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Spousal Involvement in Postpartum Care and Health Related Quality of Life of Postpartum Women in Selected Hospitals in Ondo State

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Abstract

The study assessed the level of spousal involvement and health-related quality of life (HRQoL) among postpartum women in selected hospitals in Ondo State, Nigeria. A quantitative cross-sectional descriptive design was adopted. Data were collected from 386 postnatal women between January and May 2023 using a structured questionnaire and analyzed with SPSS version 28. Descriptive statistics (frequencies and percentages) summarized participants' characteristics, while linear regression examined the association between spousal involvement and HRQoL at a 0.05 significance level. Most respondents were aged 26–35 years (53.6%), with a mean age of 33.5 years (SD = 0.7). The majority had two children (32.1%), were Christians (74.1%), and of Yoruba ethnicity (60.1%). About 6.0% had no formal education, 62.7% were self-employed, and 39.4% earned less than ₦30,000 monthly. Overall, 14.9% reported poor spousal involvement in postpartum care. HRQoL was generally high (77%), although 23% had low scores. The most common reason for limited spousal participation was distance from residence to the hospital (57.5%). Sociodemographic factors such as age, parity, religion, ethnicity, education, occupation, and income were significantly associated with spousal involvement. Spousal involvement was also significantly associated with HRQoL ($F[2,384] = 281.95$, $p < 0.001$, $R = 0.651$, $R^2 = 0.423$, Adjusted $R^2 = 0.422$, $SE = 0.857$). These findings underscore the need for targeted awareness and educational interventions to enhance spousal support and improve maternal well-being during the postpartum period.

Keywords: Health-related quality of life; Postpartum; Spousal Involvement; Women

1.0 Introduction

The postpartum period is a critical phase in a woman's life, characterized by substantial physical, psychological, and emotional adjustments. Although pregnancy is widely recognized as a period of increased vulnerability, many complications associated with pregnancy occur during the postpartum period (Grab *et al*., 2022). A significant proportion of maternal deaths result from pregnancy-related conditions arising during this time, contributing to maternal mortality (Arisukwu *et al*., 2021; Fantaye, 2020). In Nigeria, postpartum health issues have increasingly attracted research attention. Despite improvements in maternal health indicators, progress remains insufficient to achieve the Sustainable Development Goals (SDGs) by 2030. Many of the countries lagging behind are in sub-Saharan Africa, including Nigeria (Dey *et al*., 2021; United Nations, 2020).

The World Health Organization (WHO, 2022) defines the postpartum period as beginning one hour after delivery and extending up to 42 completed days postpartum. This period is crucial for both mothers and newborns. Numerous postpartum complications have been documented, including excessive or prolonged bleeding, breastfeeding difficulties, urinary incontinence, depression, psychosis, post-traumatic stress disorder, anxiety, fatigue, constipation, and sleep disturbances (Yaya *et al*., 2023). Although these symptoms are often perceived as temporary, when untreated they may be associated with functional impairment and poor emotional well-being (Ojukwu *et al*., 2020). Inadequate care during this period may result in significant morbidity and mortality (Kruk *et al*., 2018). Despite the substantial physiological and psychological changes that occur, the postpartum period frequently receives limited attention, which may adversely affect women's quality of life.

Health-related quality of life (HRQoL) has emerged as an important outcome in maternal health research because it reflects women's perceived physical, psychological, and social well-being during and after pregnancy (Gomora *et al*., 2022). Studies conducted in Nigeria and other settings have shown that postpartum conditions are associated with reduced HRQoL (Ojukwu *et al*., 2020; Grab *et al*., 2022; Lagadec & Ibanez, 2016). However, most existing studies have focused primarily on clinical complications or have been conducted in high-income countries. Furthermore, limited research has examined the role of spousal involvement as a determinant of HRQoL within specific sociocultural contexts in southwestern Nigeria. In Ondo State, where cultural norms, family structures, and access to health facilities may influence maternal experiences, there is insufficient empirical evidence on the level of spousal involvement during the postpartum period and how it relates to women's HRQoL. Addressing this gap is essential for developing context-specific interventions aimed at improving maternal well-being.

