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The experiences of partners in supporting healthy lifestyle behaviors during pregnancy: a scoping review.

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Abstract

Background

Maintaining a healthy lifestyle during pregnancy is important for maternal and child health. Partners can play a key role in supporting healthy nutrition and physical activity behaviors, yet there is currently no comprehensive overview of their experiences in providing such support. This scoping review aimed to explore partners' the barriers and facilitators in supporting healthy nutrition and physical activity behaviors during pregnancy.

Methods

A scoping review was conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews guidelines and the Joanna Briggs Institute methodology. Searches were performed in PubMed, Embase, CINAHL, Web of Science, Scopus, and grey literature databases. Studies were included if they explored partners' barriers or facilitators in supporting healthy nutrition and/or physical activity during pregnancy. Data were extracted independently by two reviewers and synthesized narratively. Barriers and facilitators were mapped onto the Capability, Opportunity, Motivation–Behavior model and the Theoretical Domains Framework.

Results

Three overarching themes emerged: the need for knowledge, information, and practical guidance; the influence of relationship, household, and social contexts on support behaviors and the importance of partners' perceptions of their role during pregnancy. A key finding was that partners' sense of responsibility during pregnancy emerged as a central determinant of support, with greater involvement reported among those who viewed pregnancy as a shared responsibility.

Conclusion

Partners play an important role in supporting healthy lifestyle behaviors during pregnancy, but their support is shaped by interacting individual, relational, environmental, and healthcare system factors, including the extent to

which partners are included in antenatal care. Family-based approaches that strengthen shared responsibility and actively involve partners in maternity care may enhance healthy lifestyle support during pregnancy and improve family health outcomes.

Introduction

Maintaining a healthy lifestyle during pregnancy, particularly through a balanced diet and regular physical activity (PA), is essential for the health of both the expectant mother and the unborn child. Adequate nutrition has been shown to improve both physical and mental well-being in early pregnancy.[1,2] Engaging in regular PA during pregnancy contributes to recommended gestational weight gain which reduces the risk of adverse pregnancy outcomes such as gestational diabetes mellitus (GDM) and preeclampsia.[3]

Healthy lifestyle behaviors adopted by pregnant women are influenced not only by their own fatigue and time constraints, but also by their partner's support.[4–6] Healthy lifestyle behaviors in pregnancy do not occur in isolation but are embedded within a shared household system, in which support from family members, particularly partners, plays a crucial role, as partners mutually influence food choices and patterns of PA.[6–8]

Partner support can be understood through the social support theory as a multidimensional construct encompassing emotional, instrumental, appraisal, and informational support exchanged within a close interpersonal relationship. Emotional support refers to expressions of empathy, care, and understanding; instrumental support involves practical assistance such as cooking or grocery shopping; appraisal support includes feedback and assistance in decision-making; and informational support consists of providing advice and relevant knowledge. These forms of support are conceptualized as relational and dynamic processes, occurring through ongoing interactions between partners and shaped by the needs and perceptions of both individuals.[9] Specifically, regarding nutrition, partner support is described as crucial for shaping the home food environment and supporting healthy dietary behaviors during pregnancy, primarily through practical involvement and shared decision-making in food purchase and preparation.[10] In addition, greater perceived partner support has been associated with higher levels of moderate-to-vigorous PA among pregnant women, highlighting the relevance of partner support for both dietary and PA behaviors during pregnancy. [4]

Partner support can be broadly understood as any partner behavior, interaction, or influence that may affect healthy lifestyle behaviors during pregnancy, whether with a positive or negative health outcome. Partners may exert both positive and negative influences on healthy lifestyle behaviors, as some encourage increased food intake or

reinforce unhealthy eating habits, while others promote healthier dietary habits and greater engagement in PA during pregnancy.[7] Partners may be motivated to support a healthy lifestyle, for example by striving to act as role models for their future child [11] or by maintaining their own health in anticipation of parenthood.[6] In contrast, other partners may adopt a more passive attitude, refraining from involvement in lifestyle-related decisions to preserve relationship harmony [11] or due to a perceived lack of knowledge about healthy lifestyle behavior during pregnancy. [5] The transition to parenthood is therefore described as a key life-stage transition that can serve as a window of opportunity for changes in lifestyle behaviors, although these changes may be either positive or negative depending on individual and contextual factors.[12]

To better understand the factors that influence partners' support in healthy lifestyle behaviors during pregnancy, behavioral science frameworks can provide a theoretical lens. The Capability, Opportunity, Motivation-Behavior (COM-B) model proposes that behavior arises from the interaction between three key components: capability, opportunity, and motivation.[13] Capability encompasses the psychological and physical capacity to perform a behavior. Opportunity refers to external factors that facilitate or hinder behavior, such as social influences and environmental resources. Motivation includes the cognitive and emotional processes that energize and direct behavior, such as beliefs, attitudes, intentions, and goals.[14] The Theoretical Domains Framework (TDF) complements the COM-B model by subdividing capability, opportunity, and motivation into theoretical domains, such as knowledge, skills, social influences, environmental context and resources, beliefs about capabilities, beliefs about consequences, and social role and identity.[15]

Although partner involvement in pregnancy-related health behaviors has been examined in individual studies, a comprehensive synthesis of partners' barriers and facilitators in supporting nutrition and PA during pregnancy remains limited. This gap restricts the development of theoretically grounded and contextually appropriate couple-based interventions. To address this gap, the present study explored the literature on partners' experiences in supporting healthy lifestyle behaviors, specifically nutrition and PA, during pregnancy. By synthesizing how partners experience their supportive role, this review identifies both barriers and facilitators of supporting a healthy lifestyle during pregnancy.

