



Research Article

Sustainable Development Goals, Democratic Governance, and Maternal Health in Nigeria: A Sociological Assessment

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Abstract

Maternal mortality remains one of the starkest indicators of social inequality and institutional failure in Nigeria, a country that accounts for a disproportionate share of global maternal deaths despite its enormous human and material resources. This paper offers a sociological assessment of the relationship between the Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality), democratic governance, and maternal health outcomes in Nigeria. Drawing on secondary data from the Nigeria Demographic and Health Survey, the World Health Organization, the World Bank, and civil-society budget analyses, the paper situates maternal mortality within a broader framework of structural functionalism, the social determinants of health, and institutional/governance theory. It argues that maternal death in Nigeria is not merely a clinical or logistical failure but a manifestation of weak democratic accountability, poor fiscal commitment to health, entrenched patriarchal norms, and uneven federal governance that leaves subnational health systems fragile and under-resourced. The paper reviews Nigeria's trajectory from military rule to the Fourth Republic, evaluates progress toward SDG 3.1, and identifies the sociological mechanisms corruption, elite capture, weak citizen participation, and gendered power relations that mediate the governance-health nexus. It concludes with policy-relevant recommendations anchored in strengthening democratic institutions, community participation, and gender-responsive budgeting as pathways to reducing maternal mortality and advancing the SDGs by 2030 and beyond.

Keywords

Sustainable Development Goals, Democratic Governance, Maternal Health, Maternal Mortality, Nigeria, Sociology of Health, Social Determinants of Health

1. Introduction

1.1. Background to the Study

The health of a mother during pregnancy, childbirth, and

the postpartum period is widely regarded as one of the most sensitive barometers of a society's development, the functioning of its institutions, and the value it places on the lives of women. In Nigeria, this barometer has consistently registered

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distress. Global estimates place Nigeria's maternal mortality ratio (MMR) among the highest in the world, with modelled estimates from the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), and the World Bank placing the figure at 993 deaths per 100,000 live births in 2023, compared with a global average of 197 and an African regional average of 442 [1]. Nigeria alone is estimated to account for nearly 28.5 percent of maternal deaths recorded worldwide, giving a Nigerian woman a lifetime risk of dying from pregnancy-related causes of roughly 1 in 19, compared with 1 in 4,900 in the most developed countries [2, 3].

These figures are not simply medical statistics; they are sociological facts in the Durkheimian sense patterned, structured, and reproduced by the organisation of Nigerian society itself. Maternal death in Nigeria is unevenly distributed: it is concentrated among poor households, rural communities, and the northern geopolitical zones, and it is inseparable from questions of education, income, infrastructure, security, and the capacity of the state to deliver basic services [4, 5]. It is this patterning the fact that where and to whom one is born predicts whether one's mother survives childbirth that makes maternal mortality a matter for sociological, and not only biomedical, inquiry.

The year 2015 marked the transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs), a normative and policy framework adopted by 193 United Nations (UN) member states, including Nigeria. SDG 3 commits states to "ensure healthy lives and promote well-being for all at all ages," with target 3.1 specifically calling for the reduction of the global maternal mortality ratio to fewer than 70 per 100,000 live births by 2030. Nigeria's own trajectory whether measured by the Nigeria Demographic and Health Survey (NDHS) household-based estimate of 512 deaths per 100,000 live births in the period preceding the 2018 survey, or by internationally modelled estimates falls far short of this benchmark, and at current rates of progress the country is unlikely to meet the target within the stipulated timeframe [4, 6].

At the same time, Nigeria has, since 1999, operated as an unbroken (if imperfect) democracy the longest uninterrupted civilian rule in its post-independence history. This is significant because democratic governance is widely theorised, in both political sociology and public health scholarship, as a facilitating condition for improved social welfare outcomes: democracies are expected to be more responsive to citizen needs, more transparent in resource allocation, and more accountable through periodic elections, an active civil society, and a free press [7, 8]. Yet more than two decades into Nigeria's Fourth Republic, the promise of democratic dividends has not translated into commensurate improvements in maternal survival. This paradox sustained electoral democracy alongside persistently poor maternal health outcomes is the central puzzle this paper interrogates.

This paper therefore undertakes a sociological assessment

of the intersection between the SDG agenda, the practice of democratic governance, and maternal health outcomes in Nigeria. It asks: how, and through what mechanisms, does the character of Nigeria's democratic governance shape the country's capacity to reduce maternal mortality and achieve SDG 3? The paper proceeds by reviewing the relevant literature and theory, describing its methodology, presenting an integrated analysis and interpretation of the structural, cultural, and institutional mechanisms linking governance to maternal outcomes, and concluding with policy-oriented recommendations.

