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# SDG-3: APPRAISING THE NIGERIAN GOVERNMENT POLICY DIRECTION AND IMPLEMENTATION ON PHYSICIANS' WELLBEING

**Love Ogbeyalu Charles Ukeagu**
Department of Microbiology, Immunology and Pharmacology, St George's University, St George's, Grenada.
**Email**: lovecharlesukeagu@yahoo.com

**Abstract**
It is on record that the Nigerian government has implemented various policies and interventions to achieve Sustainable Development Goal 3 (SDG-3), which focuses on ensuring healthy lives and promoting well-being for all. However, the country still faces significant health challenges, including high maternal and child mortality rates, infectious diseases, and inadequate healthcare infrastructure. This called for an appraisal of the Nigerian government's policy direction, implementation and critical interventions in achieving SDG-3. The problem is that, despite efforts to improve healthcare, Nigeria's healthcare system still faces significant challenges, including inadequate funding, low manpower, poor infrastructure, and unequal access to healthcare services. The study inquired if there is any policy of the Nigerian government that will suitably aid in achieving SDG-3 especially for Physicians' duty and wellbeing? Using the qualitative method of criticism and the Health Policy Analysis Framework, this study reviewed existing literature on policy documents in Nigeria. The major findings indicated that while the Nigerian government has made frantic efforts at improving healthcare, there are significant gaps in policy implementation, funding, recruitment and access to healthcare services. The study also identified areas of strength, including the development of national health policies and programs and concluded that the Nigerian government's policy direction, implementation and critical interventions have been inadequate in achieving SDG-3 thereby, putting a strain on the physician duty and wellbeing because of inadequate healthcare Infrastructure and manpower.

**Keywords:** Nigerian Government, Policy Direction, Sustainable Development Goal, Physicians Strain, Duty, Wellbeing.

## Introduction

In the pursuit of Sustainable Development Goal 3 (SDG-3) which is to ensure healthy lives and promote well-being for all at all ages, the Nigerian government has enacted numerous health sector policies, strategic plans, and targeted interventions. Despite this policy efforts, the country's healthcare system continues to sit on a paradox which is persistent underperformance amidst proclaimed reforms. This shortcoming is particularly evident in the wellbeing of physicians, whose work environment, morale, and retention remain critically undermined by systemic failures. Nigeria remains one of the highest contributors to global maternal mortality, accounting for approximately 20% of global deaths related to pregnancy and childbirth (World Health Organization, 2023). It also struggles with extreme shortages of healthcare personnel, with physician-to-population ratios as low as 1:5,000 in some states which is far below the WHO's recommended threshold of 1:600. This scarcity not only overstretches Nigeria's doctors but undermines their psychological, professional, and ethical stability. Thus, the question is no longer whether the Nigerian government is committed to SDG-3 in rhetoric, but whether its policies and interventions translate into working conditions that support the physicians tasked with realizing those health goals. For instance, Ogba (2024 p.3), in evaluating the implementation of the Intermittent Preventive Treatment for malaria in pregnancy (IPTp-SP) policy in Nigeria, revealed that despite policy updates and official endorsement, uptake remains abysmally low due to "poor provider knowledge and commodity shortages". Though the study focuses on malaria control in pregnant women, the implications are translatable: meaning that when policy ignores the critical infrastructure and human resource requirements necessary for implementation, the burden falls squarely on front-line workers, who must navigate policy expectations without adequate support.

Adebayo *et al*. (2018) note that the doctor-to-patient ratio in tertiary hospitals often exceeds safe limits, which directly correlates with stress, burnout, and emigration. According to the Nigerian Medical Association (NMA), more than 15,000 Nigerian doctors practice abroad, mostly in the UK, US, and Canada, citing unfavourable working conditions as the primary cause (NMA, 2022). These statistics underscore the systemic neglect of physician wellbeing not as an unintended side-effect of resource constraints, but as a structurally entrenched failure in healthcare governance. Such failures pose a fundamental challenge to SDG-3. Physician wellbeing encompasses not just physical or mental health but the totality of their working conditions, professional development, compensation, autonomy, and societal respect. In Nigeria, however, these dimensions are frequently compromised by policy misalignments. Take, for example, the National Health Insurance Scheme (NHIS), which was designed to improve healthcare access and reduce out-of-pocket spending. While the scheme has expanded coverage for certain population segments, its implementation has often left physicians disempowered. Uzochukwu *et al*. (2015 p. 417) observes that, "physicians frequently report delayed payments, bureaucratic bottlenecks, and inconsistent policy guidelines" all of which contribute to job dissatisfaction. What was intended as a policy to improve patient access also inadvertently introduced new administrative burdens on physicians without commensurate structural support. SDG-3 therefore, requires both human and institutional efforts, and Nigeria's health policy environment reveals a troubling asymmetry between these two. While institutional targets are meticulously stated in plans and policies, the human dimensions especially those concerning health workers are treated as afterthoughts. For instance, the 2020 *Revised National Health Policy* contains extensive sections on disease prevention, maternal health, and health financing but offers only cursory

attention to physician retention, mental health support, or workload management (Federal Ministry of Health, 2020). This omission illustrates a broader policy shortfall that views health workers instrumentally, not as stakeholders whose wellbeing is central to policy success and calls for an evaluation all over again.

