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Research Article

Communal Violence and the Health Security of Rural Women in Benue State-Nigeria

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Abstract: Incessant communal violence in Benue State-Nigeria has increased the level of vulnerability, food, economic and health challenges in the area especially among the rural women thereby compromising their health security. This paper therefore focuses on the effects of communal violence on health security of rural women in Benue state. Data for the study was drawn from 400 respondents using semi–structured interviews and focus group discussion methods. The gathered data was analyzed both quantitatively and qualitatively. The findings of the study revealed that communal violence have many negative effects on health security of women in the area. The vulnerability of women to physical, sexual and psychological attacks during and after violence predisposes them to so many health challenges including physical injuries, pregnancy complications, emotional trauma, distortions in family dynamics and hyper- reactions among other problems. The study recommends the use of proactive community– driven approaches in managing communal violence, prosecution and punishment of masterminds and provision of humanitarian as well as psychological services to women who are victims of communal violence to safeguard their health security in the area.
Keywords: Communal, Violence, Health, Security, Rural, Women, Benue.

Introduction

Communal violence refers to the situation where violence is perpetrated across ethnic lines and victims are based on ethnic group's membership. This typically takes the form of mutual aggression in which members of all involved ethnic groups perpetrate violence and also serve as its victims (Horowitz, 2000). Communal violence has become a common phenomenon in Africa (Irene, 2016). These conflicts mostly ethnic, intra and inter communal in nature have posed a great concern to all spheres of human endeavour. Communal violence has the propensity to directly and indirectly affect the socio-economic activities among communities in the warring camps (Osinubi & Osinubi 2006). Bur (2002) alludes that the nature of communal violence in Tiv communities is mostly inter–ethnic violence and intra-ethnic violence as well as political violence. He also pointed out that the dimension of armed violence is perpetrated by armed ''militia''. According to Akpehe (2018), the jeremiad of communal violence lies in its precarious nature of undermining human well-being, social capital, institutions and sustainable development of the affected communities thereby resulting to extreme poverty and acute underdevelopment that endure even when the violence subsides. It is sad to note that protracted violence among communities in the area is an enemy of health security. There is a well-established correlation between the exposure of countries to communal violence and the

deterioration of health security of the populace. The violence disrupts food production through physical destruction and plundering of crops and livestock, harvest and food reserves. It destroys, farm capital, conscript young and able bodied males and females, taking them away from the farm work and suppresses income earnings occupation.

While conflict inflicts suffering on everyone, women and children are particularly affected by its short-and long-term effects. Sexual assault and exploitation are frequently employed as tools of war; victimization leads to isolation, alienation, prolonged emotional trauma, and unwanted pregnancies that often result in abandoned children. As culturally-designated caregivers, women must struggle to support their families and keep their households together while the traditional bread-winners – husbands and sons – are caught up in the fighting and are unable to provide for their families. The new role as primary provider exposes many women to further abuse. Conflict shatters the comfort of predictable daily routines and expectations within families and communities. Women and girls are equally affected in a fragile environment where social services they once depended on degrade or disappear. Although conflict may, in some cases, improve gender relations as a result of shifts in gender roles (some changes even improve women's rights) by and large its impact on women is devastatingly negative (USAID, 2015).

Various scholarly works such as that of the, Varvar (2000), Bur (2002), Ubwa (2002), Alubo (2003), Angya (2005), Oboh & Hyande (2006), Iorkosu (2007), Sambe, Avange & Alakali (2013), Dzurgba, (2013), Alimba, (2014), Ishor, Iorkosu & Apavigba,(2017) have focused on the causes and effects of communal violence in Benue Valley and Middle Belt of Nigeria at large but left out some health challenges faced by women during and after the communal violence such as post-traumatic stress disorders (PSTD), dysfunctional families and communities, rape and worsening states of already existing medical conditions of the victims. The thrust of this paper is therefore to fill in the gap by assessing the extent to which communal violence have affected the health security of women in Benue State.

