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Literature Review

The Achievements of Sustainable Development Goals on Primary Health Care between India and Nigeria from September 2015 to September 2016

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Abstract

The worldwide gains made during the 15 years that the Millennium Development Goals (MDG) were implemented, required a broader approach that would address the entire human endeavor referred to as the Sustainable Development Goals (SDG). It has been decided by the UN and other developing partners to support the global implementation of the SDG. A functional Primary Health Centre (PHC) can only be maintained by cross-sectoral partnerships in terms of finance, participation, and beneficiary equity. By 2030, India would spend over $14.4 billion on SDGs. There will probably be a sizable financial vacuum unless states dedicate a sizable percentage of their resources to the social sector, given the Union government's recent cutbacks to social sector programmes. High growth and redistribution are insufficient and uneven; it is expected that, aside from domestic income, private money will be an important source of funding for the SDGs. By 2030, Nigeria will require roughly $10.7 billion to carry out its SDG programmes successfully. The National Health Act (NHA), the actualization of the 15% State health expenditure, the efficient use of donor monies in projects, and the basket financing that some States currently have are all intentions to infuse roughly 1% of the federal revenue expenditure into PHC services.

In India and Nigeria, such relationships exist both nationally and globally, but the implementation process vary. They both operates state-driven primary health care (PHC) systems that receive input from various national directorates. The National Primary Health Care Development Agency (PHCDA) channels controls through the State Primary Health Care Development Agency (SPHCDA), whose goal is to ensure that primary health care is provided under one roof (PHCUOR). According to this study, each implementation model is effective for providing PHC services. However, strict policies that governs the implementation of activities, monitoring and evaluation will decide if the SDG on PHC would be successfully achieved in both nations by 2030.

Keywords: United Nations (UN); Sustainable Development Goals (SDGs); Millennium Development Goals (MDGs)

Introduction

The United Nations (UN) launched the Sustainable Development Goals (SDGs) initiative. Known formally as "Transforming Our World: the 2030 Agenda for Sustainable Development," the SDGs are a group of seventeen ambitious "Global Goals" that include 169 targets in total.

In September 2015, states endorsed 17 Sustainable Development Goals (SDGs) at the UN General Assembly, following the eight Millennium Development Goals (MDGs) that have defined progress over the past 15 years. In order to "Ensure healthy lives and promote well-being for all at all ages," SDG 3 specifically addresses health. Thirteen targets make up this goal: two deal with environmental health, three with addiction, three with communicable, non-communicable, and reproductive health, and one with attaining universal health coverage (UHC). The four other priorities are workforce and health finance, global health risk preparedness, tobacco control, vaccinations and medications.

Many of the challenges outlined in SDG 3—which include issues with reproductive and child health, communicable diseases, chronic illnesses (including multimorbidity), addiction, and other mental health problems—can be addressed through a person-centered and population-based approach to primary health care [1-5].

Differences in primary health care systems and human resources between countries are unavoidable. In order to deliver clinical care and immunizations, a primary care system must be operational to attain universal health coverage (UHC) in a way that is both equitable and economical. Therefore, a primary health care (PHC) that is well-integrated and prepared is crucial [6].

Furthermore, PHC can help fulfil a number of the other 16 SDGs. For instance, the study Closing the Gap in a Generation highlighted PHC's contribution to tackling the social determinants of health.

Globally, primary care teams can offer real-world examples from their daily work that highlight their contributions to each of the SDGs: ending poverty, promoting healthy eating, health education and lifelong learning, empowering individuals and communities to promote justice and lessen inequality, facilitating access to clean water and sanitation, fostering innovation, advocating for sustainable and healthy living conditions, and fostering peaceful communities [7]. With the introduction of the PHC Performance Initiative, the Gates Foundation, World Bank Group, and WHO have taken center stage as the UN Inter-agency and Expert Group continues to discuss the SDG indicators [8]. This programme will play a significant role in determining how primary health care changes over the next 15 years and in directing the related research agenda, along with the forthcoming WHO People-Centered and Integrated Health Services Strategy and the Global Strategy on Human Resource for Health: Workforce 2030. These programmes ought to motivate governments to fund and track the development of high-caliber, empirically-based, comprehensive, and integrated PHC. If this is not done now, there is a chance that vertical disease-oriented programmes will not succeed [9]. Equality in UHC and the realization of primary health care's full potential as a sustainable development tool would suffer as a result of this gap.

Literature Review

The research literature review for this article was specific to the trends of events that surround the PHC services in India and Nigeria. Hence, research questions that will precisely guide the review are made and the bibliographic or article databases, websites and other sources were carefully studied and cited as references.

The absence of reference to PHC in SDG is a serious oversight considering the 15 years of MDG and 37 years since the Alma-Ata declarations as well as about 7 years of the World Health Report in The Lancet series on PHC. However, "two conclusions could be drawn: first, that primary health care is dispensable and peripheral to achieving sustainable development; or, second, that PHC is so integral to the path towards the SDGs that reference in a goal or target would undermine its cross-cutting role. The second conclusion was widely expected, but with caution, as "the scarcity of a proposed strategy for implementation and its monitoring for accountability and scale-up purposes" was one of the factors that contributed to PHC's documented failure in many settings since the Alma-Ata declaration [10]. This issue needs to be addressed in the development of implementation strategies for the SDGs. If the agenda is not explicit about how health systems with good-quality comprehensive primary care can be achieved, or how to measure progress towards this goal, we risk repeating the failures of the past.