This study is grounded in Social Support Theory, which posits that emotional, informational, instrumental, and appraisal support from significant others can positively influence health outcomes and coping capacity. Spousal involvement represents a critical form of social support during the postpartum period, potentially influencing women's adaptation to physiological and psychological changes. In addition, the Ecological Model of Health underscores the interaction between individual, interpersonal, community, and sociocultural factors in shaping health outcomes. Within this framework, spousal support operates at the interpersonal level and may interact with broader sociocultural and economic conditions to influence maternal HRQoL.

Spousal involvement in maternal care has been recognized as an important factor associated with women's well-being (Annoon *et al*., 2020). International frameworks, including the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women, emphasize male participation in reproductive and maternal health (WHO, 2002). Spousal

involvement may include emotional, physical, psychological, spiritual, sexual, and financial support (Arisukwu *et al*., 2021; Ranjkesh *et al*., 2020), as well as companionship that may reduce loneliness and support coping during the postpartum period (Nasiri & Abdolmaleki, 2017). However, empirical evidence on the extent of such involvement and its relationship with HRQoL among postpartum women in Ondo State remains limited. Therefore, the objective of this study was to assess the level of spousal involvement and examine its association with health-related quality of life among postpartum women attending selected hospitals in Ondo State, Nigeria.

2.0 Materials and Methods

2.1 Study Setting

The study was conducted in Ondo State, South-Western Nigeria, across health facilities located within the three senatorial districts: Ondo North, Ondo Central, and Ondo South. Ondo State lies approximately between latitudes 5°45′N and 8°15′N and longitudes 4°45′E and 6°00′E. The state is bounded by Ekiti State (North), Osun State (West), Ogun State (South-West), Edo/Delta States (East), and the Atlantic Ocean (South). Ondo State has 18 Local Government Areas and is predominantly populated by Yoruba ethnic groups (including Akoko, Owo, Ondo, Ikale, Ilaje, and Akure), with Ijaw-Arogbo and Ijaw-Apois communities in some riverine areas.

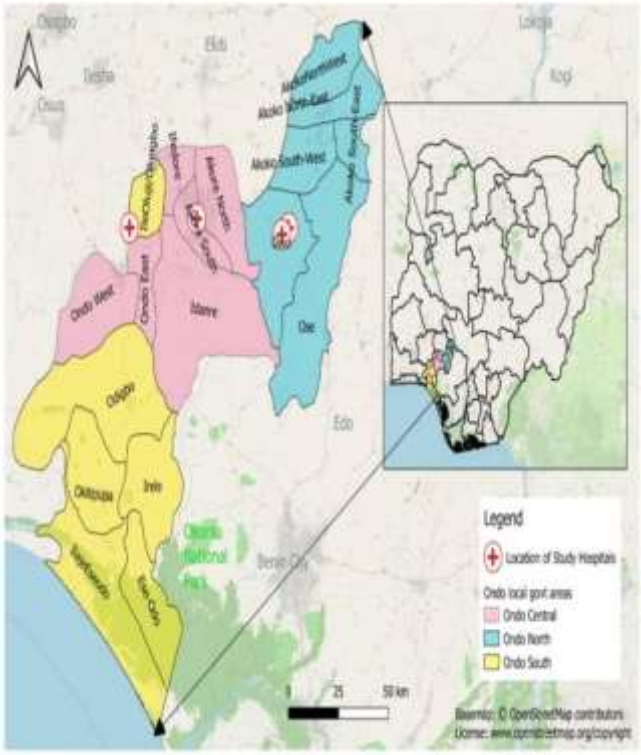

Fig 1: A map of the study location (adapted from Geophysicist).

2.2 Research Design

A cross-sectional quantitative descriptive survey design was used to assess the level of spousal involvement and to examine its association with health-related quality of life (HRQoL) among postpartum women attending selected hospitals in Ondo State.