Methods

Study design

A scoping review was to explore partners' the barriers and facilitators in supporting healthy nutrition and physical activity behaviors during pregnancy. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines were used.[16] Moreover, the research strategy used in this review followed the Joanna Briggs Institute Manual for Evidence Synthesis.[17] The review protocol was registered with the Open Science Framework (https://doi.org/10.17605/OSF.IO/P9AVH).

Eligibility criteria

Eligibility criteria were developed using the SPIDER framework (Sample, Phenomenon of Interest, Design, Evaluation, and Research type).[18] The review included studies involving partners of pregnant women, irrespective of gender. Eligible studies explored partners' experiences of supporting healthy nutrition and/or physical activity during pregnancy, including barriers, facilitators, and support-related behaviors. Qualitative, quantitative, and mixed-methods studies were eligible for inclusion. Cross-sectional, longitudinal, and retrospective studies were eligible for inclusion. Studies could collect data either during pregnancy or retrospectively, provided that participants reflected on experiences that occurred during pregnancy. Conference papers, opinion papers, letters, and studies focused on instrument development or validation were excluded. Studies focusing exclusively on tobacco use, alcohol use, sleep, mental health or illicit drug use were also excluded. In addition, studies conducted outside the context of pregnancy were excluded unless pregnancy-related findings were reported separately. Studies including both pregnancy and postpartum periods were eligible when pregnancy-specific findings could be extracted separately. No publication date restrictions were applied.