When tracking the advancement of primary healthcare delivery that will achieve the SDGs, national governments and other stakeholders must set high standards for themselves. Indicators that can capture the values of equity, community involvement, prevention, appropriate technology, and inter-sectoral collaboration that support the Alma-Ata declaration are used in this monitoring. Additionally, indicators that can capture the elements of first contact, continuity, comprehensiveness, coordination, and community orientation that, according to research, contribute to the success of primary care services are used [11].

Health financing indicators need to track government expenditure in this area and provide information on the economic accessibility of primary care services.

The primary care workforce is perhaps the backbone of the overall health system, serving as the interaction between the community, the health system, and other sectors. Monitoring should be done on the density, distribution, and performance of this workforce, which consists of family physicians, allied health professionals, nurses, and community health workers [12-14].

While this is going on, addressing the underfunding of the PHC [15-17] research agenda within health systems research will help us understand how to stop and reverse the brain drain of health professionals, as well as how to scale up the primary care workforce while taking into account the available national resources [18,19].

The researcher realized that when PHC system is put in place properly the other 16 SDG will be addressed easily. Countries need strong political will, sound economic policies, and coordinated international efforts to achieve UHC. Measuring progress towards the implementation of PHC is no easy task, yet it is the lynchpin to achieving UHC and is pivotal across the SDGs. Instruments that

assess the strength of primary health care can be used to measure many of the dimensions described here, and have been successfully used in some countries.

At present, the challenge is in enhancing their appropriate application worldwide, and for stakeholders to respond to their findings. As the UN Inter-agency and Expert Group continues to deliberate on the SDG indicators, the Gates Foundation, World Bank Group, and WHO have stepped into the spotlight with the launch of the Primary Health Care Performance Initiative. This initiative, alongside the upcoming WHO People-centered and Integrated Health Services Strategy and the Global Strategy on Human Resource for Health: Workforce 2030, will be important in shaping how PHC develops in the next 15 years and in steering the associated research agenda [20].

These initiatives should encourage governments to invest in and measure progress towards good-quality comprehensive and integrated PHC that would be based on sound evidence. The risk at this juncture of not doing so is that, the pursuit of vertical disease-oriented programmes will prevail. Such a pursuit will be at the cost of equitable UHC and the realization of the full potential of PHC services' contribution to sustainable development.

How the PHC systems are structurally organized in both countries:

In India, the PHC, sometimes referred to as public health centres [21,22], are state-owned rural health care facilities [23,24]. They are essentially single-physician clinics usually with facilities for minor surgeries. Presently there are 28,863 PHCs in India [23]. They are organized as follows:

- Primary health care - Primary health centers and Sub-centers
- Hospital health center - CHC, Rural hospital, District hospital, Specialist hospital, Training hospital.
- Health insurance scheme – ESI and CGHS.
- Others available - Railway and Defense health centers.

Apart from the regular medical treatments, PHCs in India have some special focuses [25].

- **Infant immunization programs:** Immunization for newborns under the national immunization program is dispensed through the PHCs.
- **Anti-epidemic programs:** The PHCs act as the primary epidemic diagnostic and control centres for the rural India. Whenever a local epidemic breaks out, the system's doctors are trained for diagnosis. They identify suspected cases and refer for further treatment.
- **Birth control programs**: Services under the national birth control programs are dispensed through the PHCs. Sterilization surgeries such as vasectomy and tubectomy are done here.
- **Pregnancy and related care:** A major focus of the PHC system is medical care for pregnancy and child birth in rural India. This is because people from rural India resist approaching doctors for pregnancy care which increases neonatal death. Hence, pregnancy care is a major focus area for the PHCs.
- **Emergencies:** All the PHCs store drugs for medical emergencies which could be expected in rural areas. For example antivenoms for snake bite, rabies vaccinations, etc. All these services are fully subsidized.

In Nigeria, the Federal, State, and Local levels of government are all concurrently responsible for providing PHC [26]. The delivery of healthcare is evidently influenced by private healthcare providers. However, the state government oversees the various general hospitals (secondary healthcare) and the local government concentrates on dispensaries (PHCs), which are regulated by the federal government through the National Primary Health Care Development Agency (NPHCDA), the federal government's role is primarily limited to coordinating the affairs of university teaching hospitals and Federal Medical Centres (tertiary healthcare) [27].

In Nigeria, the primary health centers are organized into five levels [28] as follows:

- Level 5 – The medical officer of health (MoH) who is a medical doctor that supervises a group of primary health centres (PHC) in each local government.
- Level 4 – A nurse /midwife heads a PHC center and consult with the supervisory MOH in difficult cases. In local governments where there are no medical officers, the most senior nurse deputizes as supervisor.
- Level 3 – Community Health Officers (CHO) are next in ranks to the Nurses and they head the PHC centre in the absence of a Nurse.
- Level 2 – Community Health Extension Workers (CHEWs) provide care at the dispensary within communities.
- Level 1 – Volunteer Health Workers (VHWs) and Traditional Birth Attendants (TBAs) are informally trained as Ad-hoc staff to help the PHC centres with case findings and community engagement.

