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Management Of Ethno-Religious Conflicts In Nigeria Amidst Insufficient Health Facilities: Empirical Insights From Benue And Enugu States Of Nigeria

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Abstract
This study examined the status of public healthcare institutions and its impact in the management of fallouts of ethno-religious conflicts in Nigeria, from 2000 to August 2021, using four communities in Benue and Enugu States. Specifically, it sought to find out if Nigeria has adequate healthcare facilities that could meet the needs of emergency services in conflict situations; and whether the state of the healthcare facilities had significant positive impact on the management of fallouts of ethno-religious conflicts in Nigeria. With the aid of cross-sectional design, structured Health Facilities and Care Quality Assessment Questionnaire (HFCQAQ), and SPSS tools, data was collected from 200 participants resident in four (4) communities of Makurdi and Gwar in Benue State, and Nimbo and Eha-Amufu in Enugu State, and analysed. Results of the analyses revealed that healthcare facilities in the communities were insufficient and obsolete, and had negative impact on the management of the fallouts of ethno-religious conflicts in the communities. The paper recommends, among others, the declaration of state of emergence in the health sector for the modernisation and procurement of facilities.

Keywords: Ethno-religious relations, Conflict management, Conflict victims, Healthcare, Benue and Enugu States, Nigeria

Introduction

From the early days of independence, Nigeria has continued to experience conflicts of different magnitudes, mostly the ethno-religious ones. The 1967 – 1970 civil war, the Maitatsine religious conflicts of the 1980s, the 1992 Zango-Kataf crisis, the Shagamu religious crisis of 1999, the Jos conflicts (1994 – 2008), the Kano conflicts (1980– 2001), and Herders – Farmers conflicts since the turn of the century mainly are prominent among such conflicts (Otite &

Albert, 1999; Igbokwe, 2000; Kwaja 2009). These conflicts claimed thousands of lives and left more than thousands that were fatally wounded, bleeding with bullet wounds, or in coma (Hill & Asthana, 2006; Olasope, 2012; New York Times, 2018). Others were afflicted with Post-Traumatic Stress Syndrome (PTSS) (Dogara, 2010; Onwoma, 2014). This paper examines the management of these fallouts of ethno-religious conflicts in the light of the state of health facilities in Nigeria between 2000 and August 2021, using three communities – Makurdi and Gwar in Benue State and Nimbo in Uzo-Uwani LGA and Eha-Amufu in Isi-Uzo, Enugu State – as the main focus.

For various reasons, intermittent ethno-religious clashes and attacks, especially between the indigenous farmers and marauding herdsmen, has been a recurring phenomenon in different towns/villages of the mentioned communities in both Benue (Business Standard, 2013; Ejembi, 2020; Uja, 2021) and Enugu (Okoli, Odu & Nwaiwu, 2021; J.J. Media, 2016; Ozor, 2012) States, among many other communities in Nigeria, and more so since the turn of the century. Apart from the attendant destruction of properties and means of livelihood, these clashes and attacks usually lead to numerous killings and injuries that require urgent medical attention on the part of the victims. In other words, the availability of adequate healthcare facilities, drugs and qualified/trained health personnel as well as the readiness of both governmental and non-governmental agencies to promptly respond to such situations and the victims remain pivotal.

Healthcare system in Nigeria has passed through different stages of transformation and schemes in the bid to resolve prevailing public health crisis. These include the introduction of the Nigeria Basic Health Service Scheme (NBHSS), Midwives Service Scheme (MSS), National Immunization Coverage Scheme (NICS), National Health Insurance Scheme (NHIS) and Nigerian Pay for Performance Scheme. Among other objectives, each scheme sought to provide healthcare facilities, enhance greater access to basic healthcare services, and reduce mortality rate among the population. Unfortunately, the various Primary Healthcare Centres (PHCs) in Nigeria have continued to experience insufficient skilled manpower, insufficient provision of drugs and other medical aids, dilapidated buildings and infrastructures, unhygienic environments and lack of security personnel and facilities.

