	
	Non-ideal reproductive age (< 20 years old)	46 (37.1%)
	Healthy reproductive age (20-35 years old)	62 (50.0%)

No	Woman's Characteristic	Frequency (%)
	High risk reproductive age (> 35 years old)	16 (12.9%)
b.	Pregnant women's jobs	
	Farmer	0 (0%)
	Civil servants/TNI/police	4 (3.2%)
	Private or self-employed	44 (35.5%)
	Unemployed	76 (61.3%)
c.	Parity	
	1	54 (43.5%)
	2	44 (35.5%)
	3	22 (17.7%)
	4	4 (3.2%)
d.	Abortion history	
	Once	16 (12.9%)
	Never	108 (87.1%)
Total		124 (93.9%)

Table 2 shows that most companions of pregnant in the study area were aged 25–35 years, worked as private employees or were self-employed, and had incomes below the district minimum wage (IDR 4,856,026). Companions in the 25–35 age range are a productive age group generally associated with more stable physical and mental health, as well as sufficient energy to provide support during pregnancy, childbirth, and the postpartum period. The type of employment also influences the form of support provided by companions. Jobs with relatively regular working hours, even when associated with low income, allow for more consistent physical and emotional presence.

Table 2. Characteristics of family members accompanying pregnant women in disaster-prone villages in Mojokerto Regency in 2025.

No	Companion Characteristics	Frequency (%)
1	Age of companion	
	Transition to adulthood (< 25 years old)	30 (22.7%)
	Early adulthood (25-35 years old)	52 (39.4%)
	Adulthood (> 35 years old)	42 (31.8%)
2	Companion jobs	
	Farmer	6 (4.5%)
	Civil servants/TNI/police	6 (4.5%)
	Private or self-employed	110 (83.3%)
	Unemployed	2 (1.5%)
3	Income	
	< Rp 4,856,026	106 (80.3%)
	> Rp 4,856,026	18 (13.6%)
Total		124 (93.9%)

The Role of Family Support to Maternal Well Being in Disaster Prone Area

Table 3 shows that most mothers with negative family support felt unhappy with their pregnancies, while mothers with positive family support tended to feel happy. Social support is a factor influencing the happiness of high-risk pregnant women. Therefore, increasing maternal happiness should be viewed as a goal in itself, rather than merely a byproduct of reducing depression. Maternal happiness is an excellent subjective indicator for measuring maternal well-being, representing a broader mental health status than simply the presence or absence of mental disorders. Discussion of maternal happiness is still very rare among researchers. The results of this study revealed that 48.7% of maternal happiness in disaster-prone areas is determined by family support. Family support in disaster-prone areas is a protective factor for pregnant women against unhappiness. Pregnant women who receive positive family support are able to prevent maternal unhappiness, with 22.73 times more likely to feel happy than those who do not receive support. This indicates the limited role of families in providing support appropriate to mothers' needs.

Table 3. The Role of family support to maternal well-being in disaster prone area n 2025

No	Family Support	Maternal Well Being			
		Maternal Happiness		Maternal Health	
		Happy	Unhappy	Good	Bad
1	Negative support	14 (11.3%)	44 (35.5%)	32 (25.8%)	26 (21.0 %)
2	Positive support	58 (46.8%)	8 (6.5%)	50 (40.3%)	16 (12.9%)
Total		72 (58.1%)	52 (41.9%)	82 (66.1%)	42 (33.9%)
Logistic regression test result		P value = 0.000 R ² =0.487 OR=0.044 (CI 95%= 0.017-0.114)		P value = 0.015 R ² =0.064 OR=2.539 (CI 95%= 1.182-5.455)	

Table 3 shows that most respondents with negative support had good health status, while those with positive support were also in good condition. The proportion of unhealthy mothers was higher among pregnant women with negative support than among those with positive support. The results of the logistic regression test explained that pregnant women with positive support were 2.539 times healthier than those with negative support. The influence of family support on maternal health accounted for 6.4%; the remainder was determined by other factors in disaster-prone areas. Family support remains a protective factor for maternal health, though its effect is not as strong as its impact on maternal happiness.