Literature Review

This section reviews literature with particular emphasis on the concepts of communal violence and health security and their nexus.

Conceptual Clarification

The basic concepts discussed here are communal violence and health security.

Communal Violence

Communal is derived from a Latin word 'communis' which means commonis. Communal relates particularly to groups, and it involves things commonly used, shared or experienced by a group in a society. Such things can be resources or conflict. When it is conflict, it is known as communal conflict. Communal conflict is a social conflict that relates to a group or groups in a society. When it occurs within a group, it is known as intra-communal conflict and inter-communal conflict when it occurs between groups. It is worth noting that these groups have common social ties, which may make the competition that may ensue to be fierce. The point is that the misuse or unequal distribution of the available resources that should be jointly enjoyed by a group will produce conflict. The conflict will usually be complex to tackle because of the level of hatred that would probably have been cultivated among the parties in the process (Sonmer, Ferron & Cavill, 2014).

Communal conflict is considered by Azuonwu (2002) as a conflict that occurs between two or more communities. Oboh & Hyande (2006) described communal conflict as involving two or more communities engaging themselves in disagreement or act of violence over issues such as claims for land ownership, religious and political differences leading to loss of lives and destruction of properties. Communal violence (sometimes inter-communal violence) is a situation where violence is perpetuated across ethnic lines, and victims are chosen based upon ethnic group membership.

Dzurgba (2006) was of the opinion that communistic violence is that which occurs between two or more communities over territorial land farmland and territorial water for fishing. These definitions revealed that communal conflict is more or less community conflict or ethnic conflict. This is not surprising because communal by its interpretation as a phenomenon that is common to a particular group characterizes a community or ethnicity. Ikureko, Udo & Esin (2012) attested to this fact when he said that communal friction is what is usually described as ethnic conflict. More so, for communal contenders to have been described as culturally distinct people, tribes, or clans in heterogeneous societies, who hold or seek a share in state power.

Yecho (2006), Aboki & Hagizi (2011) indicated that the causes of communal conflicts are not static but rather dynamic and varied in nature depending on the socio-economic and geo-political circumstances at the time. Hembe (2000) and Faleti (2003) identified that political struggle and colonization, while Lyam (2000) mentioned loss of soil fertility, soil erosion, deforestation, bush burning and flooding as some of the causes of communal conflict. Alemika & Okeye (2002) pointed out that the fundamental causes of communal conflict are poor economic conditions, high level of illiteracy, the quest for, and fear of domination by other groups, land disputes, market ownership, chieftaincy tussle and party politics.

Similarly, Varvar (2000) and Dunmoye (2003) indicated that increased demand for land for agriculture, unemployment, rural hunger, poverty impoverishment causes or triggers communal conflict in Nigeria. Deprivation, exploitation and domination of minority groups by major ethnic groups and leadership problem were highlighted by Angya & Doki (2006) as factors that can exert communal crisis. Equally, religious differences, competition for livelihood resources and traditional chieftaincy tussles were enumerated by Oboh & Hyande (2006) as potential communal conflict triggers in the country. For instance, competitions for land and chieftaincy tussle are the major causes of communal conflict in north-central Nigeria. For instance, in Nasarawa in 1993, Alago, Hausa and Tiv clashed over land and chieftaincy from 1995-2005, the Egburra and Bassa in Toto clashed over land, chieftaincy and politics. In 1989, 1990 and 1997, intra-communal conflict occurred in Ipav in Gboko based on land problem. On June 2003, Ekepedo and Ogori clashed over land ownership in Kogi/ Edo States and from 2015 to date there existed communal violence in Benue Konshisha LGA like that of Ugambe/ Mbayegh, Mbamaa/ Mbausu Ugande/ Mbaise, Ukan/Gaav. Alubo (2002) argued that in Benue Valley, the pressure on land from all directions heightens the proliferation of ethnic and communal conflicts in the region, including the political ones, most of them arising from the land question.

