

# Association between perceived spousal support and the quality of life of women with breast and gynaecological cancers in Nigeria: A cross-sectional study

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## Abstract

**Objective:** This study examined the association between perceived spousal support and the quality of life (QoL) among Nigerian women undergoing treatment for breast and gynaecological cancers. It aimed to assess how emotional, practical, financial, and health-related support from spouses influences patients' physical, psychological, social, and spiritual well-being.

**Method:** A cross-sectional descriptive survey was conducted among 133 Nigerian women receiving treatment for breast or gynaecological cancers. Data were collected online using structured questionnaires, including a 20-item spousal support scale and the City of Hope Quality of Life-Brief Instrument. Descriptive statistics, Chi-square tests, Pearson correlation, and multiple regression analyses were performed using SPSS version 17.

**Results:** The majority of respondents reported low to very low levels of emotional (58.7%), practical (66.2%), and financial (68.4%) spousal support. Significant impairments were observed across all QoL domains, especially psychological and social well-being. A moderate-to-strong positive correlation was found between perceived spousal support and overall QoL ( $r = 0.49$ ,  $p = 0.0496$ ), with the strongest correlation in the psychological domain ( $r = 0.51$ ,  $p = 0.0291$ ). Regression analysis showed that spousal support significantly predicted overall QoL ( $\beta = 0.38$ ,  $p < 0.01$ ), accounting for 31% of the variance.

**Conclusion:** Perceived spousal support plays a critical role in enhancing the quality of life for women with breast and gynaecological cancers in Nigeria. Interventions to improve partner engagement and reduce caregiving burden may improve clinical and psychosocial outcomes in this population.

**Keywords:** Spousal support, Quality of life, Breast cancer, Gynaecological cancer, Nigeria

## Plain English Summary

This study looked at how support from husbands affects the well-being of Nigerian women being treated for breast and gynaecological cancers. The researchers sought to determine whether emotional, financial, practical, and health-related support from spouses contributed to these women's improved physical, mental, social, and spiritual well-being. To find out, they surveyed 133 women across Nigeria who were receiving cancer treatment. The women answered questions online about the support they received from their

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husbands and how they felt about their overall quality of life. The results showed that most women felt they received very little emotional, financial, or practical support from their spouses. Many of them reported struggling with physical symptoms, emotional stress, social isolation, and spiritual uncertainty. Women who reported receiving more support from their husbands were more likely to feel better overall, particularly in terms of their mental and emotional well-being. Interestingly, women in newer marriages were more likely to receive support, while those in long-term marriages often got less. The study also found that age and cancer type did not strongly affect the level of support. In conclusion, the study highlights how important husbands' support is for women's health during cancer treatment. The authors suggest that educating men about the value of emotional and practical support could help improve outcomes for their wives. They also recommend that health programs include couple-focused counselling and support to ease the burden of cancer care.

## Background

Breast and gynaecological cancers are leading causes of cancer-related mortality among women worldwide, posing substantial public health challenges (1, 2). Breast cancer alone accounts for one-third of all newly diagnosed cancers in women and remains a major contributor to gynaecological cancer-related deaths (1). In Nigeria, these cancers represent a significant burden, marked by late-stage presentations, limited healthcare infrastructure, cultural stigmas, and inadequate screening programs. Late diagnoses, coupled with restricted access to advanced oncology care and the prevalence of financial constraints, often lead to suboptimal treatment outcomes and poor survival rates (3).

While globally, improved survival is linked to comprehensive strategies—early detection, quality treatment, palliative care, and survivorship planning—such approaches are less accessible in Nigeria due to systemic healthcare barriers (4). Despite ongoing efforts like awareness campaigns and enhanced healthcare provider training, Nigerian women with breast and gynaecological cancers continue to face numerous challenges in receiving timely and effective care. Within this context, the role of spousal support is gaining recognition as a critical factor influencing quality of life and overall patient outcomes.

Supportive care, including psychosocial, physical, and spiritual interventions, is now considered a cornerstone of evidence-based cancer care worldwide. Research has highlighted that spousal involvement can improve access to healthcare services, foster emotional and psychological resilience, and strengthen marital relationships (5). However, cultural norms in Nigeria often limit men's participation in women's health issues, including cancer treatment. Misconceptions, stigmas, and fears of diminished intimacy or fertility further discourage open communication and partner support, adding emotional and psychological strain to affected women (6).

