

SOCIO-DEMOGRAPHIC PROFILE AND MATERNAL QUALITY OF LIFE AMONG POSTPARTUM WOMEN IN IBADAN METROPOLIS

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Abstract

Maternal QoL (MQoL) has been reported as an all-encompassing term representing women's physical, psychological, social and functional well-being in the postpartum period. Yet, there is a paucity of information on the influence of socio-demographic factors on maternal quality of life in postnatal women in Nigeria. The study examined the socio-demographic determinants of maternal quality of life among postpartum women in Ibadan Metropolis. A descriptive cross-sectional study was conducted among 522 postpartum women selected through multistage sampling. Data were collected through a structured questionnaire named Maternal Postpartum Quality of Life Questionnaire (MAPP-QOL) and was analyzed through descriptive statistics, Pearson's correlation, independent t-test and one-way ANOVA at 0.05 level of significance. The majority of the respondents were in the age group of 25–34 years (67.2%), married (81.5%), attained secondary education (48.7%) and had a monthly income of less than ₦ 50,000 (52.8%). The overall maternal quality of life was moderate (Mean = 3.21 ± 0.68). The highest mean score was observed in the spouse relationship domain (3.61 ± 0.72), and the lowest in the financial domain (2.89 ± 0.81). Quality of life of postpartum women showed significant correlations with age ($r = .21, p < .001$), level of education ($F[3,518] = 8.34, p < .001$), marital status ($t[520] = 5.67, p < .001$), and household income ($r = .34, p < .001$). However, neither parity ($r = .04, p = .38$) nor religion ($t(519) = 1.21, p = .23$) were significantly related to maternal quality of life. Based on the results, the study advocates for the enhancement of socio-economic empowerment schemes, the facilitation of access to maternal health care services and policy action on broader social determinants of maternal well-being.

Keyword: Maternal quality of life, postpartum women, socio-demographic characteristics

Introduction

Maternal health is an essential part of public health and sustainable development as it impacts the health and well-being of women, infants, families, and communities. Although significant progress has been made globally in reducing maternal mortality through improved antenatal care, skilled birth attendance, emergency obstetric services, and postnatal care, approximately 287,000 women still died from pregnancy- and childbirth-related causes in 2020, with nearly 70% of these deaths occurring in sub-Saharan Africa (World Health Organization [WHO] et al., 2023). These numbers demonstrate enduring inequities and stressed that maternal healthcare should go beyond saving a woman's life to supporting her overall well-being throughout pregnancy, birth and postpartum. Therefore, integrated maternal, newborn and child health (MNCH) interventions are required for enhanced maternal health outcomes along the continuum of care (Chima-Oduko et al., 2026).

On the other hand, maternal health has historically been monitored through indicators such as maternal mortality, maternal near-miss, obstetric complications, and neonatal survival. But these indicators offer only a fragmented picture of women's health because a significant proportion of women have persistent physical complaints, psychological problems, social difficulties and functional impairments in the postnatal period (Oweibia et al, 2025; Wei et al, 2025). However, there has been a re-orientation in maternal health research towards highlighting maternal well-being and quality of life as core markers of quality care (WHO, 2022; Lee et al., 2025). Moreover, maternal mortality remains a global priority, increasing attention has shifted toward improving maternal quality of life as a key indicator of successful maternal healthcare (Souza et al, 2024; Anumudu et al, 2025). Thus, this aligned with the Sustainable Development Goal 3 which advocates for healthy life and well-being for all, and not just for the reduction of mortality.

Moreover, the postpartum period is a crucial yet often overlooked stage in maternal health. It has traditionally been considered to be the first six weeks after childbirth, but there is evidence that the process of postpartum recuperation takes place over months and possibly even up to one year (WHO, 2022; Lee et al., 2025). At the same time, postpartum women are also undergoing hormonal changes, adjusting to new family roles, and managing increased responsibilities for caregiving facing depleted sleep, breastfeeding, hormonal changes, financial worries, evolving family structure, and heightened caregiving obligations, some have even described the postpartum period as one of the life's most challenging eras

(Van der Woude et al., 2015; Wu & Jin, 2025; Lopez-Gonzalez & Mikes, 2026). However, sociocultural factors and expectations of motherhood may influence how these challenges are perceived, reported, and managed (Samuel-Ajayi et al, 2026).