Health Security

Health, according to United Nations Organization (UNO) (1995) is a fundamental human right and not merely a social good. It is an asset for individuals in the family, community and nation irrespective of age, sex, origin or race. Health is not only a physical condition of a person, but rather, they are also socio-cultural conditions of people or societies. The WHO (2007 & 2019) further defined health as a state of complete physical, mental and social well-being and not merely the absences of disease or infirmity and "global public health security" as "the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries". In this regards, health security therefore places premium on protection against threats consistent with pre-existing public health conditions. Generally, health is vital resource that no community could trade it off. The absence of health security of people leads public health insecurity (Akpehe *et al.*, 2020). The concept of health insecurity is used to mean a situation where people or group of people face real or imagined threats to their health while the absence of these threats is termed health security. Determinants of health insecurity may include generalized violence and food insecurity. It may manifest in terms of malnutrition especially in children, emergence or worsening of disease entities, physical and mental injuries and even death (Akpehe, Kwaghga & Akpehe, 2018).

Communal Violence and Health Security of Women

Communal violence has far–reaching effects on the health security of women. According to Taft, Blyth & Murphy (2016), some of the health challenges women face during communal violence include sexual abuse by male family members–fathers, husbands, cousins and uncles– as well as by trusted authority figures, such as religious leaders and members of the security forces with attendant consequences such as unwanted pregnancies (with complications of premature deliveries and unsafe abortions), sexually transmitted infections (including HIV) and post-traumatic stress disorders. These sexual abuses women suffer during communal violence may range from forced nudity, mass rapes, gang-rapes, genital and breast mutilation, and insertion of objects into bodies etc.

Khanna (2008) also maintains that in addition to the obvious physical injuries inflicted by burns, arms and weapons women go through during communal violence, they experience considerable mental trauma and stress, as well as hunger due to curfews, isolation and hiding, and infections and epidemics due to living in inhumanly unsanitary conditions of refugee camps when communal violence occur. With regard to mental health consequences, repeated subjection to sexual violence as well as witnessing family members and other women from the community being violated engendered a psychological threat perception among women who survive communal violence predisposing them to varying degrees of post-traumatic stress disorders (Khanna, 2008).

Another deficiency of communal conflict is the production of humanitarian problems such as internally displaced persons (IDPs) camps. Ikurekong, Udo & Esin (2012) aver that a common and significant challenge women face during such times is the inability to comfortably and with dignity maintain optimal menstrual hygiene with attending consequences. In many emergency contexts, women and girls lack access to basic health materials, such as sanitary pads, cloths and underwear, which are needed to manage menstrual periods. Privacy is often non-existent while in transit, or in camps or informal settlements and they often lack easy access to toilets, which even if available, may lack doors, locks and lighting and are inadequate to manage menses (Osinubi & Osinubi, 2006). Access to water and places to wash and dry reusable pads and cloths (for those who cannot afford the disposable sanitary pads) or to dispose of used materials are often scarce (Avav, 2002; Bahati, 2009). Such factors can increase their risk for exposure to violence and exploitation, particularly at nighttime when seeking out private spaces to manage sanitary needs (Albert, 2001; Ubwa, 2002).

The international committee of the Red Cross in Africa (ICRC, 2015) reported that during armed conflicts, displaced women and girls as well as female heads of households are particularly vulnerable and at risk of certain kinds of violence, including sexual violence. Because their husbands are missing, detained or taking part in the fighting, displaced women and female heads of households often have to shoulder the burden of being a single parent. This means providing by themselves the family's income, deciding by themselves about their children's education, and guaranteeing by themselves the safety of their family. Apart from these direct health consequences of violence, there are indirect and long-term health consequences. Massive destruction of lives and properties as well as disruption of social, political and economic lives of the communities lead to increasing impoverishment and therefore chronic hunger among the rural poor especially women and their children. Furthermore, women who are widowed and displaced due to communal violence become the sole providers for their children and thus face extreme financial pressures which increase their vulnerability to abuse (Khanna, 2008; Taft, Blyth & Murphy, 2016).

