

Beyond Employment Status: Employment Quality, Women's Health Agency and Maternal Healthcare in Nigeria

Halima Bashir Muhammad^{1*}, Godwin Chiyem Samson²

¹Department of Nursing, Faculty of Nursing Sciences Maryam Abacha American University Maradi,
Niger Republic

²Rockworks Agro Nigeria Limited Abuja-FCT

*Corresponding Author

DOI: [https://doi.org/ 10.47772/IJRISS.2026.100800648](https://doi.org/10.47772/IJRISS.2026.100800648)

Received: 26 August 2026; Accepted: 31 August 2026; Published: 15 September 2026

ABSTRACT

Women's employment is frequently treated as a marker of economic empowerment, although its health implications depend on the conditions and protections attached to work. This study examines employment quality, healthcare decision-making, and the maternal-health context in Nigeria, while evaluating whether labour, maternity, and health-insurance arrangements align with women's employment patterns. Published estimates from the 2024 Nigeria Demographic and Health Survey (NDHS) and Q1 2024 Nigeria Labour Force Survey (NLFS) provide the principal employment and agency evidence; the 2025–26 Nigeria Mini-Demographic and Health Survey (NmDHS) and 2024 Nigeria Verbal Autopsy and Social Autopsy (NVASA) report provide recent maternal-health and institutional context. Employment quality is examined through remuneration, continuity, employment relationship, sector, informality and social protection. Among women who worked in the preceding year, 12.2% were unpaid, 19.1% worked seasonally, and 70.4% were self-employed; 96.4% of employed women were in informal employment. Participation in decisions concerning one's own healthcare was 58.8% among married women employed for cash and 56.2% among those employed without cash remuneration, compared with 29.4% among women who had not worked. The NmDHS shows persistent maternal-care inequalities, while NVASA documents financing constraints alongside evidence that state insurance schemes and the Basic Health Care Provision Fund can reduce out-of-pocket barriers. Because individual-level 2024 NDHS microdata were unavailable, employment-health associations remain descriptive. The findings identify a mismatch between women's employment structure and protections most readily accessed through standard employer-employee relationships, supporting more portable health and maternity protection for informal and irregular workers.

Keywords: Employment quality; Women's health; Gender; Healthcare autonomy; Maternal healthcare; Social protection

INTRODUCTION

Women's employment is widely regarded as a potential source of economic autonomy and improved health, but the benefits associated with work depend on the remuneration, security and protection embedded in the employment arrangement. In Nigeria, a binary employed/not-employed classification obscures considerable heterogeneity: regular salaried employment, seasonal trading, unpaid family labour and own-account activity are grouped despite different implications for income stability, time autonomy and access to social protection.

Contemporary national evidence makes this heterogeneity difficult to ignore. The Q1 2024 Nigeria Labour Force Survey (NLFS) recorded similar labour-force participation rates for women and men, yet women were more likely to be self-employed and informally employed (National Bureau of Statistics [NBS], 2024). The 2024 Nigeria Demographic and Health Survey (NDHS) likewise documents substantial variation in women's remuneration and employment continuity (Federal Ministry of Health and Social Welfare [FMoHSW] et al.,

2025). Female participation rates therefore provide only a partial indication of whether work generates predictable resources or effective employment protection.

These distinctions have direct public-health relevance. Employment conditions can shape access to money for transport and treatment, the opportunity cost of attending health facilities, and women's influence over decisions concerning their own healthcare. Such constraints are especially consequential in maternal health, where antenatal attendance, facility delivery and postnatal care are mediated not only by service availability but also by household resources, mobility and the ability to absorb time and income losses associated with seeking care.

Nigeria's institutional architecture complicates this relationship. Labour protections are most readily invoked within identifiable employer–worker relationships, whereas much of women's economic activity occurs through self-employment and informality. Health-insurance legislation adopts a broader population approach, yet statutory eligibility does not by itself ensure enrolment, continuity of coverage or financial access to care.

Nigerian studies have consistently linked women's autonomy and socioeconomic position with maternal-health service use, while labour-market evidence documents pervasive informality. These literatures, however, remain only weakly connected. Employment is commonly entered into maternal-health models as a binary characteristic or occupational category, and legal analyses seldom examine whether statutory protections correspond to the employment arrangements observed in national population data.

This study brings these strands together through an integrated secondary-data and doctrinal design. The 2024 NDHS and Q1 2024 NLFS are used to examine remuneration, employment continuity, employment relationship, informality and healthcare decision-making; the 2025–26 NmDHS updates the maternal-health context, and the 2024 NVASA report provides recent evidence on maternal mortality, care seeking, health financing and implementation. The doctrinal analysis evaluates the extent to which labour, maternity and health-insurance protections correspond to women's concentration in informal, self-employed, seasonal and unpaid work.

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

From Employment Status to Employment Quality

Employment occupies a conditional rather than uniformly protective position in public health. Work can generate income, social participation and access to employment-related benefits, but it can also expose workers to insecurity, inadequate pay, hazardous conditions and psychosocial strain. The WHO Employment Conditions Knowledge Network consequently situated employment relations and working conditions among the structural determinants of health (Employment Conditions Knowledge Network, 2007). Benach et al. (2014) developed this perspective through the concept of precarious employment, locating health risk in unequal and insecure employment relations as well as in the physical characteristics of work.

Subsequent scholarship supports a multidimensional approach. Kreshpaj et al. (2020) identify employment insecurity, inadequate income and weak rights or protection as recurring dimensions of precarious employment. Reviews also associate precarious work with poorer health and wellbeing while noting substantial measurement variation and the dominance of evidence from high-income settings (Jaydarifard et al., 2023; Hajat et al., 2024). Ahonen et al. (2025) further caution that evidence on the harms of precarious work does not establish that all better-quality employment is uniformly health-promoting.

Accordingly, this study treats employment quality as multidimensional rather than imposing a binary precarious/non-precarious classification. The Nigerian datasets provide information on remuneration, continuity, employment relationship, sector and informality but no validated composite scale. This is consistent with the International Labour Organization's treatment of job quality as comprising distinct dimensions such as earnings, security, working time, safety, social protection and equality (International Labour Organisation, 2020). Disaggregation is especially important for self-employment, which may represent autonomy or insecure subsistence work depending on context.

Gender, Informality and the Organisation of Work

Gendered inequalities in access to occupations, productive assets, finance, and discretionary time shape employment quality. Women's disproportionate responsibility for unpaid care can restrict mobility and working hours and narrow the range of employment that can be combined with household responsibilities. Informal work may therefore offer necessary flexibility while simultaneously providing weaker income security, limited bargaining power and fewer enforceable protections.

