

Assessment of Perceived Social Support, Quality of Life and Resilience among Pregnant Women in Northern Nigeria

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Abstract

Background: Pregnancy causes inevitably significant psychological and physiological impacts on the woman. It causes high emotional changes and occasionally mental disturbances. These make pregnancy a period of life that requires the woman to have bio-psycho-social adjustments through good social support, quality of life, and resilience.

Aim: This study was aimed at assessing the Perceived Social Support, Quality of Life, and Resilience among pregnant women in northern Nigeria.

Methods: The study was descriptive and adopted a cross-sectional design. Multidimensional Scale of Perceived Social Support, short Form (SF-36) Health Survey 1.0 Questionnaire and Connor-Davidson RS Scale were used for data collection. The sample size was 307, determined using Cochran's sample size determination formula. Respondents were selected using systematic sampling. Data were analyzed using SPSS version 26 with Kruskal-wallis test and Dunn's pairwise tests for inferential analysis.

Results: The findings revealed that most of the respondents had good to very-good perceived social support (23.1% and 27.2%), and a poor level of perceived quality of life. (76.6%) and had good to very-good resilience (28.6% and 40.3%). In terms of perceived social support, significant differences in age, parity, educational level, and family economic status were shown while age, parity, and family

economic status were shown to have a significant difference in terms of quality of life. Findings also revealed that resilience was shown to have significant differences in age, parity, and level of education.

Conclusion: Healthcare workers especially midwives should consider pregnant woman's perceived social support, quality of life, and resilience when rendering their services.

Keywords: *Midwives, Pregnancy, Quality of life, Resilience, Social support*

Introduction

Pregnancy is an important period for both woman and her family (Yu et al., 2020), and among the critical situations encountered by a woman in her lifetime (Gaafar & El-Habashy, 2017). Pregnancy causes inevitably significant psychological and physiological impacts on a woman (Priya et al., 2018), causing high emotional changes and occasionally mental disturbances (Staneva et al., 2015). Anxiety and depression are common experiences among pregnant women worldwide; with prevalence from 6.0% to 57.0% and 8.5% to 44.4%, respectively (Ma et al., 2019). These make pregnancy a period of life that requires bio-psycho-social adjustments from women (Calou et al., 2014), and required women to have good social support, quality of life (QOL), and resilience (RS).

One of the key components for handling psychological challenges in pregnancy is social support (Maharlouei, 2016). Social support during pregnancy is provided by important persons like parents, husbands, sisters, brothers, other relatives, or friends (Masoudnia, 2011). Perceived social support (PSS) is the subjective perception that people around the matter are helpful in case of need. It moderates an individual's stress response and protects from the stress's harmful effects (Vakilian et al., 2018). The three dimensions of social support are: The emotional dimension has to do with a person's concerns; the instrumental dimension deals with receiving material support; and the informational dimension takes care of providing advice and guidance (Ghorbani et al., 2014).

According to Gaafar & El Habashy, 2017, Quality of Life (QOL) is defined as "individuals' perception of their sense of well-being regarding their values, demands, and goals" It is crucial in controlling the level of stress during pregnancy. It was asserted that pregnancy might be a factor that could lead to a reduction in QOL (Lagadec et al., 2018). Moreover, pregnant women with lower QOL experience greater stress than women that have better QOL (Gaafar & El Habashy, 2017). Cordero et al. (2019) asserted that better QOL is among the major health challenges in the 21st century. One of the crucial aspects of prenatal care is improving pregnant women's QOL (Mirghafourvand et al., 2016).

RS is the ability of an individual to positively adjust and adapt to adversity and maintain mental health stability (Ristevska-Dimitrovska et al., 2015). RS is potentially useful in improving the

health of pregnant women and their neonates (Jin, 2021). The higher adverse childhood experience associated with poorer women's mental health outcomes was found only among those with low levels of RS; these childhood negative impacts may be buffered by RS (Armans et al., 2020). Women with a high level of RS reported fewer symptoms of post-traumatic syndrome disorder, less depression, less fear of childbirth, and fewer additional traumas after birth (Young & Ayers, 2021).