Studies show that marital dynamics—such as communication, shared coping strategies, and intimacy—play a crucial role in helping couples navigate the challenges posed by breast and gynaecological cancers (7). When male partners are actively involved, the quality of life for patients tends to improve. However, many men in Nigeria who undertake caregiving roles experience unique psychological pressures, compounded by societal reluctance to acknowledge vulnerability (3). These challenges often strain marital relationships, hinder spousal support, and ultimately affect recovery trajectories for women.

## Objective

The main objective of this study was to examine the association between perceived spousal support and quality of life among women with breast and gynaecological cancers in Nigeria. Specifically, the study examined levels of perceived spousal support and quality of life. Also, the association between sociodemographic variables and spousal support was assessed. And finally, the relationship and predictive correlations between spousal support and quality of life were explored.

## Methods

### *Study Design and Setting*

This research employed a cross-sectional descriptive survey design to examine the relationship between perceived spousal support and the quality of life of Nigerian women with breast and gynaecological cancers.

### *Participants and Sampling*

Participants in the study were women who met the following inclusion criteria: Nigerian citizenship, active treatment for breast or gynaecological cancers, basic knowledge of computers or mobile device use, regular internet access, and ownership of at least a smartphone. Participants were recruited using a convenience sampling approach supplemented by snowball sampling. Information flyers describing the study and its eligibility criteria

were posted on multiple online platforms. Prospective participants who met the criteria were encouraged to share the study details with other eligible individuals, facilitating additional recruitment. This approach ensured a diverse participant pool and increased accessibility.

**Data Collection Tools and Instruments**

**1 Structured Questionnaire on Perceived Spousal Support:**

This 20-item questionnaire was specifically developed to measure women’s perceptions of the support provided by their spouses. Items were scored on a Likert-type scale ranging from “Always” to “Never,” with points assigned to each response option. The questionnaire covered various dimensions of spousal support, including emotional, practical, and informational support.

**2 City of Hope Quality of Life-Brief Instrument:**

To assess participants’ quality of life, the study employed the City of Hope Quality of Life-Brief Instrument, which is derived from the WHO Quality of Life-Brief (8). This tool includes 46 items spread across four domains: Physical Well-being, Psychological Well-being, Social Well-being, and Spiritual Well-being. Responses for all domains were recorded on a Likert scale ranging from 0 (low quality of life) to 10 (high quality of life).

**Instrument Reliability and Pretesting**

To ensure the reliability and validity of the instruments, a pilot test was conducted among a group of breast cancer patients who were not part of the final study population but shared similar characteristics. Cronbach’s alpha was calculated to assess internal consistency, resulting in reliability coefficients of 0.82 for the spousal support questionnaire and 0.76 for the quality-of-life instrument.

**Data Collection Procedure**

Data collection was conducted entirely online, allowing participants to complete the survey at their convenience. The survey was hosted on Qualtrics and distributed via a direct link and QR code. Recruitment efforts were focused on reaching eligible women across Nigeria through a variety of online platforms, including social media, religious groups, and socio-cultural forums.

On average, the survey required 10–15 minutes to complete. The use of an online format ensured anonymity and allowed participants from different regions of Nigeria to contribute, thus enhancing the study’s reach and representativeness.

**Data Analysis**

The collected data were analysed using the Statistical Package for Social Sciences (SPSS) version 17. Descriptive statistics, including means, frequencies, and standard deviations, were used to summarise demographic characteristics and to categorise levels of perceived spousal support and quality of life. Hypotheses were tested using Chi-square analysis to examine associations between categorical variables, Pearson correlation analysis to assess the strength and direction of the relationship between spousal support and quality of life, and multiple regression analysis to determine the predictive impact of spousal support on quality of life while controlling for sociodemographic and clinical variables.

**Results**

The study sample included 133 couples, providing insight into their age distribution, marital duration, and the type of cancer diagnosed in the wives. According to results in Table 1, the most common age range for wives was 40–49 years (37.6%). The majority of couples had been married for 11–20 years (37.6%). Breast cancer was the most frequently reported diagnosis (60.2%), followed by ovarian (18.8%) and cervical cancers (15%).