Informality gives these concerns wider significance. The International Labour Organisation estimated that more than 60% of the world's employed population worked informally in 2018, with the highest proportions in developing regions (International Labour Organisation, 2018). Women are also concentrated in weakly protected forms of work, including contributing family work, domestic work, home-based production and street vending (International Labour Organisation, 2022). Across African social-protection systems, many such workers occupy a 'missing middle' between contributory schemes and tax-financed protection.

Closing this gap requires arrangements that do not depend on a single employer. Flexible contributions, public subsidies and mechanisms suited to irregular earnings are therefore central to social-protection debates in African informal economies (International Labour Organisation & United Nations Development Programme, 2021). Maternity protection presents the same challenge because women in informal employment remain exposed to income loss around childbirth, and effective maternity cash-benefit coverage remains limited in sub-Saharan Africa (International Labour Organisation, 2024). Nigeria's high female self-employment and informality make these institutional questions particularly salient.

Theoretical Framework: Resources, Agency and Achievements

The theoretical framing draws principally on Kabeer's (1999) resources-agency-achievements formulation of empowerment. Within this formulation, employment is best understood as a potential resource rather than as an outcome synonymous with empowerment. Its significance depends on whether the resources generated through work expand women's capacity to define and pursue valued choices. Economic activity can therefore coexist with limited control over earnings, while work yielding modest income may still alter mobility, information, social networks or bargaining capacity.

Decision-making indicators commonly used in DHS research capture only selected dimensions of agency. The SWPER index developed by Ewerling et al. (2017), and subsequently extended to low- and middle-income countries (Ewerling et al., 2020), distinguishes decision-making, social independence and attitudes toward violence. A recent systematic review of empowerment measurement in sub-Saharan Africa similarly documents wide variation in conceptual domains and operational indicators (Shipanga et al., 2026). Participation in decisions about one's own healthcare is therefore treated here as a measure of health-related agency rather than as a comprehensive measure of women's empowerment.

Employment may influence health-related agency through several channels. Independent earnings can reduce financial dependence, regular work may strengthen perceived household contribution, and market or workplace interaction can widen information and social networks. The relationship may also run in reverse: women with greater education, mobility or bargaining power may be more able to work, while those entering insecure employment because of poverty may acquire little control over resources. Employment quality therefore matters to both the resources generated through work and their capacity to support agency.

Healthcare Decision-making: Nigerian and Regional Evidence

Evidence from Nigeria shows that healthcare decision-making is socially and geographically patterned. Using the 2013 NDHS, Osamor and Grady (2018) found that women's participation in healthcare decisions varied with age, education, household wealth, residence, occupation, home ownership, region and partner characteristics. The pronounced regional variation is important because it places household agency within wider social and normative environments rather than attributing it to employment or income alone.

Regional evidence supports the same interpretation. Idris et al. (2023) identify employment or occupation, education, wealth, partner characteristics and residence among recurrent correlates of women's healthcare decision-making. Multilevel DHS analyses similarly report greater autonomy among working women alongside associations with community education, residence, insurance and household wealth (Negash et al., 2023; Tafere et al., 2026). These cross-sectional findings establish patterned association rather than direction of causality.

Women's Agency and Maternal Healthcare Utilisation

Women's agency and maternal-health service utilisation are closely studied, although associations vary in magnitude and consistency. Across 31 sub-Saharan African countries, Chol et al. (2019) report generally modest associations between autonomy measures and antenatal care or skilled birth attendance, with substantial cross-country heterogeneity. Gebeyehu et al. (2022) reach a similar conclusion in a systematic review and meta-analysis. Agency therefore cannot be treated as sufficient where distance, cost, service quality or availability remain binding constraints.

Nigerian studies nevertheless indicate that women's economic position and participation in household decisions are relevant to maternal healthcare. Ifelunini et al. (2022) linked control over healthcare expenditure and women's own income with greater demand for maternal-health services. Imo (2022) associated participation in decisions concerning one's own healthcare and control over earnings with aspects of antenatal-care use. Odusina and Oladele (2023) reported a significant relationship between a composite autonomy measure and maternal-health utilisation, while Adedokun et al. (2023) identified employment alongside education, wealth, residence, region and access barriers.

A recurring limitation is the treatment of employment itself. In much of the maternal-health literature, work enters models as a working/not-working variable or broad occupational category, obscuring differences between year-round cash employment, seasonal work and unpaid family labour. These arrangements can produce markedly different consequences for transport affordability, time away from work, income continuity during pregnancy and access to employment-linked protection. Existing Nigerian evidence therefore supports connections among employment, agency and maternal healthcare without establishing whether variation in employment quality alters those relationships.

Labour and Social Protection as Part of the Health Pathway

Labour regulation and social protection influence whether economic participation can be converted into health security. Stable earnings can make treatment and transport more affordable, but paid leave determines whether clinic attendance entails income loss; maternity benefits protect income when work is interrupted; occupational-safety regulation addresses work-related risks; and health insurance can reduce expenditure at the point of care. Employment may therefore expand resources while leaving substantial health-access costs intact when protective institutions are absent or inaccessible.

These institutional limitations are particularly consequential in informal economies. Employer-liability models of maternity protection can leave self-employed and informal workers outside effective coverage and may also create incentives for discrimination against women of reproductive age (International Labour Organisation, 2024). Social insurance, tax financing and hybrid arrangements are consequently central to extending protection beyond standard employment. In Nigeria, the Labour Act and the National Health Insurance Authority Act distribute protection through different legal and financing routes; whether those routes correspond to women's actual employment arrangements is therefore a substantive public-health question rather than a purely doctrinal one.

Synthesis and Research Gap

The literature converges on three closely related propositions. Employment quality is multidimensional and may influence health through earnings, security, working conditions and social protection. Employment is frequently associated with women's healthcare decision-making, but this relationship is intertwined with education, wealth, household relations and community context. Nigerian maternal-health studies also associate employment and

agency with service utilisation, yet rarely distinguish the quality of work or examine whether legal and financial protection remains continuous across different employment arrangements.

The unresolved issue is therefore not simply whether employed women differ from non-employed women. It concerns how the conditions of women's work intersect with health-related agency and with the institutional arrangements that determine whether economic participation translates into effective healthcare access. Published aggregate data cannot establish a causal pathway, but they can identify the distribution of employment-quality characteristics, document corresponding differences in health-related agency, and assess whether existing legal and financing arrangements fit the employment forms visible in national evidence.