**Objectives of the Study**

The objectives of this research are to:

i. Examine the Nigerian government's policy direction in relation to SDG-3, with an emphasis on how these policies have addressed or overlooked the wellbeing of physicians.
ii. Analyse how the implementation of health policies under SDG-3 has influenced the working conditions, motivation, and retention of physicians in Nigeria.
iii. Identify the critical interventions introduced by the Nigerian government to improve healthcare delivery under SDG-3, and assess their direct and indirect effects on physicians' work environment.
iv. Explore the consequences of neglecting physician wellbeing on the broader goal of achieving SDG-3 in Nigeria.
v. Recommend actionable strategies for repositioning health policy implementation in Nigeria to centre physician wellbeing as a core component of SDG-3 success.

**Statement of the Problem**

Despite Nigeria's consistent alignment with the global health agenda, particularly the Sustainable Development Goals (SDGs), Nigeria continues to record some of the worst health outcomes in Sub-Saharan Africa. Specifically, Sustainable Development Goal 3 (SDG-3) has remained largely aspirational in the Nigerian context. Key indicators such as maternal mortality, child survival rates, infectious disease prevalence, and healthcare access persist at an alarmingly low levels, with little correlation to the increasing number of policies and strategies released by the government. While much attention has been paid to infrastructure with little yield, insurance schemes, and disease control programs, there remains a critical gap in how these efforts engage with the actual wellbeing of the medical professionals expected to implement them particularly physicians. Many government initiatives fail to account for the human implications of poor funding, equipment shortages, bureaucratic overload, and absence of mental health support for physicians. Rather than operating as central stakeholders in policy design and delivery, Nigerian physicians are frequently treated as disposable cogs in a failing system. This has led to widespread professional dissatisfaction, high rates of emigration, recurrent strike actions, and in severe cases, mental health crises and loss of life. These realities raise pressing concerns. If the wellbeing of healthcare workers is continually undermined, how can any nation expect to achieve sustainable health outcomes for its citizens?

The disconnect between policy intentions and healthcare workforce realities continues to frustrate meaningful implementation. According to Ogba (2024 p.4), poor policy uptake in areas like malaria prevention among pregnant women was directly linked to "commodity shortages and healthcare provider prescription issues" (p. 4). This failure was not due to lack of policy, but rather a lack of structured support for frontline implementers such as doctors who were expected to meet national targets without adequate tools. These micro-level failures are pointers of a broader national pattern where physicians are overburdened, under-resourced, and insufficiently consulted in the policy process. Furthermore, while national documents such as the *National Strategic Health Development*

*Plan II* (2018–2022) identify physician training and retention as areas of concern, actual budgetary and institutional commitment to addressing these issues has been weak. Omoluabi (2020 p.49) argues that human resource provisions in Nigeria's health policies "often lack concrete implementation frameworks or monitoring mechanisms," which makes it difficult to hold actors accountable or measure progress. The result is a proliferation of health sector policies without an accompanying rise in physician motivation, capacity, or service quality.

In addition, government interventions like the Basic Healthcare Provision Fund (BHCPF) and the National Health Insurance Scheme (NHIS), though intended to improve healthcare access, often increase the bureaucratic burden on physicians without resolving core issues like salary delays, infrastructure deficits, or patient overload. Oladejo *et al*. (2021 p.20), in their study on healthcare workers during the COVID-19 pandemic, observed that "more than 30% of physicians in Lagos reported physical exhaustion, lack of protective equipment, and thoughts of resignation". The problem is thus not merely about system inputs, but about the structural conditions that affect how physicians perform and survive within those systems. The summary of the central problem of the study are as follows: the persistent neglect of physician wellbeing in the policy design, implementation, and evaluation processes of SDG-3 in Nigeria, which undermines both service delivery and the attainment of national health goals. This is not a peripheral issue but a fundamental flaw that compromises Nigeria's entire health development agenda. By failing to systemically give priority to the welfare, motivation, and engagement of physicians, the Nigerian government not only jeopardizes the implementation of health policies but also worsens workforce decline, deepens public health risks, and delays the realization of SDG-3.

**Research Questions**

The research questions that informs and guides the logical direction of this study are:

i. What are the key health policy directions pursued by the Nigerian government in line with Sustainable Development Goal 3 (SDG-3)?
ii. How have these policies been implemented, and what are the practical implications of their implementation for physicians' work wellbeing?
iii. In what ways do Nigerian physicians experience the effects of national health policies on their professional wellbeing, motivation, and retention?
iv. What are the critical policy and structural gaps affecting physician wellbeing in Nigeria's journey toward achieving SDG-3?
v. What policy reforms and strategic interventions can be recommended to strengthen the wellbeing of physicians and enhance Nigeria's progress toward SDG-3?