**Table 1. Sociodemographic Characteristics of Husbands and Wives (n=133)**

Variable	Category	Frequency (n)	Percentage (%)
Age of Wife (years)	20–29	10	7.5%
	30–39	25	18.8%
	40–49	50	37.6%
	50–59	35	26.3%
	60 and above	13	9.8%
Duration of Marriage	0–5 years	20	15.0%
	6–10 years	35	26.3%
	11–20 years	50	37.6%
	21–30 years	20	15.0%
	31 years and above	8	6.0%
Type of Cancer	Breast	80	60.2%

Ovarian	25	18.8%
Utero Cervical	20	15.0%
Vaginal	8	6.0%

The assessment of spousal support in Table 2 revealed varying levels of emotional, practical, financial, and health-related spousal support. Emotional support was rated as low or very low by 58.7% of respondents, suggesting potential gaps in psychological support. Practical and financial

support followed a similar trend, with more than 60% of participants rating them as low or very low. Notably, health-related support had the highest proportion of respondents indicating moderate or high support (39.1%), possibly due to direct caregiving involvement.

**Table 2: Levels of Perceived Spousal Support (n=133)**

Support Domain	Likert Scale	Frequency (n)	Percentage (%)
Emotional Support	High	20	15.0%
	Moderate	35	26.3%
	Low	50	37.6%
	Very Low	28	21.1%
Practical Support	High	15	11.3%
	Moderate	30	22.6%
	Low	55	41.4%
Financial Support	Very Low	33	24.8%
	High	14	10.5%
	Moderate	28	21.1%
Health-Related Support	Low	56	42.1%
	Very Low	35	26.3%
	High	21	15.8%
Health-Related Support	Moderate	31	23.3%
	Low	50	37.6%
	Very Low	31	23.3%

Quality of life (QoL) assessment in Table 3 demonstrated significant challenges in multiple domains. Physical well-being was rated low or very low by nearly half (49.6%) of the participants, reflecting the debilitating effects of cancer treatment. Psychological well-being followed a

similar pattern, with 50.4% reporting low or very low scores, indicating a need for mental health support. Social and spiritual well-being also showed substantial areas of concern, with 55.6% and 45.1% of respondents, respectively, rating them at low or very low levels.

**Table 3: Quality of Life of Women with Breast and Gynaecological Cancers**

Domain	Level	Frequency (n)	Percentage (%)
Physical Well-being	Very High	7	5.3%
	High	15	11.3%
	Moderate	45	33.8%
	Low	48	36.1%
Psychological Well-being	Very Low	18	13.5%
	Very High	9	6.8%
	High	16	12.0%
	Moderate	41	30.8%
Social Well-being	Low	44	33.1%
	Very Low	23	17.3%
	Very High	7	5.3%
	High	13	9.8%
Social Well-being	Moderate	39	29.3%
	Low	52	39.1%
	Very Low	22	16.5%

Spiritual Well-being	Very High	11	8.3%
	High	20	15.0%
	Moderate	42	31.6%
	Low	44	33.1%
	Very Low	16	12.0%

The relationship between sociodemographic factors and spousal support levels showed that the duration of marriage was significantly associated with the level of support provided by husbands ( $\chi^2 = 19.713, p = 0.0426$ ). Age was not significantly associated with spousal support. Younger couples (20–29 years) reported higher levels of support, while older couples (50+ years) more frequently

reported low or very low support. Couples married for 0–5 years had higher support levels, whereas those married for over 20 years reported the lowest. No statistically significant association was found between cancer type and support levels. However, breast cancer patients reported the highest levels of spousal support, and women with vaginal cancer reported the lowest.

**Table 4: Association between sociodemographic characteristics and perceived spousal support**

Variable	Category	High Support	Moderate Support	Low Support	Very Low Support	$\chi^2$	P-Value
Age of Wife	20-29	5	5	7	3	14.451	0.272
	30-39	8	12	15	5		
	40-49	5	10	20	15		
	50-59	2	6	8	10		
	60 and above	0	2	5	5		
Age of Husband	20-29	4	4	6	3	11.932	0.451
	30-39	6	10	15	5		
	40-49	7	12	25	11		
	50-59	3	6	6	9		
	60 and above	0	3	3	5		
Duration of Marriage	0-5 years	5	8	5	2	19.713	0.0426
	6-10 years	8	12	10	5		
	11-20 years	5	10	25	10		
	21-30 years	2	4	10	4		
Type of Cancer	31+ years	0	1	5	5	12.802	0.171
	Breast	15	25	30	10		
	Ovarian	4	6	10	5		
	Cervical	1	3	10	6		
	Vaginal	0	1	3	4		

Correlational analysis in Table 5 revealed a positive relationship between perceived spousal support and overall quality of life (QoL) ( $r = 0.49, p = 0.0496$ ). The highest correlation was in the psychological domain ( $r = 0.51$ ). The correlation with spiritual well-being was  $r = 0.39$ . Correlations

with physical, social, and psychological QoL were moderate to strong. Correlations across all domains ranged from  $r = 0.39$  to  $r = 0.51$ . The strongest correlation was in the psychological domain.