At all levels, infant immunization, anti-epidemic programs, prenatal and antenatal with emergency services are offered in Nigeria. The PHCs or dispensaries near the insurgency areas are encouraged to come up with Health camps that will serve the displaced people with complete medical care.

The nature of implementation of PHC programs in both countries:

India's healthcare system is hybrid, combining both governmental and private providers of medical services[29]. Nonetheless, the majority of private healthcare providers in India are centered in urban areas and offer secondary and tertiary healthcare services. Based on population patterns, a three-tiered public health care infrastructure has been established for rural areas and is outlined below [30].

Sub-centers

A sub-center (SC) is established in a plain area with a population of 5000 people and in hilly/difficult to reach/tribal areas with a population of 3000, and it is the most peripheral and first contact point between the primary health-care system and the community. Each SC is required to be staffed by at least one auxiliary nurse midwife (ANM)/female health worker and one male health worker (for details see recommended staffing structure under the Indian Public Health Standards (IPHS)). Under National Rural Health Mission (NRHM), there is a provision for one additional ANM on a contract basis.

SCs are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes. The Ministry of Health and Family Welfare is providing 100% central assistance to all the SCs in the country since April 2002 in the form of salaries, rent and contingencies in addition to drugs and equipment.

Primary health centers

A primary health center (PHC) is established in a plain area with a population of 30 000 people and in hilly/difficult to reach/tribal areas with a population of 20 000, and is the first contact point between the village community and the medical officer. PHCs were envisaged to provide integrated curative and preventive health care to the rural population with emphasis on the preventive and promotive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Program (MNP)/Basic Minimum Services (BMS) Program. As per minimum requirement, a PHC is to be staffed by a medical officer supported by 14 paramedical and other staff. Under NRHM, there is a provision for two additional staff nurses at PHCs on a contract basis. It acts as a referral unit for 5-6 SCs and has 4-6 beds for in-patients. The activities of PHCs involve health-care promotion and curative services.

Community health centers

Community health centers (CHCs) are established and maintained by the State Government under the MNP/BMS program in an area with a population of 120 000 people and in hilly/difficult to reach/tribal areas with a population of 80 000. As per minimum norms, a CHC is required to be staffed by four medical specialists, that is, surgeon, physician, gynecologist/obstetrician and pediatrician supported by 21 paramedical and other staff. It has 30 beds with an operating theater, X-ray, labour room and laboratory facilities. It serves as a referral center for PHCs within the block and also provides facilities for obstetric care and specialist consultations.

First referral units

An existing facility (district hospital, sub-divisional hospital, CHC) can be declared a fully operational first referral unit (FRU) only if it is equipped to provide round-the-clock services for emergency obstetric and newborn care, in addition to all emergencies that any hospital is required to provide. It should be noted that there are three critical determinants of a facility being declared as a FRU: (i) emergency obstetric care including surgical interventions such as caesarean sections; (ii) care for small and sick newborns; and (iii) blood storage facility on a 24-hour basis.

On the basis of the distributional pyramid, currently there are 722 district hospitals, 4833 CHCs, 28 839 PHCs and 148 366 SCs in the country.

President Ibrahim Babangida declared the Primary Health Care (PHC) plan to be the cornerstone of health policy when it was introduced by the federal government of Nigeria in August 1987 [31].

Its main stated objectives, which were meant to affect the entire country, were to: accelerate the development of health care personnel; improve the collection and monitoring of health data; ensure that essential drugs are available in all areas of the nation; implement an Expanded Programme on Immunisation (EPI); improve nutrition nationwide; raise public awareness of health issues; create a national family health programme; and widely promote oral rehydration therapy as a treatment for diarrheal The Ministry of Health and the participating local government councils—which