**Literature Review**

Nigeria, like many low and middle-income countries, has declared strong commitments toward achieving Sustainable Development Goal 3 (SDG-3) which is not enough though because the very individuals expected to drive this goal often face persistent hardship, systemic neglect, and a declining quality of professional life. However, literature that places physicians' wellbeing at the centre of SDG-3 analysis in Nigeria remains scarce which necessitated the current study.

Since aligning with the SDGs in 2015, Nigeria has launched several major health initiatives such as the *Basic Health Care Provision Fund (BHCPF)*, *National Strategic Health Development Plan II*, and the expansion of the *National Health Insurance Scheme (NHIS)* into the *National Health Insurance Authority (NHIA)*. These policies aim to reduce maternal

mortality, improve immunisation coverage, and expand access to primary healthcare. Many scholars argue that the translation of these goals into practical realities has been irregular and under-resourced leading Abimbola *et al.* (2015 p. 3) to argue that, Nigeria's health governance system is decentralised "in a way that often fragments accountability and obscures responsibility for health outcomes". This bureaucratic fragmentation results in gaps in workforce planning, delayed policy implementation, and weak oversight. More critically, most of these policies focus predominantly on service coverage and financing while paying little attention to the wellbeing of health personnel, particularly physicians. SDG-3 emphasizes well-being for all, yet Nigerian health policy frequently interprets this as patients only, excluding providers from the wellbeing equation. Physicians in Nigeria frequently operate in extreme overburdened conditions, underpaid, and under-protected. Ogundiran *et al.* (2020 p.629) systematically reviewed physician burnout in Nigeria and found alarming levels across tertiary and secondary care facilities. The most cited causes were excessive workload, poor remuneration, and job insecurity. According to the authors, "the lack of systemic response to physician distress has made burnout appear inevitable".

Similarly, Ugochukwu *et al*. (2021 p.162), investigating the pandemic's toll on Nigerian doctors, found that over 65% of respondents reported high psychological distress, compounded by inadequate personal protective equipment and the threat of violence from patients or their families. While temporary mental health interventions were suggested, "no structured psychosocial support system existed at the institutional level". If doctors are emotionally and mentally depleted, their capacity to deliver safe and empathetic care is diminished thereby undermining the very foundation of SDG-3. Ogunsemi *et al.* (2022 p.4) further emphasise that policies crafted at the federal level often exclude the realities of clinical professionals. In their study on workforce migration, they argue that "the failure to integrate doctors into planning structures contributes significantly to the mass emigration trend". The Nigerian Medical Association (NMA), though often vocal during strikes or wage negotiations, has limited influence in the day-to-day policy shaping. Instead, decisions are typically made by politicians, administrators, and foreign consultants. This exclusion creates a disconnection between policy ambition and frontline viability. Doctors are then left to implement directives without consultation, preparation, or context. Oleribe *et al*. (2019 p.6) aptly refer to this dynamic as a form of institutional detachment, where "the implementers of health interventions are rarely given a seat at the planning table". For physicians, this marginalisation breeds disillusionment fuelling internal brain drain (movement from public to private facilities) and external migration.

Corruption and weak institutional accountability have also deepened the crisis facing Nigerian doctors. Onwujekwe *et al*. (2019) expose how corrupt practices across Nigeria's health sector from procurement rackets to ghost workers divert funds meant for service improvement. They argue that systemic corruption erodes morale and efficiency, further alienating healthcare workers. Physicians who witness or experience the effects of these corrupt structures often report feelings of helplessness and disillusionment. Fagbamigbe and Akinyemi (2016 p.8) identifies significant disparities in access to basic services between urban and rural areas, stating that "doctors in underserved regions operate without functional equipment or career advancement opportunities". This contributes to the uneven distribution of physicians and the deepening of geographical health inequalities. One of the most severe consequences of neglecting physician wellbeing is the escalating wave of doctor migration. Nigeria is currently among the top exporters of physicians to countries like the UK, Canada, and Saudi Arabia. The reasons for this exodus are neither secret nor new including

violence, unpaid salaries, poor working conditions, and lack of institutional recognition. Ameh *et al.* (2021 p.20) on a study on job satisfaction among Nigerian health workers found that physicians reported the lowest levels of satisfaction, with many citing unsafe environments and "the psychological toll of treating patients with limited resources and endless bureaucratic bottlenecks".

