MATERNAL LABOUR FORCE PARTICIPATION AND UPTAKE OF DELIVERY PLACE AMONG WOMEN OF REPRODUCTIVE AGES IN NIGERIA.

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ABSTRACT

The study examines variables that measure maternal labour force participation as it influences
uptake of delivery place among women in Nigeria. The study analyzed data from 2018 Demographic and Health Survey on 27,176 women who participate in labour force. The result showed that about 65% of respondents participate in labour force with 49% of the respondents who utilized health facility during delivery. Majority (51%) of the respondents who were working had home delivery. This study shows that women participation in labour force as a form of empowerment did not influence the choice of women to utilize health care facility. Beyond economically empowering a woman, there is need to tackle the power relations that exist between man and woman.

Keywords: Gender, Maternal mortality, women empowerment, Labour Force.

INTRODUCTION

Maternal mortality has been on the increase with grave socioeconomic consequences (Olonade et al., 2019). Approximately 295 000 women worldwide, died from causes related to pregnancy and childbirth in 2017 (WHO 2019). The vast majority of these deaths (94%) occurred in low-resource settings, and most could have been prevented (WHO 2019). Maternal mortality is the highest by far in sub-Saharan Africa, Nigeria inclusive, where the lifetime risk of death from pregnancy-related conditions is very high (WHO 2019). Maternal death is the most extreme consequence of poor maternal health outcomes (APHA 2017). Furthermore, due to insufficient care during pregnancy and delivery or the first critical hours after birth, more than 30 million women in developing regions suffer from serious diseases and disabilities (Bukama et al., 2020). These includes uterine prolapse, pelvic inflammatory disease, fistula, incontinence, infertility, and pain during sexual intercourse (Bukama et al., 2020). A large proportion of these deaths and complications could be prevented by access to basic maternity and improved delivery care (Bukama e al., 2020). As access to proper medical attention and hygienic conditions during and after delivery has been found to significantly reduce the risk of complications and infections that may lead to death, disabilities or serious illness for the mother, baby, or both (Bekuma et al., 2020).

Women's access to healthcare has been linked to gender power relations in most low-and-middle-income countries (Yaya et al., 2019). Most of the communities in these countries are patriarchy by nature (Onwutuebe 2019; Makama 2013; Dogo 2014), hence men as the gate-keepers exercise control over the women within their social class, especially within families and household. In these societies, the contributions of women to household decisions making are marginal because men are principally in charge of economic resources, they decide where, when and how their wives access health services. The decision-making power of women is an important factor which influences maternal healthcare service utilization (Fasina et al., 2020). Thus, mainstreaming gender with reproductive health care should be a front burner issues and both government and nongovernmental actors must be at the forefront of this. The Beijing Declaration recognized that women's participation in household decision-making on matters concerning their health will yield a corresponding positive effects on their health outcomes. There is a growing recognition worldwide of *the health consequences* of gender inequality

(Cornish, 2019; Yaya et al., 2019) and several studies, platforms and conventions have recognized that gender subordination of women will result in negative consequences on both women's health behavior and health outcomes.

Just like other countries in the sub-Saharan African region, Nigeria bears a large disproportionate burden of maternal mortality and ill health compared with the developed world (Ahuru 2019; Fagbamigbe & Idemudia, 2017). Annually, between 56,000 and 60,000, women and 241,000 newborn babies die from pregnancy-related complications in Nigeria (Ahuru 2019). Underutilization of maternal and childcare services has been reportedly slow in Nigeria and to a large extent it is responsible for the high rate of both maternal and child deaths nationwide (Ahuru 2019; Idemudia 2017).

Empowerment of women is seen as very crucial, due to their disadvantaged and vulnerable social position. Women are at the receiving end of social and economic inequality, which in turn affect their abilities to make vital decisions including those involving their health. Women are disempowered as a result of power relations which relegate them to the background and this affect every spheres of their lives including choice of place of delivery. An assessment of women empowerment indicators for Nigeria shows that the female folks are disempowered, and disadvantaged (Ahuru 2019). Thus, women labour force participation has been depicted as a strategy to empower women, as it is believed that women who are economically empowered will challenge the status quo and power imbalance. The 2013 Nigerian National Demographic and Health Survey (NDHS) reported that of the women surveyed, only 30% had the freedom to partake in economic activities outside their homes and that 70% depended on their spouses for sustenance (Ahuru 2019). Also, only 66% of women who earned cash exercise control over their income (Ahuru 2019). Furthermore, while 82% of women earned less than their husbands, only 5% earned as much as their husbands. The above assessment reveals that most of these women are subordinated to men, and gender disparity remains high (Ahuru 2019). It is therefore expected that the unbalanced power relationship between Nigerian men and women will play a major role in women's decision to use modern health services and also uptake of delivery space (Ahuru 2019). As important as this issue is, there are limited studies that have examined the influence of maternal labour force participation as a form of women empowerment on maternal care utilization in Nigeria from a gender perspective. Against this backdrop, the study drew upon secondary data from the NDHS to explore the influence of maternal labour force participation on uptake of delivery place among women in Nigeria using a gender lens.