2.3 Study Population, Eligibility Criteria, Sample Size, and Sampling Method

2.3.1 Study Population

The study population comprised postpartum women attending postnatal clinics/wards in selected hospitals in Ondo State during the data collection period (January-May 2023).

2.3.2 Inclusion Criteria

Participants were eligible if they:

i. were postpartum women within (0-42 days or ≤6 weeks postpartum) at the time of recruitment;
ii. attended postnatal services in the selected hospitals during the study period;
iii. were married or in a stable union and had a spouse/partner (for spousal involvement assessment);
iv. were aged (≥18 years); and
v. shows consent.

2.3.3 Exclusion Criteria

Women were excluded if they:

i. were critically ill or medically unstable at the time of data collection;
ii. had severe cognitive/psychiatric impairment limiting ability to respond;
iii. declined consent or withdrew participation; or
iv. had incomplete questionnaires beyond acceptable limits for analysis.

2.3.4 Sample Size Determination

Sample size was estimated using a single population proportion formula assuming 95% confidence level (Z = 1.96), margin of error (d) of 5% (0.05), and proportion (p) set at 50% (0.5) due to limited prior estimates:

$$n = \frac{za/2^2pq}{d^2} = \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.05)^2} = 385$$

Where n=required sample size, Zα/2=critical value for normal distribution at 95% confidence level equals 1.96, (Z-value at α=0.05), p=proportion of women 50%, d=margin of error of 5%.
To account for potential non-response, a 4% allowance was added, resulting in a target sample size of 400. A total of 400 questionnaires were distributed; 396 were returned (99% response rate). After data cleaning, 10 questionnaires were excluded due to substantial incomplete responses, leaving 386 for analysis.

2.3.5 Sampling Technique

A three-stage sampling approach was used:
Stage 1: Hospitals were grouped by senatorial districts (Ondo North, Ondo Central, Ondo South).
Stage 2: In each district, one hospital with high delivery/postnatal attendance was purposively selected: Mother and Child Hospital, Akure (Ondo Central); Federal Medical Centre, Owo (Ondo North); and General Hospital, Ile-Oluji, Ondo South).

Stage 3: Eligible postpartum women attending postnatal clinics/wards in the selected hospitals during the data collection period were recruited consecutively using convenience sampling until the required sample size was achieved.

2.4 Instrument for Data Collection and Measures

Data were collected using a structured questionnaire comprising three sections:

Section A: Socio-demographic and obstetric characteristics

This section included items on age, parity/number of children, age of last born, mode of last delivery, ethnicity, religion, educational status, occupation, and monthly income.

Section B: Spousal involvement in postpartum care

Spousal involvement was measured across domains such as emotional support, financial support, accompaniment to clinic/hospital visits, assistance with newborn care, and household support and the responses were rated. A composite score was computed by summing item scores, with higher scores indicating greater spousal involvement.

Section C: Health-related quality of life (HRQoL)

HRQoL was assessed using the WHOQOL instrument. Domain scores were computed according to WHO scoring guidelines: items were coded, negatively worded items reverse-scored where applicable, raw domain scores computed, and transformed to 0-100 such that higher scores reflect better HRQoL. HRQoL was categorized as “high” versus “low”

2.5 Validity and Reliability of the Instrument

Face and content validity were established by expert review from specialists in maternal and child health and research methodology. Based on their feedback, ambiguous items were revised for clarity. Reliability testing was conducted using a pilot study among postpartum women at General Hospital, Owo, involving 10% of the calculated sample size (38 participants). The questionnaire was administered twice to the same participants with a 28-day interval. Internal consistency reliability was assessed using Cronbach’s alpha for the spousal involvement scale and HRQoL domains. Test-retest reliability was assessed yielding a reliability coefficient of 0.89.

2.6 Data Collection Procedure

Data collection was conducted with the assistance of trained research assistants (two per facility). The assistants received one-day training covering study objectives, eligibility criteria, recruitment procedures, questionnaire administration, and ethical considerations (confidentiality, privacy, and informed consent). Eligible participants were approached during postnatal clinic/ward visits, the study was explained, and written informed consent was obtained before questionnaire administration.