1.2. Statement of the Problem

Nigeria's maternal health crisis persists despite the existence of a national policy architecture ostensibly designed to address it: a National Health Policy, a National Strategic Health Development Plan, a Basic Health Care Provision Fund, and formal domestication of the SDGs through the Office of the Senior Special Assistant to the President on SDGs. The persistence of high maternal mortality in the presence of these frameworks suggests that the problem is not primarily one of policy design but of governance of the will, capacity, and accountability structures required to translate policy into practice.

Three specific governance deficits are implicated. First, chronic underfunding: Nigeria pledged, under the 2001 Abuja Declaration, to allocate at least 15 percent of its annual budget to health, yet allocations have hovered between 4 and 6 percent for over two decades, reaching only about 5.2–5.4 percent in the 2025 federal budget, leaving a funding gap of trillions of naira relative to the pledged benchmark [9, 10]. Second, weak subnational accountability: because primary health care the frontline platform for antenatal, delivery, and postnatal services is constitutionally the responsibility of local governments, and because local government autonomy and fiscal transparency in Nigeria remain compromised by state-level control of the joint account system, service delivery is highly uneven and vulnerable to elite capture and corruption [11]. Third, weak citizen voice: despite regular elections, mechanisms for citizens particularly rural women to hold health officials and elected representatives accountable for service failures remain underdeveloped.

The problem, then, is not the absence of goals but a governance deficit that undermines their realisation. This paper treats that deficit as a sociological object of analysis, examining how power, culture, and institutions in Nigeria's democracy combine to produce and reproduce maternal mortality as a social outcome.

1.3. Objectives of the Study

This paper is guided by the following objectives: (i) to examine the trajectory of Nigeria's engagement with the Sustainable Development Goals, with specific reference to SDG 3.1

on maternal mortality; (ii) to assess the character of democratic governance in Nigeria's Fourth Republic and its implications for public health financing and service delivery; (iii) to identify, from a sociological standpoint, the structural, cultural, and institutional mechanisms that link the quality of democratic governance to maternal health outcomes; and (iv) to propose evidence-informed, sociologically grounded recommendations for strengthening the governance-health nexus in pursuit of the SDGs.

2. Literature Review

2.1. Theoretical Framework

This paper draws on three complementary theoretical perspectives: structural functionalism, the social determinants of health framework, and institutional/governance theory.

Structural Functionalism

Structural functionalism, associated with Talcott Parsons [12] and elaborated in medical sociology through the concept of the "sick role," conceives of society as a system of interrelated institutions the family, the economy, the polity, and the health system each performing functions necessary for social equilibrium. Applied to maternal health, functionalism directs attention to how the political institution (the state and its democratic apparatus) is expected to perform an integrative and adaptive function: mobilising and allocating resources so that other subsystems, including the health system, can perform their roles. When the political subsystem fails to adequately resource and coordinate the health subsystem as reflected in chronic sub-Abuja-Declaration budgeting the entire system experiences dysfunction, manifested in outcomes such as high maternal mortality. Functionalism therefore provides a systemic lens for understanding maternal death not as an isolated clinical event but as evidence of a breakdown in the coordination between political and health institutions.

Social Determinants of Health

The World Health Organization's Commission on Social Determinants of Health [13] argues that health inequities arise from the unequal distribution of power, money, and resources the "causes of the causes" of ill health. Maternal mortality in Nigeria is patterned along the same axes of inequality that structure Nigerian society more broadly: income, rural-urban residence, education, and region. This framework is valuable because it resists reducing maternal death to individual behaviour (for example, "delay in seeking care") and instead locates the problem within the socio-economic and political structures that determine whether a pregnant woman has access to a functioning primary health centre, a skilled birth attendant, an all-weather road, or the means to pay for emergency obstetric care. Governance is, in this framework, itself a social determinant: the quality of governance shapes the distribution of the more proximate determinants of maternal survival.

Institutional and Governance Theory

Institutional theory, as developed in the work of scholars

such as Douglass North [14] and applied to African governance by Bratton and van de Walle [15], emphasises that formal democratic rules (constitutions, elections, federalism) do not automatically produce good governance outcomes; informal institutions patron-client networks, elite bargains, and neopatrimonial practices often subvert formal rules. This perspective is central to understanding the Nigerian case, where the formal architecture of democracy (regular elections, a federal structure, statutory health financing instruments) coexists with informal practices of corruption, budget padding, and weak enforcement that hollow out the substantive accountability democracy is meant to provide. Together, these three frameworks allow the paper to move from the macro-institutional (democratic governance) to the meso-structural (resource allocation and health-system organisation) and finally to the micro-level lived experience of maternal risk.