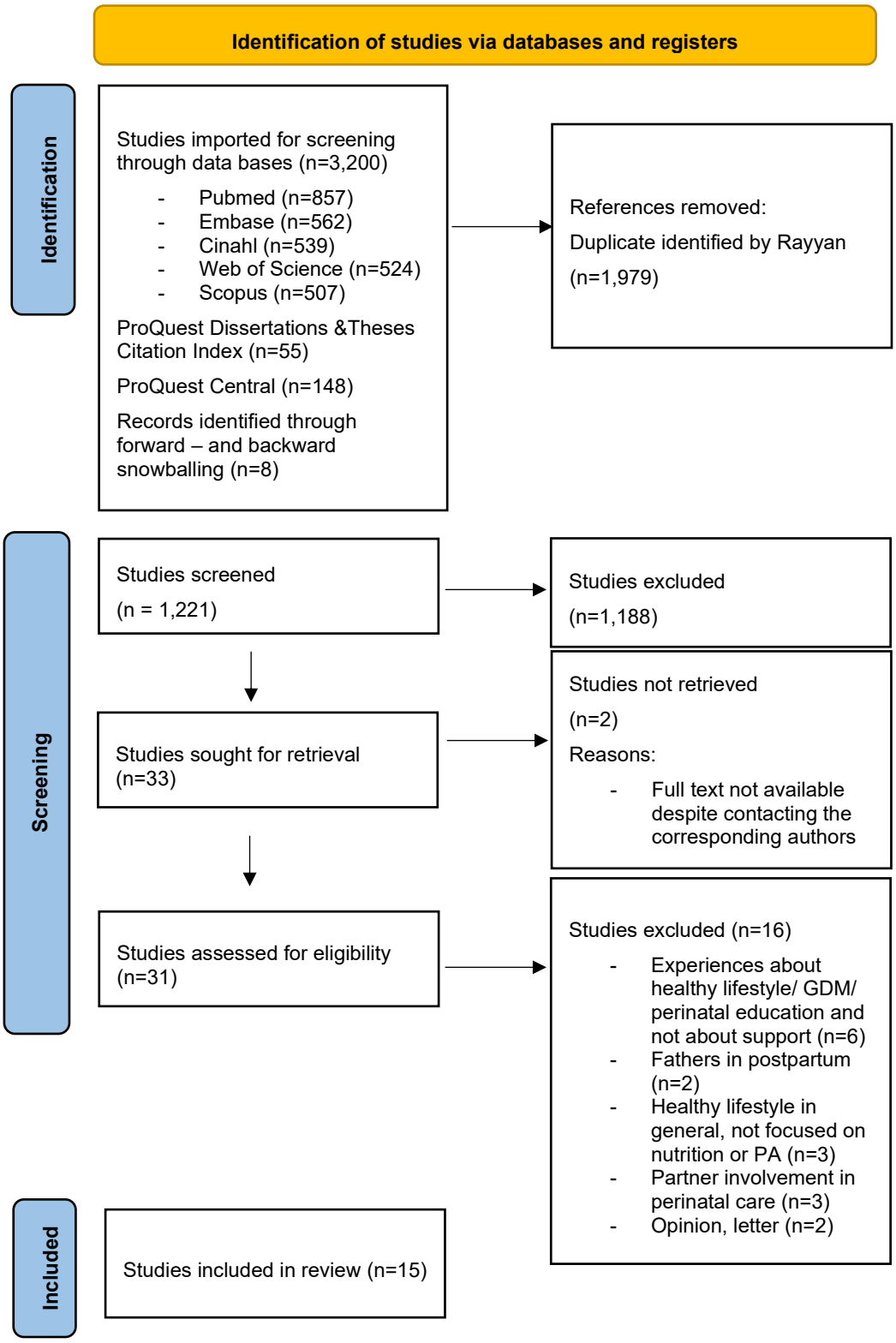
Search strategy

A comprehensive search was conducted on 6 October 2025 in the databases of PubMed, Embase, CINAHL, Web of Science, and Scopus. Grey literature was searched for in ProQuest Dissertations & Theses Citation Index and ProQuest Central. Three predefined concepts, "pregnancy period", "healthy lifestyle", including PA or eating behavior, and "partner support", were combined into a search string tailored to each database. The complete search strategies were deposited in searchRxiv and are available at: https://doi.org/10.1079/searchRxiv.2026.01512 (pubmed), https://doi.org/10.1079/searchRxiv.2026.01508 (Cinahl), https://doi.org/10.1079/searchRxiv.2026.01511 (Web of Science Core Collection), https://doi.org/10.1079/searchRxiv.2026.01509 (Embase), https://doi.org/10.1079/searchRxiv.2026.01510 (ProQuest). No filters or search limits were applied. The search string was reviewed and optimized in collaboration with an experienced librarian.

Study selection

All retrieved references were imported into Rayyan.[19] The screening process was conducted from 6 October 2025 until 31 December 2025. Titles and abstracts were independently screened by two reviewers (L.M. and L.V.), with calibration meetings held after the first 50, 100 and 600 records to ensure consistency. Full-text articles were assessed by the same reviewers, with reasons for exclusion documented. Reference lists of included studies were manually screened, and forward snowballing was conducted using Web of Science and Scopus. Conflicts were resolved through discussion. The study selection process is presented in a PRISMA 2020 flow diagram (Figure 1). An updated search was conducted on 18 September 2026, and newly identified records were screened using the same study selection procedures.

Figure 1: PRISMA flow diagram



Data extraction and synthesis

A data extraction form was developed to collect study characteristics (authors, year of publication, country of origin, study aims, population characteristics, and methodology) as well as findings related to partners' experiences in supporting healthy lifestyle behaviors during pregnancy. Data extraction was performed independently by two reviewers (L.M. and L.V.) in March 2026. Prior to formal data extraction, the extraction form was piloted independently on two articles and refined following discussion. Any discrepancies during the extraction process were resolved through discussion until consensus was achieved. If no consensus was reached between the two reviewers, disagreements were resolved through consultations with a third senior researcher (A.B.).

In a first step, all findings related to partners' experiences in supporting healthy lifestyle behaviors during pregnancy were extracted. Support was broadly defined as any partner behavior, interaction, or influence that could affect healthy lifestyle behaviors during pregnancy. During this phase, barriers and facilitators were identified using predefined definitions. Barriers were defined as factors that hindered partners' ability to support healthy lifestyle behaviors, whereas facilitators were defined as factors that enabled or promoted such support.

In a second step, the identified barriers and facilitators were deductively mapped onto the COM-B model.[13] Each extracted finding was assigned to one of the COM-B domains based on whether it reflected a determinant related to physical or psychological capability, physical and social opportunity, and reflective or automatic motivation. When necessary, discussions were held between reviewers to reach agreement on the most appropriate classification.

In a third step, findings within each COM-B domain were further specified using the TDF.[15] This allowed for a more detailed categorization of determinants within the broader COM-B domains. For example, psychological capability was further differentiated into TDF domains such as knowledge, skills, and behavioral regulation, while social opportunity was further specified using domains such as social or professional role and identity [20].

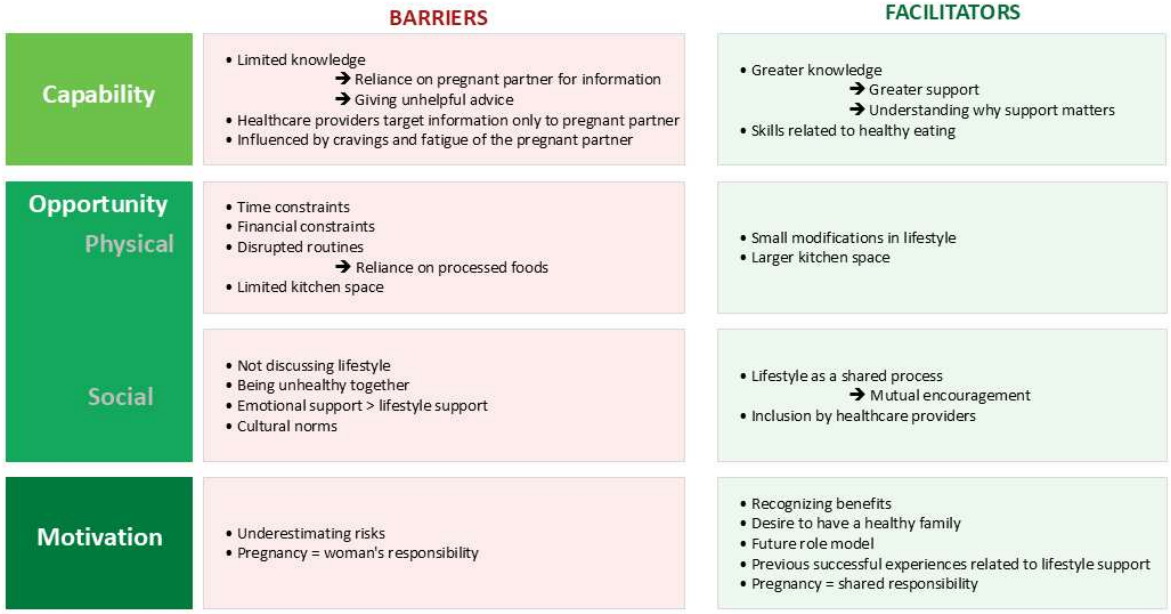
Contradictory findings were retained and reported where relevant, reflecting contextual differences across studies.