Scholars such as Ogundele and Olafimihan (2009), Orunaboka & Nwachukwu (2012) have revealed that lack of proper maintenance culture, insufficient funding, prevalence of obsolete equipment, and under-staffing characterise healthcare facilities in the Less Developing Countries, including Nigeria, and have significantly continued to undermine service delivery.

It is, therefore, necessary to observe that adequate provision of health facilities is a basic requirement for the provision of effective healthcare services under any condition, in any culture, and development (Erinosho, 2006; Ademiluyi & Aluko-Arowolo, 2009). The literature holds that effective provision of healthcare facilities dovetails into availability of workable complementary health technological and professional/skilled human resources, good road networks, availability of good transport system, water supply systems, regular electricity supply, and administrative readiness to feasible systemic adjustment to cope with emergencies (World Health Organization, 2010; 2007). Obi, Abe & Okojie (2013) and Eboreime, Abimbola

& Bozzani (2015) argue that private health service providers provide these components of good facilities more than their public counterparts.

Thus, most of the Nigerian public healthcare facilities tend to be deficient in terms of human resources, infrastructural and equipment requirements and medication services. The facilities are characterized by lack of vital equipment, absence of logistic supports, insufficient skilled personnel, insufficient electricity, poor government funding and bureaucratic bottlenecks which undermine staff recruitment and training, substandard services and poor infrastructure since the 21st century (Alkali & Bello, 2020). Others include poor maintenance of buildings, medical equipments and vehicles, shortage of drugs and 'out of stock' drug syndrome (Ilozor, 2013; Okoroh 2012). This situation results from insufficient government support for the healthcare system, corruption and mismanagement of fund and purchase of sub-standard items (Omoluabi, 2016; Ahmed & Gidado, 2010).

The consequences of the above state of facilities in the health sector for the quality of healthcare services and quality of care delivery under emergency situations have been the concern of many scholars. Scholars like Flegel (2015) were concerned with its impact on the medical services required by patients on referrals from primary and secondary healthcare institutions and observed the prevalence of medical errors and poor healthcare delivery due to insufficient facilities. Nikhil, Vinod & Achala (2016) made similar finding on the use of malfunctioning equipments wherein test results experience deviations and errors. On the other hand, Loughrey, Fitzpatrick, Connolly, & Donnelly (2002) averred that insufficient facilities in healthcare institutions significantly affect the type of surgical medical care provided to patients negatively. King et al. (2013) focused on the insufficient communication facilities and observed that poor communication undermines the accurate information dissemination on the health status of patients, increases their re-hospitalization and causes delays and staff stress together with frustration among patients. To the best of the knowledge of the researchers and from available/accessible literature reviewed, no scholar has examined the consequences of insufficient health facilities on the management of fallouts of victims of ethno-religious conflicts in Nigeria. This forms the focus of the present study.

Research Questions

The following questions are being examined in this article:

1. Do hospitals in Nigeria have adequate healthcare facilities that meet the needs of emergency services in conflict situations?
2. Have healthcare facilities made any significant positive impact on the management of fallouts of ethnic and religious conflicts in Nigeria?

Materials and Methods

This research utilised a cross-sectional model to collect and analyze information from residents, health professionals, and patients at four public health facilities within and around Makurdi and Gwar in Benue State, as well as Nimbo and Eha-Amufu in Enugu State. These communities have been experiencing series of ethnic driven herders – farmers' conflicts, at different times, since 2000. With the aid of the researchers'-developed and structured Health Facilities and

Care Quality Assessment Questionnaire (HFCQAQ), data was collected through simple random sampling method from 200 participants drawn from the four communities and the accessible hospitals (i.e. 50 each). The HFCQAQ is divided into two sections, A (socio-demographic information) and B (questions intended to get research-related answers), and it is formatted using a five-point Likert scale with the options: strongly agree, agree, no opinion, disagree, and strongly disagree.