2.7 Data Analysis

Data were entered and analyzed using SPSS version 28. Descriptive statistics (frequencies and percentages) summarized participant characteristics, spousal involvement levels, and HRQoL categories. Chi-square tests assessed associations between socio-demographic variables and spousal involvement category. Linear regression analysis was conducted to examine the association between spousal involvement (predictor) and HRQoL (outcome), adjusting for relevant covariates. All statistical tests were two-tailed, with significance set at $p < 0.05$ and 95% confidence intervals reported.

2.8 Ethical Considerations

Ethical approval was obtained from the Health Research Ethics Committee of Federal Medical Centre, Owo (Ref: FMC/OW/380/VOL.CLXII/125) and Ondo State Ministry of Health, Akure (Ref: OSHREC03/01/23/496). Participants were informed about the purpose of the study, voluntary participation, confidentiality, and the right to withdraw at any time without consequences. Written informed consent was obtained. No identifying information (e.g., names) was collected, and completed questionnaires were accessible only to the researchers.

3.0 Results

3.1 Demographic Characteristics

Table 1 presents the socio-demographic characteristics of the respondents. The predominant age group was 26–35 years (207; 53.6%). The mean age of respondents was 33.5 years (SD =0.7). Regarding parity, 122 (31.6%) had one child, while 124 (32.1%) had two children, making two children the most frequently reported category. The majority of participants were Christians (286; 74.1%), while 17 (4.4%) practiced traditional religion. Yoruba women constituted 232 (60.1%) of the sample, followed by Igbo women (48; 12.4%). Only 23 (6.0%) had no formal education, while 196 (50.8%) had post-secondary education. Most participants were self-employed (242; 62.7%). Monthly income distribution showed that 152 (39.4%) earned less than ₦30,000, while 118 (30.6%) earned more than ₦30,000.

3.2 Spousal Involvement in Postpartum Care

Figure 2 illustrates the overall level of spousal involvement. The majority of respondents (85.1%) reported good spousal involvement, while 14.9% reported poor involvement, based on the predefined scoring criteria described in the Methods section. Table 2 presents specific areas of spousal participation. High levels of involvement were reported in daily housework (351; 90.9%), assistance with healthcare of the baby (345; 89.4%), concern about the woman's health (345; 89.4%), concern about the wife's sleeping pattern (342; 88.6%), and assistance with baby care (342; 88.6%). However, some women reported limited involvement in certain areas, including concern about their employment (87; 22.5%), sexual life (84; 21.8%), time for other children (82; 21.2%), and financial independence (81; 21.0%).

3.3 Health-Related Quality of Life (HRQoL) During the Postpartum Period

Figure 3 shows the overall classification of HRQoL. Based on the scoring criteria described in Section 2.4, 77% of respondents were classified as having high HRQoL, while 23% had low HRQoL. At the item level, a small proportion of women reported dissatisfaction in specific domains. Nineteen (4.9%) were very dissatisfied with the amount of pain experienced, and 17 (4.4%) were very dissatisfied with incision/episiotomy outcomes and neighborhood support. Seventeen (4.4%) reported moderate dissatisfaction with their sexual life. A proportion of respondents reported slight dissatisfaction with the amount of health information received (28; 7.3%), perceived control over their lives (27; 7.0%), and physical appearance (26; 6.7%).

Conversely, 165 (42.7%) were very satisfied with their personal faith. Many respondents reported moderate satisfaction with pain levels (187; 48.1%), energy for daily activities (183; 47.4%), spouse appraisal (154; 39.9%), and spouse emotional support (152; 39.4%).

3.4 Association Between Demographic Characteristics and Level of Spousal Involvement

Chi-square analysis was conducted to assess the association between socio-demographic variables and the level of spousal involvement. Age, number of children, religion, ethnic group, education level, occupation, and monthly income were significantly associated with the level of spousal involvement ($p < 0.05$).