Finally, the extracted data were synthesized narratively. Findings were organized according to the COM-B domains and corresponding TDF domains.

Results

Barriers and facilitators influencing partners' support for healthy lifestyle behaviors during pregnancy were identified across all COM-B components and corresponding TDF domains. See Figure 2 for an overview of the results.

Figure 2: Barriers and facilitators of partners in supporting a healthy lifestyle during pregnancy



Of the 15 included studies, 11 used a qualitative design, 2 used a quantitative design and 2 used a mixed-methods design. Six studies focused primarily on nutrition, [5,6,9,10,21–23] three focused primarily on PA [6,24,25] and the remaining studies addressed both behaviors.[11,26–30] Across the included studies, the vast majority of participating partners were male. [5,6,10,21–23,26–30] Only three studies included female partners.[9,24,25] Among studies examining both nutrition and PA, findings generally contained more data regarding nutrition and dietary support, with Greenhill & Vollmer[28] providing relatively equal attention to both behaviors. Characteristics of the included studies are presented in Table 1.

[Insert – Table 1: Characteristics of the included studies – here]

Capability

Partners reporting limited knowledge about healthy eating and PA in pregnancy presented a key barrier across studies. Partners often relied on their partner as the main source of information and were unsure about safe PA or appropriate nutrition during pregnancy.[5,11] Furthermore, several studies suggested that knowledge deficits were not solely individual factors but were partly shaped by limited access to partner-focused information from

healthcare professionals. Partners frequently reported that information regarding healthy lifestyle behaviors was primarily directed towards pregnant women, leaving them uncertain about how to support dietary and PA recommendations effectively. [5,23,26,30]

Greater knowledge was associated with greater reported ability to provide instrumental support, such as purchasing appropriate foods, supporting dietary recommendations, and assisting with lifestyle changes.[26] For example, partners who attended educational sessions on GDM reported actively buying whole meal products, because they understood their relevance for maternal and infant health.[30] Although these findings were frequently reported in studies involving partners of women with GDM, similar patterns were also observed in the broader pregnancy context. Partners who reported lacking knowledge about healthy eating or PA during pregnancy tended to rely on precautionary approaches, such as selecting foods perceived as safe rather than nutritionally optimal or discouraging PA due to concerns about potential risks for the mother or baby.[5,6,23]

Knowledge appeared to be associated with appraisal support. Better-informed partners were more likely to understand why their support was important, reinforce healthy lifestyle recommendations and encourage adherence to dietary and PA advice. Partners who reported limited knowledge were more likely to provide unhelpful advice, underestimate risks associated with GDM or unintentionally discourage recommended lifestyle changes. Partners expressed a desire for more information and practical guidance on how to support healthy lifestyle behaviors during pregnancy, both among partners of women with GDM and in the broader pregnancy context.[9,30]

Quantitative findings supported these qualitative observations. Spousal knowledge about PA was positively correlated with spousal support for PA during pregnancy, suggesting that greater knowledge was associated with more supportive behaviors.[25]

In addition to knowledge, skills related to healthy eating were reflected in partners' reported ability to provide support. Partners who became involved in meal preparation often reported feeling overwhelmed and lacking confidence in knowing how meals should be adapted to meet dietary recommendations, thereby limiting their ability to provide effective instrumental support.[27]

Behavioral regulation represented another barrier to support throughout the studies. Some partners did not consciously monitor the dietary intake of the pregnant partner, while others struggled to maintain healthy habits themselves. Partners described inconsistency in adhering to healthy behaviors, including "secret eating" and

difficulties resisting unhealthy foods. In addition, some partners reported being influenced by the unhealthy cravings or changing food preferences of the pregnant woman.[5,9,23,27] Similar patterns were observed for PA. Partners reported that reductions in PA during early pregnancy due to pregnancy-related symptoms, such as nausea, fatigue, or discomfort, often developed into habits that were difficult to reverse later in pregnancy. In some cases, partners reinforced these sedentary routines by adapting their own behavior to that of the pregnant woman rather than actively supporting healthy lifestyle behaviors.[6]

Opportunity

Physical opportunity

Environmental constraints such as financial difficulties, limited time, and disrupted routines because of impending parenthood were related to partners' ability to provide instrumental support for healthy eating, such as purchasing, preparing and maintaining healthy foods within the household. Because of that, several partners described difficulties ensuring the continuous availability of healthy foods. Limited access to convenient healthy food options constrained partners' ability to create a supportive home food environment and often resulted in greater reliance on processed foods and convenience meals.[21–23]