In Nigeria, women are exposed to the risk of getting psychologically traumatized through situations like limited social support. In addition to this, poverty is a great causative factor of trauma amongst many Nigerian women (Adimula & Ijere, 2018). In a study conducted in northern Nigeria majority of the pregnant women reported a moderate level of quality of life during pregnancy (Lawan et al, 2019). Also, resilience has been documented as a protective factor against stress in pregnancy in developing and developed countries (García-León et al., 2019). According to Nghargbu and Olaniyan (2019) women's education, ethnicity, age and wealth are among the significant factors in the use of ANC in Nigeria.

The aforementioned situations exist in Nigeria, and the assessment of social support and RS in pregnancy helps identify pregnant women at higher risk of mental illnesses like depression during pregnancy (Rashid & Mohd, 2017). Also, health professionals especially midwives need to put into consideration factors determining the QOL while giving care to pregnant women (Daglar et al., 2020). These, coupled with a deficit of studies on pregnant women's social support, QOL, and RS in Nigeria make this study pertinent.

Materials and Methods

The study was descriptive and adopted a cross-sectional design. It was conducted among pregnant women attending antenatal care (ANC) in Sir Yahaya Memorial Hospital Birnin-Kebbi, Kebbi State, Nigeria. The sample size was 307, determined using Cochran's sample size determination formular. The instruments for data collection include:

Multidimensional Scale of PSS: It is a 12-item scale that assesses the perceived social support of the respondents. It has three subscales, the family subscale constitutes items 3, 4, 8, and 11; the friends' subscale constitutes items 6, 7, 9, and 12; and the significant others subscale constitutes items 1, 2, 5, and 10. A five-point Likert scale with subscale Cronbach's alpha between 0.75-0.82 (Laksmi et al., 2020). The measuring scale used for this study was: 0.00-300=poor PSS; 3.01-3.50=fair PSS; 3.51-4.00=good PSS; 4.01-4.50=very-good PSS; 4.51-5.00=excellent PSS.

Short Form (SF-36) Health Survey 1.0 Questionnaire: The adapted five-point Likert scale, short Form (SF-36) Health Survey 1.0 Questionnaire (RAND, 2016) with Cronbach's alpha reliability of 0.77. The questionnaire is originally a 36-item instrument assessing the QOL of individuals physically, emotionally, and socially. However, to suit this study it is modified to 19 items. The

measuring scale used for this questionnaire was: 0.00-300=poor QOL; 3.01-3.50=fair QOL; 3.51-4.00=good QOL; 4.01-4.50=very-good QOL; 4.51-5.00=excellent QOL.

Connor-Davidson RS Scale: This is a test that measures resilience or how well one is equipped to bounce back after stressful events, tragedy, or trauma. The adapted Connor-Davidson RS Scale (Gonzalez et al., 2015) is a five (0-4) point Likert scale with a reliability of 0.82 using Cronbach's alpha (Lukong & Jafaru, 2021). There are different versions of the scale, however, the CD-RISC-10 version was selected due to its suitability for this study. All the 10 items were modified to suit this study. The 10-item scale was from the original 25 items of the scale. Gonzalez, Moore, Newton, and Galli (2015) described the ten-item scale as psychometrically superior when compared to the unidimensional 25-item scale as well as the five-factor 25-item scale. The measuring scale used for this questionnaire was: 0.00-2.50=poor RS; 2.51-3.00=good RS; 3.01-3.50=very-good RS; 3.51-4.00=excellent RS.

Respondents were selected using systematic sampling after obtaining the sampling frame and calculating the sampling interval. The sample was then obtained by selecting every *n*th number of the sampling interval. The questionnaires were self-administered with the interviewer-administered method for respondents that could not read. Seventeen questionnaires were unanalysable, making the total number of respondents to be 290. Data were analyzed using SPSS version 26 and presented mean levels frequencies and percentages, and Kruskal-Wallis test was used for inferential statistical analysis to test the differences in the mean ranks. Dunn's pairwise tests were done between the pairs of the groups (using Bonferroni correction adjustment). Kebbi State Health Research Ethical Review Committee gave ethical approval for the study with registration number 106:12/2021.

Results

Table 1 shows that 36.9% of the respondents were within the age brackets 15-24 and 25-34 respectively. Fifty percent of the respondents were having 1-3 parity. Respondents with tertiary education had the highest percentage (39.0%) than other levels of education. The majority (57.6%) of the respondents were from middle-class socioeconomic families.