**Table 5: Relationship Between Perceived Spousal Support and QoL**

QoL Domain	Correlation Coefficient (r)	p-value
Physical	0.42	0.0442
Psychological	0.51	0.0291
Social	0.46	0.0168

Spiritual	0.39	0.1077
Overall QoL	0.49	0.0496

As shown in Table 6, perceived spousal support significantly predicted overall quality of life (QoL), even after controlling for age, cancer type, and husband's age. The analysis indicates that women who perceived greater support from their spouses tended to report higher QoL. Age of the wife also emerged as a significant inverse predictor, suggesting that older women reported lower QoL. Although cancer type and husband's age showed

trends toward influencing QoL, these associations did not reach statistical significance. Overall, the model explained 31% of the variance in QoL scores, highlighting the central role of spousal support in influencing the well-being of women with breast and gynaecological cancers, while also acknowledging that other unmeasured factors may contribute to QoL outcomes.

**Table 6: Predictive Effect of Perceived Spousal Support on QoL**

Predictor Variable	Standardised Beta ( $\beta$ )	t-value	p-value
Age of wife	-0.14	-2.31	0.02
Cancer type	-0.11	-1.78	0.08
Age of husband	0.09	1.54	0.12
Perceived Spousal Support	0.38	6.78	< 0.05
<b>R<sup>2</sup></b>	0.31	-	-

## Discussion

This cross-sectional study explored the association between perceived spousal support and the quality of life (QoL) of Nigerian women undergoing treatment for breast and gynaecological cancers. Findings revealed that many participants reported low levels of emotional, practical, financial, and health-related support from their spouses. This supports previous research highlighting the challenges women face in patriarchal settings, where caregiving roles are traditionally assigned to women, even when they are ill (3). Such norms can lead to emotional disconnection, with spouses often physically present but emotionally unavailable. The low emotional and financial support observed is consistent with studies showing that women with breast cancer frequently face isolation and financial strain when partners lack emotional or material resources (9). Emotional support is critical for psychological resilience and coping. The relatively higher levels of health-related support suggest men may feel more comfortable offering task-based assistance, as observed in other research on dyadic coping (7). Poor financial support also aligns with previous findings identifying economic hardship as a barrier to sustained caregiving, especially where access to funding or social support is limited (10). This highlights the need for structural interventions that both educate spouses and provide families with financial and practical support.

QoL assessments revealed substantial impairments across physical, psychological, social, and spiritual domains, consistent with global

literature describing cancer's multifactorial burden, especially in resource-limited contexts (11, 12). Nearly half reported low physical functioning, reflecting fatigue, pain, and treatment side effects—patterns observed in earlier research on chemotherapy and radiotherapy (13). Psychologically, more than half rated their mental well-being as poor, reflecting parallels with studies linking cancer to depression, anxiety, and emotional disorientation (14). Inadequate support may amplify internalised fears and hopelessness, especially in cultures where emotional expression is discouraged. Social well-being was the most affected domain. This mirrors research showing that changes in body image, sexual function, and poor relational communication contribute to marital strain and isolation (15). Cultural ideals about femininity and fertility may worsen this isolation when treatment causes visible physical changes. Although spiritual well-being was relatively better, many still reported low scores. This is notable in Nigeria's religious context, where spirituality is a common coping mechanism. Disrupted spiritual beliefs during illness may cause women to feel abandoned, though faith-based support may mitigate these effects (16).

The duration of marriage significantly influenced spousal support. Women married for 0–5 years reported higher support, while those married over 20 years reported the least, consistent with literature suggesting emotional engagement may decline over time due to fatigue or unresolved conflicts (17, 18). This may reflect caregiving strain and changing dynamics in long-term relationships.