The home environment further shaped partners' ability to support healthy dietary behaviors. Kitchen space, organization and available equipment influenced meal preparation practices. Partners who reported having larger and well-organized kitchens reported greater ease in preparing healthy meals, whereas limited space and clutter acted as barriers to providing instrumental dietary support.[23]

Some partners reported making small modifications to the home food environment, such as balancing convenience food with healthy eating by for example adding vegetables to meals, thereby facilitating instrumental support for healthy eating.[23]

Social opportunity

Social opportunity encompassed communication patterns, relationship dynamics, healthcare involvement and cultural influences. Communication emerged as a key factor underlying appraisal and emotional support. Several studies reported that partners felt uncomfortable discussing dietary behaviors, particularly when they feared upsetting the pregnant woman. As a result, healthy lifestyle behaviors were not always discussed openly within couples, potentially limiting opportunities for encouragement or feedback.[9,28,29]

Several studies highlighted that support was often a shared process rather than an individual behavior. Couples sometimes implemented healthy lifestyle changes together and provided mutual encouragement. However, the same relationship dynamics could also reinforce unhealthy behaviors, for example when partners jointly abandoned dieting efforts or validated unhealthy food choices.[5,29] Partners often mirrored the pregnant woman's sedentary behavior, for example by lying on the sofa together when pregnancy-related fatigue reduced PA.[6]

In some cases, partners attempted to be supportive while simultaneously discouraging lifestyle changes. For example, one partner described trying to be supportive of his wife's weight concerns but occasionally encouraging less healthy choices by offering her cake when dieting became emotionally difficult.[29] Partners sometimes experienced a tension between encouraging healthy behaviors and maintaining relationship harmony. Some avoided discussing diet, weight or lifestyle behaviors because they feared upsetting their partner or believed they could not force behavior change. Others prioritized emotional support over adherence to lifestyle recommendations.[9,11,28,29]

Healthcare professionals' behavior appeared to be related to partner support through the extent to which partners were included in antenatal care. Partners described limited engagement by healthcare providers, reporting that they were rarely invited to consultations or provided with information tailored to their supportive role.[11] Partners of women with GDM reported that healthcare professionals did not provide them with information on managing GDM, resulting in partners relying on second–hand information obtained from their pregnant partner, friends, or the internet. Some partners felt that clinicians did not expect anything from them, despite considering themselves an important resource for supporting healthy lifestyle changes during pregnancy. Partners of women with GDM particularly expressed a wish to be involved in consultations addressing nutrition and lifestyle management, believing that greater inclusion would enable them to provide more informed and effective support.[26,30]

It was reported that cultural norms were also related to support behaviors. In some studies, cultural beliefs encouraged unrestricted eating, following pregnancy cravings, or maintaining traditional dietary practices despite professional recommendations. Other cultural norms reinforced the idea that pregnancy management was primarily the responsibility of women, thereby reducing partner support.[11,21,30]

Motivation

Goals and intentions were frequently reported to facilitate partner support. Many partners described a desire to support the health of the mother and baby and to prepare for parenthood. Some also expressed a wish to adopt

healthier lifestyles and act as positive role models for their future children. Pregnancy increased partners' sense of responsibility and often motivated efforts to create a healthier family environment.[11,23,28,29]

Several partners reported that pregnancy encouraged a shift from individual health considerations toward family-focused health behaviors. Healthy eating was increasingly perceived as behaviors that benefitted the entire family rather than solely the pregnant woman.[23,26,30] For example, a partner in Keely et al.[29] reported the fear that their children would experience the same weight issues as them.

Findings across studies suggested that beliefs about consequences were important facilitators of support. Partners who recognized the benefits of healthy eating and PA for maternal, fetal and family health considered supporting these behaviors to be important. Couples considered a healthy lifestyle important when they believed it could help them achieve their desired birth outcomes, or when they shared the belief that unhealthy behaviors could increase the risk of chronic diseases in their baby. They viewed pregnancy as a window of opportunity to adopt healthier lifestyle behaviors and the health of the baby emerged as a motivating factor for providing support.[9,23,24] Quantitative evidence demonstrated positive associations between a partner's beliefs about the benefits of engaging in PA during pregnancy, their knowledge regarding PA in pregnancy, and the support they provided for PA during pregnancy.[25]

On the other hand, support was reported to be hindered when partners underestimated the risks associated with unhealthy lifestyle behaviors or when they questioned recommended lifestyle advice. Examples included beliefs that pregnancy cravings should always be followed, the myth of "eating for two" in pregnancy or that dietary restrictions or PA might harm the foetus.[5,24,28,29] In the context of GDM, some partners believed that GDM is not that serious. Such beliefs occasionally resulted in support behaviors that conflicted with healthcare recommendations.[30]

Beliefs about capabilities appeared to facilitate support. Partners who had previous successful experiences with healthy lifestyles or who already practiced health-conscious behaviors before pregnancy reported greater confidence in supporting healthy eating and PA during pregnancy.[28,30]