2.2. The SDGs and Maternal Health: Global and Nigerian Context

The transition from the MDGs to the SDGs broadened the health agenda from a narrow focus on mortality reduction (MDG 5) to a more integrated commitment to universal health coverage, encompassing reproductive, maternal, newborn, and child health alongside health systems strengthening [16]. SDG target 3.1 sets a global MMR target of fewer than 70 per 100,000 live births by 2030, while target 3.8 calls for universal health coverage, including financial risk protection. Nigeria formally domesticated the SDGs, establishing an Office of the Senior Special Assistant to the President on SDGs and aligning its National Development Plan (2021–2025) with the goals. However, the country's progress reports and independent assessments consistently describe maternal and child health as among the SDG targets furthest off-track [17].

The 2023–2024 Nigeria Demographic and Health Survey, conducted by the National Population Commission with ICF and technical partners, remains the most authoritative household-based source of maternal and child health data in the country, covering fertility, antenatal and delivery care, nutrition, and mortality across Nigeria's six geopolitical zones [18, 19], although its published reports do not include an updated direct estimate of the maternal mortality ratio. Comparative analyses of the 2018 and 2023–24 surveys show that while some indicators such as immunisation coverage have modestly improved, progress on maternal mortality and skilled birth attendance remains slow and highly uneven across zones, with the North East and North West lagging significantly behind the South West and South East [20].

2.3. Democratic Governance in Nigeria's Fourth Republic

Nigeria's return to civilian rule in 1999 ended over fifteen years of military governance and inaugurated what is now the

country's longest period of continuous democratic rule. Scholars of Nigerian politics have documented a persistent gap, however, between the formal institutions of democracy periodic elections, a bicameral legislature, an independent judiciary, and a federal system with 36 states and 774 local government areas and the substantive quality of governance those institutions produce [21, 22]. Corruption is frequently identified as the central mediating variable: Chatham House's Social Norms and Accountable Governance research programme describes corrupt practice as deeply entrenched across Nigerian politics, public administration, law enforcement, and the judiciary, undermining the delivery of basic services even as most Nigerians profess disapproval of the practice [23].

This entrenchment has direct implications for health governance. A 2026 qualitative study of subnational primary health care governance in Nigeria found that weaknesses in human resource management, budgetary discipline, and enforcement of regulations at the state and local government level create conditions conducive to poor accountability and corruption within the health system [11]. Similarly, comparative public-administration scholarship on service delivery in Nigeria attributes much of the country's developmental underperformance to a governance paradigm in which formal accountability mechanisms such as legislative oversight and budget monitoring are rarely activated in practice [24].

2.4. Maternal Health Financing and Fiscal Governance

A recurring theme in the literature is the gap between Nigeria's stated fiscal commitments to health and its actual budgetary practice. Under the 2001 Abuja Declaration, African Union member states, including Nigeria, pledged to allocate at least 15 percent of national budgets to the health sector. Independent civil-society budget analyses show that Nigeria has never met this target in the twenty-four years since the pledge; allocations peaked at roughly 6.2 percent in 2012 and have generally ranged between 4 and 6 percent, with the 2024 federal budget allocating approximately 5 percent (₦1.33 trillion) and the 2025 budget approximately 5.2–5.4 percent (₦2.48 trillion), depending on whether proposed or approved budget totals are used, leaving funding gaps in the trillions of naira relative to the Abuja benchmark [9, 10, 25]. This chronic underfunding translates directly into shortages of skilled birth attendants, non-functional primary health centres, stock-outs of essential obstetric commodities, and high out-of-pocket health expenditure estimated at around 70 percent of total health spending which in turn discourages poor households from seeking timely maternal care [25].

2.5. Sociological Studies of Maternal Health-Seeking Behaviour

Nigerian medical sociologists have long documented how cultural and gendered factors mediate maternal health-seeking

behaviour, including the "three delays" model delay in deciding to seek care, delay in reaching a facility, and delay in receiving adequate care once at a facility [26, 27]. These delays are not purely individual choices; they are shaped by household decision-making power, the availability and cost of transport, the geographic distribution of functional facilities, and the responsiveness of the state to invest in rural infrastructure. Insecurity compounds these dynamics in the North East, where protracted conflict has displaced millions and disrupted health-seeking pathways, contributing to the zone recording some of the country's worst maternal and newborn health outcomes [3].