A pilot study, which enabled the researchers to restructure the Health Facilities and Care Quality Assessment Questionnaire, was conducted on an initial small sample of 20 respondents before embarking on the administration of the instrument on the whole sample drawn from the sample population. The participants consisted of 16 healthcare service providers, 49 patients, and 135 people residing in the four communities. The first and second categories of participants were the actual number of persons found present during the fieldwork while the third category were selected from a teaming population of residents found in the central markets of the communities.

Questionnaires were administered on the participants on a face-to-face basis after brief explanation of the purpose or nature of the investigation and wilful acceptance of the participants to involve themselves in the research. The contents of the questionnaire were explained in native languages to those that could neither read nor understand English language through the assistance of the educated participants. Similarly, the researchers sought and obtained the consent of the hospital management boards in the two states concerned to carry out the research before proceeding to the areas of the study.

The Statistical Package for the Social Sciences and simple percentage analysis were used to analyze the questionnaire's raw scores, which were placed into frequency tables (SPSS version 20.0). The means (x), standard deviations (SD) and statistical differences of the scores were calculated in order to address the research concerns. Variance in the statistical calculations of the responses is considerable at .05 levels.

Data Collection and Analysis

Table 1: Demographic data of respondents

S/N	Capital	Population	Marital status			Sex		Age				Educational level		
			m	s	d/w	Mal	fem	18-27	28-37	38-47	48 & above	FSLC	O/L	HLC
1	Makurdi	50	23	17	10	26	24	14	17	12	7	14	20	16
2	Gwar	50	34	5	11	28	22	21	15	9	5	19	23	8
3	Nimbo	50	21	12	17	24	26	13	21	13	3	17	20	13
4	Ehamufu	50	29	15	6	25	25	12	18	16	4	9	30	11

Total	**200**	**107**	**49**	**44**	**103**	**97**	**60**	**71**	**50**	**19**	**59**	**93**	**48**

Source: Field Work, August 2021.

Notes: S/N = Serial No.; m = Married; s = Single; d/w = Divorced/Widow; mal = Male; fem = Female; FSLC = First School Leaving Certificate; O/L= Ordinary Level; HLC = Higher Level Certificates

Table 1 above reveals that: 107 respondents (53.5%) were married, 49 (24.5%) were single, 44 (22.0%) were widows or divorced, 103 respondents (51.5%) were males, and 97 respondents (48.5%) were females. The age brackets of 18-27 consisted 30.0%, 28-37 consisted 35.5%, 38-47 consisted 25.0% and 48 & above consisted 9.5% of the respondents. On the other hand, 59 respondents (29.5%) did not possess any certificate or were holders of First School Leaving Certificate; 93 (46.5%) possessed O/L certificates while 48 respondents (24.0%) possessed Higher level certificates. From the statistics, the respondents were matured to participate in the survey, while the responses generated from them were gender sensitive.

Research Question 1: Do hospitals in Nigeria have adequate healthcare facilities that meet the needs of emergency services in conflict situations?

Table 2: Results of SPSS Analytics of replies to research question 1's subsidiary queries

S/n	Research questions	Grand Mean	Stand. Deviat.	Standard Error	Tests of Between-Subjects Effects	Sig.	Pairwise Comparisons
1	There is a good stock of medical disposables, surgical equipment, and vaccines for the treatment of emergency patients particularly victims of conflicts in public hospital in your community	2.58	1. 390	.304	334.006	.001	@ 95% confidence Interval, no adjustments
2	The public hospital in your community has good drugs storage facilities, regular supply of electricity, Oxygen services, and functional theatre for the treatment of emergency patients.	2.64	.118	.356	164.520	.004	@ 95% confidence Interval, no adjustments
3	The public health facilities in your						