CONCEPTUAL FRAMEWORK

The conceptual framework links employment quality to women's health through resources and agency. Remuneration, continuity, employment relationship, sector and informality shape the economic and social resources available to women and may influence participation in healthcare decisions. Maternal-health service utilisation is also conditioned by wealth, education, parity, gender norms, geography, service availability and the direct or opportunity costs of care. Labour, maternity and health-insurance protections form the institutional environment surrounding these relationships. Employment quality is therefore treated as a potential influence on resources and agency, not as a direct or sufficient cause of maternal-health outcomes.

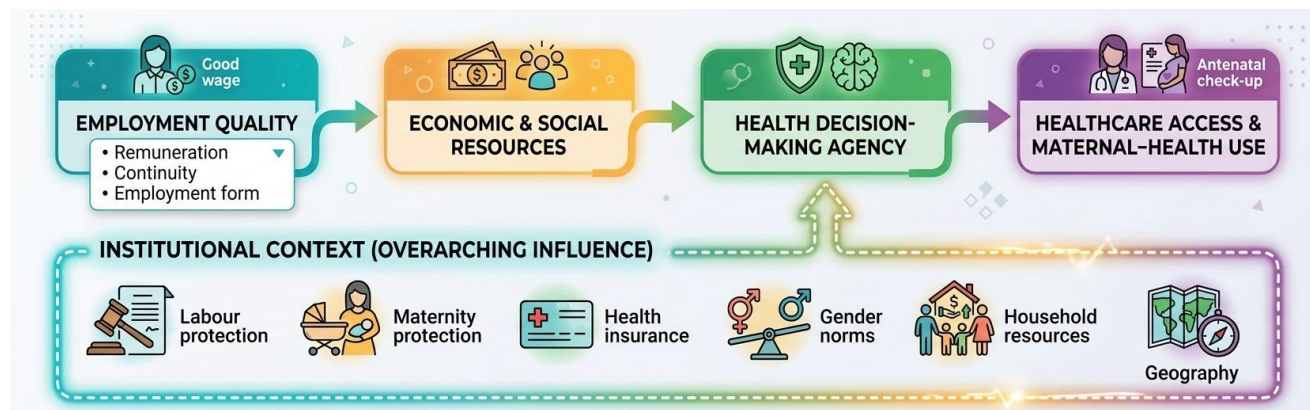


Figure 1. Conceptual Framework Linking Employment Quality, Health Agency and Maternal Healthcare

METHODOLOGY

Study Design

The study employs an integrated secondary-data and doctrinal design. Published estimates from the 2024 NDHS and Q1 2024 NLFS provide the principal evidence on employment conditions and healthcare decision-making. The 2025-26 Nigeria Mini-Demographic and Health Survey (NmDHS) updates the maternal-health and healthcare-expenditure context, while the 2024 Nigeria Verbal Autopsy and Social Autopsy (NVASA) report provides supplementary evidence on maternal mortality, care-seeking, financing, insurance and programme implementation. The doctrinal component examines how Nigeria's labour, maternity and health-insurance frameworks correspond to the employment arrangements identified in these sources.

Data Sources

Table 1. Principal Secondary Data and Doctrinal Sources

Source	Population/scope	Variables or legal issues	Role in study
Nigeria DHS 2024	Women and men aged 15-49; nationally representative	Employment, occupation, remuneration, continuity, employer type, healthcare decision-making, health insurance, maternal care	Principal employment and health-gender dataset

Nigeria Labour Force Survey Q1 2024	Working-age Nigerian population	Labour-force participation, employment, self-employment, informal employment	National labour-market context
Nigeria Mini-DHS 2025-26	Women aged 15-49; nationally and subnationally representative	Maternal care, postnatal care, household healthcare expenditure	Updated maternal-health and financial context
Nigeria NVASA 2024 Main Report	National mortality study; qualitative component purposively sampled in selected states	Maternal mortality, care seeking, health financing, insurance, BHCPF implementation	Maternal-health and institutional implementation context
Constitution of the Federal Republic of Nigeria	National constitutional framework	Equality, discrimination, health, work and welfare principles	Doctrinal analysis
Labour Act, Cap L1 LFN 2004	Statutory labour framework	Maternity protection, wage employment, working conditions	Doctrinal analysis
National Health Act 2014	National health-system framework	Health-system obligations and access principles	Doctrinal analysis
National Health Insurance Authority Act 2022	National insurance framework	Formal/informal-sector coverage; vulnerable persons	Doctrinal analysis
ILO Conventions and NORMLEX	International labour standards	Equal remuneration, discrimination, OSH, violence/harassment, maternity and domestic work	Normative benchmarking
CEDAW and Maputo Protocol	International/regional women's-rights standards	Equality, health and socioeconomic rights	Gender-rights benchmark

The 2024 NDHS supplies information on employment, remuneration, continuity, employer type, healthcare decision-making and health insurance; the Q1 2024 NLFS provides labour-force, self-employment and informality estimates (FMoHSW et al., 2025; NBS, 2024). The 2025-26 NmDHS contributes recent maternal-care and healthcare-expenditure indicators (FMoHSW et al., 2026a), while the 2024 NVASA report contributes maternal-mortality estimates and published evidence on financing, insurance, BHCPF implementation and barriers to care (FMoHSW et al., 2026b). NVASA's purposively sampled qualitative findings are used to illuminate institutional mechanisms rather than estimate prevalence.

Operationalising Employment Quality

In the absence of a validated employment-quality measure in the published tables, remuneration, employment continuity, employment relationship, sector, informality and social protection are retained as distinct dimensions. This disaggregated specification avoids imposing an a priori hierarchy across employment forms, particularly the assumption that self-employment necessarily denotes poorer-quality work, and permits each dimension to be interpreted according to the resources or protections it may confer.

Health Agency and Maternal-Health Indicators

Health-related agency is operationalised as the respondent's participation in decisions concerning her own healthcare. Maternal-health conditions are characterised using skilled antenatal care, frequency of antenatal

contacts, facility delivery, skilled birth attendance and postnatal care. These indicators are used to describe the health-service context rather than as outcomes causally attributed to employment quality. Because the published tables do not jointly disaggregate detailed employment characteristics and maternal-health indicators, adjusted associations between employment quality and maternal-health utilisation cannot be estimated from the available material.

Descriptive and Comparative Analysis

The quantitative component is descriptive and comparative. Estimates are interpreted within each source's design and population rather than pooled. The 2024 NDHS and NLFS provide the employment and agency comparisons; the NmDHS and NVASA provide temporal and institutional context. No significance tests or regression coefficients are inferred from aggregate tabulations. Individual-level 2024 NDHS recode files were unavailable to the study, precluding multivariable adjustment of employment-health associations.