Table 1. Socio-demographic variables of the respondents N=290

Variables	Frequency	Percentage
Age		
15-24	107	36.9
25-34	106	36.5
35-44	55	19.0
≥ 45	22	7.6
Parity		
1-3	145	50

Variables	Frequency	Percentage
4-6	88	30.4
7-9	41	14.1
≥10	16	5.5
Educational level		
Primary education	30	10.3
Secondary education	91	31.4
Tertiary education	113	39.0
Non-formal education	56	19.3
Family socioeconomic status		
Upper-upper class	44	15.1
Upper class	41	14.1
Middle class	167	57.6
Lower class	19	6.6
Lower-lower class	19	6.6

As indicated in table 2, the highest (63.6%) level of poor PSS is found among the ≥ 45-year age bracket. Respondents with 7-9 and ≥10 parity were having the highest percentages of poor PSS, 51.2% and 50% respectively. The respondent's level of education with the highest (56.7%) poor PSS were those with primary education. Respondents from lower and lower-lower family economic status had the highest poor PSS, 52.6% and 63.2% respectively.

Table 2. Percentage distribution of the respondents' levels of PSS by socio-demographic variables

Level of PSS	Age (Years) F(P)				Total
	15-24	25-34	35-44	≥45	
Poor PSS	20(18.7)	23(21.7)	22(40)	14(63.6)	79(27.2)
Fair PSS	21(19.6)	13(12.3)	7(12.7)	5(22.7)	46(15.9)
Good PSS	22(20.6)	33(31.1)	10(18.2)	2(9.1)	67(23.1)
Very good PSS	33(30.8)	31(29.2)	14(25.5)	1(4.6)	79(27.2)
Excellent PSS	11(10.3)	6(5.7)	2(3.6)	0(0.0)	19(6.6)
Total	107(100)	106(100)	55(100)	22(100)	290(100)
	Parity F(P)				
	1-3	4-6	7-9	≥10	Total
Poor PSS	23(15.9)	27(30.7)	21(51.2)	8(50)	79(27.2)
Fair PSS	24(16.6)	15(17.0)	5(12.2)	2(12.5)	46(15.9)
Good PSS	35(24.1)	21(23.9)	8(19.5)	3(18.8)	67(23.1)
Very good PSS	51(35.2)	19(21.6)	6(14.6)	3(18.8)	79(27.2)
Excellent PSS	12(8.3)	6(6.8)	1(2.4)	0(0.0)	19(6.6)

Level of PSS	Age (Years) F(P)					
Total	145(100)	88(100)	41(100)	16(100)	290(100)	
	Educational level F(F)					
	Primary	Secondary	Tertiary	Non-formal	Total	
Poor PSS	17(56.7)	18(19.8)	27(23.9)	17(30.4)	79(27.2)	
Fair PSS	4(13.3)	13(14.3)	19(16.8)	10(17.9)	46(15.9)	
Good PSS	5(16.7)	20(21.9)	30(26.5)	12(21.4)	67(23.1)	
Very-good PSS	3(10)	28(30.8)	31(27.4)	17(30.4)	79(27.2)	
Excellent PSS	1(3.3)	12(13.2)	6(5.3)	0(0.0)	19(6.6)	
Total	30(100)	91(100)	113(100)	56(100)	290(100)	
	Family economic status F(P)					
	Upper-upper	Upper	Middle	Lower	Lower-lower	Total
Poor PSS	13(29.6)	6(14.6)	38(22.8)	10(52.6)	12(63.2)	79(27.2)
Fair PSS	7(15.9)	4(9.8)	29(17.4)	3(15.8)	3(15.8)	46(15.9)
Good PSS	10(22.7)	10(24.4)	41(24.6)	4(21.1)	2(10.5)	67(23.1)
Very-good PSS	8(18.2)	17(41.5)	50(29.9)	2(10.5)	2(10.5)	79(27.2)
Excellent PSS	6(13.6)	4(9.8)	9(5.4)	0(0.0)	0(0.0)	19(6.6)
Total	44(100)	41(100)	167(100)	19(100)	19(100)	290(100)

PSS=Perceived Social Support.

Table 3 revealed that the poor level of QOL was very high across all the age brackets. The finding of very high or poor QOL is the same across all the variables. However, respondents with 1-3 parity had the highest percentage (82.1%) of poor QOL than other parity groups. Also, respondents with primary education levels had the lowest (63.3%) poor QOL of the other levels of education. The respondents from the family with lower-lower economic status had the lowest (47.4%) poor QOL.