Additionally, postpartum women also reported symptoms such as fatigue; perineal and caesarean wound pain; urinary incontinence; difficulties with breastfeeding; musculoskeletal pain; concerns about sexual health; anxiety, stress and depressive symptoms; low self-esteem; parenting uncertainty; and dissatisfaction with their body image (Van der Woude et al., 2015; Lee et al., 2025). These difficulties are frequently compounded by lack of money, little family support, relationship problems, isolation and poor access to health care (Sharifipour et al., 2022; Khademi & Kaveh, 2024). Therefore, postpartum health should be considered and assessed in a holistic sense encompassing physical, psychological, social and environmental aspects, rather than being limited to clinical parameters.

Maternal quality of life (MQoL) has thus been recognized as an all-encompassing signal of recovery post-delivery. MQoL is a woman's own evaluation of her physical health, psychological state, social relationships, environmental situations, level of autonomy and general life satisfaction after giving birth (Mogos et al., 2013). In contrast to traditional biomedical markers, MQoL describes women's functioning, such as their ability to carry out maternal roles, maintain relationships and engage in daily activities, which include a composite measure of maternal health (Van der Woude et al., 2015).

Postpartum quality of life is affected by a number of factors such as biological (physical symptoms), psychological (mental health), social, economic and environmental factors (Van der Woude et al., 2015; Mogos et al., 2013; Lee et al., 2025), and also by obstetric complications, family relationships, healthcare and workplace policies, community resources, and sociocultural factors (Van der Woude et al., 2015; Mogos et al., 2013; Lee et al., 2025). Higher quality of life enhances maternal infant bonding, exclusive breastfeeding, use of the health care system, good family relations, and parenting competence (Van der Woude et al., 2015). On the other hand, lower quality of life is related to postpartum depression, negative development of the infant, shorter breastfeeding duration, marital stress, low productivity, and high utilization of the health care services (Lee et al., 2025; Khademi & Kaveh, 2024).

However, some sociodemographic factors such as age, marital status, employment, social connectedness, educational background, social status, occupation, monthly income, parity, religion, ethnicity, place of living, and family size have a major impact on quality of life (Mogos et al., 2013; Van der Woude et al., 2015; Ojo 2016; Ojo & Ajayi 2020; Ogunwole et al. 2023; Adeleke et al. 2025). Younger mothers tend to have higher levels of emotional distress, lower levels of parenting self-efficacy, financial difficulties and fewer sources of social support, while older maternal age is associated with an increase in obstetric complications and length of recovery (Van der Woude et al., 2015). Greater educational level is associated with improved health literacy, use of maternal healthcare services, role in decision-making, and practice of healthy behaviours (Mogos et al., 2013). Paid employment and sufficient income at the household level are associated with better healthcare access, and better access to basic needs, including healthy food, transportation, medication, and child care services while lack of financial means is associated with mental stresses and poor outcome in maternal health (Van der Woude et al., 2015; Chima-Oduko et al., 2026). In a similar vein, marital status, family unit and parity has an effect on received emotional, practical and financial support and it could influence the postpartum experience and maternal life quality (Lee et al., 2025).

Maternal quality of life has been the focus of increasing research in high-income countries, but evidence from sub-Saharan Africa is scanty, even though the region has documented around 70% of global maternal deaths (WHO, 2023). Postpartum women in the area are confronted with a myriad of challenges, including poverty, food scarcity, poor access to integrated postnatal care, gender discrimination, intimate partner violence, cultural expectations regarding mothering, and fragile systems of social protection, all threatening maternal well-being (Chima-Oduko et al., 2026; Lee et al., 2025). Nigeria also has one of the highest maternal mortality burdens globally, yet, maternal health programmes continue to focus on the survival and utilization of services with less emphasis on women's quality of life within the postpartum period (WHO, 2023; Chima-Oduko et al., 2026).