3.5 Linear Regression Analysis of Spousal Involvement and HRQoL

Linear regression analysis was performed to examine the association between spousal involvement and HRQoL. The ANOVA results indicated that the overall model was statistically significant ($F[2, 384] = 281.95$, $p < 0.001$). The model explained 42.3% of the variance in HRQoL ($R^2 = 0.423$), while the adjusted R^2 was 0.422, indicating a moderate model fit. This suggests that spousal involvement and the included covariates accounted for 42.3% of the variability in HRQoL scores, whereas the remaining 57.7% of the variance may be attributable to other unmeasured factors.

4. Discussion of Findings

In the present study, most participants were aged 26-35 years, had one or two children, were predominantly Christians and of Yoruba ethnicity, possessed post-secondary education, and were mainly self-employed with relatively low monthly income. These findings reflect the socio-demographic characteristics of women attending postnatal services in the selected hospitals. While the mean age suggests that many respondents were within the commonly observed reproductive age range, this study does not permit conclusions about the national pattern of childbearing age in Nigeria. Rather, it describes the characteristics of postpartum women within the study setting.

The study found that a high proportion (85.1%) of respondents reported good spousal involvement in postpartum care, although 14.9% reported poor involvement. This suggests variability in partner participation within the study population. Previous Nigerian studies have reported comparable patterns of male involvement in maternal health services, although levels vary depending on study setting and measurement approach. For instance, Abie *et al*. (2023) reported suboptimal male participation in postnatal services in Ethiopia, while Annoon *et al*. (2020) documented relatively higher male involvement in another context. Differences across studies may reflect variations in sociocultural norms, health system organization, measurement tools, and urban–rural contexts rather than uniform regional trends.

Some respondents reported limited spousal support in areas such as employment concerns, sexual life, time for other children, and financial independence. These areas may represent dimensions of postpartum adjustment that extend beyond routine physical care and may involve interpersonal dynamics and role negotiation within families. Studies have shown that postpartum sexual health, employment reintegration, and financial autonomy are complex issues influenced by physical recovery, emotional well-being, and partner communication (Gutzeit *et al*., 2020; Geuens *et al*., 2023). However, the present study did not directly assess cultural beliefs or intra-household power dynamics; therefore, interpretations regarding sociocultural explanations should be made cautiously.

Sociodemographic characteristics including age, parity, religion, ethnicity, education, occupation, and income were statistically associated with the level of spousal involvement. Similar associations have been reported in studies conducted in Kenya and Tanzania, where education and socioeconomic status were linked to male partner participation in maternal health services (Gibore & Bali, 2020; Sakala *et al*., 2021). These associations may reflect broader structural and informational factors that shape health behaviors. However, due to the cross-sectional design, the findings indicate relationships rather than directional or causal effects.

Regarding HRQoL, 77% of respondents were classified as having high HRQoL, while 23% were categorized as having low HRQoL. Although the majority reported favorable overall quality of life, the proportion experiencing lower HRQoL remains clinically relevant. Previous studies in Uganda and Spain have reported that postpartum women frequently experience fatigue, pain, and emotional challenges that may affect their perceived well-being (Lokubal *et al*., 2021; Martínez-Galiano *et al*., 2019). Variations across studies may be influenced by differences in measurement tools, postpartum timing at assessment, and healthcare access.

The association identified between spousal involvement and HRQoL suggests that women reporting higher levels of partner participation also tended to report better quality of life. This finding aligns with Social Support Theory, which proposes that emotional and instrumental support from significant others may be associated with improved coping and well-being. Similar associations have been reported in hierarchical regression analyses in other contexts, where marital intimacy and partner support were linked to HRQoL outcomes during the postpartum period (Jeong *et al*., 2021; Ribeiro *et al*., 2022). Nevertheless, the cross-sectional nature of this study precludes conclusions about directionality. It is equally plausible that women with better overall well-being perceive greater support, or that other unmeasured factors influence both variables.

Although the study assessed overall HRQoL, domain-specific analyses were not conducted. This limits the ability to determine whether physical, psychological, social, or environmental domains contributed differentially to HRQoL scores. Previous research has demonstrated that specific domains particularly physical health and psychological well-being may vary significantly during the postpartum period (Jikamo *et al*., 2022). Future research employing domain-level analysis or longitudinal designs would provide a more nuanced understanding of how different dimensions of HRQoL interact with spousal involvement over time. Overall, the findings highlight the importance of interpersonal support during the postpartum period while underscoring the need for cautious interpretation due to methodological limitations.

