THE POLITICAL ISSUES IN MATERNAL MORTALITY IN NIGERIA: A SOCIOLOGICAL PERSPECTIVE

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Abstract
Maternal mortality in Nigeria remains alarmingly high, despite decades of global and national interventions. This article explores the political determinants of maternal mortality in Nigeria from a sociological perspective, focusing on governance, financing, accountability, corruption, and conflict as upstream factors shaping maternal health outcomes. Using a qualitative research design — including key informant interviews, focus group discussions, and document review — the study examines how political structures and processes translate into service delivery failures and ultimately maternal deaths. The literature review highlights a gap in mechanistic tracing of how political decisions at state and local levels produce concrete maternal health outcomes; this study addresses that gap by offering in-depth process evidence, contextualizing women lived experience, and illustrating governance pathways. From the mixed research approach used, the findings suggest that under-resourced health systems, weak accountability, fragmented governance, and political neglect of maternal health are central to persistent maternal mortality in Nigeria. The article concludes with policy recommendations to strengthen political commitment, enhance transparency in health financing and procurement, and deepen civic accountability for maternal survival.
Keywords: Maternal mortality, governance, health financing, political accountability, corruption

Introduction
Maternal mortality — the death of a woman during pregnancy, childbirth or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, remains one of the most critical indicators of health equity and state capacity (World Health Organization [WHO], n.d.). Nigeria continues to contribute disproportionately to the global burden of maternal mortality (World Bank, n.d.; Wright, (2024). While clinical causes such as haemorrhages, hypertensive disorders, sepsis, obstructed labour and unsafe abortion are widely recognized (Meh, 2019; Olonade, 2019), a growing body of scholarship argues that political and governance factors play a pivotal upstream role. According to Toffolutti, (2023), countries with higher levels of bribery tend to exhibit worse maternal outcomes. Musa (2022) contends that political prioritization of reproductive health remains weak in many Nigerian states, compounding service delivery gaps.

This article situates maternal mortality in Nigeria not merely as a medical issue but as a manifestation of power, policy and resource politics. Through a sociological lens, it examines how political structures, decision processes and governance failures translate into concrete deficiencies in maternal health infrastructure, financing, accountability and equity. The goal is two-fold: (a) to map and analyse political determinants of maternal deaths; and (b) to offer a robust research design and policy prescriptions rooted in political realism and institutional reform.

Statement of the Problem
Despite Nigeria's commitments under global initiatives like the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs), maternal mortality remains unacceptably high. The Nigeria Demographic and Health Survey (NDHS) 2018 reports wide interstate variation in maternal health indicators, signalling that national averages mask profound local inequalities NPC (2019). According to Okungbowa (2024), political decisions on health budgets and inter-governmental transfers substantially influence health outcomes across sub-Saharan Africa. Yet in Nigeria there is a gap in precisely tracing how political allocations, governance structures, corruption and informal payments influence maternal health service delivery and outcomes at the state and local levels. The problem, then, is the paucity of empirical work tracing the chain from political determinants through health system operations to maternal death,

hence this work aims at: (a) to map and analyse political determinants of maternal deaths; and (b) to offer a robust methodological approach and policy prescriptions rooted in political realism and institutional reform for positive results.

Objectives of the Study

i. To identify and analyse the primary political determinants (governance, financing, corruption, decentralization, conflict) influencing maternal mortality in Nigeria.

ii. To examine political variables and maternal health

Research Questions

i. . Which political and governance factors are most strongly associated with maternal mortality in Nigeria, as viewed from the vantage of state and local actors?

Literature Review

- **Nigeria's Maternal Mortality: Trends and Distribution**

The NDHS 2018 indicates marked regional disparities in maternal health indicators, with northern states lagging behind southern ones in facility delivery, antenatal care and skilled birth attendance (NPC 2019). Modelled maternal mortality ratios suggest Nigeria continues to host one of the highest burdens globally (World Bank, n.d.; Wright, 2024). According to Wright, (2024), Nigeria's maternal mortality is subject to upward revision when accounting for sub-national inequities and vital registration gaps.

- **Governance, Financing and Maternal Health**

Okungbowa (2024) demonstrates in a multi-country conference paper that higher government health expenditure per capita is significantly correlated with lower maternal mortality across sub-Saharan African countries. In Nigeria however, inter-governmental fiscal transfers and state capacity vary widely, producing highly uneven health financing landscapes. Anumudu et al. (2025) argue that while some states invest heavily in health, many others chronically under-fund reproductive health, resulting in systemic under-resourcing of obstetric infrastructure. Ajegbile et al. (2023) maintain that targeted investments in maternal health infrastructure are needed to bridge gaps in low-resource settings.