Due to the rapid urbanization, socioeconomic variation, disparities in access to healthcare, and dynamic family support systems in Ibadan Metropolis, it is thus an ideal setting to study maternal quality of life. The Nigerian studies to date have primarily emphasized maternal mortality, postpartum depression, infant feeding, healthcare utilisation and obstetrics outcomes with fewer of them exploring maternal quality of life as an outcome in itself or

investigating the combined effects of sociodemographic factors and perceived social support (Aregbesola & Olaniyan, 2022; Ope et al, 2025; Okeke et al, 2026; Chima-Oduko et al., 2026). This lack of evidence makes it difficult for healthcare workers and policy makers to pinpoint at-risk mothers and to create interventions that meet women's psychosocial needs. Therefore, the current study is designed to assess maternal quality of life, examine sociodemographic profile of postpartum women in Ibadan Metropolis and to determine the association between these variables.

Objectives of the study

1. To determine the socio-demographic characteristics of postpartum women in Ibadan metropolis
2. To assess the level of maternal quality of life among postpartum women
3. To examine the association between socio-demographic characteristics and maternal quality of life among postpartum women

Literature Review

Socio-Demographic characteristics of Postpartum Women

Socio-demographic characteristics are important determinants of maternal health, healthcare utilization, and maternal well-being during the postpartum period. Maternal age, marital status, educational attainment, occupation, parity, household wealth, and place of residence have consistently been identified as factors influencing women's maternal health experiences and access to healthcare services.

Abdus-Salam et al. (2022) conducted a descriptive cross-sectional study among 115 postpartum women attending the University College Hospital (UCH), Ibadan, Oyo State, Nigeria, to assess the utilization of postnatal care. Using a structured questionnaire and descriptive and inferential statistics, the study found that the respondents were predominantly married, educated, and within the reproductive age group, factors that positively influenced postnatal care utilization.

Consequently, Odufuwa et al. (2022) carried out a cross-sectional study among 390 postpartum women attending postnatal clinics in Ibadan, Oyo State, Nigeria, to investigate

determinants of mental healthcare-seeking behaviour. Using interviewer-administered questionnaires and logistic regression analysis, the study found that married, educated, and economically empowered women were more likely to seek maternal mental healthcare services.

On the other hand, Aregbeshola and Olaniyan (2022) conducted a cross-sectional analysis using data from the 2018 Nigeria Demographic and Health Survey, involving 41,821 women of reproductive age (15–49 years) across Nigeria. The study employed concentration indices and decomposition analyses to examine inequities in maternal healthcare utilization. The findings identified maternal age, educational attainment, household wealth, and employment status as significant determinants of maternal healthcare service utilization.

Additionally, Ekholuenetale et al. (2022) conducted a cross-sectional study using the 2018 Nigeria Demographic and Health Survey involving 29,992 parous women across Nigeria. The study used multivariable logistic regression to assess determinants of maternal healthcare utilization and found that age, educational level, household wealth, occupation, and place of residence were significant predictors of the utilization of skilled maternal healthcare services.

Hence, the reviewed studies demonstrate that socio-demographic characteristics play an important role in shaping maternal healthcare experiences and provide a useful basis for describing the socio-demographic profile of postpartum women in Ibadan Metropolis

Maternal Quality of life and Postpartum Women

Assessment of maternal quality of life provides insight into women's adjustment after delivery and highlights areas where postpartum support and interventions may be required. Previous studies have assessed postpartum quality of life using standardized instruments such as the World Health Organization Quality of Life Assessment-BREF (WHOQOL-BREF), Short Form-36 Health Survey (SF-36), and Maternal Postpartum Quality of Life Questionnaire (MAPP-QOL), reporting variations in overall and domain-specific quality-of-life outcomes.