Table 2. Selected descriptive statistics on employment quality, health agency and maternal healthcare in Nigeria

Domain	Indicator	Estimate (%)	Reference population/data source
Female employment	Women currently employed	57.8	Women aged 15-49, NDHS 2024
Female employment	Worked in previous 12 months but not currently working	3.9	Women aged 15-49, NDHS 2024
Female employment	No employment during previous 12 months	38.3	Women aged 15-49, NDHS 2024
Remuneration	Cash only	74.6	Women who worked in previous 12 months, NDHS 2024
Remuneration	Cash and in-kind	11.7	Women who worked in previous 12 months, NDHS 2024
Remuneration	In-kind only	1.5	Women who worked in previous 12 months, NDHS 2024
Remuneration	Unpaid	12.2	Women who worked in previous 12 months, NDHS 2024
Employment relationship	Self-employed	70.4	Women who worked in previous 12 months, NDHS 2024
Employment relationship	Employed by family member	12.6	Women who worked in previous 12 months, NDHS 2024
Employment relationship	Non-family employer	17.0	Women who worked in previous 12 months, NDHS 2024
Employment continuity	Works all year	74.4	Women who worked in previous 12 months, NDHS 2024
Employment continuity	Seasonal work	19.1	Women who worked in previous 12 months, NDHS 2024
Employment continuity	Occasional work	6.5	Women who worked in previous 12 months, NDHS 2024
Labour-market structure	Female self-employment	87.9	Employed women, NLFS Q1 2024
Labour-market structure	Female informal employment	96.4	Employed women, NLFS Q1 2024
Health agency	Own-healthcare decision participation: not employed	29.4	Currently married women, NDHS 2024
Health agency	Own-healthcare decision participation: cash employed	58.8	Currently married women, NDHS 2024
Health agency	Own-healthcare decision participation: non-cash employed	56.2	Currently married women, NDHS 2024
Health protection	Health insurance coverage	3.0	Women aged 15-49, NDHS 2024
Maternal health	Skilled antenatal care	70.7	Women with recent live birth/stillbirth, NmDHS 2025-26
Maternal health	Four or more ANC visits	58.5	Women with recent live birth/stillbirth, NmDHS 2025-26

Maternal health	Health-facility delivery	47.8	Recent live births, NmDHS 2025-26
Maternal health	Skilled birth attendance	50.0	Recent live births/stillbirths, NmDHS 2025-26
Maternal health	Postnatal check within 2 days	49.4	Women with recent live birth/stillbirth, NmDHS 2025-26

Note: Estimates derive from different analytic populations and survey designs and are presented as a descriptive profile rather than a pooled dataset. Maternal-health indicators are drawn from the 2025-26 NmDHS and are used as contemporary context; they are not attributed to employment status or employment quality in this table.

Analytical Domains for the Doctrinal Analysis

The doctrinal analysis was organised around five domains derived from the research problem: the legal coverage of workers; maternity and employment protection; gender equality, occupational health and dignity at work; health insurance and social protection; and the gap between formal entitlement and informal or non-standard employment. These domains provide a consistent basis for comparing statutory design with the employment patterns documented in the national data.

Doctrinal Methodology

The legal analysis examined the categories of workers protected, the content and conditions of maternity, health and equality entitlements, the portability and enforceability of those protections across non-standard employment, and the extent to which social-protection law compensates for gaps in employment-based coverage. International labour instruments are used as normative benchmarks according to Nigeria's ratification status. Published NVASA findings are used as law-in-context evidence concerning implementation and financing; the study does not reanalyse the underlying interview or focus-group data.

Ethical Considerations

The study relies exclusively on published aggregate statistics, published qualitative findings, peer-reviewed research and legal materials. No identifiable individual-level data were accessed, and no participants were recruited. Institutional ethical approval was therefore not required for the analysis reported here.

FINDINGS AND DISCUSSION

Descriptive Profile of Women's Employment Quality

Women's economic participation is substantial, but the conditions attached to that participation are highly heterogeneous.

Among women who had worked during the preceding 12 months, 74.6% received cash only, 12.2% received no payment, and 1.5% were remunerated solely in kind. A further 19.1% worked seasonally and 6.5% occasionally, while 70.4% were self-employed (FMoHSW et al., 2025). Employment status therefore encompasses forms of work that differ considerably in income regularity, dependence on an employer and potential access to employment-linked protection.

The NLFS presents the same structural contrast from a labour-market perspective. Female labour-force participation was 77.1% in Q1 2024, close to 77.5% among men, and the employment-to-population ratios were similarly proximate. Differences were considerably larger in employment form: 87.9% of employed women were self-employed and 96.4% worked informally, compared with 79.9% and 88.7% of men, respectively (NBS, 2024). The principal gender disparity in these indicators therefore lies less in entry into work than in the institutional form through which work is organised.

Table 3. Gender Differences in Selected Labour-Market Indicators, Nigeria, Q1 2024

Indicator	Women (%)	Men (%)	Women minus men (percentage points)
Labour-force participation	77.1	77.5	-0.4

Employment-to-population ratio	72.3	74.2	-1.9
Self-employment	87.9	79.9	+8.0
Informal employment	96.4	88.7	+7.7

Source: National Bureau of Statistics (2024), Nigeria Labour Force Survey Q1 2024.

The comparison in Table 3 reinforces this distinction. Gender gaps in labour-force participation and employment were below two percentage points, whereas female self-employment exceeded the male rate by 8.0 percentage points and female informal employment by 7.7 percentage points. Participation measures alone would therefore understate the gendered structure of employment.

Agriculture and the Concentration of Insecure Work

Employment disadvantage was particularly concentrated in agriculture. One-third of women working in agriculture received no payment, and 49.4% worked seasonally, substantially exceeding the corresponding proportions in non-agricultural work (FMoHSW et al., 2025). A binary employment indicator would classify an unpaid seasonal agricultural worker and a year-round cash-remunerated professional identically, despite markedly different access to predictable income, time security and employment-related protection.

Employment and Participation in Healthcare Decisions

The strongest employment-related contrast in the published NDHS tables concerns participation in decisions about one's own healthcare.

Table 4. Employment and Household Decision-making Among Currently Married Women

Employment/remuneration status	Own healthcare decision (%)	All three major decisions (%)	None of the three (%)
Not employed	29.4	20.5	56.7
Employed for cash	58.8	43.3	26.6
Employed without cash remuneration	56.2	43.7	26.6

Source: Nigeria Demographic and Health Survey 2024, Table 15.9.1.