METHODS

Data source and sample size

This study makes use of secondary data extracted from women of reproductive age in the 2018 NDHS. The 2018 NDHS is a cross-sectional study conducted in Nigeria to provide reliable and international information on fertility, childhood, and adult mortality, family planning and sexual and reproductive issues. In this study, only women of reproductive ages who participate in labour force and had at least a live birth five years preceding the survey were analysed. A weighted sample of 27,176 women of reproductive ages was analysed in the study.

Variables

The outcome variable in the study was the place of delivery for mothers. This was generated from information on the respondents who delivered their last birth five years preceding the survey. The responses to the variables were divided into two categories, home (which was coded as 0) and health facility (which was coded as 1).

The explanatory variables were divided into two. Labour force participation and Sociodemographic factors. Labour force participation included, employment status, type of occupation, type of employer and employment earning. Socio-demographic factors were the age of respondents, level of education, region, wealth index, place of residence and religion practiced by respondents. Maternal age groups of respondents were re-grouped as 15-19 years, 20-34 years and 45-49 years.

Definition of variables

Explanatory variables.

The explanatory variables were divided into two groups. The first group consist of; labour force participation, employment status, types of occupation, types of employer and employment earning. The second group consist of; socio-demographic factors, the age of respondents, level of education, region, wealth index, place of residence and religion practiced of respondents. Maternal age groups of respondents were re-grouped as 15-19 years, 20-34 years and 45-49 years.

Variable	Definition	Coding	Variable Identification
Employment status	Labour force participation	(1) no working	v714
		(2) working	
Types of occupation	Labour force participation	(1) Manufacture	v716
		(2) Professional	
		(3) Administration	
		(4) Sale	
		(5) Services	
		(6) Agriculture	
Type of employer		(1) Family	v719
		(2) Someone else	
		(3) Self-employ	
Employment earning		(1) not paid	v741
		(2) Cash only	
		(3) Cash and kind	
		(4) Kind only	
Age		(1) 15-19	v013
		(2) 20-34	
		(3) 35-49	

Education	(1) no-education	v106
	(2) Primary	
	(3) Secondary	
	(4) Higher	
Wealth index	(1) poorer	v190
	(2) Poorer	
	(3) middle	
	(4) Rich	
	(5) Richest	
Place of residence	(1) urban	v025
	(2) Rural	
Geographical	North central	v024
	Northeast	
	North west	
	North east	
	North south	
	North west	
Religion	Traditional	v130
	Christian	
	Islam	

Outcome variables

The outcome variable in the study was the place of delivery of mothers. This information was generated from respondents who had their last birth, five years preceding the survey. The response to the variables were divided into two categories (home) which was coded as 0 and (health facility) was coded as 1.

Variable	Definition	Coding	Variable identification
Place of delivery		(1) Home	m15_1
		(2) Health facility	

Statistical analysis

Stata 14 version was used to perform statistical analyses across levels. At the univariate level, frequency distribution was used to describe the labour force participation characteristics and socio-demographic factors. Chi-square statistic was used to examine the relationship between the explanatory variables and outcome variables. Statistical significance was set at 0.05. At the multivariate level, Logistic regression was applied to analyze the relationship pattern between

outcome variables and explanatory variables. The justification for this technique was that the outcome variables were dichotomous i.e. (0 for (Home) and 1 for (Health facility). The regression model was developed to predict the uptake of the delivery place.
The model was specified as following

$$\text{Log}(P) = \text{Log Odd} = \text{Log}(p/1-p) = a + b_1X_1 + b_2X_2 + b_3X_3 \ldots\ldots b_nX_n \qquad (1)$$

Where P is the probability of delivery place, a is the intercept, b is the slope, X_1 is the employment status, X_2 is the type of occupation, X_3 is the types of employer and X_4 is the employment earnings, n=4

RESULTS

Table1 presents maternal labour force participation characteristics. About 65% of respondents participate in labour force. However, 52% of respondents were into sale occupation and 71% were self-employed while more than half 71% were paid in cash from employment earning.