Hill and Aldag (2007) evaluated maternal postpartum quality of life among 184 mothers of preterm, near-term, and term infants in the United States using the Maternal Postpartum Quality of Life Questionnaire (MAPP-QOL). The study reported differences in maternal

quality-of-life scores according to infant gestational age, with mothers of preterm infants demonstrating lower psychological quality-of-life scores compared with mothers of term infants.

Ramzan et al. (2021) assessed postpartum health-related quality of life among 268 postpartum women in Rawalpindi, Pakistan using the Short Form-36 (SF-36) questionnaire. The study did not classify quality of life into categories such as poor or good but reported domain-specific scores. Physical functioning and social functioning recorded the highest median scores (75 each), whereas energy/fatigue (37), bodily pain (45), and general health (45) recorded the lowest scores. Based on these findings, the authors concluded that postpartum women experienced a moderately affected level of health-related quality of life, with physical and psychological challenges affecting overall maternal well-being.

Al Rehaili et al. (2023) conducted a cross-sectional study among 252 postpartum women attending eight governmental primary healthcare centres in Madinah, Saudi Arabia. Maternal quality of life was assessed using the WHOQOL-BREF, which evaluates physical health, psychological health, social relationships, and environmental domains. The study reported a mean overall WHOQOL-BREF score of 95.2 ± 16 , indicating a relatively satisfactory level of maternal quality of life among postpartum women. However, variations were observed across the different domains, with poorer quality-of-life scores associated with postpartum depression and sleep problems.

Socio-demographic Characteristics and Maternal Quality of life

Evidence from previous studies suggests that maternal quality of life is influenced by several socio-demographic, economic, psychosocial, and health-related factors.

However, Chinweuba et al. (2018) in Nigeria (Enugu State) carried out a comparative cross-sectional survey among puerperal women that had normal vaginal delivery. Assessment of maternal quality of life was done by the use of the SF-36 questionnaire. Results showed that employed women had significantly better physical, emotional, and social quality of life than those unemployed. Employment was found to be a significant predictor for QoL in the postpartum period. This study draws attention to the effect of socio-economic status on the well-being of mothers in Nigeria.

Furthermore, Mokhtaryan-Gilani et al. (2022) in Iran aimed to develop and psychometrically evaluate the Maternal Postpartum Quality of Life Instrument (MPQOL-I) using an exploratory sequential mixed methods design. Applying qualitative interviews and psychometric analyses, a 16-item instrument including five dimensions of postpartum quality of life was constructed. The tool was found to be valid and reliable. The researchers agreed that the maternal quality of life is influenced by women lived experiences in the postpartum period and suggested for cross-cultural validation. This study also supports the multidimensional aspect of postpartum quality of life.

Similarly, Aregbeshola and Olaniyan (2022) and Ekholuenetale et al. (2022) demonstrated that educational attainment, employment status, maternal age, and household wealth significantly influenced maternal healthcare utilization. Although these studies focused primarily on healthcare utilization, the identified socio-demographic characteristics are closely linked to maternal well-being and provide further evidence that women's social and economic circumstances shape their postpartum experiences and quality of life.

Thus, literature suggests that maternal quality of life is influenced by a combination of socio-demographic, economic, psychosocial, and health-related factors. However, evidence specifically examining the relationship between socio-demographic characteristics and maternal quality of life among postpartum women in Ibadan Metropolis remains limited, thereby justifying the present study.

Theoretical Framework

The Social Determinants of Health (SDH) Framework developed by the World Health Organization's Commission on Social Determinants of Health (CSDH, 2008) explains that health outcomes are shaped not only by biological factors but also by social, economic, political, and environmental conditions. The framework differentiates between structural determinants, such as education, income, occupation, gender, and governance, and intermediary determinants, including living conditions, healthcare access, nutrition, psychosocial factors, and health behaviours, which collectively influence health and quality of life (Solar & Irwin, 2010).