Among currently married women, 58.8% of those employed for cash participated alone or jointly in decisions concerning their own healthcare, compared with 29.4% of women who had not worked. Participation was similarly high among women employed without cash remuneration (56.2%). The large employed/non-employed contrast, alongside the small cash/non-cash difference, is compatible with mechanisms extending beyond earnings, including mobility, social interaction, information and household recognition. It is also possible that women with greater pre-existing autonomy are more able to work. The aggregate data cannot distinguish these explanations.

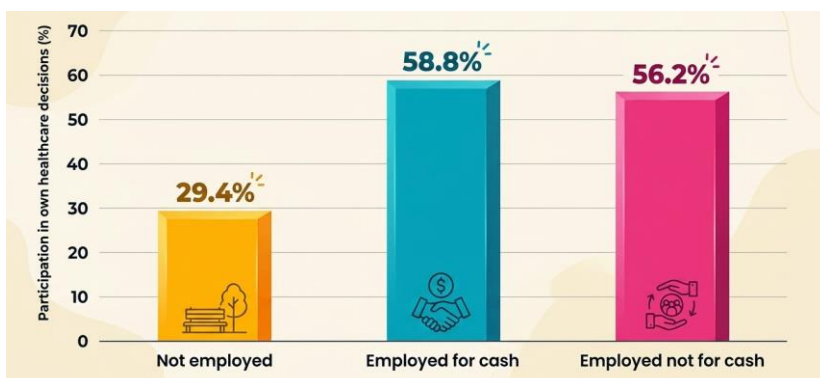


Figure 2. Employment status and women's participation in decisions concerning their own healthcare.

Maternal-Health Context

The 2025-26 NmDHS indicates improvement in maternal-service coverage but persistent inequality. Nationally, 70.7% of women with a recent live birth or stillbirth received skilled antenatal care, 58.5% completed at least four ANC contacts, 50.0% of births were attended by a skilled provider, 47.8% occurred in a health facility, and 49.4% of women received a postnatal check within two days (FMoHSW et al., 2026a). Facility delivery was 64.4% in urban and 37.0% in rural areas, 18.4% among women with no education and 90.5% among those with more than secondary education, and 18.6% in the lowest wealth quintile compared with 85.4% in the highest. It ranged from 20.4% in the North-West to 90.1% in the South-East.

The 2024 NVASA report further estimated a maternal mortality ratio of 572 deaths per 100,000 live births, rising to 656 in rural areas compared with 444 in urban areas (FMoHSW et al., 2026b). Among women who died of maternal causes, 39% had received no ANC, 11% received postpartum care within three days and 26% did not seek care for their fatal illness. These figures illustrate persistent barriers to timely maternal care but are not attributed to employment quality. Because employment and maternal-health indicators cannot be linked at individual level in the published tables, adjusted employment effects are not estimated. Earlier Nigerian studies nevertheless associate healthcare decision-making, employment, education, wealth, residence and access constraints with maternal-health utilisation (Adedokun et al., 2023; Imo, 2022).

Doctrinal Findings and Institutional Fit

Legal Recognition and Worker Coverage

Nigeria's constitutional framework combines enforceable equality protection with broader socioeconomic commitments. Section 42 prohibits specified forms of discrimination, including discrimination on the ground of sex, while section 17(3) addresses livelihoods, humane working conditions, worker health, medical facilities and equal pay. Their legal force is not equivalent: section 42 forms part of the fundamental-rights framework, whereas section 17 is situated within Chapter II and is generally non-justiciable subject to constitutional and legislative qualifications.

The central doctrinal question is therefore one of coverage and enforceability. Conventional labour regulation operates most directly where an identifiable employer-worker relationship exists, yet 87.9% of employed women in Q1 2024 were self-employed and 96.4% worked informally (NBS, 2024). A large proportion of women's work consequently occurs in settings where employer-based entitlements and conventional enforcement mechanisms have limited reach.

Maternity and Employment Protection

Section 54 of the Labour Act contains Nigeria's principal statutory maternity protections, including pre- and post-birth absence, at least half pay for qualifying women with six months of continuous service, nursing breaks and protection against dismissal during maternity absence. These entitlements are significant for covered workers, but their structure presupposes a continuing relationship with an identifiable employer and consequently corresponds imperfectly to a female workforce dominated by self-employment and informality.

The domestic framework also differs from ILO Maternity Protection Convention No. 183, including the Convention's minimum standard of fourteen weeks of maternity leave. Nigeria has not ratified Convention No. 183 or Convention No. 189 on domestic workers. These instruments are therefore not binding on Nigeria by virtue of ratification, but they remain relevant normative benchmarks for evaluating the scope, duration and inclusiveness of existing protection.

Gender Equality, Occupational Health and Dignity at Work

Nigeria has ratified ILO Convention No. 100 on Equal Remuneration, Convention No. 111 on Discrimination in Employment and Occupation, Convention No. 155 on Occupational Safety and Health, Convention No. 187 on the Promotional Framework for Occupational Safety and Health, and Convention No. 190 on Violence and Harassment. Convention No. 190 is particularly relevant to a labour market extending beyond formal

workplaces. The institutional question is whether inspection, enforcement and accessible remedies reach dispersed informal and non-standard work settings in practice.

Health Insurance and Social Protection

The National Health Insurance Authority Act 2022 is less dependent on a standard employment relationship than conventional labour protection because it establishes routes for formal-sector workers, informal-sector populations and vulnerable persons. This architecture is better aligned with Nigeria's labour market, but the existence of a statutory route does not resolve questions of affordability, enrolment, continuity of coverage or the timely flow of funds to implementing institutions.

Recent institutional evidence gives these concerns empirical substance. The 2024 NVASA report documents delayed or non-release of approved MNCH funds, weak budget monitoring and continued dependence on development partners in some settings. It also reports that state health-insurance schemes and the BHCPF reduced out-of-pocket expenditure, improved financial access and encouraged service uptake, although coverage remained uneven (FMoHSW et al., 2026b). The challenge is therefore one of reach, reliability and implementation as well as statutory design. Because NVASA does not separately evaluate the NHIA Vulnerable Group Fund, no claim is made here about its specific operational performance.

The Formal-Informal Protection Gap

The empirical and legal evidence converge on a problem of institutional fit. Much of women's work lies outside standard wage employment, while maternity leave, wage replacement and several workplace protections remain most readily claimed through a recognisable employer–employee relationship. Health-insurance law reaches beyond that model, but its practical effectiveness depends on financing flows, enrolment and continuity of coverage across changing employment circumstances.