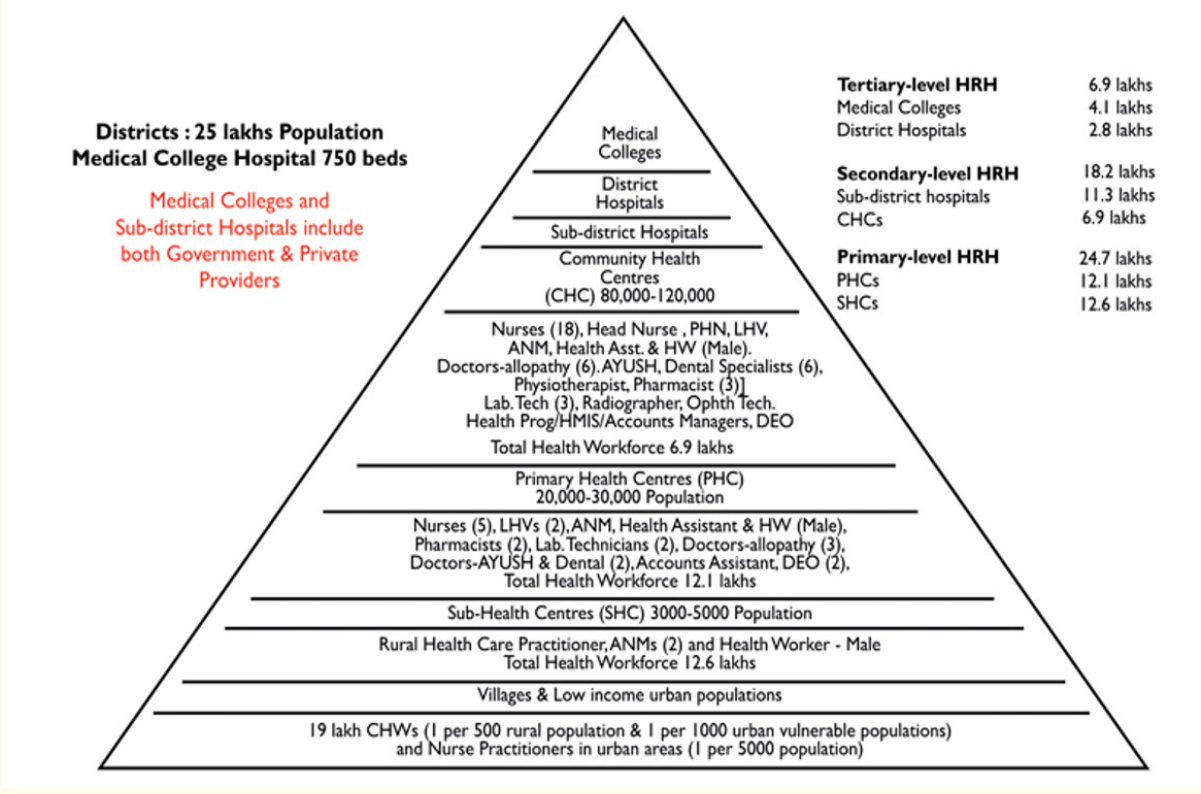

Figure 1: A community health centre in Kerala.

were directly funded by the federal government—had to work together primarily to implement these programmes.

The EPI was the most specific of these goals and most likely advanced the fastest at first. Four main paediatric illnesses were the focus of the immunisation programme: tetanus, TB, measles, polio, and pertussis. Its goal was to significantly raise the percentage of infants under two who are immunised from roughly 20 percent to 50 percent at first, then to 90 percent by the end of 1990. The programme was believed to have been implemented in more than 300 of the 449 LGAs by August 1989, after it was first introduced in March 1988.

The PHC also served as the umbrella organization for the government's population control initiative. The government strategy by the late 1980s was to severely discourage women from having more than four children. This would be a significant decrease from the predicted fertility rate of nearly seven children per woman in 1987. The government's population policy carried no formal punishments, but many health facilities provided birth control information and supplies.

Additionally, the federal government worked to increase the accessibility of prescription medications. The government made effort to promote local drug manufacturing since foreign exchange

Figure 2: A PHC in Rivers State of Nigeria.

had to be freed up for imports of vital drugs; yet, costs were only somewhat mitigated because local drug manufacturing required the importation of raw materials. Foreign aid would likely be required in order for Nigeria to reduce its foreign exchange expenditures while also implementing a significant expansion of primary health care. Nigeria's population continued to be vulnerable to a number of serious diseases throughout the 1980s, despite progress made in the fight against infectious diseases. Some of these diseases occurred in acute outbreaks that claimed hundreds or thousands of lives, while others recurred repeatedly and caused widespread infection and debilitation.

Cerebrospinal meningitis, yellow fever, Lassa fever, and, most recently, AIDS were among the former; schistosomiasis (bilharzia), malaria, guinea worm, and onchocerciasis (river blindness) were among the latter. Despite the country's advancements in agriculture and economy, malnutrition and related disorders remained a persistent issue among newborns and children in many locations.

Among the deadliest of the acute illnesses was cerebrospinal meningitis, an inflammation of the membranes around the brain and spinal cord that can be fatal and return during periodic epidemic outbreaks. Northern Nigeria is one of the most densely inhabited areas within what is known as the meningitis belt of Africa, which runs from Senegal to Sudan and is typified by a long dry season and low humidity between December and April. The northern and central belt regions were affected by the illness in 1986 and 1989. It mostly appeared during the cold, dry harmattan season, when people spend more time indoors and increase viral spread. 48 hours after symptoms appear, paralysis and oftentimes death may occur.

The federal and state administrations tried mass immunization in the affected areas in 1989 in response to the epidemics. However, authorities cited the challenge of maintaining vaccination stockpiles in the harsh northern climate—many of which also lacked proper medical facilities and transportation.

With 477 LGAs and 30,000 HFs in Nigeria, PHC activities are currently being implemented in a rewarding manner, and health promotion is getting more organized [32].

PHC services are connected to local government area referrals in order to treat complex problems that the HF is unable to manage.