This study is anchored on the SDH Framework because it provides a comprehensive explanation of how socioeconomic position influences maternal quality of life during the

postpartum period. Structural factors determine women's socioeconomic circumstances, which subsequently shape intermediate conditions such as access to healthcare, living environments, social support, and health behaviours, thereby affecting postpartum health outcomes (Solar & Irwin, 2010). The framework supports the investigation of how maternal characteristics such as age, education, marital status, employment, occupation, household income, parity, religion, ethnicity, and place of residence contribute to variations in maternal quality of life after childbirth.

According to the SDH perspective, women with higher educational attainment, employment opportunities, and adequate income are more likely to possess better health literacy, access quality maternal healthcare, and have resources that facilitate postpartum recovery. Conversely, socioeconomically disadvantaged women may experience poor living conditions, limited healthcare access, financial stress, and psychosocial challenges, which may negatively affect their quality of life (Solar & Irwin, 2010; Marmot & Wilkinson, 2006).

The framework is particularly relevant to the Nigerian context, where variations in socioeconomic status, occupation, education, income, and living conditions may contribute to differences in postpartum maternal quality of life, even among women receiving similar obstetric care (CSDH, 2008; Solar & Irwin, 2010). Additionally, Marmot (2005, 2010) described socioeconomic status as the "causes of the causes" of health inequalities because it determines exposure to health risks and access to resources that promote health. Similarly, Wilkinson and Marmot (2003) demonstrated that social gradients in education, occupation, and income are consistently associated with differences in health outcomes.

Therefore, the SDH Framework provides a strong basis for understanding maternal quality of life as a multidimensional outcome influenced by social, economic, and environmental conditions rather than biological recovery alone. It emphasizes the need for interventions that extend beyond clinical care to address social determinants such as education, poverty reduction, women's empowerment, and equitable access to maternal healthcare services to enhance postpartum maternal quality of life (Solar & Irwin, 2010; National Academies of Sciences, Engineering, and Medicine, 2016).

Methodology

This study adopted a descriptive cross-sectional research design. The study population comprised postpartum women attending postnatal and child welfare clinics in selected public primary and secondary healthcare facilities in Ibadan Metropolis, Oyo State.

The sample size was determined using Cochran's (1977) formula for cross-sectional studies. A minimum sample size of 384 was calculated at a 95% confidence level and a 5% margin of error. Because a multistage sampling technique was employed, a design effect of 1.3 was applied to account for clustering, yielding approximately 499 participants. An additional 5% was added to compensate for possible non-response and incomplete questionnaires, resulting in a final sample size of 524 postpartum women.

A multistage sampling technique involving stratified and systematic sampling was employed to select the study participants. In the first stage, Ibadan Metropolis, comprising the five metropolitan Local Government Areas (Ibadan North, Ibadan North-East, Ibadan North-West, Ibadan South-East, and Ibadan South-West), was selected as the study area. In the second stage, the sampling frame was developed from the Oyo State Ministry of Health List of Health Facilities, which identified a total of 50 public primary and secondary healthcare facilities across the five metropolitan Local Government Areas. Facilities eligibility screening was undertaken based on the study's inclusion criteria. Facilities were considered eligible if they routinely provided postnatal and child welfare services and had regular postpartum clinic attendance. Following this screening process, 32 eligible healthcare facilities, comprising 27 primary healthcare centres and 5 secondary healthcare facilities, constituted the sampling frame for the study.

In the third stage, the eligible facilities were stratified into primary and secondary healthcare levels. Using stratified random sampling, ten (10) health facilities, comprising five (5) primary healthcare centres and five (5) secondary healthcare facilities, were selected to ensure adequate representation of both levels of healthcare delivery within Ibadan Metropolis.