5. Conclusion

This study assessed the level of spousal involvement and its association with health-related quality of life (HRQoL) among postpartum women attending selected hospitals in Ondo State, Nigeria. The findings indicate that while most women reported good spousal involvement and satisfactory

HRQoL, a notable proportion experienced limited partner participation and lower HRQoL. Sociodemographic characteristics were statistically associated with the level of spousal involvement. The observed association between spousal involvement and HRQoL suggests that interpersonal support during the postpartum period may be an important consideration in maternal well-being. However, given the cross-sectional design and non-probability sampling approach, the findings should be interpreted cautiously and not as evidence of causal relationships.

These results highlight the potential value of interventions aimed at strengthening partner engagement in postpartum care, particularly through educational and awareness initiatives within healthcare settings. Efforts to improve access to postnatal services and to address identified barriers, such as distance to healthcare facilities, may also support maternal well-being. Future research using longitudinal designs and probability sampling methods is recommended to further clarify the direction and magnitude of the relationship between spousal involvement and HRQoL.

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Table 1: Demographic Data of the Women

Personal Variables		Frequency	Valid Percent %
Age of the mother	≤25	65	16.8
	26-35	207	53.6
Mean age 33.5±0.7	36-45	104	26.9
	≥46	10	2.6
	Total	386	100.0
Number of children	One sibling	122	31.6
	Two siblings	124	32.1
	Three siblings	82	21.2
	≥ four siblings	58	15.0
	Total	386	100.0
Religion of the mother	Christian	286	74.1
	Islam	83	21.5
	Traditional	17	4.4
	Total	386	100.0
Women's ethnic group	Hausa	5	1.3
	Igbo	48	12.4
	Yoruba	232	60.1
	Others	101	26.2
	Total	386	100.0
Level of education of the mother	None	23	6.0
	Primary	37	9.6
	Secondary	130	33.7
	Tertiary	196	50.8
	Total	386	100.0
Occupation of the mother	Employee	74	19.2
	Unemployed	32	8.3
	Farming	27	7.0
	Self employed	242	62.7
	House wife	11	2.8
	Total	386	100.0
Monthly earning of the mother	Less than minimum wage	152	39.4
	Minimum wage	60	15.5
	Greater than minimum wage	118	30.6
	Undecided	56	14.5
	Total	386	100.0

Table 2: Spousal Involvement in the Postpartum Care of Women

My husband's Involvement in (my):	Poor		Good	
	Frequency	Percentage	Frequency	Percentage
General wellbeing	66	17.1	320	82.9
Emotional support from	56	14.5	330	85.5
Meeting with family duties	46	11.9	340	88.1
Sexual life	84	21.8	302	78.2
Assistance with baby care at home	44	11.4	342	88.6
Having time for other children	82	21.2	304	87.8
Assistance with baby's health	41	10.6	345	89.4
Assistance in household activities	54	14.0	332	86.0
Immediate family/relatives	53	13.7	333	86.3
Paying attention to me	55	14.3	331	85.7
Care about my adequate rest	56	14.5	330	85.5
Health care	41	10.6	345	89.4
Daily routine activities at home	35	9.1	351	90.9
Sleep pattern	44	11.4	342	88.6
Financial independence	81	21.0	305	79.0
Access to medical care	59	15.3	327	84.7
Social life	52	13.5	334	86.5
Nutritional need	59	15.3	327	84.7
Employment /work	87	22.5	299	77.5