Finally, social and parental role identity and sense of responsibility strongly shaped support behaviors. A barrier emerged when partners viewed pregnancy as primarily the woman's responsibility or considered women to be the experts regarding pregnancy and nutrition. These perceptions seem to be reinforced by healthcare practices that primarily target pregnant women and provide limited opportunities for partner involvement in lifestyle

support.[11,26,30] These beliefs were associated with a more passive role in supporting healthy lifestyle behaviors and the feeling that partners do not need to take the initiative.[10,11,21,30] Facilitators emerged when partners perceived pregnancy as a shared experience and viewed support as part of their role as a partner. These partners engaged in multiple forms of support, including instrumental support through meal preparation and dietary adaptations, emotional support by providing reassurance and understanding, and appraisal support through encouragement to do PA.[11,21,24,27]

Discussion

The present scoping review explored partners' barriers and facilitators in supporting healthy lifestyle behaviors during pregnancy. Given that health behaviors are shaped by influences at multiple levels, rather than by individual factors alone, understanding partners' experiences of providing support is essential for understanding how the interpersonal environment influences healthy lifestyle behaviors during pregnancy.[31]

This review identified three overarching themes. First, partners need knowledge, information and practical guidance to feel able to support healthy behaviors. Second, support takes place within a relationship and household context, where communication, shared behaviors, social context and environmental resources can either facilitate or hinder support. Finally, partner support depends strongly on how partners perceive their role during pregnancy. Together, these findings suggest that partner support extends beyond individual motivation or knowledge alone and is embedded within broader social and healthcare contexts.

One of the most consistent findings across studies was that partner support appeared to be strongly influenced by how partners conceptualized their role during pregnancy. Partners who perceived pregnancy as a shared responsibility were more likely to actively support healthy behaviors, whereas those who viewed pregnancy as primarily the woman's responsibility tended to be less engaged. Importantly, these beliefs are not formed in isolation but are embedded within broader cultural norms surrounding the role of partners during pregnancy.[11,21,30] Furthermore, they appear to be reinforced by the healthcare system. By focusing predominantly on pregnant women, healthcare services may inadvertently reinforce the perception that pregnancy-related health is solely the woman's responsibility.[32,33] While shared responsibility is increasingly emphasized before conception,[34,35]this perspective appears to diminish once pregnancy begins.[36] Consistent with this observation, partners frequently reported that information regarding lifestyle during pregnancy was primarily directed towards women and insufficiently inclusive of partners.[23,26,30] As a result, many partners experienced uncertainty regarding their supportive role and lacked confidence in how best to support healthy lifestyle behaviors.[27] Several findings suggest

that partners may feel more involved when their role in supporting healthy lifestyle behaviors is explicitly acknowledged and facilitated. In addition to role perceptions, the findings further demonstrated that pregnancy creates a dynamic process of reciprocal influence, in which both partners affect each other's behaviors. While this mutual influence could facilitate healthy lifestyle changes, it could also reinforce unhealthy habits, particularly in response to pregnancy-related cravings or shared unhealthy behaviors.[5,26,29,30] These findings resonate with dyadic perspectives described in the literature, which conceptualize health behaviors as co-constructed within couples rather than determined by individuals alone.[11,31,37,38] This suggests that interventions targeting both members of the couple may be particularly effective in promoting healthy lifestyle behaviors during pregnancy.

Research about family-based interventions in the perinatal period has highlighted the importance of actively involving partners, providing them with practical and tailored information, and emphasizing how couples can motivate and support each other throughout pregnancy. The findings of this review support the rationale for involving both members of the couple in lifestyle interventions, as health behaviors appear to be shaped through reciprocal influences within the relationship. This interpretation is consistent with previous intervention research suggesting potential benefits of dyadic approaches to behavior change.[39] The findings further suggest that partner involvement is not solely determined by individual motivation, but also by the extent to which healthcare professionals actively engage partners in antenatal care[33,40]. Therefore, consistent guidance and support from healthcare professionals may strengthen partners' confidence and help them identify a meaningful role in promoting healthy lifestyle behaviors.[41] In addition to targeting individual and interpersonal factors, broader structural changes may be needed to facilitate healthy lifestyle behaviors.[31] The included studies highlighted financial constraints, limited time, and difficulties accessing healthy food options as barriers to partners' ability to provide support. Therefore, it is suggested that expectant and young families should have easier access to supportive resources and environments, including affordable healthy food options, convenient healthy meals, and financial incentives or reimbursement schemes that help create environments that facilitate healthy lifestyle support during pregnancy.[41]

Finally, several studies suggested that partners were motivated to support healthy lifestyle behaviors because of their desire to contribute to the health of their child and family and to act as positive role models for their future children.[9,23,26,29,30] The involvement of partners could generate benefits beyond maternal health alone. Supporting healthy lifestyle behaviors during pregnancy may also promote positive behavior change among partners themselves, thereby improving the lifetime health of the family as a whole.[42] Together, these findings reinforce

the notion that pregnancy represents a key window of opportunity for lifestyle change, not only for pregnant women but for couples and families more broadly.[12,43]

Future research

The relational nature of support has important implications for intervention development. Engaging partners as part of a wider support system may help foster shared responsibility for health behaviors and strengthen the implementation of healthy lifestyle changes within the household. Importantly, evidence suggests that interventions for example to improve maternal nutrition, with multiple integrated components are more effective than interventions solely targeting partner support.[44] This indicates that partner involvement may be most effective when embedded within broader family-, couple-, or community-centered approaches rather than being treated as an isolated behavioral target.[11,33] Such approaches acknowledge that health behaviors are shaped by interactions between partners and their wider social environment. Although romantic partners are often considered a primary source of support during pregnancy, support may also be obtained from friends, peers, and other family members. For some women, especially single mothers or those experiencing poor relationship quality, these alternative support networks may represent a preferred or more accessible source of emotional, informational, and practical support.[45–47]