Ilesanmi *et al.* (2020) also raise the issue of security, noting that physicians deployed to rural or conflict zones are often given no hazard allowance, no personal security, and no trauma support after incidents. These stressors not only push doctors to resign or emigrate but also create a ripple effect where patients are left with fewer qualified providers, and those remaining become further overburdened. A glaring gap in Nigeria's health system is the lack of institutional structures for physician mental health. While SDG-3 includes mental health as a central component, there is no policy framework within the Ministry of Health or the NHIA that recognises physician wellbeing as a strategic objective. Ugochukwu *et al*. (2021) argues that Nigerian hospitals treat physicians' psychological distress as a personal issue, not a system-level concern. This is dangerous, especially in a context where stigma around mental health is high, and support systems are scarce. As burnout becomes normalized, the risk of errors, negligence, and even physician suicide increases threatening both health outcomes and workforce sustainability. From the studies reviewed so far, it is evident that while there is a growing body of literature on health policy, SDG-3, and system reform in Nigeria, physician wellbeing remains largely underrepresented in both policy and research. Also, most national plans assess success based on maternal mortality, immunisation, or financing and not on the condition of the health workforce. Although anecdotal evidence of stress and burnout for physicians is widespread, there is minimal policy response to these concerns. Policies are also assessed for their output, not for how they affect those implementing them. Without this, health workforce management becomes reactive rather than strategic. Policymakers often interpret it in terms of health indicators alone, ignoring the human engine behind service delivery. This study shall therefore fill these critical gaps by placing physician wellbeing at the centre of SDG-3 policy appraisal.

**Theoretical Framework**

Every research endeavour requires a coherent theoretical lens through which complex realities can be better understood, dissected, and explained. In examining how Nigeria's health policies specifically those tied to SDG-3 affect physician wellbeing, this study adopts the *Health Policy Triangle Framework (HPTF),* which is a robust model that sees to the diverse interrogation of the interplay between policy content, actors, context, and processes. It was originally developed by Walt and Gilson (1994) and remains one of the most widely accepted models for health policy analysis in low and middle-income countries. It is particularly useful in understanding why well-intentioned policies often fail in practice by drawing attention not just to what a policy says (content), but who is involved (actors), where it is being implemented (context), and how it unfolds (process). Walt and Gilson (1994) notes that, policy texts often reflect political compromise rather than ground-level needs, especially in countries with centralised planning and limited accountability. In this case, Nigerian health policies routinely reflect donor priorities and technical benchmarks rather than the day-to-day realities of physicians operating in underfunded, overstretched facilities.

**Methodology**

This study adopted a qualitative and interpretive research design with the aim of critically appraising the Nigerian government's policy direction and implementation mechanisms

under SDG-3, especially as they relate to the wellbeing of physicians. Recognising the policy-heavy nature of the study and the subjective dimensions of physician experience, this design was chosen to enable in-depth engagement with textual data, policy documents, and secondary literature. The choice of methodology is anchored on the understanding that numbers alone cannot capture the structural, political, and lived complexities of physician wellbeing within a fragile healthcare system like Nigeria's.

**Research Design**

A descriptive and critical qualitative research approach was adopted. The study utilises textual analysis and document review to assess policy content, implementation gaps, and how these elements affect physician wellbeing. The analysis was interpretive in nature, drawing insights from the Health Policy Triangle Framework (Walt & Gilson, 1994), which provides a structured way to analyse the relationship between policy actors, context, process, and content. In selecting this approach, the research leans on established studies such as Gilson *et al.* (2008 p.108), who argue that health policy analysis in LMICs must "account for contextual nuance, actor dynamics, and power asymmetries," especially where implementation differs significantly from policy ideals. This position reinforces the relevance of qualitative critique in understanding how Nigerian policies operate in reality versus how they are framed on paper.

**Data Sources**

This study relied on secondary data collected from publicly available and peer-reviewed academic sources, government policy documents, institutional reports, and grey literature. The following data sources were used:

i. Policy documents such as the National Health Policy (2016), Basic Health Care Provision Fund Implementation Guidelines, and the National Strategic Health Development Plan II (2018–2022).
ii. Academic journal articles from platforms such as ScienceDirect, BMJ Global Health, Human Resources for Health, PubMed, and Global Health Action.
iii. Reports from international organisations such as the World Health Organization (WHO), the World Bank, and the Nigerian Federal Ministry of Health.
iv. News articles, op-eds, and verified interviews from reputable media outlets to support interpretations of real-time physician challenges.

The document review focused specifically on texts published between 2015 and 2024 except where the texts are highly relevant to the discourse on SDG-3 and physician wellbeing, aligning with Nigeria's official adoption and implementation window for the SDGs.

**Data Collection Procedure**

Data collection was carried out in three distinct stages:

i. Scoping Phase – A preliminary exploration was conducted using academic databases and official repositories to identify all relevant documents, especially those relating to policy implementation frameworks and physician retention strategies.
ii. Document Selection Phase – Documents were assessed based on inclusion criteria: they had to (i) address SDG-3 or the Nigerian health policy landscape; (ii) make reference to healthcare workforce or physician wellbeing; and (iii) be either official (governmental/institutional) or peer-reviewed academic publications.

iii. Content Extraction Phase – Selected documents were carefully read, with key data coded based on recurring themes such as "physician workload," "policy failure," "implementation gap," "burnout," and "governance issues."