Table 5. Doctrinal protection-gap matrix

Analytical domain	Principal instrument	Protection or principle	Empirical relevance	Identified gap
Constitutional socioeconomic protection	Constitution, s 17	Humane working conditions, worker health and welfare, medical facilities, equal pay	Establishes broad normative standards for employment and health	Chapter II protections are generally not directly justiciable because of s 6(6)(c)
Gender equality	Constitution, s 42; ILO C100 and C111	Protection against sex discrimination; equal remuneration	Relevant to gender disparities in work and earnings	Formal equality does not itself overcome occupational and employment-form segregation
Maternity protection	Labour Act, s 54	Maternity absence, partial wage replacement, nursing breaks, dismissal protection	Directly relevant to pregnancy, maternal health and continued employment	Employer-centred protection poorly fits high female self-employment and informality
Occupational health and dignity	ILO C155, C187 and C190	Safe and healthy work; protection from violence and harassment	Relevant to health effects of employment quality	Enforcement is more difficult in dispersed informal workplaces
Maternity benchmark	ILO C183	Modern maternity-protection standard	Relevant to maternity duration and income security	Convention not ratified by Nigeria
Domestic-work benchmark	ILO C189	Protection of domestic workers	Gender-relevant non-standard employment	Convention not ratified by Nigeria

Health insurance	NHIA Act 2022	Formal-sector, informal-sector and vulnerable-person coverage mechanisms	Important given exceptionally high female informality	Effective enrolment and affordability remain distinct from formal entitlement
Informal employment	Labour/social-protection system overall	Combination of employment and social protections	Dominant employment setting for Nigerian women	Fragmentation between labour status and social protection produces coverage discontinuities

Table 5 therefore identifies a gap in reach rather than an absence of protective norms. Women in informal, seasonal, unpaid or self-directed work may be legally visible within broader social-protection frameworks while remaining less able to access employment-based maternity, income and workplace protections in practice.

Integrated Discussion

Employment Quality, Labour-Market Structure and Health Agency

Female labour-force participation alone provides an incomplete account of women's economic position in Nigeria. Although women's participation and employment rates are relatively close to those of men, the organisation of work differs more sharply. Women are more heavily concentrated in self-employment and informal employment, while the NDHS also identifies substantial unpaid, seasonal and occasional work. These distinctions matter for health because the resources generated through employment depend on income regularity, continuity of work and access to enforceable or portable protection, not simply on whether economic activity occurs.

The employment–agency association reinforces this interpretation. Married women who worked, whether for cash or without cash remuneration, reported substantially greater participation in decisions concerning their own healthcare than non-employed women. The small difference between cash and non-cash workers suggests that mobility, social interaction, information and household recognition may matter alongside earnings. Causal direction remains unresolved because more autonomous women may also be better able to enter employment. Employment is therefore treated as one resource that may support agency, not as an independent source of empowerment.

This interpretation is consistent with Kabeer's resources-agency-achievements framework. Employment can enlarge the resources available to women, but those resources acquire empowering significance only to the extent that they expand the capacity to make and act upon valued choices. The distinction between labour-market participation and the quality, control and security of the resources generated through work is consequently central to the findings

Employment Conditions, Maternal Healthcare and Social Protection

The most recent maternal-health indicators complicate any simple progression from employment to health advantage. The 2025–26 NmDHS records higher national maternal-service coverage than the 2024 NDHS on several indicators, yet pronounced inequalities remain by residence, education, wealth and zone. These gradients correspond closely to the same contextual factors repeatedly identified in the autonomy and maternal-health literature, reinforcing the likelihood that employment-health relationships are confounded by socioeconomic and geographic position (FMoHSW et al., 2026a)

Employment conditions may nevertheless shape women's capacity to navigate healthcare constraints. Regular earnings can reduce transport and treatment costs, while predictable work and protected time can lessen the opportunity cost of antenatal appointments and childbirth. Seasonal work, unpaid labour and irregular earnings may have the opposite effect. The NmDHS documents substantial healthcare expenditure, and NVASA participants identify treatment and transport costs as barriers to care, supporting the importance of financial protection without establishing an employment-specific causal effect (FMoHSW et al., 2026a, 2026b).

These pathways cannot be estimated directly from the available data, so maternal-health indicators are interpreted as context rather than consequences of employment quality. Earlier Nigerian studies associate healthcare decision-making, control over resources, employment, education, wealth, residence and access barriers with service use. The present analysis adds a different point: economic activity may coexist with insufficient income security, limited time flexibility or weak social protection, constraining the conversion of agency into effective healthcare access.

Social protection is consequently part of the mechanism rather than a peripheral policy consideration. The NHIA Act provides a legal basis for extending coverage beyond formal payroll employment, while the NVASA evidence indicates that BHCPF and state insurance arrangements can reduce out-of-pocket barriers and improve care-seeking. Yet the same evidence records uneven coverage and financing implementation problems. For women whose earnings and employment status fluctuate, portability and continuity of coverage are therefore as important as formal eligibility.

Institutional Fit, Informal Employment and Maternity Protection

The doctrinal findings reveal a structural tension between the organisation of women's work and the institutional design of employment protection. Nigeria's legal framework contains important protections relating to maternity, dismissal, remuneration, occupational health and equality, but many are most readily operationalised within identifiable and continuing employer–employee relationships. This creates a problem of institutional fit in a labour market where women are predominantly self-employed and informally employed.

Maternity protection illustrates the difficulty most clearly. Entitlements tied to continuous service with a single employer are necessarily less accessible to women whose work is self-directed, seasonal, unpaid within family enterprises or otherwise outside standard employment arrangements. This does not justify treating all informal or self-employed work as precarious; rather, it identifies a structural difference in the accessibility and enforceability of maternity leave, income replacement and related protections.

A more inclusive architecture would attach core protection to the worker rather than a single employment contract. Social-insurance, tax-financed or hybrid mechanisms could preserve maternity income protection across employment transitions, while health coverage would remain continuous during periods of self-employment, irregular work or unpaid family activity. The institutional problem is one of uneven reach: legal norms exist, but their effectiveness depends on financing, enrolment and enforcement mechanisms suited to women's actual employment arrangements. NVASA evidence on uneven insurance coverage and delayed financing reinforces the distinction between formal entitlement and effective protection.

Strengths and Limitations

A principal strength of the study is the integration of recent national employment evidence with legal and social-protection arrangements relevant to women's health. It also disaggregates several dimensions of employment quality rather than treating employment status as a sufficient indicator of economic position, and uses the 2025–26 NmDHS and 2024 NVASA reports to strengthen temporal and institutional contextualisation.