Table1: Percentage Distribution of Respondents by Labour Force Participation

Labour Force Participation	Frequency (N=27,176)		Percentage 100%	
Employment status				
Not-working		14,645		35%
Working	27,176		65%	
Types of Occupation				
Manufacture		1,457		5%
Professional		2,056		8%
Administration		880		3%
Sale		14,043		52%
Services	2,870		11%	
Agriculture		5,870		21%
Employer				
Family		4,153		15%
Someone		3,757		14%
Self-employ		19,266		71%
Employment Earning				
Not-paid	4,674		17%	
Cash-only		19,322		71%
Cash and in-kind	2,786		10%	
In-kind-only		394		2%

Source: Author's analysis based on 2018 NDHS

Table 2 present distributions of respondents by socio-demographic factors. Almost half (49%) of respondents were between age 35-49 years. Thirty nine percent (39%) of the respondent had secondary education. In term of wealth index, about 24% of respondents were in the richest category. More than half 53% of respondents reside in the rural area. In term of the region, 23% of respondents were from Northwest while most practiced religion was Christianity.

Table2   Percentage Distribution of Respondents by Socio-demographic Factors

Socio-demographic factors	Frequency (N=27,176)	Percentage 100
Age of respondents		
15-19	3,007	11%
20-34	13,373	49%
35-49	10,796	40%
Education Level		
No education	8,572	32%
Primary	4,623	17%
Secondary	10,678	39%
Higher	3,303	12%
Wealth Index		
Poorer	4,197	15%
Poorer	5,087	19%
Middle	5,458	20%
Rich	6,042	22%
Richest	6,392	24%
Place of Residence		
Urban	12,838	47%
Rural	14,338	53%
Geographic Region		
North Central	4,173	15%
North East	4,028	14%
North West	6,216	23%
South East	3,563	13%
South South	3,519	13%
South West	5,677	22%
Religion		
Traditional	182	1%
Christian	14,255	53%
Islam	12,739	46%

Source: Author's analysis based on 2018 NDHS

Table 3 present distributions of respondents by delivery place. More than half (51%) of respondents delivered at home while 49% delivered at the health facility.

Table3: Percentage Distribution of Respondents by Delivery Place

Outcome Variables	Frequency (N=27,176)	Percentage 100%
Delivery Place		
Home	7,649	51%
Health Facility	7,336	49%

Source: Author's analysis based on 2018 NDHS

Bivariate analysis

Table 4 and 5 present the bivariate relationship between the outcome variable and the explanatory variable. Employment status was positively associated with uptake of delivery place. Types of occupation were positively associated with uptake of delivery place. Type of employer was also found associated with uptake of delivery place. Also, there was a relationship between employment earning and uptake of delivery place. Likewise, the relationship between the age of respondents and uptake of the delivery place was positive. Level of education was positively related to the uptake of the delivery place. Wealth index was found to be positively related to the uptake of delivery place. Region, place of residence and religion were also found to be positively related to the uptake of delivery place.

Table 4: Relationship Between Labour Force Participation and Delivery Place

Variables	Home	Health	Chi-square value	p-value
Employment Status			**174.6**	**0.000**
Not-working	291.2 (38%)	372.5 (62%)		
Working	2405 (51%)	2332 (49%)		
Types of Occupation			**709.0**	**0.000**
Manufacture	291.2 (37%)	481.8 (63%)		
Professional	263.5 (27%)	730.4 (73%)		
Administrative	39.77 (13%)	(272.5) 87%		
Sales	4596 (54%)	(3800) 46%		
Services	553 (40%)	832.8 (60%)		
Agriculture	1906 (61%)	1218 (39%)		
Employer			**425.8**	**0.000**
Family	1144 (60%)	768.4 (40%)		
Someone else	332.8 (25%)	997.9 (75%)		
Self-employed	6173 (52%)	5569 (48%)		
Employment earning			**155.2**	**0.000**
Not-paid	1098 (51%)	1072 (49%)		
Cash only	5428 (49%)	5645 (51%)		
Cash and in- kind	1012 (64%)	588.5 (36%)		
In-kind only	110.9 (79%)	29.75 (21%)		