Fiduciary processes on PHC in both countries

To be honest, the ambitious future vision that serves as the foundation for the SDGs is financially demanding and could not materialise anytime soon. Spending on public health accounts for barely 1.1% of GDP in India, compared to 2.9% and 4.1% of GDP in China and Brazil, respectively. Many countries pay even more. It is impossible to maintain a robust public health system in the absence of appropriate money, even while the precise percentage of government spending on healthcare is unknown [44].

PHCs are the most fundamental units of India's government-funded public health system. Since most medical costs are paid for out of pocket by patients and their families rather than through insurance, many households have incurred Catastrophic Health Expenditure (CHE), which is defined as medical costs that endanger a household's ability to maintain a minimal standard of living [35]. According to one study, over 35% of impoverished Indian households incurred CHE, which is indicative of the dire state in which the country's health care system is currently in. With government spending on health as a percentage of GDP declining over time and the growth of the private health care sector, the poor are left with fewer resources. In India, there are several private insurance options offered by government-sponsored health insurance pro-

grammes. About 25% of Indians, according to the World Bank, had health insurance in some capacity in 2010 [34]. This was overstated, according to a 2014 Indian government report, which estimated that just 17% of Indians had health insurance [35]. For people living in poverty, public healthcare is provided at no cost [36].

In comparison to other countries, India has a low health insurance penetration rate. Additionally, the majority of people's insurance plans, which are private health insurance plans, do not pay for prescription drugs or consultations. The only things that are covered are hospital stays and related costs. India has traditionally used more practical and indirect approaches to address issues related to medicine pricing, such as patent law and tax breaks for medical costs. The content of a medicine is not protected by Indian patent law; only its formulation. This implies that generic medications, which normally become accessible following the expiration of the patent protections granted to the drug's original manufacturer, are accessible considerably earlier in India. Indian pharmaceutical companies frequently rework the methods involved in producing generic pharmaceuticals in order to reduce the cost of medication [37]. As a result, rather than funding drug discovery, the majority of research funds in Indian pharmaceutical businesses are focused on creating methods for synthesizing pharmaceuticals. The all of India's $650 million development aid for health, which serves a population of 1.3 billion, goes towards maternal and newborn health ($110 million) and child and newborn care ($230 million) [38].

Prime Minister Narendra Modi's government unveiled plans for a national health care system known as the National Health Assurance Mission (NHAM) after the 2014 election that put him in office. The NHAM would give all citizens free medications, diagnostic services, and insurance for serious illnesses [39]. The deployment of a UHC system was postponed in 2015 because of financial issues [40].

Private health providers entered the market in the 1980s with the support of multiple government subsidies. The 1990s market opening provided additional fuel for the growth of India's private health industry [40]. The private sector, either alone or in collaboration with the government sector, has contributed the majority of the new healthcare capacity after 2005.

In Nigeria, the federal government spends around 1.5% [41] of its GDP on healthcare, compared to a total of 4.6% on healthcare. The rate of growth of per capita food production is a long-term indication of a nation's capacity to provide sustenance and prevent hunger; in Nigeria, this rate was 0.25% [42] from 1970—1990. The slight increase in per capita GDP could potentially be attributed to Nigeria's imports of food items.

Nigeria, of course, is far from the poorest country in Africa, so its total health expenditure is higher than many. "B Naturally, Nigeria is not the poorest nation in Africa, thus its overall health spending is larger than many others'. "However, the majority of it is out of pocket and is about 75% private." In 2014, Nigeria spent 3.7% of its GDP on health care, of which just 0.9% was provided by the government. Nigeria fell even lower on this metric than South Sudan [47].

In Nigeria's past, health insurance has only been used in a few specific situations: all citizens were entitled to free healthcare, which was also funded by the government; government employees received healthcare through a separate insurance plan; and private companies entered into agreements with private healthcare providers [41]. Few people, nevertheless, fit into any of the three categories.

The National Health Insurance Scheme was established by the government in May 1999 and covers both the organised private sector and the unorganised sector in addition to government employees. Legally speaking, the programme also includes prisoners, those with permanent disabilities, and children under five. With favourable revisions to the initial 1999 legislative act[41], the Obasanjo administration expanded the scheme's legislative authority in 2004.

The UN had outlined procedures for receiving financial contributions from donors and partners who were willing to support the SDG projects [43] as follows.

Financial contributors

Approximately 55% of the financial resources are being contributed through matching funds from national and international partners, including the commercial sector (for a total of over $38,500,000 as matching funds).

Australia, Bangladesh, Bolivia, Canada, Colombia, Côte d'Ivoire, El Salvador, European Commission, Guatemala, Honduras, Italy, Netherlands, Norway, Paraguay, Peru, Philippines, Portugal, Sierra Leone, Sri Lanka, Sweden, Tanzania, United Kingdom/DFID, United States/USAID, and Viet Nam are among the contributors that match funds for SDG Fund Joint Programmes.

Together with 14 different UN Agencies, the SDG-F is funding joint programmes with a combined budget of $67,000,000 in 22 different countries spread over four regions (Africa, the Arab States, Asia and the Pacific, and Latin America and the Caribbean) [43].

Public private partnership (PPP)

The SDG-F is working together with major stakeholders towards sustainable development, including the private sector.