This multi-step process allowed for a structured analysis and cross-comparison of recurring issues within different documents and contexts.

**Method of Data Analysis**

The study employed thematic content analysis grounded in the Health Policy Triangle (HPT) framework. This entailed coding textual data into four broad categories derived from HPT: content, actors, context, and process. Sub-coding was done under each category to capture issues such as resource allocation, mental health policy, institutional culture, and migration incentives. The analysis focused not just on what policies said, but also on what they failed to address. As Gilson and Raphaely (2008 p.401) point out, "absences, silences, and omissions in policy texts are as politically meaningful as inclusions". Accordingly, the study critically analysed both the presence and absence of physician-centric policy provisions. Manual coding was used, supported by a basic codebook designed to identify interrelated themes. Patterns were triangulated using peer-reviewed studies and international reports to ensure that interpretations were not solely subjective but reflected broader systemic concerns.

**Justification for Qualitative Approach**

The justification for this method is four-fold:

i. Exploratory nature of the topic: Physician wellbeing within the framework of SDG-3 policy in Nigeria is a largely underexplored field. A qualitative approach allows for more depth and flexibility in examining complex interrelationships that may not be visible through quantitative measures.
ii. Contextual and institutional focus: Since policies are products of socio-political contexts and bureaucratic processes, qualitative methods are best suited to unpack such dynamics in their full shade.
iii. Text-rich data: The study deals primarily with documents such as policy texts, reports, academic articles which lend themselves naturally to content analysis.
iv. Policy evaluation and critique: The Health Policy Triangle, as a critical policy analysis tool, requires a qualitative reading of actor interactions, political motivations, and institutional gaps with factors that cannot be captured through surveys or statistics alone.

**Scope and Delimitation**

This study is restricted to Nigeria's health policy environment between 2015 and 2024. It does not cover informal health worker categories such as traditional healers or community health volunteers. While other healthcare cadres (e.g., nurses, pharmacists) also face wellbeing issues, the study focuses exclusively on physicians (i.e., licensed medical doctors) due to their central role in clinical governance, public health strategy, and policy execution. Additionally, the study does not include primary data collection such as interviews or surveys due to time and access constraints. Instead, it synthesises existing knowledge to provide a grounded critique of Nigeria's policy posture toward physicians under SDG-3.

**Ethical Considerations**

Because this study relied on secondary sources that are publicly available, no formal ethical clearance was required. However, academic integrity and responsible citation practices were strictly observed. All authors, documents, and data sets referenced in this study are duly credited in accordance with APA 7th edition style. Moreover, care was taken to present data and analysis in a manner that is respectful, accurate, and free of political or institutional bias. While the critique is firm, it is guided by the aim of contributing meaningfully to ongoing debates about health system reforms in Nigeria.

**Findings**

The study examined the Nigerian government's policy direction, implementation practice, and intervention outcomes with respect to SDG-3, while paying particular attention to how these dynamics affect physician wellbeing while drawing its analysis from the study's research questions. Using the Health Policy Triangle Framework, data was analysed through four key lenses which are: policy content, implementation, actor involvement, and the broader socio-political context. The findings reflect both system-wide structural barriers and targeted issues facing doctors on the frontlines of care.

i. **Policy Content:** The content analysis of Nigeria's major health policies revealed a consistent omission: which is that physician wellbeing is not meaningfully addressed or defined as a policy objective. Even in flagship documents such as the *National Strategic Health Development Plan II (2018–2022)* and the *National Health Policy (2016)*, healthcare workers are framed as instruments of delivery rather than as individuals requiring structural support or protection. This omission is not just a technical oversight but carries practical consequences. Physicians across federal and state institutions work without any mental health support systems, burnout monitoring frameworks, or risk protections for medical emergencies. In Onwujekwe *et al* (2019 p.6) policy analysis, it was stated that "despite multiple references to service coverage, there is no structural mechanism for ensuring provider wellbeing". In other words, the Nigerian health policy structure assumes the continuous availability and efficiency of physicians without embedding safeguards to sustain their ability to function. The only indirect references to workforce wellbeing were located within the *Basic Health Care Provision Fund (BHCPF)* implementation guidelines, which mention performance-based financing and capacity-building workshops. However, these are primarily administrative and training functions as they do not directly address chronic issues like physician overwork, psychosocial stress, or job satisfaction. This disconnect points to a deeper structural issue such as the wellbeing of physicians which is often treated as a private concern, not a state obligation. By failing to institutionalise it within policy goals, government strategies have created a silent vacuum in which doctor welfare depends largely on informal coping mechanisms or self-initiated adjustments.