Significant at p<0.05

Table5: Relationship Between Socio-Demographic Factors and Delivery Place

Variables	Home	Health	Chi-square value	p-value
Age of respondents			**36.9**	**0.000**
15-19 years	331.5 (64%)	184.6 (36%)		
20-34 years	4912 (51%)	4819 (49%)		
35-49 years	2405 (51%)	2332 (49%)		
Education			**4081.2**	**0.000**
No-education	4630 (82%)	1008 (18%)		
Primary	1258 (51%)	1235 (49%)		
Secondary	1602 (30%)	3718 (70%)		
Higher	159.3 (10%)	1375 (90%)		
Wealth Index			**3596.8**	**0.000**
Poorest	2315 (85%)	420.1 (15%)		
Poorer	2237 (72%)	881.4 (28%)		
Middle	1663 (51%)	1523 (49%)		
Richer	952.2 (32%)	2038 (68%)		
Richest	482.5 (16%)	2474 (84%)		
Place of residence			**1735.6**	**0.000**
Urban	2028 (31%)	4433 (69%)		
Rural	5621 (66%)	2903 (34%)		
Region			**3994.2**	**0.000**
North Central	1016 (46%)	1210 (54%)		
North East	1738 (72%)	692.2 (28%)		
North West	3410 (82%)	763.9 (18%)		
South East	338.8 (20%)	1371 (80%)		
South South	652.5 (41%)	929.3 (59%)		
South West	493.6 (17%)	2369 (83%)		
Religion			**2104.4**	**0.000**
Traditional	62.9 (67%)	31.85 (33%)		
Christian	2069 (30%)	4738 (70%)		
Islam	5517 (68%)	2566 (32%)		

Significant at p<0.05

Multivariate analysis

Table 6 present odds ratio from logistic regression analysis, assessing the relationship between delivery place and labour force participation. In terms of labour force participation in relation to delivery place (Model 1) types of occupation, types of employer and employment earning were significantly associated with uptake of health facility during delivery. Women who were into sales occupation (48.8%) were less likely to uptake health facility during delivery (OR: 0.5117; 95% C.I: 0.4129-0.6341). Likewise, women who were self-employed (13.6%) were more likely to uptake of health facility during delivery than their counterparts who were employed by someone else (OR: 1.1363; 95% C.I: 0.9873-1.3079). The odds ratio of uptake of health facility during delivery decreased among employment earning. For instance, women who were paid in cash (21.8%) were less likely to uptake health facility during delivery compared with women who were not paid (OR: 0.7822; 95% C.I: 0.6594-0.9279). On the other hands, employment did not reveal a significant relationship with delivery place. Women who participate in labour force (16.7%) were more likely to uptake health facility during delivery than their counterpart who did not participate (OR: 1.1667; 95% C.I: 0.8426- 1.6156).

Table 6: Odds Ratio from Logistic Regression Analysis, Assessing the Relationship between delivery place and Labour Force Participation (Model I).

Variables	Odds Ratio	p-value	95% C.I
Employment status			
Not-participated RC			
Participated	1.1667	0.353	0.8426- 1.6156
Occupation			
Manufacture	RC		
Professional	1.2390	0.144	0.9291-1.6522
Administrative	2.5967	0.000	1.6563-4.0711
Sales	0.5117	0.000	0.4129-0.6341
Services	0.8527	0.196	0.6697-1.0856
Agriculture	0.3935	0.000	0.3041-0.5093
Type of Employer			
Someone else	RC		
Family	2.1733	0.000	1.7195-2.7470
Self-employ	1.1363	0.031	0.9873-1.3079
Employment Earning			
Not-paid	RC		
Cash only	0.7822	0.005	0.6594-0.9279
Cash and in-kind	0.5250	0.000	0.4369-0.6309
In-kind only	0.2616	0.000	0.1497-0.4570

Notes: ref is reference category **p<0.001, p<0.05, 95% confidence interval.