DISCUSSION

Maternal age is an important determinant of pregnancy risk. Liu et al. (2021) demonstrated that obstetric complications, including preeclampsia, gestational diabetes, preterm birth, and congenital abnormalities, increase significantly at maternal age ≥ 35 years, with a risk inflection point between 35.6 and 40.4 years [16]. Hochler et al. (2023) similarly reported that maternal complications increase continuously with advancing age above 35 years, without a clear clinical inflection point [17]. Among 302,484 multiparous women, those aged ≥ 35 years also had higher rates of cesarean section, preterm birth, and neonatal intensive care unit (NICU) admission than women aged 25–30 years. These findings highlight the importance of closer antenatal surveillance for women of advanced maternal age.

High physical workload is associated with increased risks of preterm birth, low birth weight, and musculoskeletal disorders, particularly during the second and third trimesters. Pregnant women exposed to high workloads have approximately a 1.44-fold higher risk of preterm birth than those performing light work [18]. Therefore, appropriate adjustment of workload, particularly in late pregnancy, is important for maternal and fetal health.

Parity also contributes to pregnancy risk. Most women in this study had parity two, which is generally considered relatively safe. However, a retrospective study in Shanghai reported that multiparity may increase the risk of placental diseases and complications, particularly when combined with advanced maternal age or a history of abortion [19]. In contrast, primiparous women have a higher risk of preeclampsia than multiparous women, possibly because of less established immunological adaptation to pregnancy [20]. A history of abortion has also been associated with preterm birth, gestational diabetes, and placental disorders, including placenta previa and placenta accreta [19]. In assisted reproductive pregnancies, previous abortion has additionally been associated with placental complications and lower live birth rates [21]. Thus, although most women in the disaster-prone areas of Mojokerto had relatively favorable reproductive characteristics, advanced maternal age, multiparity with additional risk factors, and previous abortion warrant comprehensive antenatal monitoring.

Support from productive-age companions can improve adherence to antenatal care, nutritional intake, sleep, and stress management [22]. International studies have similarly linked companion employment and support with better antenatal care utilization and birth outcomes, including optimal

birth weight and reduced preterm birth [23,24]. Conversely, long working hours, unstable employment, and income below the minimum wage may limit the companion's ability to provide physical, financial, and emotional support and may restrict access to healthcare and adequate nutrition [22,23]. Active family involvement, particularly by husbands, may therefore contribute to maternal and infant health through physical, emotional, and logistical support [22,24].

The significant contribution of family support to maternal well-being in disaster-prone areas suggests that the disaster context may strengthen the role of close social relationships in psychological well-being. Pregnant women may experience multidimensional stress from safety threats, limited healthcare access, economic disruption, and environmental uncertainty. In such circumstances, family members may become an important source of emotional regulation and psychological stability [25,26]. Consistent with the Stress Buffering Model, family support may buffer acute stress, which may explain its strong association with maternal happiness (OR = 8.069). Social support has also been shown to reduce prenatal distress and improve maternal psychological resilience [26,27]. The finding that family support explained 25.2% of the variation in maternal happiness further suggests that family-level factors can be particularly important under crisis conditions.

Good family functioning is protective against antenatal depression and is associated with greater emotional stability during pregnancy [28]. Wang et al. (2024) further demonstrated that social support reduces postpartum anxiety while improving sleep quality and resilience [27]. Although family support remains important under normal circumstances, its relative influence may become more pronounced during disasters because economic, healthcare, and community systems are disrupted [27,29].

The influence of family support on maternal health was more moderate. Maternal health depends not only on emotional support but also on clinical and structural factors, including medical history, nutritional status, gestational age, antenatal care, health workers, sanitation, transportation, and healthcare readiness. Bedaso, Adams, Peng, and Sibbritt (2023) demonstrated that social support improves health-related quality of life among pregnant women through stress reduction and enhanced coping, but its effect is stronger on mental than physical health [30]. This distinction is consistent with the present findings, in which family support appears to be primarily psychologically protective while providing additional, but not decisive, support for maternal physical health.

Family support may also influence maternal health through health behaviors. Supportive family members can encourage antenatal visits, healthy nutrition, symptom monitoring, household assistance, and timely responses to pregnancy danger signs. Social support has been shown to improve self-management among pregnant women with gestational diabetes through greater health literacy and self-efficacy [31]. The 6.4% contribution of family support to maternal health indicates that it is an important but limited determinant. Family members can serve as the first line of support but cannot replace healthcare facilities, health workers, medication, antenatal care, or emergency referral systems.