2.6. Comparative Insights from Other African Democracies

Placing Nigeria in comparative perspective sharpens the analytical point that democracy alone does not guarantee good maternal health governance; the quality and consistency of democratic institutions matter more than their mere presence. Rwanda, despite a more constrained multiparty political space than Nigeria, has achieved a dramatic reduction in maternal mortality over the past two decades through sustained state-led investment in community-based health insurance, performance-based financing for health facilities, and a highly centralised, closely monitored implementation architecture [28]. Ghana, a more directly comparable multiparty democracy, has likewise made steadier progress toward SDG 3.1 than Nigeria, aided by its National Health Insurance Scheme, more consistent (though still imperfect) health budget execution, and a more functionally autonomous local government tier. These comparisons suggest that the decisive variable is not simply whether a country holds elections, but whether its governing institutions can sustain policy commitments such as health financing benchmarks across electoral cycles and administrations without being captured or diluted by patronage politics. Nigeria's federal structure, oil-dependent fiscal base, and scale (with a population exceeding 220 million spread across 36 states) present coordination challenges that are qualitatively different from, and in some respects more difficult than, those faced by smaller or more centralised African states, but the comparative evidence nonetheless indicates that stronger implementation discipline, rather than any inherent incompatibility between democracy and maternal health improvement, is the binding constraint.

2.7. Civil Society, the Media, and Health Accountability

A further strand of the literature examines the role of non-state actors in mediating the relationship between governance and health outcomes. Nigerian civil-society organisations including the Development Research and Projects Centre, the Centre for Social Justice, the Partnership for Advocacy in Child and Family Health at Scale (PACFaH@Scale), and a

range of maternal-health-focused non-governmental organisations have become increasingly sophisticated in tracking health budget performance, publishing annual scorecards, and engaging legislators directly during budget hearings [9]. Investigative journalism and the growth of digital and social media have similarly expanded the space for public scrutiny of health-sector corruption and service failures, consistent with the broader theoretical expectation that a free press strengthens democratic accountability [8]. However, the literature also cautions that the impact of these accountability efforts on actual policy change remains limited, constrained by weak legal enforcement mechanisms, the absence of binding consequences for budget non-implementation, and the difficulty civil society faces in mobilising the rural, poorly connected communities that bear the heaviest burden of maternal mortality. This gap between vibrant civic monitoring and limited policy responsiveness is itself a sociologically significant feature of Nigeria's democratic governance, illustrating how formal openness can coexist with substantive unaccountability.

2.8. Gap in Literature

While existing scholarship offers valuable insight into Nigeria's SDG performance, democratic governance, and maternal health outcomes considered separately, few studies integrate these three literatures into a single sociological analytical frame. Most governance scholarship treats health outcomes as a downstream illustration of broader institutional failure rather than as a distinct object of analysis in its own right, while much of the public-health literature on maternal mortality in Nigeria treats governance and financing largely as background context rather than as the central explanatory variable. This paper addresses that gap by placing the governance-health nexus itself, understood sociologically, at the centre of the analysis.

3. Methodology

This paper adopts a qualitative, desk-based analytical approach rooted in the sociological tradition of secondary data analysis and document review. It synthesises data and findings from national household surveys (the Nigeria Demographic and Health Survey, 2018 and 2023–24 rounds), international agency reports (WHO, UNICEF, UNFPA, World Bank), government and civil-society budget analyses, and peer-reviewed and grey literature on governance and health systems in Nigeria. Rather than presenting new primary data, the paper's contribution lies in its integrative sociological interpretation: it applies structural-functionalist, social-determinants, and institutional theory to connect governance indicators (budgetary performance, accountability mechanisms, corruption indices) with maternal health outcomes (mortality ratios, skilled birth attendance, facility-based delivery) in a single analytical frame. This approach is consistent with established practice in the sociology of health and illness, where triangulating survey

data, policy documents, and qualitative governance research allows for theoretically informed explanation rather than description alone.

The sources chosen were purposively selected based on four clearly stated criteria. Firstly, pertinence: All of the sources had to contain data or analysis related to the impact of maternal health, health financing or governance in the health sector of Nigeria or theoretical/comparative data directly relevant to the link between health and governance. Secondly, credibility and methodology: Preference was given to nationally representative surveys with known sampling methods (NDHS); internationally produced statistical estimates with known methodology (Maternal Mortality Estimation Inter-Agency Group, UN, reported by WHO and World Bank) and peer-reviewed journal articles; civil society organization budget analysis and media reports were included only when their numbers could be traced to official budget documents. Thirdly, recency: for the statistics, the latest edition of the sources was used and all figures produced between 2024 and 2026 were checked against the original publication of the issuing institution and not against any subsequent reproductions. Lastly, accessibility: preference was given to sources publicly available so that readers can check the figures themselves and whenever they are available, DOIs or stable web addresses are given in the reference list.

Each of the selected sources were then reviewed for internal consistency of the definition and the period of time for which the indicators were measured (such as the difference between proposed versus approved budget values, or estimates based on surveys as opposed to models of maternal mortality rates), and their agreement with other independent sources. In cases of disagreement between the different sources, the discrepancy was noted and reported rather than the easier figure being chosen. If a value did not have an identifiable origin, it was either omitted or its limitation was clearly mentioned (see Section 4.5 and Table 1). The evidence thus evaluated was then synthesized through themes related to the three theoretical perspectives outlined in Section 2.1.