In the fourth stage, the number of postpartum women to be recruited from each selected facility was determined using proportionate allocation based on the average monthly attendance at the postnatal and child welfare clinics. In the final stage, systematic sampling

was employed to recruit participants. The sampling interval was obtained by dividing the estimated number of eligible postpartum women attending each selected facility during the study period by the allocated sample size for that facility. Following a random start, every sixth eligible postpartum woman attending the clinic was recruited until the required sample size of 524 participants was attained.

Data were collected using a structured questionnaire comprising two sections. Section A elicited information on respondents' socio-demographic characteristics, including age, educational level, occupation, marital status, parity, religion, ethnicity, monthly household income, and duration since delivery. Section B consisted of the Maternal Postpartum Quality of Life Questionnaire (MAPP-QOL) developed by Hill et al. (2006), a standardized and validated instrument comprising 38 items that assess maternal quality of life across five domains: Health and Functioning, Psychological/Baby, Socioeconomic, Spouse Relationship, and Family and Friends Relationship. Responses were measured on a six-point Likert scale, with higher scores indicating better maternal quality of life.

The instrument was subjected to face and content validation by experts in maternal and public health research and sociology department while reliability was established through a pilot study among 30 postpartum women who do not reside in the study area. Internal consistency reliability was estimated using Cronbach's alpha coefficient, with acceptable value of 0.83 which is considered adequate for the study. Ethical approval to conduct the study was sought and received from Oyo State Hospitals' Management Board Health Research Ethics Committee prior to the commencement of the study. Approval was likewise granted by the management of each of the chosen health facilities. Participants were recruited with the help of healthcare providers during the postnatal/child welfare clinic visit. The objectives of the study were explained to the participants who met the inclusion criteria, and written informed consent was obtained from them prior to data collection. The questionnaire was administered by the researchers and two trained research assistants. After data collection, only 522 questionnaires were properly filled and was analyzed.

Data were analyzed using IBM SPSS (Version 27). Responses were analyzed using descriptive statistics including frequencies, percentages, means, and standard deviations for sociodemographic and maternal QoL of the respondents. Inferential statistics comprising Pearson's correlation, independent samples t-test, and one-way Analysis of Variance

(ANOVA) were employed to examine the relationships between selected socio-demographic characteristics and maternal quality of life. All hypotheses were tested at a 5% level of significance ($p < 0.05$).

Result

Table 1: Socio-Demographic Profile of Postpartum Mothers (N = 522)

Variable	Category	N	%
Age (years)	15–24	98	18.8
	25–34	351	67.2
	35–44	73	14.0
Education	None	42	8.0
	Primary	101	19.4
	Secondary	254	48.7
Occupation	Tertiary	125	23.9
	Unemployed	68	13.0
	Homemaker	231	44.3
	Self-employed	153	29.3
Marital status	Formal employment	70	13.4
	Married	425	81.5
	Cohabiting	52	10.0
Parity	Single/separated/divorced/widowed	45	8.5
	Primiparous (1 child)	178	34.1
	Multiparous (2–4 children)	296	56.7
	Grand multiparous (≥ 5)	48	9.2
Household income (monthly)	< ₦50,000	276	52.8
	₦50,000–₦100,000	163	31.2
	> ₦100,000	83	16.0
Religion	Christianity	304	58.3
	Islam	215	41.1
	Traditional	3	0.6

Note. Percentages may not sum to 100% due to rounding.

The characteristics of the profile are presented in Table 1. The average age was 28.3 years (SD = 5.1, range = 17–44). Most participants were in the age group of 25–34 years (67.2%) and married (81.5%), having completed secondary education (48.7%). About 73.6% of them are homemakers or self-employ. Mean parity was 2.4 (SD = 1.3). More than half (52.8%) had a monthly household income of less than ₦50,000 (about 65 USD). Christians accounted for 58.3%, Muslims held 41.1% and Traditional believers 0.6%.

