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**Building Resilient Systems through Performance-Based-Financing in Fragile & Conflict-Affected States: Case of Insurgency Affected Districts in Adamawa State, Nigeria**

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Background

Since 2009, Northeastern Nigeria has been experiencing insurgency attacks by the Boko Haram terrorist group. By 2015 the resulting humanitarian crisis led to the displacement of over a million people, and disrupted health care delivery in 7 districts.

In Adamawa State, the PBF health reform responded through the State Primary Health Care Development Agency (SPHCDA), which sub-contracted facilities and provided services to the Internally Displaced Persons (IDP) Camp Clinics. PBF in synergy with donor intervention came together to offer a platform for improved State stewardship and coordination from multiple partners in harmonizing relief efforts during the insurgency crises.

This paper assesses the effectiveness of the PBF approach in providing health care services to the IDP camps and host communities parallel to foreign assistance on state stewardship within the health sector.

Methods

A mixed method research was used; a range of multiple sources was used to collect principal information for both qualitative and quantitative data from 2009 to 2015. Key informant interviews and documentary review were used for qualitative data while primary data from the National Health Management Information System (NHMIS) and the Nigerian PBF portal was collected for quantitative review. Simple descriptive statistical method was used to analyze the data.

Results

From our findings, the PBF model had a positive effect on key health indicators in both the sub-contracted IDP camp clinics and the principal contracted health facilities from host communities in PBF districts. Exclusively in IDP Camp Clinics, about 13,899 cases were clinically managed in children, 5495 children immunized against measles and 2927 pregnant women screened for HIV where 17 positive cases were positive.

Institutional autonomy and performance-based incentives to health workers assigned to these clinics were highly motivating and the quality of health care services provided greatly improved. A special equity bonus was accorded and used to rehabilitate damaged health facilities in affected districts in order to provide better health conditions to the displaced population as they returned to their original communities.

Discussion/Conclusion

Fragile and conflict-affected States have some of the worst health indicators in the world; however, the Adamawa example demonstrates the potential for PBF to deliver services even in an unstable setting thereby substantially improving health outcomes of high impact indices such as maternal and child health services.

Certainly this will inspire donors who seek better health results as the way forward, in supporting or re-establishing health systems in fragile and conflict-affected States.