4. Data Analysis and Interpretation

4.1. The Nexus Between Democratic Governance and Maternal Health Outcomes

The relationship between democracy and health is not automatic; it is mediated by specific institutional practices. Comparative political-economy research has shown that democracies tend to outperform autocracies on health outcomes primarily where elections are competitive, the press is free, and civil society can credibly threaten incumbents with electoral or reputational sanction for poor service delivery [8, 29]. Nigeria's democracy possesses the formal architecture for such accountability but struggles to activate it in practice, and

it is in this gap between form and function that the country's maternal health crisis is best understood.

First, at the level of resource allocation, democratic budgeting is meant to reflect a bargain between citizens' welfare needs and elected representatives' incentives to be re-elected. In Nigeria, however, health has consistently lost out in this bargain to sectors such as defence, debt servicing, and recurrent administrative expenditure that are more directly tied to elite patronage networks or perceived security imperatives. The persistent failure to meet the Abuja Declaration's 15 percent benchmark, sustained across multiple administrations and National Assemblies of differing party composition, suggests a structural rather than merely partisan pattern: health financing is not treated as a politically rewarding investment, in part because the costs of underfunding are diffuse and long-term (borne disproportionately by poor rural women), while the benefits of redirecting funds elsewhere are concentrated and immediate for political elites [9].

Second, at the level of subnational governance, Nigeria's federal structure devolves primary health care the platform through which the vast majority of antenatal and normal delivery care should be provided to local governments, which are constitutionally the tier of government closest to citizens and theoretically most accountable to them. In practice, local government autonomy has been substantially eroded by state governors' control over the State Joint Local Government Account, weakening the fiscal independence and accountability of the tier of government most responsible for frontline maternal health services. Agwu et al. [11] found that deficiencies in subnational governance structures including weak human-resource management, inconsistent funding disbursement, and limited regulatory enforcement create an enabling environment for the very corruption and poor accountability that undermine primary health care performance.

Third, democratic accountability depends on citizens' capacity to access information and demand redress. Budget transparency initiatives by Nigerian civil-society organisations (such as budget tracking by the Centre for Social Justice and the health-financing analyses of the Development Research and Projects Centre) have made health budget data more publicly available than at any point in Nigeria's democratic history, yet the translation of this transparency into electoral or legal accountability remains weak. Citizens, especially rural women who bear the direct burden of maternal mortality, are rarely positioned through literacy, organisation, or proximity to power to convert budget information into effective political pressure. This illustrates a core sociological insight: information alone does not produce accountability without corresponding social capital, organisation, and political opportunity structures.

Fourth, corruption functions as a specific mechanism converting weak democratic accountability into poor maternal outcomes. Where health-sector corruption manifests as diversion of drug and equipment procurement funds, ghost health workers on payrolls, or misallocation of the Basic Health Care

Provision Fund, the practical result is non-functional primary health centres exactly where maternal mortality is highest rural, northern, and conflict-affected areas [11, 23]. The persistence of such practices despite Nigeria's anti-corruption institutions (the Economic and Financial Crimes Commission and the Independent Corrupt Practices Commission) reflects what institutional theorists describe as the dominance of informal neopatrimonial rules over formal democratic and legal ones.

4.2. Regional and Rural-Urban Disparities as Governance Signatures

The uneven geography of maternal mortality within Nigeria offers further evidence that governance, rather than culture or geography alone, is the decisive variable. The North West and North East geopolitical zones consistently record maternal and under-five mortality rates several times higher than the South West and South East, a disparity that tracks closely with indicators of governance quality including health budget execution rates, functional primary health centre density, and security conditions rather than with fertility or cultural practice alone [4, 20]. Rural women across all zones face substantially higher maternal risk than urban women, reflecting the concentration of skilled birth attendants, functioning theatres for emergency caesarean section, and blood-transfusion services in state capitals and major cities. This spatial patterning illustrates the social-determinants principle that maternal mortality is not randomly distributed but tracks the same fault lines of infrastructure investment, security, and public-service reach that characterise Nigeria's broader governance landscape. A woman's risk of dying in childbirth is, in this sense, substantially predictable from the quality of governance in the local government area into which she happens to be born.

4.3. Sociological Analysis: Structural, Cultural, and Institutional Factors

Structural Factors

Structurally, Nigeria's maternal health crisis is inseparable from the broader political economy of underdevelopment: an oil-dependent revenue base that concentrates fiscal power at the federal level, weak non-oil taxation that limits citizens' sense of a direct "fiscal contract" with the state, and infrastructural deficits in roads, electricity, and water that compound the difficulty of delivering functional maternal health services, particularly in rural areas. These structural conditions mean that even well-intentioned health policies frequently fail at the point of implementation because the surrounding infrastructural and fiscal environment cannot sustain them.