Table 2: Mean Scores of MAPP-QOL Dimensions (N = 522)

Dimension	M	SD
Health and Functioning	3.27	0.69
Psychological/Baby	3.12	0.74
Socioeconomic	2.89	0.81
Spouse Relationship	3.61	0.72
Family and Friends Relationship	3.38	0.70
Overall QoL (total scale)	3.21	0.68

The average total MQoL score was 3.21 (SD = 0.68), suggesting moderate QoL (midpoint of the scale = 3.0). Dimension specific scores are presented in Table 2. The highest score was obtained for Spouse Relationship (M = 3.61, SD = 0.72) and Family and Friends, was slightly lower (M = 3.38, SD = 0.70). The lowest score was on the Socioeconomic subscale (M = 2.89, SD = 0.81), and next is the Psychological/Baby (M = 3.12, SD = 0.74).

Table 3: Bivariate Associations Between sociodemographic variables and overall maternal QoL

Variable	Test statistic	P	Effect size
Age (Pearson r)	r = .21	<.001	Small
Education (ANOVA)	F(3,518) = 8.34	<.001	$\eta^2 = .05$
Marital status (t-test)	t(520) = 5.67	<.001	Cohen's d = 0.84
Household income (Pearson r)	r = .34	<.001	Moderate
Parity (Pearson r)	r = .04	.38	Negligible
Religion (t-test)	t(519) = 1.21	.23	Negligible

The bivariate associations are presented in Table 3. Age was positively but weakly correlated with QoL ($r = .21$, $p < .001$). There was a significant difference, $F(3, 518) = 8.34$, $p < .001$, $\eta^2 = .05$, between levels of education in terms of quality of life; post hoc tests showed that mothers with tertiary education (M = 3.54) reported better QoL than those with secondary education (M = 3.18) or primary education (M = 2.89) ($p < .05$). Being married was also associated with significantly better QoL (M = 3.32, SD = 0.65) compared to being unmarried (M = 2.75, SD = 0.71), $t(520) = 5.67$, $p < .001$, Cohen's d = 0.84. Household

income was moderately correlated with QoL ($r = .34$, $p < .001$). Parity was not significantly associated with QoL ($r = .04$, $p = .38$). Religion did not make any significant difference, $t(519) = 1.21$, $p = .23$ (Christian vs. Muslim; Traditional was excluded because of small no of respondents).

Discussion

The postpartum women in Ibadan Metropolis were predominantly those within the 25–34 years age group, married, had secondary education, were homemakers or petty traders, and received below ₦50,000 monthly. Thus, the respondents were mainly in their prime reproductive age and had moderate level of education but many of them were faced with social economic challenges. Following the Social Determinants of Health (SDH) Framework, education, occupation, employment, and income are considered structural determinants that shape maternal health and well-being. The sociodemographic factors are also equivalent to the result of Abdus-Salam et al. (2022) and Odufuwa et al. (2022) where it was found that in Nigeria, postpartum women who utilized maternal healthcare services were predominantly married, educated and were within their childbearing age. Additionally, the finding is consistent with that of Aregbeshola and Olaniyan (2022) and Ekhoulunetale et al. (2022) that identified that age, education, household wealth and occupation as significant determinants for maternal healthcare services utilization.

The result also indicated that MQoL was at moderate level while the maximum mean score belonged to spouse relationship and the minimum mean score to family/friend relationship subscales and the socioeconomic subscale. This finding depicts a picture that postpartum women in Ibadan metropolis were reasonably well supported by their spouse and family members while the financial constraints were still seen as an obstacle for the best possible well-being during postpartum. This finding aligned with the SDH Framework that emphasizes that social and economic environment influences health.

