## **Implementing Evidence-Informed Primary Healthcare Operational Planning: Lessons from a Northern Nigerian State**

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Background:

To ensure improved performance and equitable coverage of quality Primary Healthcare (PHC) interventions, Nigeria’s National PHC Development Agency initiated the PHC Reviews in 2011. The reviews involve a facilitated quarterly evaluation of PHC performance along with evidence-based operational planning of PHC interventions by Local Government (LG) PHC managers using routine data.

Methods:

PHC reviews are implemented using a 4-step Diagnose-Intervene-Verify-Adjust (DIVA) process. ‘Diagnose’ identifies constraints to effective coverage using a modified Tanahashi Health Systems Bottleneck Analysis Model. ‘Intervene’ develops and implements action plans addressing identified constraints. ‘Verify/Adjust’ monitor performance and revise action plans.

We observed the processes and outcomes of PHC reviews in Kaduna state following one year of implementation. Kaduna state conducted its first PHC reviews in 2013 involving all LGs the DIVA framework. The reviews focused on determinants for Availability of Health Commodities; Human Resources for Health; Geographical Accessibility; Initial Utilization; Continuous Utilization; and Quality Coverage of four PHC tracer interventions (Immunization, Integrated Management of Childhood Illnesses, Antenatal Care, and Skilled Birth Attendance). Another Bottleneck Analysis was conducted in 2014 to assess performance of operational plans developed in 2013.

Results/ Discussion:

Marginal improvements in effective coverage were observed across all interventions with the highest (11%) occurring in vaccination coverage while skilled birth attendance was least with only 1% coverage improvement. Lack of trained human resources was identified by all LGs as the principal bottlenecks across all tracer interventions. This persisted after a year in spite of development of work plans to address identified constraints.  Poor quality of services ranked next, however this may be largely attributable to human resource constraints.

Assessment of work plan implementation showed that 6 out of 23 LGs completed at least 50% of planned activities for the year. Of 1562 activities planned to address PHC intervention bottlenecks in the state, only 568 (36%) were completely implemented.

Although all LGs performed the “Diagnose-Intervene” steps of the reviews, implementation of the Verify-Adjust steps was weak due principally to constraints in financing and political will. This may have been responsible for the weak results observed. Furthermore, attendance sheets showed that, contrary to the design, the community was not involved in the process.

Conclusion:

DIVA holds promise for effective bottom-up evidence-informed PHC planning in Nigeria, thus we recommend that government and all stakeholders provide adequate support for the complete process which can enhance PHC performance in Nigeria.