Methodology

This section presents the detailed methodology used in this study using the following sections;

Study Setting

The study was conducted in Benue state which lies within the lower River Benue trough in the middle belt region of Nigeria. Her geographic coordinates are longitude 7° 47' and 10° 0' East, latitude 6° 25' and 8° 8' North. Created on 23rd February 1976, Benue State, which derived its name

from River Benue is located in the middle belt region of Nigeria bordering Nasarawa state to the North, Taraba state to the East, Ebonyi, Enugu and Cross-River states to the South and Kogi state to the West. The southeast stretch of the state also shares boundary with the Republic of Cameroon.

Administratively, Benue state is divided into 23 Local Governments namely Ado, Agatu, Apa, Buruku, Gboko, Guma, Gwer, Gwer-West, Katsina-Ala, Konshisha, Kwande, Logo, Makurdi, Obi, Ogbadibo, Ohimini, Oju, Okpokwu, Otukpo, Tarka, Ukum, Ushongo and Vandeikya. The State has a projected population of over 5,741,800 people as at 2019 (NPC, 2019), comprising the Tiv, Idoma, Igede, Etulo, and Ufia inhabiting an estimated land area of 32861.25 Square Kilometers.

As an agrarian State, agriculture remains the main occupation of the vast majority of her people engaging over 75% of the entire population. Notably, Benue State is the nation's acclaimed food basket because of her rich agricultural produce which include: yams, rice, cassava, potatoes, maize, soya beans, sorghum, millet, cocoyam, mango, orange, cashew, tomato and pepper. The State has a tropical sub humid climate, with two distinct seasons, namely wet season and dry season. Benue state often experiences a mean annual rainfall of between 1,250 and 2,000 mm and a mean temperature of 32.5^0C. The state is richly endowed with both human and natural resources including minerals such as limestone, coal, kaolin and iron, which are still untapped.

The State had witnessed a considerable number of inter and intra–communal clashes on many occasions with devastating outcomes on human lives (especially women, children and the aged) and property thereby necessitating this study.

Study Population

Though, Benue State has an estimated population more than six (6) million people (NPC, 2019), due to limited time and other resources, only four hundred and twelve (412) respondents were randomly selected from the twenty three (23) LGAs to represent the population using Taro Yamanes' (1973) sample size determination formula. Study participants were males and females from 18 years and above.

Sampling Procedure

The study employed both clustered and purposive sampling techniques to draw its actual respondents. Firstly, the State was clustered into three geo-ecological zones namely: Zone A, B and C. Secondly, two Local Government Areas were purposively selected from each of the zones due to high number of cases of communal violence recorded. These include Katsina Ala and Logo in Zone A, Guma and Gwer-West in Zone B, Agatu and Oju in Zone C. Thirdly, in each of the LGAs, two council wards noted for high incidences of communal violence were purposively selected. Fourthly, a sampling frame was developed for each of the council ward using proportional allocation of 0.001 across board. The primary data were elicited from the respondents using semi–structured interviews (SSIs) and focused group discussions (FGDs) methods of data collection. The obtained data were analysed both qualitatively and quantitatively.

Results and Discussions

Socio-Demographic Characteristics of Respondents

The socio-demographic characteristics of the respondents captured in this study include sex, marital status, age, occupation, educational attainment and income. In terms of sex, all the 400 (100%) respondents were female. In respect to age, the data obtained had indicated that 92 (23%) respondents were within the youth category of 18–30 years, 195 (48.8%) respondents aged between 31 and 64 years, whereas 113 (28.2%) respondents had the age bracket of 65 years and above. The marital status of respondents showed that 96 (24%) respondents were single and 199 (49.8%) respondents were married while 105 (26.2%) respondents were widows. Furthermore, the occupational distribution of the respondents indicated that 245 (61.2%) respondents had farming as

their dominant occupation, 96 (23.8%) respondents were traders, 30 (7.5%) respondents were civil servants, and 30 (7.5%) respondents belonged to other various occupations. The study also found out that 102 (26.5%) respondents had attended and/or completed primary level of education, 189 (47.2%) respondents had attained secondary school level, and 47 (11.8%) respondents attained tertiary level of education, while 62 (15.5%) respondents were non-literate. See Table 1 for details.