ii. **Implementation Gaps:** While policies like the BHCPF promise major improvements in service delivery, the actual implementation often falls short, particularly regarding how such policies affect those at the centre of care which are doctors. Ameh *et al*. (2021 p.19) conducted a national-level study on health worker satisfaction and found that "implementation delays and bureaucratic confusion reduce the likelihood that healthcare workers experience the benefits of policy innovation". For instance, several state primary health care boards have either delayed or misappropriated funds allocated under the BHCPF, with no repercussions or clear follow-up systems. In some

facilities, physicians are unaware of any improvement plans because the funds are reabsorbed by administrative layers or diverted toward infrastructure alone. In addition to funding gaps, the absence of a national implementation monitoring tool specific to physician conditions worsens the situation. Unlike patients, whose health outcomes are periodically measured under the National Health Indicators Framework as no official mechanism exists to measure physician wellbeing outcomes be it job satisfaction, burnout rates, absenteeism due to stress, or mental health status. The only available data often come from independent surveys conducted by professional associations or academic researchers. Ogundiran *et al.* (2020 p.631), reviewing physician burnout across tertiary hospitals in Nigeria, noted that "most institutions do not have functioning Human Resource units that monitor or document health worker morale". This means implementation bottlenecks go unnoticed until doctors strike, resign, or emigrate. The findings make it clear that without tracking systems and frontline feedback loops, health policies risk becoming symbolic rather than transformative. Doctors remain on the receiving end of decisions they had no part in shaping and must implement reforms for which they are not adequately prepared or resourced.

iii. **Actors:** The exclusion of physicians who are actors from policymaking processes emerged as one of the most critical findings. While doctors are often central to service delivery and emergency response, they are rarely consulted in national health planning or evaluation sessions. Ogunsemi *et al.* (2022 p.5), in their study on health worker emigration, emphasised that "the government's reluctance to consult doctors before major workforce policies has fostered a culture of apathy and passive resistance". One major example is the National Task Shifting and Sharing Policy, which was designed to delegate tasks from doctors to nurses and community health workers. Although intended to address workforce shortages, many doctors viewed it as a downgrading of their professional autonomy, yet the policy was passed with minimal physician input. Even at the level of professional organisations like the Nigerian Medical Association (NMA), the engagement with government is often limited to wage negotiations, not broader systemic reforms. This results in reactive, rather than proactive, doctor-government interactions. Abimbola *et al*. (2015 p.5) describe this pattern as "elite capture of policy space, where participation is based on title rather than field experience". Doctors at the lower and middle ranks are the most affected. They are expected to implement broad reforms sometimes involving electronic health record systems, task-sharing, or reporting innovations without prior consultation or even basic orientation. Many find themselves improvising, interpreting, or even resisting policies that feel out of touch with local realities. This lack of actor inclusion compromises policy legitimacy with physicians who are not involved in shaping the system feel no deep obligation to protect or sustain it. The resulting atmosphere is one of mistrust, poor communication, and bureaucratic fatigue.

iv. **Contextual Barriers:** The socio-political context in Nigeria imposes severe constraints on physicians' wellbeing. The prevailing health infrastructure, particularly in rural and conflict-affected areas is often inadequate. Doctors deployed to such areas face long hours, erratic power supply, non-functional equipment, and personal security threats. According to Ilesanmi *et al*. (2020 p.74), "most rural doctors do not receive hazard allowances or trauma support, even when posted to high-risk zones". During the COVID-19 pandemic, these contextual vulnerabilities became more visible. Physicians in states like Zamfara, Borno, and Niger were operating in isolation centres without PPE,

ventilation support, or psychosocial services. Ugochukwu *et al*. (2021 p.160) reported that "doctors in these settings described their work as battlefield duty without armour or exit strategy". Several quit public service or migrated internally to urban private hospitals. Even in relatively secure urban centres like Abuja or Lagos, the workload disparity remains extreme. Due to workforce shortages, doctors in teaching hospitals often handle patient volumes that exceed recommended limits. Emergency physicians, in particular, are frequently on 24-hour call rotations without adequate rest periods or supportive supervision. The context is further compounded by a cultural narrative that views physician resilience as a given. In many government circles, complaints from doctors are viewed as entitlement rather than warning signs. This mindset delays systemic reforms and deepens the psychological toll on doctors who continue to work under exhausting and sometimes humiliating conditions.

v. **Mental Health:** Mental health, despite being a key component of SDG-3, remains one of the most neglected aspects of physician wellbeing in Nigeria. None of the national policies reviewed including the *NHIA Act (2022)* or *National Health Policy (2016)* makes explicit provision for the mental wellness of doctors. Burnout, depression, and anxiety are rarely discussed in institutional meetings or state-level planning sessions. In their review of stress among physicians during the pandemic, Ugochukwu *et al*. (2021 p.165) found that "over 68% of doctors reported symptoms of emotional exhaustion, but none had access to an institutional counselling system". Many resorted to self-medication, avoidance behaviour, or spiritual support networks. While informal coping strategies may provide temporary relief, they cannot substitute for structured mental health policies or support systems. The stigma surrounding mental health also discourages doctors from speaking up. Those who attempt to seek help are often labelled as weak or unserious. As a result, many suffer in silence, leading to avoidable errors, professional disengagement, and in extreme cases, suicide. This systemic neglect has long-term implications. A mentally distressed workforce cannot sustainably deliver quality care. Without intervention, physician morale will continue to decline, weakening Nigeria's ability to meet its broader SDG-3 targets.