Nevertheless, greater partner involvement does not automatically translate into better outcomes. Tokhi et al.[44] highlighted that interventions should be carefully designed to avoid reinforcing existing gender inequalities or reducing women's autonomy in health-related decision-making. Consequently, successful partner-inclusive interventions should balance the benefits of partner support with the preservation of women's agency, autonomy, and shared decision-making within the relationship. Interventions should aim to promote equitable partnerships in which both members of the couple are supported in making informed lifestyle decisions.[44]

Finally, partners frequently reported providing instrumental support, such as preparing meals or taking over household tasks when women experienced pregnancy-related symptoms including fatigue or nausea.[9,27,28] While these behaviors were generally perceived as supportive, it remains unclear whether such adaptations consistently resulted in healthier dietary patterns or how they may have influenced the level of PA of the pregnant partner. For example, reducing household responsibilities may enable pregnant women to rest more, but may also inadvertently increase sedentary behavior.[6] Future research should therefore examine not only whether support is provided, but also how different forms of partner support influence maternal lifestyle behaviors and health outcomes in practice.

Strengths and limitations

To our knowledge, this is the first scoping review to examine partners' barriers and facilitators in supporting both nutrition and PA behaviors during pregnancy. A major strength of this review is that it synthesizes the perspectives of partners, a group that is often overlooked in pregnancy-related health research and interventions despite their important influence on maternal health behaviors. By identifying the barriers and facilitators experienced by partners, this review provides a foundation for the development of targeted, family-centered approaches to promote healthy lifestyle behaviors during pregnancy.

However, several limitations should be acknowledged. Most included studies focused primarily on nutrition, while considerably less evidence was available regarding PA support. Furthermore, most included participants were male partners, limiting the transferability of findings to female partners and other family structures. In addition, a substantial proportion of studies involved partners of women with GDM, which may limit transferability to the general pregnant population. The findings should also be interpreted in light of the cultural diversity of the included studies, which were conducted across Europe, North America, Asia, and Africa. Cultural norms may influence perceptions of partner involvement, gender roles, pregnancy-related responsibilities, and lifestyle practices. Consequently, barriers and facilitators identified in this review may operate differently across cultural contexts.

No formal quality appraisal was conducted, consistent with the exploratory aim of this scoping review. As a result, it was not possible to determine whether findings from higher-quality studies were more reliable than those from studies with methodological limitations.

Conclusion

Partners play an important role in supporting healthy lifestyle behaviors during pregnancy, yet their ability and willingness to provide support are influenced by multiple interacting factors. This scoping review identified knowledge and access to information, perceptions of the partner role during pregnancy, and relationship and contextual factors as key determinants of partner support. These findings highlight the need for partner-inclusive approaches that acknowledge the relational nature of health behaviors during pregnancy and actively involve partners in lifestyle promotion and maternity care. Such approaches may enhance support for healthy nutrition and PA during pregnancy and contribute to improved health outcomes for mothers, children, and families.

List of abbreviations

COM-B: Capability, Opportunity, Motivation and Behavior Model

FFQ: food frequency questionnaire

GDM: Gestational Diabetes Mellitus

PA: Physical Activity

PHFE: physical home food environment

PRISMA-ScR: Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews

SB: sedentary behavior

TDF: Theoretical Domains Framework

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Figure 1: PRISMA flow diagram

Figure 2: barriers and facilitators of partners in supporting a healthy lifestyle during pregnancy ordered via the COM-B model.

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Table 1: Characteristics of the included studies

Declarations

Ethics approval

Not applicable.

Consent for publication

Not applicable.

Competing interest

The authors declare that they have no competing interest.

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609 Table 1: Characteristics of the included studies