	community has a good stock of some medical equipment that are in good working condition for the treatment of emergency patients like victims of conflicts and accidents such as thermometer, autoclaves, stethoscope, heat sterilizer, sphygmomanometers etc.	1.02	.239	.241	240.296	.001 & .003	@ 95% confidence Interval, no adjustments
4	The healthcare facility in your community has a good stock of basic and non-expired drugs such as Ceftriaxone, Diazepan, Oxytocin, Calcium Gluconate, Magnesium Sulphate, Saline Solution, Ferrous Salt, Folic Acid and Paracetamol etc.	2.09	.345	.058	189.002	.000	@ 95% confidence Interval, no adjustments
5	The healthcare facility in your community has good and functional emergency and delivery vehicles for referrals.	2.58	.239	.241	240.296	.003	@ 95% confidence Interval, no adjustments
6	The healthcare facility in your community has the required medical team to render appropriate services during emergencies and ethno-religious conflicts	3.26	.505	.123	192.330	.006	@ 95% confidence Interval, no adjustments

Source: SPSS analysis of responses to research questions

The cumulative responses to research question '1', in table '2', which sought to know if there were good stocks of medical disposables, surgical equipments, and vaccines for the treatment of emergency patients, particularly victims of conflict, in public hospitals have a grand mean of 2.58 and a standard deviation of 1.390, according to the results of SPSS univeriate analysis. The result of the tests for between-subject effects shows a significance level of .001. The data

from the four healthcare facilities' significant level of differences were analyzed using Pairwise Comparisons and it revealed Least Significant Difference, which is the same as making no adjustments. This is because the findings revealed .001 levels when the mean difference should be significant at the .05 level. As a result, the overall mean of 2.58, which represents 'Disagree' in the Likert scale measure, was accepted and implies that public hospitals in the four communities did not have good stock of medical disposables, surgical equipment and vaccines for the treatment of emergency patients, particularly victims of conflicts.

The response analysis of research question 2 which asked whether public hospitals in the study areas had adequate drug storage facilities, reliable electricity, oxygen services, and functional operating rooms for treating emergency patients, revealed a grand mean of 2.64, a standard deviation of .118 and a level of significance of .004. The data from the four healthcare facilities were analyzed using Pairwise Comparisons which, likewise, revealed the Least Significant Difference which is the same as making no alterations. This is due to the fact that the data showed a .004 level of significance whereas the mean difference should be significant at the .05 level. As a result, the cumulative mean of 2.64, which corresponds to the Likert scale measure of "Disagree," was accepted and which implies that public hospitals in the four communities did not have good drugs storage facilities, regular supply of electricity, Oxygen services and functional theatre for the treatment of emergency patients.

Equally, analysis of responses to question 3, which sought to find out if public health facilities in the study areas had good stock of medical equipment for the treatment of emergency patients like victims of conflicts and accidents, revealed a grand mean of 1.02 and standard deviation of .239 while 001 and.003 were revealed as levels of significance by the Tests of Between-Subjects Effects. Pairwise comparisons of the data from the four healthcare facilities and their significant degree of differences also exhibited Least Significant Difference which is the same as making no adjustments. This is because the results revealed .001 and .003 levels when the mean difference should be significant at the .05 level. As a result, the cumulative mean of 1.02, which in the Likert scale measure denotes "Strongly Disagree," was accepted. The above outcome suggests that the public health facilities in the study areas did not have sufficient supply of medical equipments for the treatment of emergency patients such as those who were wounded in accidents and conflicts.

The answers to question 4 which asked if the healthcare facilities in the four study areas had good stock of basic and non-expired medications like Ceftriaxone, Diazepan, Oxytocin, Calcium Gluconate, Magnesium Sulphate, Saline Solution, Ferrous Salt, Folic Acid and Paracetamol, among others, were analyzed. The results revealed a grand mean of 2.09 and a standard deviation of .345. The .000 level of significance was revealed by the tests for between-subject effects. Least Significant Difference, or "no adjustments," was also revealed by the Pairwise Comparisons study of participants' responses and degrees of differences. This is because the data revealed .000 when the mean difference should be .05, which is significant. Hence, the cumulative mean of 2.09, which in the Likert scale measure denotes "Disagree," was accepted and which implies that the healthcare facilities did not have good stock of basic and non-expired drugs.