Table 1. Socio-Demographic Variables of the Respondents

Variable	Frequency N=400	Percentage (100 %)
Age		
14-30	92	23.0
31-64	195	48.8
65 above	113	28.2
Sex		
Male	0	0.00
Female	400	100
Education		
Non Literate	62	15.5
Primary	102	25.5
Secondary	189	47.2
Tertiary	47	11.8
Marital status		
Single	96	24.0
Married	199	49.8
Widowed	105	26.2
Occupation		
Farmer	245	61.2
business	95	23.8
civil servant	30	7.5
Others	30	7.5
Source: Field work, March, 2019		

Communal Violence and Health Security of Rural Women in Benue State–Nigeria

Though this study could not embark on an elaborate clinical evaluations of the sampled respondents, the perceived health reports of respondents and personal observations on the effects of communal violence on the health security of rural women in Benue state were examined and implications were drawn. The study outcomes have indicated that incidences of violence in Benue local communities had inflicted numerous short and long–term challenges on the health security of women victims in the area either directly or indirectly. The short–term effects were such challenges that inflicted but a temporal pain or burden on the victims whereas the burdens of the long–term effects were long–lasting and/or permanent. Thus, the statistical results from the study showed that 34 (8.5%) respondents suffered displacement, 62 (18%) respondents sustained various degrees of physical injuries, 20 (5.0%) respondents had pregnancy miscarriages and premature deliveries during the violence, 50 (12.5%) respondents reported that they had suffered some cases of sexual assaults including rape and 30 (7.5%) respondents suffered hunger and starvation during and after violence. Furthermore, 40 (10%) respondents indicated they had suffered from poor sanitary conditions, 46 (11.5%) respondents pointed out that communal violence prevented their access to health care facilities especially reproductive health care services (RHCS), 58 (14.5%) respondents had reported mild to severe cases of psychological trauma and stress, 33 (8.25%) respondents had reported cases of high blood pressure as a result sight and sound of arms and ammunitions during the crises whereas, 27 (6.75%) respondents had reported cases of gastro–intestinal ulcer due to hunger and poor nutrition. The aforementioned problems posed health security challenges during and after the communal violence in Benue State. See Table 2 for statistical details.

Table 2. Communal Violence and Health Security or Rural Women

Variable	Frequencies	Percent
Displacement	34	8.5
Physical injuries	62	15.5
Miscarriages and premature deliveries	20	5.0
Sexual Assaults	50	12.5
Hunger and starvation	30	7.5
Poor sanitary conditions	40	10.0
Deprived access to health care facilities	46	11.5
Psychological trauma and stress	58	14.5
High blood pressure	33	8.25
Gastro–intestinal ulcer	27	6.75
Source: Field work (2019).		

The preponderance percentages of physical injuries (15.5%), sexual assaults (12.5%) and psychological or emotional trauma (14.5%) from Table 2 above depicts the extent to which women are made more deplorable and vulnerable to more adverse health conditions during and after incidences of communal violence in our local communities. Considerable number of these assaults were reported to have been inflicted on women victims while on transit in search of safety and after settlement in relief camps implying more jeopardy on women's physical and emotional wellbeing as well as their general health security. Reported cases of increase in food shortages, poor nutrition, shelter, sanitary services, inadequate access to health care services, lack of safe drinking water and privacy suffered by women during and after communal violence across the study area were found in the study to have further undermined women's health conditions especially, their reproductive health statuses. This confirms Mckay (1998) findings that girls and women are especially vulnerable to physical and sexual assault while they are in transit or resettling camps where poor services are experienced. The finding also tallies with the International Committee of the Red Cross in Africa (ICRC, 2015) that reported that during armed conflicts, displaced women and girls as well as female heads of households are particularly vulnerable and at risk of certain kinds of violence, including sexual violence.