Cultural Factors

Culturally, patriarchal gender norms continue to shape household decision-making around maternal health-seeking, including decisions about whether, when, and where a woman may seek antenatal or emergency obstetric care, often requiring the consent or financial provision of a husband or male

relative. Son preference, early marriage, and limited female educational attainment in some regions of the country further compound women's structural vulnerability, intersecting with weak governance to produce compounded disadvantage. Additionally, Chatham House's research on Nigerian social norms around corruption suggests that cultural tolerance of patronage and reciprocity while publicly condemned is embedded in everyday transactions, including within health facilities, where informal payments are frequently required to access ostensibly free services, further disadvantaging the poorest women [23].

Institutional Factors

Institutionally, the mismatch between Nigeria's formal federal architecture and the informal practices that govern its operation sometimes termed the "formal-informal institutional gap" is the crucial mediating factor connecting democracy to health outcomes. Elections occur regularly, but they are frequently contested on the basis of identity, patronage distribution, and short-term material inducements rather than sustained policy platforms around service delivery, weakening the incentive for officeholders to prioritise long-horizon investments such as primary health care system strengthening. Legislative oversight of the health budget, while constitutionally robust, is in practice under-resourced and rarely results in sanctions for non-implementation of budgeted health projects. This helps explain the puzzle set out in the introduction: Nigeria's democracy is real in form, but its accountability functions the mechanisms meant to translate citizen need into public resource allocation remain institutionally weak, and it is this weakness, more than the absence of democracy itself, that sustains the country's maternal health crisis.

Intersectionality: Gender, Class, and Region

An intersectional reading of the evidence attentive to how gender, class, and region combine rather than operate in isolation clarifies why aggregate national statistics can understate the severity of risk faced by the most disadvantaged Nigerian women. A poor, rural, northern woman with no formal education experiences a compounding of disadvantage across every social determinant simultaneously: she is least likely to have decision-making autonomy over her own health-seeking, least likely to live within reach of a functional primary health centre, least likely to afford transport or user fees in an emergency, and most likely to reside in an area affected by insecurity or weak local governance. By contrast, an urban, educated, middle-class woman in Lagos or Abuja, even amid the same national governance weaknesses, benefits from proximity to private and public tertiary facilities and greater household bargaining power. This intersectional patterning demonstrates that "Nigeria's" maternal mortality ratio is in fact an aggregate of starkly different underlying risk profiles, and that governance interventions which fail to specifically target the most structurally disadvantaged women rather than assuming uniform national impact are unlikely to meaningfully shift the aggregate figure.

4.4. Challenges to Achieving SDG 3 in Nigeria

Several interlocking challenges constrain Nigeria's progress toward SDG 3.1. Chronic health underfinancing, discussed above, remains the most consistently documented obstacle, compounded by heavy reliance on out-of-pocket spending that excludes the poorest households from timely care. Human resource shortages reflected in Nigeria's ongoing loss of doctors and nurses to large-scale emigration further erode the health workforce needed to staff primary health centres, particularly in rural and northern areas [9]. Insecurity and conflict, especially in the North East and parts of the North West, have displaced millions of people and destroyed health infrastructure, disproportionately affecting the very zones already recording the country's worst maternal outcomes [3].

Weak data systems and the long intervals between nationally representative surveys constrain real-time monitoring of progress, limiting the capacity of both citizens and policymakers to hold government accountable between survey rounds. Federal-state coordination challenges, including inconsistent implementation of the Basic Health Care Provision Fund across states, produce uneven progress that a national-level SDG report can obscure. Finally, the abortion-restrictive legal environment in Nigeria has been identified as a contributing factor to unsafe abortion-related maternal deaths, an issue that remains politically and culturally sensitive and therefore largely absent from mainstream policy debate [5].

A further, often underappreciated, challenge is the sheer scale and diversity of the governance task itself. With more than 220 million people, over 250 ethnic groups, and 774 local government areas operating under widely varying capacity and resource endowments, uniform national policy prescriptions frequently fail to account for the vastly different implementation environments across Nigeria's states. A primary health care financing model that functions reasonably well in a relatively stable, well-resourced southern state may be entirely unworkable in a conflict-affected northern state with limited administrative capacity, and national SDG progress reporting can obscure this variation by presenting single, aggregated indicators. Overcoming this challenge requires not merely more funding or better policy design in the abstract, but governance systems flexible and accountable enough to adapt implementation to radically different subnational contexts precisely the kind of adaptive, responsive capacity that weak democratic accountability currently undermines.