The Sustainable Development Goals Fund (SDG-F) has developed a Private Sector Advisory Group comprised of global business leaders from significant companies to better coordinate public-private partnerships for sustainable development. These influential individuals are assisting the SDG-F in creating a blueprint outlining how public-private partnerships can offer comprehensive solutions for accomplishing the new SDGs. Its objective is to work together and talk about workable answers to the shared problems of modern sustainability. BBVA Microfinance Foundation, Ebro Foods, EY Consulting Services, Ferrovial, Grupo Nutresa, H&M, Microsoft, Organización Ardila Lülle, Public Foundation, SABMiller, Sahara Group, Seres Foundation, and Tongwei Solar are among the collaborating business partners on the list.

Management

A Steering Committee that meets at least once a year and provides overall guidance and strategic direction is made up of UN Agencies, participating and contributing Member States, and various SDG-F stakeholders, including representatives from the private sector and matching fund contributors.

The SDG-F Secretariat, a small, specialized, technical team based in the UNDP's Bureau of External Relations and Advocacy, will oversee the programmatic, advocacy, evaluation, and knowledge management aspects of the SDG-F and make sure that the decisions made by the Steering Committee are implemented and followed through on.

What has been achieved on PHC in both countries since SDG take off?

The Sustainable Development Goals (SDG), which span the years 2015 through 2030, are taking the role of the Millennium Development Goals. The task of implementing the SDGs has been delegated to a newly established national entity, the National Institute for Transforming India (NITI) Aayog (commission), which was established in January 2015. The process of aligning the federal government's ministries and Centrally Sponsored Schemes (CSS) with the SDGs has already been finished.

The objective of the 2015 establishment of the NRHM and the 2013 strengthening of the NUHM's functions is to optimize PHC services for the achievement of the SDGs in India.

In India, additional health development partners are collaborating to ensure the success of the SDGs. The social inclusion programme of Sightsavers is one of these partners; it includes monitoring tools that collect data broken down by gender, caste, and religion, enabling us to reach the most marginalised people [44]. Additionally, the PHC system is strengthened and every citizen is assisted in having access to healthcare, education, nutrition, and poverty alleviation via UNICEF, WHO, BMGF, and USAID.

With the aim of achieving the goals of the vision through multi-stakeholder engagement from the public and private sectors working together to create equitable economic growth, the UNDP led the development of the SDG guidelines in Nigeria. The millennium development goals (MDGs) teach us that accountability, inclusivity, and partnership are essential to the SDGs' successful implementation. We understand that in order to improve success, collaborations involving multiple levels, sectors, governments, and stakeholders are necessary [46].

The President of Nigeria's senior special assistant for SDG stated, "Our roles are to coordinate the advocacy, partnerships, and implementation of the SDGs." The process of energising partners in ministries, departments, and agencies (MDAs), civil society organizations, academia, international development partners, vulnerable population groups, states, and local governments to work on domesticating the SDGs in Nigeria has started.

The MDG directorate is now known as the SDG directorate, and it now acts as the office responsible for organizing the execution of SDG projects. PHC deployments and rollouts are financed and overseen by a large number of health developing partners. In cooperation with the federal and state ministries of health, Sightsavers is supporting programmes aimed at controlling and eradicating five neglected tropical diseases in six states of Nigeria. The most disadvantaged communities' health and well-being will be greatly enhanced by the control and eradication of NTDs in these districts, which will also boost economic outcomes, advance the larger development goals, and help accomplish Goal 3 [45].

What are the challenges in both countries that will deter their SDG progress?

In terms of mother and child survival, India managed to come close to meeting the MDGs.

The SDG agenda contains only one health goal, as opposed to the three specific health goals of the MDGs. Its thirteen broad aims account for both the unfinished business of the MDGs and the present epidemiological incidences. It takes into accounts NCDs, the negative consequences of environmental risks, and epidemics. Additionally, this goal is connected to a number of other SDGs, including those related to food security, education, gender equality, poverty, and water and sanitation. India would need to concentrate its efforts on four areas to address obstacles and optimise SDG performance.

Defining indicators

Our track record suggests that we have not been particularly effective in establishing pertinent metrics to gauge results. The definition of quality education has not been achieved. Because of India's narrow definition of "safe" drinking water—which views tube wells and hand pumps as equally safe as piped water supplies—official statistics indicates that 86% of Indians have access to safe drinking water, putting us "on track" to meet the MDG goal for drinking water. But the quantity of fatalities and illnesses caused by water due to diarrhoea clearly indicate, this is not the case" [48].

Financing SDGs

A recent analysis projects that India will need to spend about US$14.4 billion by 2030 to accomplish the SDGs. There will probably be a sizable financial vacuum unless states dedicate a sizable percentage of their resources to the social sector, given the Union government's recent cutbacks to social sector programmes. Furthermore, there are insufficient redistribution and rapid growth. The United Nations MDG 2014 report states that in 2010, India alone was home to one-third of the world's 1.2 billion extremely poor people, despite the country experiencing rapid economic growth. With these limitations, private funding may prove to be an essential source of funding for the SDGs, putting aside domestic funds.