Table 3. Percentage distribution of the respondents' levels of QOL by socio-demographic variables

Level of PSS	Age (Years) F(P)				
	15-24	25-34	35-44	≥45	Total
Poor QOL	84(78.5)	88(83.0)	40(72.7)	10(45.5)	222(76.6)
Fair QOL	14(13.1)	12(11.3)	12(21.8)	9(40.9)	47(16.2)
Good QOL	8(7.5)	5(4.7)	2(3.6)	2(9.1)	17(5.9)
Very good QOL	1(0.9)	1(0.9)	0(0.0)	1(4.6)	3(1.0)
Excellent QOL	0(0.0)	0(0.0)	1(1.8)	0(0.0)	1(0.3)
Total	107(100)	106(100)	55(100)	22(100)	290(100)
	Parity F(P)				
	1-3	4-6	7-9	≥10	Total
Poor QOL	119(82.1)	72(81.8)	21(51.2)	10(62.5)	222(76.6)

Level of PSS	Age (Years) F(P)					
	Fair QOL	169(11.0)	119(12.5)	15(36.6)	5(31.3)	47(16.2)
Good QOL	9(6.2)	3(3.4)	4(9.8)	1(6.3)	17(5.9)	
Very-good QOL	1(0.7)	2(2.3)	0(0.0)	0(0.0)	3(1.0)	
Excellent QOL	0(0.0)	0(0.0)	1(2.4)	0(0.0)	1(0.3)	
Total	145(100)	88(100)	41(100)	16(100)	290(100)	
	Educational level F(P)					
	Primary	Secondary	Tertiary	Non-formal	Total	
Poor QOL	19(63.3)	72(79.1)	87(76.9)	44(78.6)	222(76.6)	
Fair QOL	10(33.3)	13(14.3)	15(13.3)	9(16.1)	47(16.2)	
Good QOL	1(3.3)	6(6.6)	9(7.9)	1(1.8)	17(5.9)	
Very-good QOL	0(0.0)	0(0.0)	1(0.9)	2(3.6)	3(1.0)	
Excellent QOL	0(0.0)	0(0.0)	1(0.9)	0(0.0)	1(0.3)	
Total	30(100)	91(100)	113(100)	56(100)	290(100)	
	Family economic status F(P)					
	Upper-upper	Upper	Middle	Lower	Lower-lower	Total
Poor QOL	35(79.5)	33(80.5)	135(80.8)	10(52.6)	9(47.4)	222(76.6)
Fair QOL	6(13.6)	4(9.8)	24(14.4)	6(31.6)	7(36.8)	47(16.2)
Good QOL	3(6.8)	3(7.3)	7(4.2)	1(5.3)	3(15.8)	17(5.9)
Very-good QOL	0(0.0)	1(2.4)	0(0.0)	2(10.5)	0(0.0)	3(1.0)
Excellent QOL	0(0.0)	0(0.0)	1(0.6)	0(0.0)	0(0.0)	1(0.3)
Total	44(100)	41(100)	167(100)	19(100)	19(100)	290(100)

It is indicated in table 4 that very-good RS had the highest (40.3%) percentages across all the variables. But respondents with ≥ 45 years had the highest (27.3%) poor RS. The majority (62.5%) of the respondents with ≥ 10 parity had very-good RS. Respondents with primary education had the highest (16.7%) level of poor RS and lowest (13.3%) level of excellent RS. Respondents from the upper-upper class and upper-class family economic status had the lowest poor RS, 0.0% and 2.4% respectively. The poor RS increased with a decrease in family economic status.

Table 4. Percentage distribution of the respondents' levels of RS by socio-demographic variables

Level of PSS	Age (Years) F(P)				
	15-24	25-34	35-44	≥ 45	Total
Poor RS	3(2.8)	3(2.8)	7(12.7)	6(27.3)	19(6.6)
Good RS	32(29.9)	30(28.3)	17(30.9)	4(18.2)	83(28.6)
Very-good RS	48(44.9)	40(37.7)	19(34.5)	10(45.5)	117(40.3)
Excellent RS	24(22.4)	33(31.1)	12(21.8)	2(9.1)	71(24.5)
Total	107(100)	106(100)	55(100)	22(100)	290(100)