4.5. Summary of Quantitative Data Used in this Study

This section presents, in tabular form, the key quantitative data drawn from secondary sources and used to ground the analysis above. The figures are presented as reported in the cited sources; where sources use different methodologies (for example, household-survey-based versus internationally modelled maternal mortality estimates), this is noted rather than

reconciled, consistent with the paper's methodological approach.

Estimates of maternal mortality rates in Table 1 are quite different and this difference can be explained through methodology and not through any inconsistencies in the evidence. For instance, the NDHS estimate is a direct estimate that uses sibling survival histories (the direct sisterhood method) where women surveyed provide information about the survival status of their sisters. Such measures are based on reference periods of around seven years prior to the survey such that the rate of 512 per 100,000 live births in 2018 refers to an average over 2012-2018 period and has a large confidence interval. Information based on sibling histories is also subject to under-reporting due to deaths that occur among migrating and long dead sisters and because timing of death in relation to pregnancy is poorly reported. On the other hand, the UN inter-agency estimates (993 per 100,000 live births in 2023) are generated using a Bayesian statistical modeling framework that incorporates all available national data, which includes sibling histories in the Demographic and Health Surveys,

along with, along with covariates such as the total fertility rate, gross domestic product per capita, and the proportion of births delivered by skilled birth attendants, while accounting for under-reporting and misclassification in the input data. The estimated number will therefore always be higher than the survey-based estimate in countries where civil registration coverage is not complete, such as Nigeria; it is reported on an annual basis; and each new round updates the entire time series.

There are two important considerations for this study. First, the modelled series is utilized for cross-country comparisons as well as measuring progress towards SDG target 3.1, as it forms the officially accepted indicator for SDG reporting purposes which can be compared across countries and years, while the NDHS data are primarily used for internal analyses of patterns in Nigeria based on zones, place of residence, and socio-economic status. Second, the 2023-2024 NDHS reports have not released any updated direct maternal mortality ratio [19]; the estimate of 512 per 100,000 live births cited in some secondary sources in relation to 2024 is the 2018 figure quoted [5] and is shown as such in Table 1 below.

Table 1. Nigeria's Maternal Mortality Ratio (MMR) in Comparative and Historical Context.

Indicator	Value	Year	Source
NDHS 2018 direct (household-survey-based) MMR	512 per 100,000 live births	2018	[4]
NDHS 2023–24 direct (household-survey-based) MMR	No updated estimate published (the 2018 figure of 512 is restated as 2024 in some secondary sources)	2024	[5, 19]
WHO/UNICEF/UNFPA/World Bank modelled MMR	993 per 100,000 live births	2023	[1, 6]
Nigeria MMR (historical baseline)	1,344 per 100,000 live births	2000	[5]
Global average MMR	197 per 100,000 live births	2023	[1]
African regional average MMR	442 per 100,000 live births	2023	[1]
Nigeria's share of global maternal deaths	28.5%	2020 (reported 2023)	[2]
Lifetime risk of maternal death, Nigeria	1 in 19	2020	[2]
Lifetime risk of maternal death, most developed countries	1 in 4,900	2020	[2]
SDG 3.1 target MMR	Fewer than 70 per 100,000 live births	By 2030	[16]

Source: Compiled by the authors from [1, 2, 4-6, 16, 19]. The NDHS and UN inter-agency (modelled) estimates use different methods and are not directly comparable (see Section 4.5).

Table 2. Federal Government Health Sector Budget Allocation, 2021–2025.

Fiscal Year	Health Sector Allocation (₦)	Approx. % of Total Federal Budget	% of Abuja Declaration Target (15%) Met
2021	₦547 billion	4.5%	30.0%
2022	₦826.9 billion	Not specified in available sources	Not specified in available sources
2023	₦1.17 trillion	Not specified in available sources	Not specified in available sources
2024	₦1.33 trillion	≈5.0%–5.6%	≈33%–37%

Fiscal Year	Health Sector Allocation (₦)	Approx. % of Total Federal Budget	% of Abuja Declaration Target (15%) Met
2025	₦2.48 trillion	≈5.15%	≈34.3%

Source: Compiled by the authors from [9, 10, 25]. Ranges reflect variation between proposed-budget and approved-budget figures cited across sources.

Table 3. Health Sector Share of Nigeria's Total Federal Budget, Selected Years (2015–2025).

Year	Health Allocation (% of Total Federal Budget)	Notes
2015	6.19%	
2016	4.23%	Lowest share in the period reviewed
2017	4.24%	
2024	5.61%	Highest share recorded after 2015
2025	5.15%	

Source: [9]. All years shown remain below the 15% Abuja Declaration benchmark.