Table 7 presents the odds ratio from logistic regression analysis, assessing the relationship between delivery place and socio-demographic factors (Model II). Level of education, wealth index, place of residence and region are the socio-demographic factors with a significant association with the uptake of the health facility. The odds ratio of uptake of health facility during delivery increases tremendously as educational level improved. Respondents who had higher education (15%) were **seven times** more likely to uptake health facility during delivery than their counterpart who had no education (OR: 7.1498; 95% C.I: 5.4603- 9.3620). Likewise, the odds ratio of uptake of health facility during delivery increase progressively as the wealth index of respondents improves. Respondents who were in the richest category (66.8%) were **five times** more likely to uptake health facility during delivery compared to their counterparts who were poorest (OR: 5.6678; 95% CI: 4.3529-7.3800). Moreso, Northwest (69.9%) with a high proportion of respondents were less likely to uptake health facility during delivery compared to

respondents in Northcentral (OR: 0.3012; 95% 0.2433-0 .3730). Likewise, respondents who reside in a rural area were (14.9%) less likely to uptake health facility during delivery than their counterparts who reside in an urban centre (OR: 0.8515; 95% C.I: 0.7345- 0.9871). On the other hand, the age of respondents and religion did not show a significant association with the uptake of health facility during delivery. Respondents who were between age group 20-34 years (6.9%) were less likely to uptake health facility during delivery compared to counterpart within age 15-19 years (OR: 0.9310; 95% C.I: 0.7132- 1.2153). Also, respondents who practised Christian religion (67.1%) were more likely to uptake health facility during delivery than their counterpart who practiced traditional religion (OR: 1.6706; 95% C.I: 0.9900 -2.8189).

Table 7: Odds Ratio from Logistic Regression Analysis, Assessing the Relationship between Place of Delivery and Socio-demographic Factors (Model II).

Variables	Odds Ratio	p-value	95% C.I
Age of respondents			
15-19 years	RC		
20-34 years	0.9310	0.599	0.7132- 1.2153
35-49 years	1.0047	0.973	0.7665- 1.3169
Education			
No-education	RC		
Primary	1.8494	0.000	1.6031- 2.1335
Secondary	2.6996	0.000	2.3154- 3.1476
Higher	7.1498	0.000	5.4603- 9.3620
Wealth Index			
Poorest	RC		
Poorer	1.7150	0.001	1.4361- 2.0482
Middle	2.7756	0.000	2.2856- 3.3707
Richer	4.0328	0.000	3.2508- 5.0028
Richest	5.6678	0.000	4.3529-7.3800
Place of Residence			
Urban	RC		
Rural	0.8515	0.033	0.7345- 0.9871
Region			
North Central	RC		
North East	0.6152	0.000	0.4901- 0.7723
North West	0.3012	0.000	0.2433-0 .3730
South East	1.4394	0.002	1.1390- 1.8190
South South	0.4315	0.000	0.3454-0.5391
South West	1.8219	0.000	1.4617-2.2708
Religion			
Traditional	RC		
Christian	1.6706	0.055	0.9900 -2.8189
Islam	1.008	0.976	0.5854-1.7369
Notes: ref is reference category **p<0.001, p<0.05, 95% confidence interval.			

DISCUSSION

Globally, more than 800 women die each day from pregnancy-related complications (UNICEF 2020). In the sub-Saharan region, where the highest number of maternal deaths occur, there are around 200 000 maternal deaths every year (WHO 2019). Ensuring the utilization of proper health care facility will halt the havoc of maternal death in Nigeria and play a vital role in the attainment of the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) (Fagbamigbe and Idemudia 2017). It is believed in some quarters that economic empowerment of women would lead to all round improvement in the life of women but how valid is this belief? This study thus, explored the influence of labour force participation on uptake of place of delivery among women in Nigeria using a gender lens.