The responses to question 5, which inquired if the medical facilities in the four areas had good and functional emergency and delivery vehicles for referrals, were analyzed. The results indicated a grand mean of 2.58 and a standard deviation of .239. The Tests of Between-Subjects Effects showed a significance level of .003. Least Significant Difference, or "no adjustments," was realised from the Pairwise Comparisons study of participant responses and degrees of differences. This is due to the fact that while the data revealed a .003 mean difference, the difference should be significant at the .05 level. As a result, it showed that the cumulative mean of 2.58, which corresponds to the Likert scale measure of "Disagree," implied that the healthcare facilities did not have good and functional emergency and delivery vehicles for referrals.

The results from the analysis of the responses to question six, which aimed to determine if medical facilities had the necessary staff to provide proper care during emergencies and inter-ethnic conflicts, revealed a 3.26 grand mean and a .505 standard deviation. A significance level of .006 resulted from the tests for between-subject effects. Least Significant Difference, or "no adjustments," resulted from the Pairwise Comparisons study of participant responses and degrees of differences. This is because while the data revealed a .003 mean difference, the difference should be significant at the .05 level. Therefore, the cumulative mean of 3.26, which in the Likert scale measure denoted "No Opinion," was accepted. This implied that the majority of the participants were unable to decide whether healthcare facilities in the four communities had the necessary medical team to provide appropriate services during emergencies and ethno-religious conflicts.

Research Question 2: Has healthcare facilities made any significant positive impact on the management of fallouts of ethno-religious conflicts in Nigeria?

Table 3: Findings of SPSS Analyses of responses to research question 2's subsidiary questions

S/n	Research questions	Grand Mean	Stand. Deviat.	Standard Error	Tests of Between-Subjects Effects	Sig.	Pairwise Comparisons
7	Lack of good and functional emergency and delivery vehicles for referrals has led patients to spend more money to hire vehicles, waste more time, and in most cases die on transit to a better equipped hospital	4.14	.918	.056	226.652	.002 & .000	@ 95% confidence Interval, no adjustments
	The absence of good stock of medical equipment and basic drugs in public health						@ 95% confidence

8	facilities has led the management of public health facilities to either patronise street drug dispensers or refer victims of conflicts/ emergencies to private hospitals	4.18	1.018	.022	1007.002	.001	Interval, no adjustments
9	Victims of conflicts that sustained serious wounds die most of the times in the public hospital in your community due to errors, delay, and ineffective services	4.21	1.109	.156	62.673	.002 & .004	@ 95% confidence Interval, no adjustments
10	Most of the times, relatives of ethno-religious conflict victims prefer to treat them with herbal medicine due to distrust created by out-dated and insufficient health facilities in your community	4.03	1.523	.098	875.001	.003	@ 95% confidence Interval, no adjustments
11	The management of healthcare facilities in your community mobilises the entire staff irrespective of profession and recall those on leave during conflict generated emergencies	4.43	0.239	.100	362.003	.000	@ 95% confidence Interval, no adjustments

Source: SPSS analysis of responses to research questions

Answers to question seven in table three were analyzed using SPSS to determine whether a lack of suitable emergency and delivery vehicles for referrals resulted in patients paying more to rent vehicles, wasting more time and, in most cases, passing away while on transit. The figures show a 4.14 overall grand mean and a .918 standard deviation. The test of between-subjects effects' Pairwise comparison analysis indicated Least Significant Difference, which is the same as leaving things alone. The tests for between-subjects effects provided significance values of .002 and .000. Because of this, the mean difference was considered significant at the .05 level. As a result, the cumulative mean of 4.14, or "Agree" in the Likert scale measure, was

accepted. This implies that the absence of good and functional emergency and delivery vehicles for referrals had caused patients to spend more money on rental cars, waste more time and, in many cases, die while travelling to hospitals with better equipments.