Further investigations from focused group discussion sessions also revealed that women suffer a great deal of physical and sexual assaults including beating, matchetting, slashing, abductions, nudity, breast sucking, inserting of objects into their vagina, mutilation and rape in the hands of local militants, security operatives and sometimes, relations whom they seek refuge from. These according to discussants, result to multiple health implications such as sexually transmitted diseases including HIV, Vesico-vaginal fistula (VVF), unwanted pregnancies, miscarriages, fractures, trauma, shame, abdominal pains, high blood pressure and death.

A discussant from Tse–Torkula in Guma LGA who survived the horror and terror of sexual assault during communal violence has this to say:

> *They came into our compound and started shooting sporadically. My husband, his three brothers and my son were gunned down and slashed like grasses. We became helpless and ran into the nearby bushes yet the men pursued and caught us there. The one with gun commanded us to lie down and they tripped us naked and ganged raped us. After raping us, they inflicted wounds on our bodies and left us to suffer the pain and shame (FGD, 2019).*

Another discussant from Apa-Agatu village who also witnessed the terror of communal violence reported thus:

> *What they did to my daughter–in–law, Susana was terrible and wicked. She was heavily pregnant near delivery so she could not run faster than them. They caught her close to the market square while some of us ran and hid in the bush. She was begging and screaming for help but to no avail. The wicked marauders after raping her to coma tore her belly, took out the baby with a sword and butchered it. Then they left her there naked to die in the pool of her blood with no one to help her. In fact, there's nothing women did not see during the attack. Sometimes, I feel, it is even a curse to be a woman (FGD, 2019).*

In addition to the obvious physical injuries and sexual assaults inflicted on women during moments of communal violence, the study gathered some perceived reports of psychological trauma and stress (14.5%) due to horrible sights of killings, especially of husbands and close relations, rapturing sound of arms and ammunitions, intimidation and maiming, isolation, hunger and living in dehumanized conditions on internally displaced persons' camps (IDPCs) from the respondents. The trauma, according to majority of the respondents had inflicted levels of mental and mode disorders on its victims. Respondents also attributed the rising rate of hyper–reactions especially, high blood pressure (8.25%) and gastro–intestinal ulcer (6.75%) to trauma and stress victims went through during violence and in IDP Camps. These findings were likened to post-traumatic stress disorders which corroborates Akpehe *et al.,* (2019) who discovered that high levels of trauma, stress and hopelessness coupled with the state of inadequacies in the IDPCs have also exacerbated the victims' level of fear/anxiety, aggression and hyper reactions including hypertension among others whereas shortages of good medical attention and emotional imbalances have lowered the general health conditions of disaster victims.

Further findings from group discussants in Tom-atar village, Logo LGA indicated that although the communal violence had subsided, the psychological trauma, stress and fear that women experienced during the incidences had refused to leave them. In the words of a victim who narrated her ordeal and that of other women during the attack on their community:

> *I find it difficult to forget how the wicked herders murdered my husband and my sons in front of me. The shrilling voice of my helpless son, Terhemen, who was crying and calling me to plead with the wicked militants re-echoes daily in my head and heart. I even offered myself for my sons but my plea fell on wicked deaf ears. They succeeded in making me a widow and a childless woman in one day. All they did was to away my joy, hope and pride and turned me into an object of scorn and shame. What's the essence of living again? Only death can make me forget this (FGD, 2019).*

The foregoing implies therefore that some victims are still suffering from perceived psychological threat that usually make their trauma acute and may be responsible for the reported cases of hypertensives and other underlying ailments as well as death even after the violence had been called off in the area. Perceived fear of reoccurrence and acute anxiety among women victims were also reported to have exerted adverse effects on other aspects of victims' lives including farming, education, work and business thereby making their living conditions more deplorable. These findings agrees with those of Swiss & Geller, (1993) who maintained that girls and women usually contend with the humiliation, shame, and anguish engendered by sexual violence: flashbacks, difficulty reestablishing intimate relationships, persistent fears, and a blunting of enjoyment in life even when the violence is over.