Table 3: Show Health Related Quality of Life Distribution among Postpartum Women

HRQoL Items	VD	MD	SD	SS	MS	VS
Your health	13(3.3)	7(1.8)	17(4.4)	45(11.6)	158(40.6)	146(37.5)
Amount of pain you get	19(4.9)	16(4.1)	25(6.4)	51(13.1)	187(48.1)	88(22.6)
Energy for daily activities	13(3.4)	16(4.1)	19(4.9)	64(16.6)	183(47.4)	91(23.6)
Control over your life	16(4.1)	27(7.0)	27(7.0)	62(16.1)	137(35.5)	117(30.3)
Your physical appearance	13(3.4)	16(4.1)	26(6.7)	72(18.7)	143(30.1)	116(30.1)
Amount of sleep	15(3.9)	11(2.8)	22(5.7)	82(21.2)	145(37.6)	111(28.8)
Your breast	11(2.8)	10(2.6)	19(4.9)	66(17.1)	131(33.9)	149(38.6)
Your incision/episiotomy	17(4.4)	19(4.9)	23(6.0)	50(13.0)	136(35.2)	141(36.5)
Your sex life	12(3.1)	17(4.4)	23(6.0)	56(14.5)	127(32.9)	151(39.1)
Your peace of mind	9(2.3)	11(2.8)	14(3.6)	59(15.3)	145(37.6)	148(38.3)
Personal faith in God	8(2.1)	12(3.1)	11(2.8)	55(14.2)	135(35.0)	165(42.7)
Happiness in general	10(2.6)	7(1.8)	18(4.7)	55(14.2)	150(38.9)	146(37.8)
Your life in general	14(3.6)	7(1.8)	16(4.1)	64(16.6)	152(39.4)	133(34.5)
Your neighborhood	15(3.9)	12(3.1)	13(3.4)	55(14.2)	166(43.0)	125(32.4)
Breastfeeding	6(1.6)	13(3.4)	16(4.1)	67(17.4)	145(37.6)	139(36.0)
Informational support	7(1.8)	8(2.1)	28(7.3)	65(16.8)	149(38.6)	129(33.4)
Spouse financial support	9(2.3)	11(2.8)	22(5.7)	75(19.4)	141(36.5)	128(33.2)
Spouse emotional support	12(3.1)	11(2.8)	24(6.2)	74(19.2)	152(39.4)	113(29.3)
Spouse appraisal	14(3.6)	14(3.6)	23(6.0)	72(18.7)	154(39.9)	109(28.2)

Note: VD-very dissatisfied, MD-moderately dissatisfied, SD-slightly dissatisfied, SS-slightly satisfied, MS-moderately satisfied and VS-very satisfied.

Table 4: Demographic Data and Level of Spousal Involvement

Parameters	Options	X^2	Sig. p<0.05
Age of the mother	≤25	14.933	7.815
	26-35		
	36-45		
	≥46		
Children	1	32.114	7.815
	2		
	3		
	≥4		
Religion	Christian	30.508	5.991
	Islam		
	Traditional		
Ethnic group	Hausa	30.606	7.815
	Igbo		
	Yoruba		
	Others		
Educational level	None	20.891	7.815
	Primary		
	Secondary		
	Tertiary		
Occupation	Employee	18.534	11.070
	Unemployed		
	Trader		
	Farming		
	Self employed		
	House wife		
Monthly earning	< Minimum wage	67.513	7.815
	Minimum wage		
	>Minimum wage		
	Undecided		

Table 5: Linear Regression Model of spousal involvement and HRQoL

Model	Sum of Squares	D/f	Mean Square	F	Sig.
Regression	207.081	2	207.081	281.952	.000[b]
Residual	282.031	384	.734		
Total	489.111	385			
Model summary		R	R Square	Adj. R square	Std. Error of the Estimate
		.651	.423	.422	.857