Level of PSS	Age (Years) F(P)					
	Parity F(P)				Total	
	1-3	4-6	7-9	≥10		
Poor RS	4(2.8)	6(6.8)	7(17.1)	2(12.5)	19(6.6)	
Good RS	39(26.9)	27(30.7)	14(34.1)	3(18.8)	83(28.6)	
Very-good RS	62(42.8)	32(36.4)	13(31.7)	10(62.5)	117(40.3)	
Excellent RS	40(27.6)	23(26.1)	7(17.1)	1(6.3)	71(24.5)	
Total	145(100)	88(100)	41(100)	16(100)	290(100)	
	Educational level F(P)				Total	
	Primary	Secondary	Tertiary	Non-formal		
Poor RS	5(16.7)	5(5.5)	5(4.4)	4(7.1)	19(6.6)	
Good RS	12(40)	19(20.9)	32(28.3)	20(35.7)	83(28.6)	
Very-good RS	9(30)	35(38.5)	49(43.4)	24(42.9)	117(40.3)	
Excellent RS	4(13.3)	32(35.2)	27(23.9)	8(14.3)	71(24.5)	
Total	30(100)	91(100)	113(100)	56(100)	290(100)	
	Family economic status F(P)					
	Upper-upper	Upper	Middle	Lower	Lower-lower	Total
Poor RS	0(0.0)	1(2.4)	12(7.2)	3(15.8)	3(15.8)	19(6.6)
Good RS	14(31.8)	10(24.4)	49(29.3)	5(26.3)	5(26.3)	83(28.6)
Very-good RS	20(45.5)	17(41.5)	65(38.9)	6(31.6)	9(47.4)	117(40.3)
Excellent RS	10(22.7)	13(31.7)	41(24.6)	5(26.3)	2(10.5)	71(24.5)
Total	44(100)	41(100)	167(100)	19(100)	19(100)	290(100)

In table 5, it is shown that there were significant differences in PSS, QL and RS across all the variables except in QOL with educational level and in resilience with a family economic status where significant differences were not detected.

Table 5. Kruskal-Wallis Test and Pairwise test of the differences in the respondents' levels of PSS, QOL, and RS

Variables	PSS P (Pairwise P)	QOL P (Pairwise P)	RS P (Pairwise P)
Age	0.000 (0.000; 0.000)	0.021 (0.021)	0.018 (0.053)
Parity	0.000 (0.012; 0.000)	0.001 (0.002; 0.004)	0.009 (0.005)
Educational level	0.000 (0.019; 0.000)	0.656 (Nil)	0.001 (0.045; 0.006; 0.018)
Family economic status	0.000 (0.051; 0.007; 0.000; 0.006)	0.001 (0.002; 0.017; 0.008)	0.122 (Nil)

Discussion

In this study, the level of poor PSS increased with an increase in age. Following this, also, the level of excellent PSS decreased with an increase in age. The same was also found on the parity; probably because age most of the time could determine the number of children. The level of education might have some effects on PSS, since in this study respondents with primary education levels were having the highest poor PSS. In the family economic status variable, lower and lower-lower family economic status had the highest poor PSS and at the same time lowest excellent PSS. These could be an indication of the influence of age, level of education, and family economic status on PSS. The elderly pregnant women perceived less social support than the younger ones. The less educated pregnant women perceived less social support than the highly educated. Also, pregnant women from poor families perceived less social support than those from rich families. Therefore, these three variables need to be considered in providing support to pregnant women for the possible prevention of adverse outcomes of the pregnancy.

There was a very strong significant difference between the PSS mean ranks of age groups, parity groups, educational level groups, and family economic status groups, respectively. The differences were detected between ≥ 45 and 25-34, and between ≥ 45 and 15-24, with $P < 0.001$ respectively. There were differences between ≥ 10 and 1-3 parity and between 7-9 and 1-3 parity, $P < 0.05$ and 0.001 respectively. Differences were also found between primary education and tertiary education and between primary education and secondary education, $P < 0.05$ and 0.001 respectively. The differences were found between lower-lower class and upper-upper class, $P = 0.05$; lower-lower class and middle class, $P < 0.01$; lower-lower class and upper class, $P < 0.001$; as well as lower class and upper class. $P < 0.01$. Contrary to these findings, a study conducted by Yu et al. (2020) found no significant association between the respondents' age, educational degrees, and income level with PSS, $P > 0.05$ respectively. However, the authors used only women in the second trimester. Following the finding of this study, Abdollahpour et al. (2015) found a statistically significant difference in PSS according to parity.