The principal limitation arises from reliance on published aggregate tables. These data cannot adjust the association between employment and healthcare decision-making for individual, household and contextual confounders, nor can they jointly cross-classify health-related agency or maternal-health indicators with employment continuity, employer type, sector, informality or occupation. Individual-level 2024 NDHS microdata were not available to the study at the time of analysis.

The NDHS, NLFS and NmDHS differ in survey design, reference populations and employment or health definitions; their estimates are therefore complementary rather than directly interchangeable. The NVASA qualitative findings are based on purposive sampling in selected settings and are used to illuminate implementation mechanisms, not to estimate national prevalence. Doctrinal analysis identifies formal entitlements and institutional design but cannot independently establish the extent of enforcement or practical access.

Future research using individual-level 2024 NDHS data should examine employment characteristics, healthcare decision-making and maternal-health outcomes through survey-weighted multivariable models that adjust for, at minimum, education, household wealth, parity, residence and geographic region. Such analysis would permit assessment of independent associations and potential effect heterogeneity that cannot be resolved from aggregate tabulations.

CONCLUSION AND RECOMMENDATIONS

Conclusion

Recent evidence portrays women's employment and health in Nigeria as a problem of both participation and institutional quality. Women are extensively engaged in economic activity, but their employment is disproportionately informal, self-employed and, for substantial minorities, seasonal or unpaid. Employment is also descriptively associated with greater participation in decisions concerning one's own healthcare, although the available aggregate data cannot determine whether this relationship reflects employment effects, selection into work or shared socioeconomic determinants.

The wider health and institutional evidence sharpens the significance of that finding. The 2025-26 NmDHS shows improvement in several maternal-care indicators but persistent inequalities by residence, education, wealth and region, while the 2024 NVASA report documents a continuing maternal-mortality burden and financing barriers alongside evidence that BHCPS and state insurance arrangements can improve financial access. The legal analysis shows that employment-based maternity and workplace protections remain most accessible within conventional employment, whereas health-insurance law is broader but dependent on effective financing, enrolment and implementation.

Taken together, the evidence supports an analytical and policy focus extending beyond female employment participation to the quality of work, control over resources and continuity of protection. For women concentrated in informal and irregular employment, the public-health value of work depends partly on whether maternity income security and health coverage remain accessible when employment status, earnings or employer relationships change.

Recommendations

1. Labour-market monitoring should treat female participation as one component of economic inclusion rather than its endpoint. Routine reporting should include gender-disaggregated measures of remuneration, employment continuity, informality, occupational position and access to social protection so that expansion of work opportunities can be distinguished from improvements in work quality and security.
2. Labour and maternity protection should be recalibrated to contemporary employment heterogeneity. Reform should clarify how core protections extend to economically dependent, casual, domestic and other non-standard workers and review maternity entitlements against ILO Convention No. 183. Ratification would have greater substantive value if accompanied by domestic provisions capable of reaching women outside continuous formal employment.
3. Portable maternity income protection should follow the woman rather than a single employer. A dedicated cash benefit could combine public financing, social-insurance contributions and targeted subsidies, with eligibility maintained across employment transitions. For low-income and informally employed women, enrolment at antenatal-care contact points could provide a practical access route, with eligibility linked to existing health-insurance or national identification systems rather than proof of continuous service.
4. Informal-sector contribution arrangements should reflect irregular cash flow. Small weekly or monthly payments through USSD, mobile-money or agent networks could reduce the barrier created by annual lump-sum premiums, while seasonal schedules could accommodate cyclical earnings. Market

associations, cooperatives and women's trader groups could serve as enrolment and collection channels, linking existing dues to voluntary micro-contributions and matched public subsidies rather than imposing new regressive levies.

5. Implementation of the NHIA Act and BHCPF should emphasise continuity, targeting and accountability. NVASA evidence on delayed fund release and uneven insurance coverage supports digital tracking of transfers, transparent reporting of disbursement and enrolment, and mechanisms that preserve coverage across employment changes. Low-income pregnant women could receive fully or substantially subsidised contributions through the vulnerable-group and BHCPF architecture with state counterpart funding and clear audit rules.
6. Maternal-health programmes should incorporate employment constraints into assessments of access to care. Lost earnings, inflexible work, limited control over income and transport costs may affect continuity of care even where services are nominally available. Future individual-level NDHS analysis should test whether employment-quality dimensions remain associated with healthcare decision-making and maternal-health utilisation after adjustment for wealth, parity, education, residence and geographic region.

REFERENCES

1. Adedokun, S. T., Uthman, O. A., & Bisiriyu, L. A. (2023). Determinants of Partial and Adequate Maternal Health Services Utilisation in Nigeria: Analysis of Cross-Sectional Survey. *BMC Pregnancy and Childbirth*, 23, 457.
2. African Union. (2003). Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. African Union.
3. Ahonen, E. Q., Winkler, M. R., Bosmans, K., Gunn, V., & Julià, M. (2025). Could Better-Quality Employment Improve Population Health? Findings from a Scoping Review of Multi-Dimensional Employment Quality Research and a Proposed Research Direction. *American Journal Of Industrial Medicine*, 68(3), 225-249.
4. Benach, J., Vives, A., Amable, M., Vanroelen, C., Tarafa, G., & Muntaner, C. (2014). Precarious Employment: Understanding an Emerging Social Determinant of Health. *Annual Review of Public Health*, 35, 229-253.
5. Chol, C., Negin, J., Agho, K. E., & Cumming, R. G. (2019). Women's Autonomy and Utilisation of Maternal Healthcare Services In 31 Sub-Saharan African Countries: Results from the Demographic and Health Surveys, 2010-2016. *BMJ Open*, 9(3)
6. Constitution of The Federal Republic of Nigeria 1999 (As Amended).
7. Employment Conditions Knowledge Network. (2007). Employment Conditions and Health Inequalities: Final Report to The WHO Commission on Social Determinants of Health. World Health Organisation.
8. Ewerling, F., Lynch, J. W., Victora, C. G., Van Eerdewijk, A., Tyszler, M., & Barros, A. J. D. (2017). The SWPER Index for Women's Empowerment in Africa: Development and Validation of an Index Based on Survey Data. *The Lancet Global Health*, 5(9), E916-E923.
9. Ewerling, F., Raj, A., Victora, C. G., Hellwig, F., Coll, C. V. N., & Barros, A. J. D. (2020). SWPER Global: A Survey-Based Women's Empowerment Index Expanded from Africa to All Low- and Middle-Income Countries. *Journal of Global Health*, 10(2), 020434.
10. Federal Ministry of Health And Social Welfare of Nigeria, National Population Commission [Nigeria], & ICF. (2025). Nigeria Demographic and Health Survey 2024.
11. Federal Ministry of Health and Social Welfare of Nigeria, National Population Commission, & ICF (2026a). Nigeria Verbal Autopsy and Social Autopsy Study 2024: Main report
12. Federal Ministry of Health and Social Welfare [Nigeria], National Population Commission [Nigeria], & ICF. (2026b). Nigeria Verbal Autopsy and Social Autopsy Study 2024: Main Report
13. Gebeyehu, N. A., Gelaw, K. A., Lake, E. A., Adela, G. A., Tegegne, K. D., & Shewangashaw, N. E. (2022). Women Decision-Making Autonomy on Maternal Health Service and Associated Factors in Low- and Middle-Income Countries: Systematic Review and Meta-Analysis. *Women's Health*, 18, 17455057221122618.