5. Conclusion and Recommendation

5.1. Summary and Conclusion

This paper has argued that Nigeria's persistently high maternal mortality, and its consequent underperformance on SDG 3.1, cannot be adequately understood through a purely biomedical or health-systems lens. Rather, maternal death in Nigeria is best understood sociologically as the outcome of a governance deficit embedded within a formally democratic but substantively weak system of accountability. Structural-functionalist, social-determinants, and institutional theoretical perspectives converge on a common conclusion: Nigeria possesses the formal institutions of democracy but has yet to consistently activate the accountability mechanisms fiscal discipline, subnational autonomy, citizen participation, and anti-corruption enforcement necessary to convert democratic governance into improved population health. Achieving the Sustainable Development Goals' maternal health targets will therefore require more than renewed technical or clinical investment; it will require a deliberate sociological and political strategy to close the gap between Nigeria's formal democratic architecture and its substantive practice of accountable, welfare-oriented governance.

5.2. Recommendations

For Government and Policymakers

First, health financing reform: the National Assembly and state houses of assembly should institutionalise a binding, jus-

tifiable mechanism rather than a voluntary declaration obligating progressive movement toward the Abuja Declaration's 15 percent benchmark, complemented by expansion of the Basic Health Care Provision Fund and health insurance schemes that reduce reliance on out-of-pocket payment for maternal services.

Second, strengthening subnational accountability: genuine local government fiscal autonomy, including direct disbursement from the Federation Account rather than routing through state joint accounts, would restore the accountability link between citizens and the tier of government most responsible for primary health care, alongside strengthened monitoring of the Basic Health Care Provision Fund's implementation at facility level.

For Health Programme Managers and Civil Society

Third, community-based social accountability mechanisms: investment in ward-level health committees, participatory budget tracking by community-based organisations, and support for civil-society budget-monitoring initiatives can help convert budget transparency into effective citizen pressure, particularly when paired with efforts to build the organisational capacity of rural women's groups.

Fourth, gender-responsive governance: expanding girls' education, delaying age at first marriage, and increasing women's representation in local and state legislative bodies can shift the cultural and political incentive structures that currently deprioritise maternal health investment, consistent with SDG 5's emphasis on gender equality as a cross-cutting enabler of SDG 3.

For Long-Term System Strengthening

Fifth, security and infrastructure investment: sustained investment in rebuilding health infrastructure and restoring security in conflict-affected zones, alongside rural road and

electrification programmes, is a precondition for translating any financing or policy reform into actual service access in the areas of highest maternal risk.

Sixth, strengthening data and oversight systems: more frequent, subnationally disaggregated health data collection, alongside stronger legislative oversight capacity and civil-society budget-tracking partnerships with the National Assembly, would improve the timeliness and credibility of accountability mechanisms between national surveys.

5.3. Limitations of the Study

As a desk-based, secondary-data synthesis, this paper is subject to several limitations that should inform how its conclusions are read. It relies on nationally representative but periodically collected survey data, meaning that the most recent indicators available at the time of writing may not fully capture very recent policy changes or shocks. The modelled MMR estimates produced by international agencies and the household-based estimates derived directly from the Demographic and Health Survey use different methodologies and are not always directly comparable, a discrepancy that is itself noted in the literature and that this paper has sought to present transparently rather than reconcile artificially. Finally, because the analysis is conducted at a predominantly national and zonal level, it cannot capture the fine-grained, facility-level or individual-level qualitative dynamics that a primary ethnographic or interview-based study of maternal health governance would reveal; the paper's sociological claims about mechanisms are therefore best understood as theoretically grounded interpretations of secondary evidence, offered to guide and ideally to be tested further by future primary research.

There are biases associated with reliance on secondary data and policy documents as well. The official government documents and the SDG progress reports tend to paint a good picture of performance, while the budget analysis done by civil society groups, though important in terms of transparency, come from organisations whose motive is to push for more expenditure on health and hence could have a bias towards highlighting under spending. The budget estimates are different depending on whether the budget estimates being considered are proposed, approved, or allocated, and the media analysis will not always clarify this issue. Publication bias and selective bias also impact the body of knowledge because studies and reports that appear in the literature focus on those geographic locations and issues that receive funding and media coverage, while conflict zones can get underrepresented due to the difficulty in collecting data from them. Lastly, as in any form of interpretive desk study, the choice and analysis of sources depends on the judgement of the authors. This report tried to reduce such biases by using a triangulation of independent sources, choosing primary sources over secondary ones, and pointing out discrepant data among sources.

Abbreviations

MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
NDHS	Nigeria Demographic and Health Survey
PACFaH@Scale	Partnership for Advocacy in Child and Family Health at Scale
SDGs	Sustainable Development Goals
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Author Contributions

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Mamuda Abubakar: Data curation, Investigation, Validation, Writing – review & editing

Suleiman Kawuwa: Resources, Supervision, Visualization, Writing – review & editing

Conflicts of Interest

The authors declare no conflicts of interest.

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