Although age was not statistically significant, younger couples tended to report more support. This could indicate shifting gender norms and greater emotional openness among younger men, as noted in prior studies (19). Conversely, older spouses may be less emotionally expressive or overwhelmed by caregiving. Cancer type was not significantly associated with support levels, but breast cancer patients reported slightly higher support. This may reflect broader awareness and advocacy efforts compared to gynaecological cancers, which often remain stigmatised and culturally silenced (20).

Significant positive correlations were found between perceived spousal support and all QoL domains, reinforcing literature that links partner support to improved well-being in cancer care (21). The strongest correlation was in the psychological domain ( $r = 0.51$ ), echoing Zhang et al.'s findings on the benefits of emotional availability from spouses (5). Moderate correlations with physical and social QoL also reflect studies showing that consistent support helps women manage side effects and maintain relationships (22). Though weaker, the correlation with spiritual QoL still suggests that spousal encouragement contributes to spiritual strength. Regression analysis confirmed that perceived spousal support significantly predicts overall QoL ( $\beta = 0.38$ ,  $p < 0.01$ ), accounting for 31% of its variance. This aligns with findings by Petermann-Meyer et al., who highlighted the impact of family, especially spousal support, on survivorship outcomes (23). Older age also predicted lower QoL, consistent with Shalata et al.'s findings that older patients face compounded health and emotional challenges (14). While cancer type and husband's age were not significant predictors, observed trends warrant further investigation. Overall, the study underscores the vital role of spousal support in enhancing health outcomes for women with cancer. While individual and spiritual resources matter, a supportive partner offers essential buffering in emotionally and physically taxing circumstances.

#### *Limitations*

This study has some limitations. First, its cross-sectional design prevents conclusions about causality between spousal support and quality of life; longitudinal studies are needed to capture changes over time. Second, online convenience and snowball sampling may have introduced selection bias, limiting generalizability to women without internet access, particularly in rural or underserved areas. Third, self-reported data are

vulnerable to social desirability and recall bias, potentially affecting response accuracy. Intervention-based research is needed to test culturally appropriate strategies that enhance male partner involvement, reduce stigma, and address both the emotional and financial challenges of caregiving.

#### *Recommendations*

Based on the study findings, it is recommended to implement targeted health education for male spouses to increase awareness of their supportive role during breast and gynaecological cancer treatment. Counselling and emotional resilience training for couples should be included to promote psychological well-being, with special focus on older couples and those in long-term marriages. Structural interventions should also provide education on psychosocial care and offer financial and practical support to families. Enhancing spousal engagement in these ways can significantly improve the quality of life for affected women.

#### **Conclusion**

This study highlights the vital impact of perceived spousal support on the quality of life of Nigerian women with breast and gynaecological cancers. Many reported low emotional, practical, and financial support, linked to poorer well-being, especially psychologically. Support levels were higher in newer marriages, indicating marital duration as a key factor. The findings call for culturally tailored efforts to boost male partner involvement, reduce stigma, and ease caregiving burdens. Empowering spouses through education, emotional training, and financial support could enhance patient outcomes. Future research should use longitudinal, mixed methods and include both partners' perspectives to guide policy and care.

#### **List of Abbreviations**

BUHREC: Babcock University Health Research Ethical Committee  
QoL: Quality of Life  
SPSS: Statistical Package for the Social Sciences  
WHO: World Health Organisation

#### **Declarations**

##### *Ethics Approval and Consent to Participate*

Ethical approval was granted by the Babcock University Health Research Ethical Committee (BUHREC). Prior to participating, individuals reviewed a digital consent form outlining the study's purpose, voluntary nature, confidentiality measures, and the right to withdraw at any time

without penalty. Participants were required to electronically sign the consent form, indicating their understanding and agreement. Additionally, all guidelines for ethical online research were followed, ensuring that participant data remained secure and confidential.

#### *Consent for Publication*

All authors have reviewed and approved the final manuscript and consent to its publication.

#### *Availability of Data and Materials*

The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

#### *Competing Interests*

The authors declare that they have no competing interests.

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#### *Authors' Contributions*

O-BM: Conceptualization, data collection, analysis, manuscript drafting and revision.

OET: Study design support, manuscript review and editing.

KO: Data entry, statistical analysis, literature review, manuscript drafting and revision.

M-AOD: Data collection and management, formatting, manuscript drafting and revision.

NCU: Supervision, methodology design, statistical guidance, critical revision, manuscript drafting and revision.

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