The findings also suggest that different forms of family support may not be equally available. Practical support, such as assistance with housework, transportation, and childbirth preparation, is highly valued by pregnant women, but emotional and informational support are also important for security and coping [24]. Limited emotional attention, health information, or financial assistance may contribute to negative perceptions of family support [32]. Therefore, interventions should involve immediate family members and strengthen practical, emotional, informational, and financial support. Practical support can reduce physical burden; emotional support can reduce stress and anxiety; informational support can facilitate informed decision-making; and financial support can improve access to healthcare, nutrition, medication, and other maternal and infant needs.

Physical health is an important determinant of maternal well-being during pregnancy and postpartum. Meta-analytic evidence shows that physical activity during pregnancy reduces low back and pelvic girdle pain [33], while higher postpartum physical activity is associated with better functional capacity and quality of life [34]. Adequate physical activity and sleep are also associated with lower stress, anxiety, and depression. Conversely, postpartum physical problems, including pain, incontinence, and breastfeeding difficulties, predict poorer maternal mood [35]. Sleep quality is likewise strongly associated with postpartum quality of life [36]. These findings emphasize the importance of maintaining physical health as part of comprehensive maternal well-being.

Economic status is another important determinant of maternal well-being. Perceived insufficient income is associated with lower well-being, while economic well-being may strengthen the beneficial

effects of a healthy diet on depressive symptoms. Low income, rental housing, and lack of insurance have also been associated with poorer postpartum mental health [37], while low socioeconomic status increases the risk of postpartum depression partly through stress and inadequate support [38]. Economic vulnerability may therefore affect maternal well-being both directly and through reduced access to resources and support.

Perceived pregnancy risk can also adversely affect maternal well-being. Perceived risk mediates the relationship between prenatal self-efficacy and postnatal well-being, while greater pregnancy health literacy may reduce risk perception and pregnancy-related anxiety [39]. Higher perceived pregnancy risk has been associated with increased stress, and perceived infection risk during the COVID-19 pandemic negatively affected maternal outcomes, although social support and mindfulness moderated these effects [40]. Women at risk of preterm birth also reported higher anxiety and depression and lower well-being [41]. Improving maternal knowledge and coping resources may help reduce the psychological burden associated with perceived pregnancy risk.

Social expectations, pregnancy-related stress, and readiness for motherhood also influence maternal well-being. Psychosocial factors such as social expectations and stress consistently predict poorer maternal mental health [42]. Education programs that improve readiness for motherhood can enhance maternal adjustment and well-being, while perceived social support and cultural expectations influence coping and emotional outcomes [43]. Pregnancy-specific stressors and social norms are also associated with poorer mental well-being during the transition to parenthood [44]. Greater parenting confidence and readiness for discharge may reduce psychological distress [45], whereas pressure to meet social expectations may increase anxiety and depression and reduce parental self-efficacy [46]. Maternal stress and anxiety may also increase across gestation, particularly during the third trimester, while well-being declines.

This study has several limitations. It did not examine companion knowledge of pregnancy and postpartum warning signs or identify the types of support most needed during these periods. Future studies should therefore assess whether companion knowledge moderates the relationship between family support and maternal outcomes. In addition, when the companion is the husband, future research should distinguish between biological husbands and substitute husbands because their emotional relationships, responsibilities, and capacity to provide support may differ. The findings suggest that family support may improve maternal health partly by increasing maternal happiness. Family support provides emotional, practical, informational, and financial resources that can increase feelings of security and reduce stress. Greater happiness may subsequently promote better sleep, emotional stability, health-seeking behavior, and adherence to healthy practices, thereby indirectly supporting maternal health. However, in disaster-prone areas, family support should be viewed as complementary to, rather than a substitute for, accessible healthcare services, adequate nutrition, economic protection, and effective emergency referral systems.

CONCLUSION

The study concluded that in the disaster-prone areas of Mojokerto Regency, most pregnant women lacked family support. Most pregnant felt unhappy during their pregnancy and postpartum period in the disaster area. Family support factors, including financial, practical, informational, and emotional support, significantly influenced maternal happiness during pregnancy and the postpartum period. Family support can influence a mother's happiness. A happy mother has a positive impact on maternal health because she is likely to experience lower stress levels and is better able to handle both physical and emotional difficulties during pregnancy and after childbirth. Therefore, a health empowerment program is needed to encourage the mother's immediate family to support her during pregnancy, specially for groups living in disaster-prone areas. Positive support supports the health and safety of mothers and their babies.