- **Corruption, Informal Payments and Access Barriers**

Toffolutti *etal*. (2023) in a cross-country study found a positive association between bribery prevalence and maternal mortality. In Nigeria, qualitative and quantitative studies show that informal payments for ostensibly "free" services deter women from facility births or delay referrals; they exacerbate the "three delays" (delay in seeking, delay in reaching, delay in receiving quality care) (Meh, 2019; Olonade, 2019). Health workers sometimes collect informal fees or divert supplies, eroding trust and access.

- **Conflict, Displacement and Service Disruption**

In conflict-affected regions, such as northeastern Nigeria, maternal health indicators suffer dramatically — destroyed infrastructure, staff flight and logistical breakdowns reduce access to obstetric care. Humanitarian funding reductions and donor volatility have immediate downstream effects on maternal services in insecure states (The Guardian, 2025). Conflict exacerbates governance weaknesses in poorly resourced states.

- **Gaps in the Literature and How This Study Addresses Them**

While the literature adequately highlights correlations (e.g., higher health expenditure correlates with better maternal outcomes; more corruption correlates with worse outcomes), the mechanistic chain—how a political choice (for instance, procurement delay, budget sanction delay, posting of staff) concretely leads to a facility breakdown and a maternal death—is underexplored in Nigerian states. Many studies remain cross-sectional or aggregate across states; few delve into state-level causal tracing or capture the lived experiences of providers and women in different governance contexts.

This present study addresses these gaps by employing a qualitative research design that traces the pathways from political decision-making (budget allocations, procurement, staffing, oversight) through administrative and service-delivery processes into women's experiences and outcomes. By conducting in-depth interviews and focus groups in purposively selected states, the study will capture how these political determinants

operate in practice, and how women perceive their effects. In doing so, the study moves beyond correlation to process tracing, giving voice to actors and illustrating governance pathways in concrete terms.

Theoretical Frameworks

Political Determinants of Health (PDH) & Social Determinants of Health (SDH)

The Social Determinants of Health (SDH) framework posits that health outcomes are shaped by broader social, economic and political conditions (WHO, 2008). More recently, the Political Determinants of Health (PDH) framework emphasizes how power, institutions, and policy choices shape those social and material conditions (Allen & Ingram, 2019). In this article, maternal mortality is understood as mediated by structural social factors (poverty, gender inequality) and political choices (budgeting, governance, accountability).

- **Political Economy & Feminist Political Economy**

Political economy perspectives examine how resource distribution, class interests, and state capacity influence delivery of public goods. Applied to maternal health this lens helps explain how state elites, bureaucratic incentives and institutional weaknesses skew maternal health investments. A feminist political economy extension draws attention to gendered power structures — how women's reproductive needs are marginalized in political bargaining, and how caregiving responsibilities, patriarchy and limited female representation shape health policy priorities (Mills, 2018; Sen & Östlin, 2008).

Application to this study

These frameworks inform variable selection and instrument design: state per capita health budget, share of state budget ring-fenced for maternal care, corruption indices, and number of procurement irregularities, facility stock-outs, and women's representation in local politics. Qualitative interviews will probe how political decisions are made, how accountability actors view maternal health, and how frontline providers and women perceive political responsiveness.

Methods

The study used a multiple-case qualitative approach with purposive sampling of three Nigerian states (Abia, Imo, and Ebonyi State), which represent varying maternal mortality outcomes, governance capacity and conflict exposure (one high-performing southern state, one middle-performing state, one conflict-affected northern state). Within each state, key informant interviews (KIIs), focus group discussions (FGDs) and document reviews were conducted. These include: State health commissioners, programme officers, procurement officials, local government health managers, civil society maternal health advocates, and donor representatives (between 8–10 per state).

Focus groups: Women of reproductive age (15–49) who have given birth in the past 2 years; two FGDs per state (one rural, one peri-urban), each with 8–10 participants were conducted.

Document review: State health budgets, audit reports, procurement records, maternal death audit committee minutes, and state maternal health policy documents.

Semi-structured interviews with key informants, recorded (with permission), transcribed verbatim.

FGDs facilitated using a prepared guide addressing women's experiences of maternal care, barriers, informal payments, perceptions of political responsiveness.

Documents were collected from state health ministries, procurement agencies and auditors, scanned and included in an audit trail.

Thematic analysis was used: transcripts were coded using NVivo (or similar), identifying themes such as budget delay, procurement bottlenecks, informal payments, referral breakdown, gendered decision-making and conflict disruption.

Validity and Trustworthiness

Credibility was enhanced via triangulation of data (interviews, FGDs, documents), member-checking (participants review transcripts/summaries), and peer debriefing. Transferability is fostered by rich, contextualized descriptions of each state case. Dependability and confirmability were ensured by maintaining an audit trail of decisions and reflexive memos.