In terms of indirect implications of communal violence on the health of women, majority (80.07%) of the respondents maintained that communal had caused more than 70% damage to farm crops in the area thereby reducing total food production, availability and affordability. This by implication had undermined victims' access and choices to food and nutrition living them more vulnerable to hunger, starvation and malnourishment. Further findings also revealed that women who are made widows and displaced during communal violence became heads and bread winners of their

households thereby facing more socio–economic and psychological pressures which increase their vulnerability to assaults and ill health. This finding is in line with views of Taft *et al.,* (2016) and Khanna (2008) that women who are widowed and displaced due to communal violence become the sole providers for their children and thus face extreme financial pressures which increase their vulnerability to abuse. A Chi-Square-based test of the significance and strength of the association between communal violence and health security of women in Benue State shows a strong association between these variables (see Table 3 for details).

Table 3. Chi–square test of the nexus between communal violence and the lowering health security of women

Chi-Square Test

	Value	Df	Asymp. Sig (2–sided)
Pearson Chi–Square	176.116[a]	4	.000
Likelihood Ratio	227.177	4	.000
Linear–by–Linear Association	120.625	1	.000
N of Valid Cases	400		
a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.48			

Symmetric Measures

	Values	Approx. Sig.
Nominal by Nominal Phi	.661	.000
Cramer's V	.501	.000
Number of valid cases	400	
a. Not assuming the null hypothesis b. Using the asymptotic standard error assuming the null hypothesis		

The above statistical test found that the value of Chi-Square (X^2) in the association is = 176.116 at a degree of freedom (df) of = 4 and P value of 0.000. Since P–value is less than 0.05; it means that the variables are significantly associated. Furthermore, the measured strength of the association between communal violence and health security of women found the nominal by nominal Phi (Ø) value of 0.66, while that of Cramer's V is = 0.50 indicating that the association is moderately strong. This implies therefore that incidences of communal violence might have accounted for more than half of the health challenges of women victims in the area. In light of the foregoing, it could be inferred that communal violence is inimical to health security agenda of the modern day Nigeria not just the women fork. It exposes the victims to physical, sexual and emotional attacks and imbalances with associated levels of hyper–reactions. Hence, it is a menace that requires urgent attention both locally and internationally.

Conclusion/recommendation

On the whole, empirical evidences in the course of the study have shown a strong link between communal violence and health security of women in the study area implying that communal violence constitutes a high threat to women's health and the general wellbeing of people within the study area. Notable health challenges among victims associated with the menace of communal violence as reported by the study include: physical injuries, sexual assaults, reproductive health challenges and social–psychological imbalances. Others are hunger, starvation and malnutrition, psychological trauma (post-traumatic stress disorders), limited access to basic social services such as health care delivery, quality education, shelter and social groups. Furthermore, the violence disrupts food production chain thereby limiting its availability, accessibility and affordability among the rural poor and vulnerable groups leading to poor nutrition and food insecurity.

There is therefore an urgent need for community gatekeepers, local area authorities and state government as well as non–governmental agencies to join hands in fighting the menace of communal violence in our local communities. One way of doing this should be by prosecuting and punishing people found guilty of masterminding, perpetrating communal violence and/or sponsoring local militants to unleash to execute it. The study further recommends that there should be community–driven conflict management and resolution committees to resolve misunderstandings between the aggrieved parties timely before they escalate to violence. This may likely minimize the frequency of communal violence in the rural areas. Furthermore, the local and state governments and community–based organisations should employ the services of clinical psychologists to help alleviate the psychosocial impacts of communal violence on women during and after its occurrences. There is also need for the local and state governments to step-up security operatives, provide health care and humanitarian services as well as economic empowerment schemes etc. in the affected areas. Finally, all stakeholders should support the existing agencies working with IDPs to provide succor and security to displaced women who are taking refuge in relief camps. These will help in improving the health security and general well-being of people especially women who are more vulnerable during and after violence in the area.

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