When responses to question 8 were analyzed using SPSS, it was determined that the management of public health facilities had either referred victims of conflicts or emergencies to private hospitals or patronized street drug dealers due to lack of adequate supplies of medical equipment and basic drugs. The Least Significant Difference, which is equal to making no modifications, was revealed by the Pairwise Comparisons analysis of the Tests of Between-Subjects Effects at the .001 level of significance. This is due to the fact that the mean difference ought to be substantial at the .05 level. Hence, the cumulative mean of 4.18, which corresponds to the Likert scale measure of "Agree," was approved and it implies that absence of good stock of medical equipment and basic drugs in public health facilities led the management of public health facilities within and around the four communities to either patronise street drug dispensers or refer victims of conflicts/emergencies to private hospitals.

When responses to question 9 were analyzed using SPSS, it was determined that the majority of seriously injured combatants died in the public hospitals of the four communities as a result of mistakes, delays and inefficient care. A grand mean of 4.21 and a standard deviation of 1.109 were obtained from this investigation. The Pairwise Comparisons study of the Tests of Between-Subjects Effects indicated Least Significant Difference, which is equal to making no modifications, at levels of significance of .002 and .004. The reason for this is that the mean difference ought to be significant at the .05 level. As a result, the cumulative mean of 4.21, which corresponds to the Likert scale measure of "Agree," was accepted which implies that victims of conflicts that sustained serious wounds died most of the times in the public hospitals in the four communities due to errors, delay and ineffective services.

Analysis of responses to question 10, which sought to find out if relatives of ethno-religious conflict victims preferred to treat them with herbal medicine due to distrust created by out-dated and insufficient health facilities, revealed a 4.03 grand mean and a 1.523 standard deviation. The Pairwise Comparisons study of the Tests of Between-Subjects Effects, with a .03 level of significance, revealed the Least Significant Difference, which is equal to making no adjustments. This is due to the fact that the mean difference ought to be considered significant at the .05 level. The cumulative mean of 4.03, or "Agree" in the Likert scale measure, was therefore accepted and which implies that family members of victims of ethno-religious conflict preferred to treat them with herbal medicine because of the mistrust that outdated and subpar health facilities in their communities had fostered.

The conclusions drawn after scrutinizing the responses to question 11, which asked whether the management of healthcare facilities usually mobilized the entire staff, regardless of profession, and recalled those on leave during conflict-generated emergencies, revealed a grand mean of 4.43 and a standard deviation of .239 for the responses. The Pairwise Comparisons study of the Tests of Between-Subjects Effects indicated Least Significant Difference, which

is the same as making no modifications, at the .000 level of significance. This is due to the fact that the mean difference ought to be substantial at the .05 level. Thus, the cumulative mean of 4.43, which corresponds to the Likert scale measure of "Agree," was accepted and which implies that the management of the four healthcare facilities mobilised the entire staff irrespective of profession and recalled those on leave during conflict generated emergencies.

Findings and Discussion

This paper investigated the status of public healthcare facilities in Makurdi, Gwar, Eha-Amufu and Nimbo communities between 2000 and August 2021, and hereby states the following findings:

i. Public hospitals in the four communities did not have good stock of medical disposables, surgical equipment and vaccines for the treatment of emergency patients particularly victims of conflicts during the period covered by the study;
ii. Public hospitals in the four communities did not have good drugs storage facilities, regular supply of electricity, Oxygen services and functional theatre for the treatment of emergency patients during the period;
iii. Public health facilities in the four communities did not have good stock of medical equipment for the treatment of emergency patients such as victims of conflicts and accidents;
iv. Healthcare facilities in the four communities did not have good stock of basic and non-expired drugs;
v. The healthcare facilities did not have good and functional emergency and delivery vehicles for referrals;
vi. It is uncertain whether healthcare facilities in the four communities had the required medical team to render appropriate services during emergencies and ethno-religious conflicts.