14. Hajat, A., Andrea, S. B., Oddo, V. M., Winkler, M. R., & Ahonen, E. Q. (2024). Ramifications of Precarious Employment for Health and Health Inequity: Emerging Trends from the Americas. *Annual Review of Public Health*, 45(1), 235-251.
15. Idris, I. B., Hamis, A. A., Bukhori, A. B. M., Hoong, D. C., Yusop, H., Shaharuddin, M. A-A, Fawwazah, N. A., & Kandayah, T. (2023). Women's Autonomy In Healthcare Decision-Making: A Systematic Review. *BMC Women's Health*, 23, 643.
16. Ifelunini, I. A., Agbutun, A. S., Ugwu, S. C., & Ugwu, M. O. (2022). Women Autonomy and Demand For Maternal Health Services in Nigeria: Evidence from the Nigeria Demographic and Health Survey. *African Journal of Reproductive Health*, 26(4), 65-74.
17. Imo, C. K. (2022). Influence of Women's Decision-Making Autonomy on Antenatal Care Utilisation and Institutional Delivery Services in Nigeria: Evidence from the Nigeria Demographic and Health Survey 2018. *BMC Pregnancy and Childbirth*, 22, 141.
18. International Labour Organisation. (1951). Equal Remuneration Convention, 1951 (No. 100). International Labour Organisation.
19. International Labour Organisation. (1958). Discrimination (Employment and Occupation) Convention, 1958 (No. 111). International Labour Organisation.
20. International Labour Organisation. (1981). Occupational Safety and Health Convention, 1981 (No. 155). International Labour Organisation.
21. International Labour Organisation. (2000). Maternity Protection Convention, 2000 (No. 183). International Labour Organisation.
22. International Labour Organisation. (2006). Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187). International Labour Organisation.
23. International Labour Organisation. (2011). Domestic Workers Convention, 2011 (No. 189). International Labour Organisation.
24. International Labour Organisation. (2018). Women and Men in The Informal Economy: A Statistical Picture (3rd Ed.). International Labour Office.
25. International Labour Organisation. (2019). Violence And Harassment Convention, 2019 (No. 190). International Labour Organisation.
26. International Labour Organisation. (2020, January 27). Measuring Job Quality: Difficult but Necessary. ILOSTAT.
27. International Labour Organisation. (2022). Engendering Informality Statistics: Gaps and Opportunities (ILO Working Paper No. 84). International Labour Organisation.
28. International Labour Organisation. (2024). World Social Protection Report 2024-26: Universal Social Protection for Climate Action and a Just Transition. International Labour Office.
29. International Labour Organisation & United Nations Development Programme. (2021). Informality and Social Protection in African Countries: A Forward-Looking Assessment of Contributory Schemes. International Labour Organisation & United Nations Development Programme.
30. Jaydarifard, S., Smith, S. S., Mann, D., Rossa, K. R., Salehi, E. N., Srinivasan, A. G., & Soleimanloo, S. S. (2023). Precarious Employment and Associated Health and Social Consequences: A Systematic Review. *Australian and New Zealand Journal of Public Health*, 47(4), 100074.
31. Kabeer, N. (1999). Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment. *Development and Change*, 30(3), 435-464.
32. Kreshpaj, B., Orellana, C., Burström, B., Davis, L., Hemmingsson, T., Johansson, G., Kjellberg, K., Jonsson, J., Wegman, D. H., & Bodin, T. (2020). What is Precarious Employment? A Systematic Review of Definitions and Operationalisations from Quantitative and Qualitative Studies. *Scandinavian Journal of Work, Environment & Health*, 46(3), 235-247.
33. Labour Act, Cap L1, Laws of the Federation of Nigeria 2004.
34. National Bureau of Statistics. (2024). Nigeria Labour Force Survey Q1 2024. National Bureau of Statistics.
35. National Health Act 2014. <https://p4h.world/en/documents/national-health-act-2014/>
36. National Health Insurance Authority Act 2022, No. 17. <https://www.nhia.gov.ng/wp-content/uploads/2024/03/NHIA-Act-2022-Gazetted-Copy.pdf>

37. Negash, W. D., Kefale, G. T., Belachew, T. B., & Asmamaw, D. B. (2023). Married Women's Decision-Making Autonomy on Health Care Utilisation in High-Fertility Sub-Saharan African Countries: A Multilevel Analysis of Recent Demographic and Health Survey. *PLOS ONE*, 18(7), E0288603.
38. Odusina, E. K., & Oladele, O. S. (2023). Is There a Link Between the Autonomy of Women and Maternal Healthcare Utilisation in Nigeria? A Cross-Sectional Survey. *BMC Women's Health*, 23, 167.
39. Osamor, P. E., & Grady, C. (2018). Factors Associated With Women's Health Care Decision-Making Autonomy: Empirical Evidence from Nigeria. *Journal of Biosocial Science*, 50(1), 70-85.
40. Shipanga, I., Oyedele, O., & Kazembe, L. (2026). Women's Empowerment Measurements In Sub-Saharan Africa: A Systematic Literature Review. *Women's Health*, 22, 17455057251401817.
41. Tafere, T. Z., Aschalew, A. Y., Kefale, G. T., Dellie, E., Worku, N., Tsehay, C. T., Hagos, A., & Baykemagn, N. D. (2026). Individual and Community-Level Determinants of Women's Healthcare Decision-Making Autonomy in Extremely High and Very High Maternal Mortality Sub-Saharan African Countries: A Multilevel Mixed-Effects Analysis. *BMJ Open*, 16(7), E111914.
42. United Nations. (1979). Convention on the Elimination of All Forms of Discrimination Against Women. United Nations.