Monitoring and ownership

In connection with this, ownership will present a third major challenge. It has been reported that NITI Aayog will be heavily involved in monitoring progress, but Aayog members have voiced concerns about their capacity to handle such a massive undertaking. In addition, if states are expected to play a major role (due to the devolution that followed the 14th Finance Commission), ownership will be necessary not only at the federal level but also at the state and local levels.

Measuring progress

The last and most crucial issue is how to gauge success or growth. According to the government itself, it was nearly impossible to accurately measure the development of even the MDGs due to data non-availability (especially with regard to sub-national levels), periodicity problems, and limited coverage of administrative data. Gender disparities persist in our social inclusion plan, where fewer women than males are covered, even though gender equality is emphasized in our initiatives.

Despite the fact that the SDGs offer broad objectives and targets, it is crucial to keep in mind that national and state governments will still be responsible for setting priorities, selecting appropriate local policies, utilizing innovation, and making sure that an implementation and monitoring plan is in place. Then and only then will we have a chance to make sure that the S in SDGs stands for successful [48].

The payment of health professionals, communication, and manpower are the three main areas of issue in Nigeria [49]. A significant issue with funding and HF accessibility stems from hard-to-reach locations. There are still gaps in the weak data harmonization and partners mapping for collaborative support.

Regarding leadership and governance, there is a lack of political commitment to PHC development because LGAs continue to oversee PHC systems, and inter-sectoral collaboration—one of PHC50's main tenets—is given less consideration.

Regarding health care funding: There is little to nothing to support the actual delivery of services, there is no clearly defined policy on the financing of PHC services, and the existing funds are scarce enough for ongoing expenses. It is still evident that the "Abuja target 2001" of having at least 15% of government spending go towards health at all levels.

Human resources for health must deal with low employee morale, inadequate staffing levels in PHC facilities, and inadequate logistical support.

Because of Boko Haram, there is an insurgency in the country's northeast.

It can be difficult to track PHC accomplishments because of the absence of widespread PHC service coverage, apathy towards operational research, and unstable electricity, particularly in rural areas where services are difficult to provide around-the-clock.

All sectors of society need to talk about the SDGs more in order to promote effective ownership, the use of PHC services, and everyone's engagement.

Research Methods

Answering research questions and controlling variations are the two main goals of the study design. A cross-sectional survey that was qualitative and retrospective was employed in this investigation. When there is little knowledge about a phenomenon of interest, a descriptive design is a non-experimental research method intended to shed light on it and provide new information. It entails the methodical collecting and presentation of data to paint a clear picture of a specific circumstance. It is applicable to phenomena that can be disclosed in terms of quantity and is based on the measurement of quality or amount. Conversely, the purpose of a cross-sectional research survey is to measure the distribution of specific variables within a study population.

Since this study described the factors that contribute to the evolution of PHC systems in India and Nigeria, a descriptive design was adopted. Additionally, because the replies obtained through desk review were established, objectively quantified, and compared with other prior studies, the quantitative approach was employed. Furthermore, a cross-sectional design was employed since the data collected allowed for comparisons between the two nations. This kind of study design was suitable since it required less time and was less costly because secondary data was also used.

Historical background of the study areas

India: is a nation that makes up the majority of South Asia. It is a constitutional republic made up of 47 states, each having significant autonomy over its own affairs, 7 union territories with limited authority, and the Delhi national capital area, which comprises New Delhi, the capital of India. China is the most populated country in the world, with almost one-sixth of the world's total population living in India.

With the start of British direct rule in 1858, the subcontinent was brought together politically and economically. Following the end of British rule in 1947, the subcontinent was divided into two countries based on religion: India, which was home to the majority of Hindus, and Pakistan, which was home to the majority of Muslims. Later, the eastern half of Pakistan broke away to become Bangladesh. English remained a widely used lingua franca, many British institutions (including the parliamentary system of government) remained in existence, and India remained a member of the Commonwealth. An active English-speaking intelligentsia flourished, and Hindi was made the official language along with several other regional tongues.

India is still one of the world's most ethnically diverse nations. India is home to numerous castes and tribes, hundreds of minor linguistic groups from various language families that are unconnected to one another, and over a dozen main linguistic groupings, in addition to its numerous faiths and sects. The population is still mostly made up of religious minorities, such as Muslims, Christians, Sikhs, Buddhists, and Jains; taken as a whole, their numbers surpass those of all other nations save China. Although sincere efforts have been made to foster a sense of national identity among this diverse community, tensions between surrounding communities have persisted and occasionally have led to violent outbursts. However, social regulation has made significant progress in easing the infirmities that formerly plagued. However, social policy has made a significant contribution to reducing the disadvantages faced by women, tribal people, "untouchable" castes, and other historically marginalized groups in society. India was fortunate to have had a number of internationally renowned leaders during its independence, chief among them Mohandas (Mahatma) Gandhi and Jawaharlal Nehru, who inspired the people at home and elevated India's standing overseas. The nation's influence in international affairs has grown.