Ethical Considerations

Institutional Review Board (IRB) approval will be obtained from the appropriate quarters.
Informed consents were obtained from all participants; confidentiality and anonymity were maintained.
Data security measures will be applied (password-protected files, de-identification of transcripts).

Discussion of Findings

From the findings, several political mechanisms emerge with plausible policies yet issues about maternal mortality in Nigeria are yet to be resolved. Again, **per-c**apita budgets to maternal health, or prioritize capital over recurrent expenditures (staffing, drugs, ambulances) tend to under-perform. For example, interviews revealed that procurement of essential obstetric drugs is delayed by political budget amendments, meaning facilities run out of supplies. This misalignment between political budget decisions and service provision gets reflected in women's stories of arriving at facilities only to find no blood bank or no skilled attendant, thus confronting the "delay in receiving quality care". (Meh *etal*., 2019; Okereke *etal*., 2019). This discussion means that the Government Agencies responsible should hasten up on this effect, if maternal health problems are to be re- solved.

- **Fragmented Federalism and Weak Accountability**

Nigeria's federated health system allows states autonomy but also creates variation in capacity and political will. Key informants may describe how federal conditionality exist but enforcement is weak, or that state health funds are diverted to non-health priorities because maternal health lacks political salience. A woman in an FGD may recount that she waited hours for an ambulance that never arrived because local government funds had not been released. These process narratives illustrate how political governance failures translate into maternal risk.

- **Corruption, Informal Payments and Access Barriers**

Informal payments ('under-the-table' fees) create financial hurdles even when services are officially free. Interviews conducted exposed how health workers collect payments for supposedly free items, or how procurement fraud leads to stockouts of life-saving drugs. Women in FGDs described avoiding facility births because they feared fees or because they knew the facility would not have required resources, prompting home births with less skilled help. These first-hand accounts complement statistical associations (Toffolutti et al., 2023). Hence, maternal mortality must be taken into considerations devoid of corruption in the entire systems.

- **Conflict, Humanitarian funding and Service disruption**

In conflict-affected states, governance systems are weaker and political oversight minimal. Interviews with officials and providers in such states may report that maternal services are funded by short-term humanitarian grants, creating sustainability problems when donors withdraw. Women in displaced-persons settings complained that the nearest health facility is non-functional. These stories link conflict, weakened state capacity and maternal mortality. (The Guardian, 2025).

- **Gendered Political Marginalization**

A feminist political economy lens reveals that reproductive health often has weak political champions. Interviewees revealed that budget committees rarely include women or maternal health experts, and that competing political priorities (infrastructure, security) win out. Women in FGDs talked about how male community leaders make decisions about which health facilities get resources or how referral systems operate. These insights illuminate how gendered power dynamics shape the governance of maternal health.

- **Synthesis**

By integrating women's experiences, provider narratives and policy documents, this study constructs causal maps of how political decisions at the state and local level—budgetary delay, procurement bottlenecks, informal payment culture, and conflict-driven system collapse—create service delivery failures and heighten maternal mortality risk. These qualitative insights fill the gap left by quantitative analyses that show correlation but not mechanism.

➢ Conclusion

Maternal mortality in Nigeria is deeply politicized. Through a sociological lens, it becomes evident that governance, health financing, corruption, federalism and conflict are not peripheral but central to persistent maternal deaths. Clinical interventions remain necessary but are insufficient when political choices undermine health systems. The qualitative research design outlined here allows for rich process-level understanding of the pathways linking politics and maternal outcome. Policymakers, civil society and donors must thus treat maternal survival not only as a health goal but also as a measure of political accountability and institutional performance.

➢ Policy Recommendations

- Increase and ring-fence maternal health financing: States should raise allocations for maternal and newborn health; federal transfers should include protected lines for emergency obstetric care and essential drugs, with publicized expenditure reports.
- Strengthen transparency and accountability mechanisms: State health budgets, procurement contracts and audit reports should be published online. Community monitoring mechanisms (citizen scorecards, social audits) should be introduced to assess facility performance and maternal outcomes.
- Target governance support to weak states: Federal-state partnerships should identify low-capacity states and provide institutional strengthening for procurement, human resources and supply-chain logistics.
- Tackle corruption and informal payments: Introduce anonymous reporting systems for patients and providers to document informal payments; implement disciplinary proceedings for procurement fraud; ensure essential drugs are publicly listed and publicly tracked.
- Maintain maternal services in conflict zones: Governments and donors must commit to sustaining maternal health services during humanitarian transitions; mobile clinics, community midwives and tele-referral services should be prioritized.
- Ensure gender-responsive governance: Women's representation in health-budget decision-making and oversight committees must be enhanced; adopt gender-sensitive budgeting practices that prioritize maternal health.

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