a. Dependent Variable: level of spousal involvement

a. b. Predictors: (Constant), Level of HRQoL during postpartum period

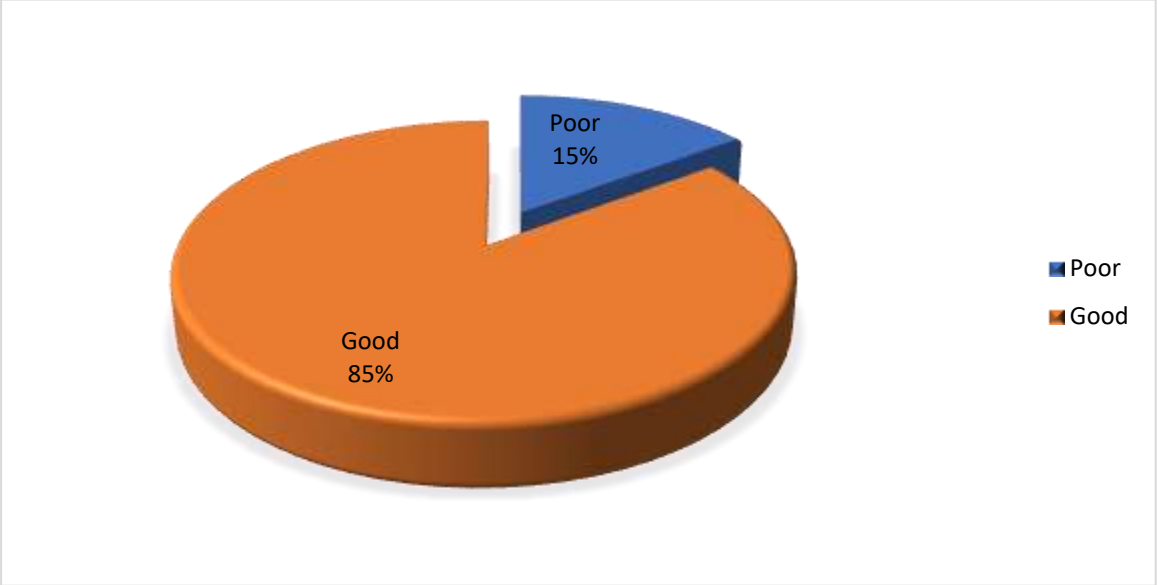

Fig. 2: Level of Spousal Involvement in the Postpartum Care

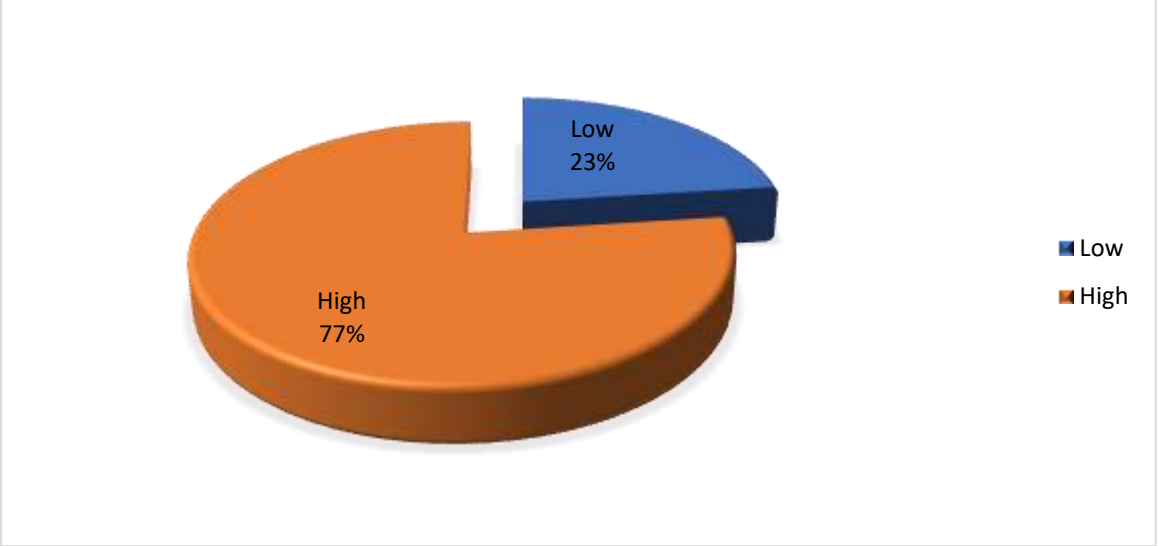

Fig. 3: level of HRQoL among Postpartum Women