From these findings it is safe to conclude that public healthcare facilities in Makurdi and Gwar in Benue State, and Nimbo and Eha-Amufu in Enugu State did not have adequate and required health facilities for the treatment of fallouts of ethno-religious conflicts. These findings corroborate earlier empirical observations made by scholars such as Alkali & Bello (2020), Ilozor (2013) and Okoroh (2012) over the years. The implication of the findings for fiscal administration is that the various levels of governance in Nigeria were either indifference to the perennial problem of poor healthcare facilities during annual appropriation or that managers of health care facilities were engulfed in the misappropriation of allocated funds. If the later was the case, as earlier observed by scholars such as Omoluabi (2016) and Ahmed and Gidado (2010), then, certain agencies and Boards with oversight functions on the healthcare sector during the period were ineffective or non-functional.

The paper equally explored the impact of the status of healthcare facilities in the communities during the period, which was found to be insufficient and obsolete and hereby makes the following submissions:

i. Lack of good and functional emergency and delivery vehicles for referrals caused patients to spend more money to hire vehicles, waste more time and, in most cases, die on transit in search of better-equipped hospitals;
ii. Absence of good stock of medical equipments and basic drugs led the management of the four public health facilities to either patronise street drug dispensers or refer victims of conflicts/ emergencies to private hospitals;
iii. Victims of conflicts who sustained serious wounds died most of the times in the public healthcare facilities of the four communities due to errors, delay and ineffective services;
iv. Relatives of ethno-religious conflict victims preferred to treat them with herbal medicine due to distrust created by out-dated and insufficient health facilities in their communities.

It therefore holds that the management of fallouts of ethno-religious conflicts in the face of insufficient healthcare facilities in Benue and Enugu States of Nigeria had fatal consequences. Most of the victims that survived at the scene of the conflicts died in healthcare facilities where they were expected to be healed. Therefore, it is safe to state that healthcare facilities in Nigeria did not make any significant positive contribution towards the management of fallouts of ethno-religious conflicts during the period covered by this study.

Conclusion

The effectiveness and success of any healthcare provider depends on the availability of adequate and good functional facilities. These facilities include adequate infrastructures, modern machines, vaccines, basic and frequently used drugs, skilled/professional staff, good transport and referral systems and adequate and constant supply of electricity and water etc. In Nigeria, it is the responsibility of the state to make such provisions; however, anecdotal evidences have shown the prevalence of lack of these facilities in most public hospitals. Nevertheless, different reforms were introduced as panacea to the scenario.

In spite of the acclaimed reforms, it is one of the findings of this paper, using the hospitals in Benue and Enugu States, that the syndrome of insufficient and obsolete healthcare facilities continued to prevail in Nigeria's health sector during the study period. The study highlights the inadequacies, dysfunctions and obsolescence of medical equipment as well as the inaccessibility of alternative healthcare resources in public hospitals as against government propaganda of revolutionising the sector through many programmes. This presupposes that healthcare establishments were unable to achieve the required minimal standards.

In the four communities studied, hundreds of residents were killed due to ethno-religious and herders-farmers conflicts. Thousands of others were injured or fatally wounded during such conflicts and the various public healthcare facilities in the communities could not offer good medical services. This was as a result non-availability of adequate and functional facilities such as basic drugs, ambulances, regular electricity and water supply, surgical machines and equipment and appropriate personnel to handle such emergencies. The management of the

various hospitals resorted to the assistance of street drug dispensers, giving referrals to conflict victims and the use of available drugs and equipments in spite of their inappropriateness and expired status. Inevitably, some of these actions led to the death of some of the patients while others spent so much money in search of medical treatment in private healthcare facilities thereby leading to delays and occasional death of such patients. Consequently, many of the relatives of conflict victims opted to treat them using herbal medicine that was accessible to them.

This paper, therefore, recommends that declaration of state of emergency in the healthcare sector with consequential appropriation of 30% of the annual budget of federal, state and local governments to the sector. Furthermore, a facility audit and inventory of all public healthcare facilities should be initiated immediately. A special health tax fund should be established by the federal government to propel the private sector to donate, at least, 5% of their annual profits for the adequate provision of facilities in the health sector. Finally, relevant agencies that wield oversight functions in the health sector should be seen to be active or face public prosecution or closure.

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