Moreover, maternal age, education, marital status and monthly/weekly household income had significant associations with maternal QoL, but parity and religion did not. Older women, married women, women with tertiary education and women who belonged to wealthier household significantly had a better maternal QoL. These results support the SDH Framework as well as Marmot (2005) claim that socioeconomic circumstances are the

'causes of the causes' of health inequalities. However, these factors are expected to raise the degree of health literacy, improve access to healthcare services, and empower women to make better decision on maternal health care. The current result obtained in the study corroborate that of Aregbeshola and Olaniyan (2022) and Ekholuenetale et al. (2022) that financial challenges and socio-economic status hinder maternal health and overall utilization of postnatal care services. Besides, the strong correlation found between marital status and maternal quality of life in this study is in line with the findings of Anumudu et al. (2025) who reported that married women reported having a better quality of life after childbirth as a result of emotional, financial and practical support from their husbands. On the other hand, parity and religion had not a significant effect on the maternal QoL indicating that reproductive history and religion had less impact on the postpartum QoL compared to the economic status in this group of women.

Implications of Findings

The findings of the present study are relevant to the SDH Framework and highlight the fact that maternal quality of life is affected by biological, social, economic, and demographic factors. Moderate QoL level in mothers with postpartum suggests that many women handle the postpartum period relatively well

The positive association between age and maternal QoL suggests benefits of accumulated life experience, emotional maturity, financial security and social support as older mothers, which may represent life-course influences on health-related outcomes. In a similar vein, education was the most important predictor, underscoring education as a social resource that facilitates health literacy, autonomy in decision-making, potential for employment, and means to adequate healthcare.

The strong effect of marital status underlines the relevance of the family as an emotional and financial resource, as well as one of practical help, with married women reporting higher quality of maternal life than non-married women. Maternal quality of life was also significantly affected by household income, indicating that the socioeconomic status is still a major determinant of health that allows access to quality health care, healthy food, and decent housing as well as other environmental factors. That the domain of socioeconomic

was the lowest scoring quality-of-life domain highlights the influence of poverty and economic distress on postpartum well-being.

In contrast, the lack of significant associations of parity and religion with maternal quality of life may imply that socioeconomic determinants of maternal well-being are more important than either family size or religious affiliation.

Conclusion

The study established that the maternal quality of life of the respondents was average which the highest quality-of-life scores was recorded in the spouse relationship domain and lowest in the socioeconomic domain among postpartum women in Ibadan Metropolis. Age, education, marital status, and income were significant predictors of maternal quality of life, whereas parity and religion were not. These results highlight the significance of socioeconomic and demographic determinants in postpartum well-being within the frame of the Social Determinants of Health Framework. Consequently, the results suggest that maternal quality of life is socially patterned and influenced by inequalities in education, income and family support. This reinforces the importance of policies and interventions at a level beyond clinical postpartum care to tackle the wider social determinants of health: women's education, economic empowerment, fortified-family support systems and poverty reduction initiatives.

Recommendations

- a) Government should strengthen health insurance coverage to reduce out-of-pocket maternal healthcare expenditures and reduce maternal healthcare expenditure incurred by households, and develop a referral mechanism that links mothers who are financially struggling to social welfare and support services. It is anticipated that these interventions would contribute towards ameliorating the socioeconomic problems, which was identified as the domain with lowest in the maternal quality of life.
- b) Policymakers should enable and enhance the access of postpartum women, especially those from poor families, to socio-economic empowerment schemes such as vocational skills training, income-generating schemes, microcredit schemes and

social protection programmes related to maternity, to strengthen their financial situation.

- c) Healthcare professionals should provide antenatal and postnatal interventions tailored to the needs of the younger woman (such as counselling, parenting information, support from seasoned mothers, and psychosocial assistance) to improve maternal quality of life in younger women who have less life experience and social support.
- d) Governmental bodies, healthcare providers, and non-governmental organizations must work towards mainstreaming comprehensive maternal health education within the continuum of antenatal and postnatal care which could improve health literacy, evidence-based decision-making, and appropriate utilization of maternal healthcare services.
- e) Couples and family members should also be engaged in maternal health education, counselling, and postnatal care in the health centers. Psychosocial support and community services should also be made available to single mothers as a form of support to the diminished family care which has the potential to undermine their quality of life.

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