Author et al., year	Country of origin	Aim of the study	Design	Population	Sample size (partners)	Data collection methods
Almli et al., 2020	Norway	The aim of this study was to explore the partner's experiences and knowledge of gestational diseases, and how the partner wishes to contribute to lifestyle change. Focus on: nutrition and PA	Qualitative	Partners of women with GDM or pre – eclampsia during postpartum about pregnancy experiences Parity not reported	11 men	Face-to-face focus group discussions and interviews (semi-structured)
Bhaskar et al., 2024	India	To test the knowledge of the male partner regarding maternal nutritional issues, to ascertain the self-efficacy of husbands regarding maternal nutritional issues, and to assess the attitude of the male partner towards social norms regarding maternal nutritional issues. Focus on: nutrition	Quantitative	Partners in pregnancy (second and third trimester) of women with anaemia Parity not reported	98 men	Face-to-face questionnaires: validated questionnaire about knowledge, attitudes, and practices regarding maternal nutritional issues
Benton et al., 2025	United Kingdom	To explore the impact and experiences of Gestational Diabetes Mellitus on fathers in the perinatal period Focus on: nutrition and PA	Qualitative	Partners in pregnancy and postpartum of women who had currently GDM or had been diagnosed with GDM within the past 3 years. Mixed parity sample	9 men	Face-to-face interviews (semi-structured)
Choi & Fukuoka, 2018	United States of America	To examine the association between spousal characteristics (belief, knowledge, social support, and PA level) and pregnant women's PA level Focus on: PA	Quantitative	Couples in pregnancy. Women with an inactive lifestyle but willing to be physical active. Mixed parity sample	18 partners - 1 female - 17 male	Online Questionnaires: - The Social Support and Exercise Survey (modified for partners of pregnant women) - The Multidimensional Outcome Expectations for Exercise Scale (MOEES) modified for partners - Self developed questionnaire to assess knowledge of partners about PA in pregnancy - Stanford Brief PA Survey - PA Stages of Change - 7-Day PA Recall. (last 3 = for pregnant women) - Short-form of the International Physical Activity Questionnaire (IPAQ) (for partners)
Greenhil & Vollmer, 2019	United States of America	To explore the first-time pregnant couples' perception of the father's role in relation to a pregnant woman's food and activity behavior during pregnancy. Focus on: nutrition and PA	Qualitative	Couples in pregnancy Mixed parity sample	11 men	Telephone interviews (semi-structured)
Guo et al., 2024	China	To explore the experiences of women with gestational diabetes mellitus (GDM) and their partners and examine the factors influencing partner involvement in GDM management, seeking to inform a targeted couple-based intervention Focus on: nutrition and PA	Qualitative	Couples during pregnancy (third trimester) with women with GDM Mixed parity sample	14 men	Face-to-face interviews (semi-structured)
Hopkins et al., 2018	United States of America	To describe themes among shared PA goals and perceptions of partner support during the first	Qualitative	Couples during pregnancy (first and third trimester) and postpartum	97 partners - 1 female - 96 male	Online questionnaires - One question: "Would

		trimester, at 36-weeks gestation, and at six months postpartum Focus on: PA		Nulliparous		you mind telling us about your thoughts on PA during pregnancy, and how your partner supports that or not?"
Keely et al., 2017	United Kingdom	1) To explore the experiences, attitudes and health-related behaviors of pregnant women with a BMI >40 kg/m2; and to identify the factors and considerations which shape their beliefs, experiences and behaviors, and how these may change during and after pregnancy 2) To determine the impact, if any, of the beliefs and attitudes of significant members of the women's families and social networks upon the women's experiences, attitudes and health related behaviors in relation to weight and pregnancy Focus on: nutrition and PA	Qualitative	Couples during pregnancy of women with BMI > 40kg/m² Mixed parity sample	7 men	Face-to-face interviews (semi-structured)
McLean et al., 2020	Sierra Leone	To assess shifting norms of fatherhood and masculinity among young, urban men in eastern Sierra Leone Focus on: nutrition	Qualitative	Partner only during pregnancy, living in poverty Parity not reported	106 men	Face-to-face interviews (semi-structured)
Peles et al., 2024	United Kingdom	To investigate primiparous women's partners for knowledge, attitudes, and practices regarding the PHFE, and to assess if the first pregnancy provides a teachable opportunity to enhance the PHFE of first-time pregnant couples. Focus on: nutrition	Mixed-methods	Partner during pregnancy (second and third trimester) and postpartum Nulliparous	15 men	- Face-to-face interviews (semi-structured) - Online questionnaires (FFQ)
Peles et al., 2026	United Kingdom	To explore how UK first-time expectant fathers engage with the PHFE assesses whether the transition to fatherhood acts as a 'teachable moment' for healthier PHFE and situate results within diverse cultural perspectives. Focus on: nutrition	Mixed-methods	Partners during pregnancy (second and third trimester) and postpartum Nulliparous	14 men	Face-to-face interviews (semi-structured) and online questionnaires (FFQ)
Rhodes et al., 2021	United Kingdom	To investigate the role partners play in pregnant women's energy balance behaviors, and to identify barriers and facilitators to participating as a couple in a digital intervention to encourage healthy eating and PA in pregnancy. Focus on: nutrition and PA	Qualitative	Men and women during pregnancy (last trimester) and postpartum Nulliparous	15 men	Online focus group discussions (semi-structured)
Van Lonkhuijzen et al., 2023	The Netherlands	To explore the perspectives of pregnant women and their partners concerning the partner's role in promoting a healthy dietary intake during pregnancy Focus on: nutrition	Qualitative	Couples during pregnancy (first and third trimester) Mixed parity sample	8 partners - 1 female - 7 male	Face-to-face and online interviews (semi-structured)
Versele et al., 2021	Belgium	To identify determinants of changes in eating behavior	Qualitative	Couples during pregnancy and postpartum	20 men	Face-to-face focus group discussions (semi-structured)

		across the transition to parenthood (i.e., during pregnancy up to 1 year postpartum) in both women and men Focus on: nutrition		Mixed parity sample		
Versele et al., 2022	Belgium	To identify determinants of changes in PA and SB across the transition to parenthood (i.e., during pregnancy up to one year postpartum) in both women and men. Focus on: PA	Qualitative	Couples during pregnancy and postpartum Mixed parity sample	20 men	Face-to-face focus group discussions (semi-structured)

Note. FFQ: Food Frequency Questionnaire.; GDM: Gestational Diabetes Mellitus.; PA: Physical Activity; PHFE: Physical Home Food Environment; SB: sedentary behavior.

Supplementary Files

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- Table1.docx