vi. **Physician Emigration:** The findings also reveal a sharp increase in physician migration as a coping response to systemic neglect. Young doctors, in particular, are actively pursuing exit routes to the United Kingdom, Canada, Saudi Arabia, and Australia. The reasons are not merely economic but are deeply tied to the absence of professional support, institutional respect, and policy alignment. Ogunsemi *et al*. (2022 p.3) observed that, "most doctors cite lack of institutional protection and bureaucratic delays as key push factors not just salary differences". Government attempts to curb migration such as imposing bond clauses or withholding training certificates have not been effective.

**Discussion**

The findings of this study show clearly that although Nigeria's health policy frameworks under SDG-3 may appear comprehensive on paper, in practice, they fall short of addressing the realities of physicians working within the system. Thus, the implications of these findings are examined alongside engaging critically with the literature and interpreting what the gaps in policy, process, and actor involvement mean for the goal of sustainable physician wellbeing in Nigeria's healthcare system.

i. **Lack of Institutional Focus on Physician Wellbeing:** What stands out immediately is the absence of physician wellbeing as a stated objective in most Nigerian health policy

documents. This silence is not just rhetorical but carries material consequences for how doctors are treated and what level of support they can expect from the state. Onwujekwe *et al*. (2019 p.6) noted that "policy documents routinely mention service delivery goals and access improvement but are silent on frontline worker conditions". From this, it becomes clear that physicians are not being actively positioned as stakeholders in need of protection or investment; instead, they are simply viewed as agents for delivering policy goals. This mindset reproduces a cycle where the expectations from doctors are high, but institutional investment in their wellbeing remains minimal.

ii. **Misalignment Between Policy Content and Frontline Experience:** The findings suggest a striking disconnect between what Nigeria's health policies say and what actually plays out at the facility level. For example, while policies like the *Basic Health Care Provision Fund* promise to improve service delivery at the primary level, doctors working in rural and semi-urban facilities often do not see any real improvement in working conditions. Ameh *et al*. (2021 p.21) captured this gap when they stated that "the implementation of BHCPF across states has been highly uneven, with little visible impact on frontline worker morale or retention". The reason for this misalignment, as shown in this study, is two-fold: bureaucratic inefficiency and absence of physician input during policy formulation. Implementation bottlenecks such as delayed fund release or political interference turn even well-structured policies into paper exercises. Furthermore, since doctors are usually not involved in planning stages, they lack the opportunity to ensure the relevance or adaptability of those policies to clinical realities.

iii. **Power and Participation:** It was evident from the findings that doctors, especially at the junior and middle levels, are largely excluded from the spaces where major health policies are debated or finalised. This exclusion has a demoralising effect and also reduces the likelihood that such policies will be embraced or supported by those tasked with implementation. Ogunsemi *et al.* (2022 p.4) made this point clearly when they observed that "the consistent side-lining of health workers during planning has contributed to the breakdown of policy ownership at facility level". Without participatory mechanisms that give doctors voice and agency in decision-making, policies are likely to remain disconnected and ineffective. To build a more inclusive system, there must be deliberate effort to institutionalise frontline consultation into policy design. Until then, the system risks repeating cycles of failed reforms and growing mistrust between government and physicians.

iv. **Psychological and Emotional Costs of Public Service:** The psychological and emotional cost of working in Nigeria's public health system is perhaps the most underreported crisis facing physicians today. Beyond infrastructure challenges or poor pay, many doctors are struggling with profound emotional and psychological fatigue, what Ogundiran *et al.* (2020 p.631) categorised as "deep-rooted emotional exhaustion, marked by depersonalisation and low personal accomplishment". Doctors are working under intense pressure, often in overcrowded wards, without adequate tools, rest, or even recognition. What makes the situation worse is the absence of institutional support with no counselling services, routine mental health checks, and culture of wellbeing in government hospitals. The psychological toll is not just personal; it affects the overall functionality of the healthcare system. Without emotionally stable and supported physicians, SDG-3 targets around quality care and universal health coverage will remain unattainable.

v. **Insecurity and Conflict on Physician Retention:** Another important layer revealed by this study is the impact of insecurity on the practice environment. Many Nigerian doctors, especially those working in Northern Regions, operate under real threats to their lives. Armed conflict, kidnappings, and attacks on health facilities are now frequent in several parts of the country. Ilesanmi *et al*. (2020 p.75) noted that "doctors posted to high-risk zones often lack institutional protections, hazard allowances, or even psychological preparation". This means that doctors are left to navigate life-threatening work conditions on their own without state support or legal recourse in the event of trauma. Many physicians are simply refusing to work in certain locations. Others who do remain suffer from chronic anxiety, hypervigilance, and emotional detachment. The insecurity crisis, therefore, is not just a security issue as it is a workforce and wellbeing issue, and a policy failure all at once.