Despite ongoing domestic issues and economic inequality, modern India is becoming more prosperous physically and culturally. This is demonstrated by its highly diversified industrial base, well-developed infrastructure, and one of the world's largest pools of scientific and engineering talent. Its agricultural growth is also accelerating, and its exports of vibrant music, literature, and film are rich and varied. India features three of the most populous and cosmopolitan cities in the world: Mumbai (Bombay), Kolkata (Calcutta), and Delhi, despite the fact that the majority of the country's population still lives in rural areas. India is currently home to the majority of the world's leading software and IT companies, with Bangalore, Hyderabad, and Chennai (Madras) ranking among the world's high-technology centers with the quickest rates of growth.

Nigeria: is a nation that is on Africa's western coast. Nigeria's terrain is varied, with tropical climates that range from dry to humid. But Nigeria's people are what make the country so different.

Figure 3: Map of India showing boundaries.

Although there are hundreds of languages spoken in the nation, English is the official tongue. These languages include Yoruba, Igbo, Fula, Hausa, Edo, Ibibio, and Tiv. The nation is rich in natural resources, especially natural gas and petroleum deposits.

Figure 4: Map of Nigeria showing boundaries.

Lagos, the former capital, continues to be the nation's most important commercial and industrial hub. Modern Nigeria began in 1914 when the British Protectorates of Northern and Southern Nigeria were united. The country gained independence on October 1, 1960, and in 1963 adopted a republican constitution but chose to remain a Commonwealth member. The military replaced the First Republic, ruling for 13 years, and again during the Second Republic, which ran from 1979 to 1983, before another 15 years of military rule. Abuja is now the New Federal Capital of Nigeria.

Population of the Study

India: India is the second largest country in the world after China. The current India population is 1.3 billion with 51.6% as males and 48.4% as females.

Total population (2015)	1,300,000,000
Gross national income per capita (PPP international $, 2013)	5
Life expectancy at birth m/f (years, 2015)	67/70
Probability of dying under five (per 1 000 live births, 0)	not available
Probability of dying between 15 and 60 years m/f (per 1 000 population, 2015)	216/142
Total expenditure on health per capita (Intl $, 2014)	267
Total expenditure on health as % of GDP (2014)	4.7

Table a

Nigeria: Nigeria is the largest country in Africa. The current population is 191 million with 50.6% as males and 49,7% as females.

Total population (2015)	182,202,000
Gross national income per capita (PPP international $, 2013)	5
Life expectancy at birth m/f (years, 2015)	53/56
Probability of dying under five (per 1 000 live births, 0)	not available
Probability of dying between 15 and 60 years m/f (per 1 000 population, 2015)	368/318
Total expenditure on health per capita (Intl $, 2014)	217
Total expenditure on health as % of GDP (2014)	3.7

Table b

Results

A table of comparism was established for similar variables amongst the two countries and extrapolated.

Table 1: Showing comparism of variables for PHC performance on SDG in both countries below.

S. No.	Variables	India	Nigeria
1	Population	i.3 bil.	191mil.
2	HFS	28,863	30,000
3	Actual %GDP Spent on Health	0.90%	1.5%
4	Any Senior Person leading the SDG team	Director of NITI	Director General SDG office
5	Availability of office for SDG coordination	Yes	Yes

Discussion

Ensuring that no one is left behind is the sole objective of SDG-3. It gives room to put health at the forefront of the agenda for economic growth. It can also act as a springboard for implementing the UHC in both nations. Additionally, the following are the main policy recommendations to implement SGD-3.

First off, since health ought to be the top priority and the cornerstone of the economic plan for both the federal and state governments. In order to increase public spending on public health from its present percentage of GDP, national health policies are desperately needed in both countries, as are stronger political commitments and efforts.

Secondly, the nations should step up their efforts to eradicate or drastically lower non-communicable diseases (NCDs), such as malaria, tuberculosis, and others. The initiatives and programmes must be implemented broadly but locally.

Thirdly, every HF should work with the government to establish the UHC, which would be all-inclusive and housed in one location. It will assist in keeping individuals out of poverty by reducing out-of-pocket medical expenses. Fourth, a strong rural health system needs to be established by the federal and state governments. Rural communities' public health infrastructure requires additional upkeep, staffing, and basic supplies.

The lack of funds can be addressed by multi-sectoral partnerships and financing contributions, but a robust system of monitoring, assessment, and accountability must also be developed in order to prevent widespread corruption in rural public health.

Conclusion

The summarized points highlighted from this research on SDG achievements in PHCs implementation in India and Nigeria if adhered to by both countries would help them to achieve about 90% success in SDG-3.

Recommendations

Top on agenda for both countries would be:

- Funding all PHC programs is inevitable for SDG-3 to be achieved.
- Health insurance that will cater for health care services at PHC level could allow the enrolment of all for into nearby HFs.
- Infrastructure, equipment and more staffing of PHCs will also boost uptake of services at every level.
- Training and re-training of staff that would be continuous based on rotational basis on health care modules at all levels is sacrosanct for successful SDG-3 legacy.
- Data harmonization, collection, research and archiving with interval monitoring, evaluation and effective accountability will surely leave no stone untouched in SDG-3 implementation.

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