Very high poor QOL across all the respondents' variables in this study is critical. However, the high level of middle to lower-lower economic status among the respondents might be a contributing factor to the high poor QOL. This is because financial dissatisfaction leads to poor QOL (Bai et al., 2018). This finding is contrary to a study by Mazúchová et al. (2018) in which the majority of the women (55.60%) had a very good QOL. A statistically significant difference in mean ranks of QOL was detected between the age groups; between the parity groups, and between the family economic status groups. The detected differences were found between the age bracket 25-34 and ≥ 45 , $P < 0.05$; between 4-6 parity and 7-9 parity, and between 1-3 and 7-9 parity. $P < 0.01$ respectively; between the upper-upper class and lower-lower class; upper class and lower-lower class; middle class and lower-lower class. $P < 0.01$, $P < 0.05$, $P < 0.01$ respectively.

The lower age respondents had higher poor QOL than the higher age respondents. Also, the lower parity respondents had a higher poor QOL than the lower parity respondents. This could be due to the different levels of maturity among them. The lower age respondents, usually with lower parity had a lower maturity level and hence may have higher life expectations and need for care. Both respondents with secondary education and respondents with tertiary education had a higher poor QOL than respondents with primary education, which might be due to differences in expectations of life. The highly educated people may have higher expectations of life than people with lower education levels. Also, women from higher socioeconomic families may have higher expectations than women from lower socioeconomic status. Thus, women from higher socioeconomic status had higher poor QOL.

In this study, the highest reported overall level of RS was very-good RS. This finding is contrary to the finding of a study in China by Jin et al. (2019), in which participants reported moderate levels of RS. However, the authors used only women with second pregnancies as the participants of the study. In this study, there was a significant difference in mean ranks of RS by age. The difference was found to be between the ≥ 45 and 25-34 age brackets, $P=0.05$. This is by a finding by Olajubu et al. (2021), in which there was a significant relationship in RS between age groups, $P<0.001$. However, the same study had a contrary finding with this study in which they found RS to have no significant association with educational types, $P>0.05$. In this study, the differences in mean ranks of RS were found between primary education and tertiary education, $P<0.05$; primary education and secondary education, $P<0.01$; non-formal education and secondary education, $P<0.05$. The difference might be because the authors (Olajubu et al., 2021) used pregnant teenagers only as of the subjects of the study, while this study used general pregnant women. Therefore, RS is likely to be decreasing with the increase in age; and increase with an increase in levels of education. Concerning these, it is pertinent in providing care during pregnancy to consider women of higher age and women with lower levels of education for resilience development.

In this study, there was a significant difference in RS mean ranks of parity groups. The difference was detected between 7-9 and 1-3 parity, $P<0.01$; which could be an indication that parity influences RS of pregnant women. It seems that lower parity women was having higher RS than the higher parity women. The RS of the women may decrease with an increase in parity, the same with the decrease in RS with an increase in age. This is expected since the parity in most cases could be determined by the age of the woman. Also, there was no significant difference in mean ranks of RS between the different family economic statuses of the respondents, $P>0.05$. The influence of endurance and resisting pregnancy challenges culture in the study area might be the reason for the lack of differences in RS between different family economic status groups. Healthcare professionals should strive to develop the pregnant women's RS by considering their socio-demographic variables like age, parity, and level of education. The elderly pregnant women, high parity women, and women with low educational levels require more attention in developing RS.

Implications of the findings

There is a need for more efforts on the part of healthcare professionals in providing highly effective care to pregnant women in such a way that their QOL and RS are enhanced. The healthcare professionals in collaboration with pregnant women's families need to provide care that would serve as an enhancer to pregnant women's PSS. The caring, advice, and information to pregnant women are crucial to the development of PSS and in turn, the QOL and RS would also be developed. In doing so, it is highly pertinent that the socio-demographic variables, age, parity, level of education, and socioeconomic status are considered. The elderly women, women with high parity, women with lower levels of education, and those from lower economic status families need more support for the development of QOL and RS.

Conclusion

The majority of the respondents had PSS that centered around good and very good. However, there were very high poor QOL among the respondents. The RS of the respondents ranges from good to excellent. The age, parity, educational level, and family economic status were found to have some differences in the mean ranks of PSS, QOL, and RS respectively. Therefore, healthcare workers especially midwives should consider these three important factors when rendering their services to pregnant women.

Conflict of Interest

The authors have no conflict of interest to disclose.

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