vi. **Physician Exodus:** The exodus of Nigerian doctors to countries like the UK, Canada, and Saudi Arabia based on the findings, is a rational response to a system that has persistently failed to prioritise wellbeing, safety, or professional respect. Ogunsemi *et al.* (2022 p.3) affirmed that "young doctors are increasingly using emigration as an exit strategy to avoid systemic collapse, not just to earn higher wages". It means that retention is not simply a matter of salary scale but of system integrity and psychological investment. When doctors leave *en masse,* the losses are multidimensional. The country loses years of educational investment, younger doctors lose mentors, and patients are left with overburdened or inexperienced replacements. Government attempts to restrict emigration through bonding schemes or policy threats have failed because they do not address the root causes of dissatisfaction. To stem the tide, the government must focus on building an environment where doctors want to stay. That begins with credible health policies, functional support systems, and an honest appreciation of physician experiences.

**Conclusion**

This study has offered a critical appraisal of the Nigerian government's approach to implementing Sustainable Development Goal 3 (SDG-3), with a specific focus on how these policy efforts affect physician wellbeing. Using the Health Policy Triangle Framework as a guiding principle, the study exposed several layers of policy and structural deficits, particularly in relation to how physicians experience the Nigerian healthcare system not as planners or beneficiaries of policy, but often as overstretched tools in a failing system. The findings made it evident that, despite numerous health policies and strategic plans, physician wellbeing has not been given due institutional recognition. Across the reviewed policies, there is a disturbing silence on mental health support, workload redistribution, workplace safety, and psychosocial resilience of doctors. Even when health policies such as the *Basic Health Care Provision Fund* attempt to address workforce capacity, their implementation has been riddled with inconsistency, politicisation, and inadequate monitoring mechanisms. It was also discovered that physicians especially younger and mid-level practitioners are largely excluded from policymaking conversations that directly affect their work. This disconnection between decision-makers and implementers fosters apathy and contributes to what several scholars have called a policy-practice gap. Furthermore, the wider context of insecurity, weak infrastructure, and low budgetary allocation to the health sector continues to erode the confidence of physicians in public health governance. Many doctors no longer see themselves as partners in the delivery of SDG-3 goals but rather as casualties of a system

that fails to protect them even as it expects the best from them. In sum, it is not enough to proclaim SDG-3 objectives in policy documents. For Nigeria to truly promote health and wellbeing for all, the wellbeing of the physicians who deliver these services must be systemically integrated into the health policy environment.

**Recommendations**

To address the systemic gaps identified in this study and reposition Nigeria's healthcare sector on a sustainable path under SDG-3, the following recommendations are proposed:

i. The Federal Ministry of Health and relevant agencies should revise national policies such as the *National Health Policy*, *National Strategic Health Development Plans*, and *Basic Health Care Provision Fund Guidelines* to include dedicated sections on physician wellbeing.
ii. Hospitals across the country, especially teaching and tertiary hospitals, should establish mental health and counselling units specifically for medical staff. Confidential support services, group therapy, burnout recovery programs, and time-off provisions should be structured into the HR policies of all government hospitals.
iii. Professional medical associations (e.g., NMA, ARD) and frontline clinicians should be involved in every major policy dialogue regarding healthcare workforce reforms. Their participation should go beyond reactive negotiations or strike resolutions.
iv. The Federal Ministry of Health should create policy advisory panels that include frontline doctors especially younger ones to help evaluate ongoing interventions and provide on-the-ground insight into what works and what does not.
v. There should be a national data dashboard or reporting framework dedicated to tracking physician-related metrics, including job satisfaction, burnout levels, emigration rates, patient load per doctor, and exposure to traumatic events.
vi. Nigeria must move closer to fulfilling the Abuja Declaration of allocating at least 15% of the national budget to health. Within this allocation, specific budget lines should be created for workforce wellbeing, not just infrastructure and equipment.
vii. Doctors working in high-risk regions must be treated as frontline workers under duress. Hazard allowances should be reviewed and expanded, and protective measures including security escort options, trauma care coverage, and risk insurance should be institutionalised. Incentives such as student loan forgiveness, accelerated promotions, and sabbatical provisions should also be offered to those serving in under-resourced and dangerous areas.
viii. Finally, the Federal Government and development partners should officially recognise physician wellbeing as a measurable target under SDG-3. This would enable Nigeria to align better with WHO's calls for workforce resilience and ensure that health delivery is not achieved at the cost of health worker dignity. By doing so, the country will not only protect its doctors but will also build a stronger, more responsive, and sustainable health system.

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