The result of this study shows that 51% of women participating in labour force had home delivery while just 49% utilized health facility during delivery. Surprisingly, just 38% of women who are not employed had home delivery while majority (62%) utilized health facility during delivery. From this result, it can be deduced that participation of women in labour force did not influence their decision to utilize health care facility during delivery, as majority of the employed women still had home delivery. This shows that there are underlining gender issues which must be addressed, as economic empowerment alone cannot dismantle the power relations that exist between men and women. There is high level of gender inequality in Nigeria giving rise to issues working against women. This needs to be adequately addressed as economic empowerment of women alone may not result in their total well-being. Maternal mortality remains an international public health problem and thousands of women still die each year from preventable causes before, during, and after giving birth (Li et al., 2020; Sageer et al., 2019; WHO 2019).   Conversely, the sustained high rates of maternal deaths in Nigeria signifies unequal access to healthcare services for pregnancy and delivery (Yaya et al., 2019). Access to healthcare has been linked to gendered power relationships in low- and middle-income countries (Morgan et al., 2018). Most communities in Nigeria are patriarchal by nature (Onwutuebe 2019; Makama 2013; Dogo 2014). Most households in Nigeria are headed by men who are also the gate-keepers. They exercise exclusive control over household economic resources and also dictate the number of resources that are allocated to maternal healthcare-related needs. They influence or make decisions on all aspects of women's reproductive health (Darteh et al., 2019). Several Nigerian women do not earn income and for those who earned income, they are hardly in control of their earned income (Makama 2013; Ajieroh, 2009). Consequently, many Nigerian women depend on their husbands for healthcare-related costs (Yaya et al., 2019). Unfortunately, in several families in Nigeria, women do not make a significant contribution to decisions concerning their health. Given the patriarchal nature of several families in Nigeria (Makama 2013), the men make all decisions concerning their wives' health. Therefore, it is good that intervention programmes to reduce gender disparities at home fronts be implemented in Nigerian settings.

It was also observed from the study that across the different labour force, there are varying percentage of women who had home delivery and those who utilized health care during delivery. In the manufacturing industry, only 37% of the women had home delivery while 63% utilized the health facility. More of the women who are professionals (73%) utilized the health care facility while just 23% had home delivery. It was observed that among the women who were into sales, 54% had home delivery while just 46% utilized the health facility. A very high percentage of women in the Agriculture (61%) had home delivery while minority (39%) utilized health care facility. This implies that participation in some sectors of the labour force influence the utilization of health care facility than the other, as more women in the agricultural sector had home delivery than the others.

The findings also revealed that 82% of women with no education had home delivery while just 18% utilized health care facility. Conversely, only 10% of respondents with higher education had home delivery while a huge percentage (90%) utilized health care facility. Education serves as a proxy for knowledge, awareness, cognitive skills and values. This is evidenced by the fact that Educated mothers are more likely to make use of public health services than their non-educated counterparts (Molla et al., 2020; Paul and Chouhan, 2020; Babalola and Fatusi 2009). Women who are educated are most likely to challenge patriarchal norms, speak out for themselves and other women, which will bring about gender equality in all areas.

In addition, the studies also showed that 85% of the poorest, 72% of the poorer, 51% of the middle, 32% of the richer and 16% of the richest had home delivery. It can be deduced from this finding that the economic status of the women played a significant role in their choices of place of delivery. This explains the fact that it is not enough for women to participate in labour force but there should be equality in employment, as most women are found in low wage employment

as a result of gender equality. In societies dominated by patriarchal norms, girls and women are often expected to adhere to strict gender related behaviors, practices and responsibilities and they do experience cultural restrictions on their choices and opportunities that men do not (Steege et al., 2020; Adisa et al., 2019; Marcus et al., 2015). The low value placed on women and girls perpetuates a variety of harmful yet common attitudes and practices that can negatively impact them for the rest of their lives (Melo, 2019). In patriarchal societies, women in labour force are mostly found in low wage sector in which majority of the women are poor and this will in turn influence the choice they made in uptake of place of delivery, as poor socio-economic status of women may serve as financial barriers to maternal care utilization (Dahab and Sakellariou, 2020; Olonade et al., 2019). In a patriarchal society like Nigeria, Men are often the heads of households and act as gatekeepers. They tend to have control over their household's economic resources and are decision-makers in all aspects of women's reproductive health, as a woman may participate in labour force but not economically empowered because she does not have power over her income due to the fact that the woman and everything she owns belong to the husband. This will in turn result in poor health decision and influence her choice of place of delivery, which will lead to high maternal mortality rate.

Conclusion
This study shows that women participation in labour force as a form of empowerment did not influence the choice of women to utilize health care facility. This is due to the fact that there are underlining gender issues that need to be deconstructed. The UN contends that if healthcare systems are to respond adequately to problems caused by gender inequality, gender must be considered from the beginning of any developmental research, intervention or policy. Beyond economically empowering a woman, there is need to tackle the power relations that exist between a man and a woman. In addition, gender equality must be ensured in order to foster women's utilization of proper health care facility to bring an end to maternal mortality. More avenue should also be created to sensitize women who participate in labour force about the dangers associated with delivery at non-health care facilities in other to reduce maternal and child mortality in Nigeria.

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