CHAPTER 2
The consequences of conflict

Countries suffer from many different consequences of violent conflict. Violent conflict kills people in different ways — although it is often difficult to estimate how many. Civilians and soldiers are killed in combat; people die because of a higher prevalence of diseases; and people are killed because of an increase in violent crime. Wars force mass migration. Countries that have experienced violent conflict also face a high risk of renewed conflict. Conflict also has economic consequences. It leads to unemployment and loss of income owing to disruption of economic activity, destruction of infrastructure, uncertainty, increased cost of doing business, and capital flight. Furthermore, social spending is often cut to accommodate increased military spending, and the economy undergoes structural changes. Dealing with the consequences of violent conflict is a humanitarian imperative; but it is also important because it decreases the risk of the conflict recurring.

This chapter examines the social and economic consequences of conflict.

Social consequences

Mortality levels

The literature distinguishes between "battle deaths" — combatants and civilians killed during military operations — and "total war deaths" — which include battle deaths and deaths from disease, starvation, malnutrition, and crime.

Battle deaths

Between 1960 and 2005, about 6.6 million battle deaths were recorded in state-based armed conflicts worldwide. Figure 2.1 breaks this total down by region. About 1.6 million battle deaths — about 24 percent of the global total — were recorded in Africa; and about 3.6 million — 54 percent of the total — in Asia.

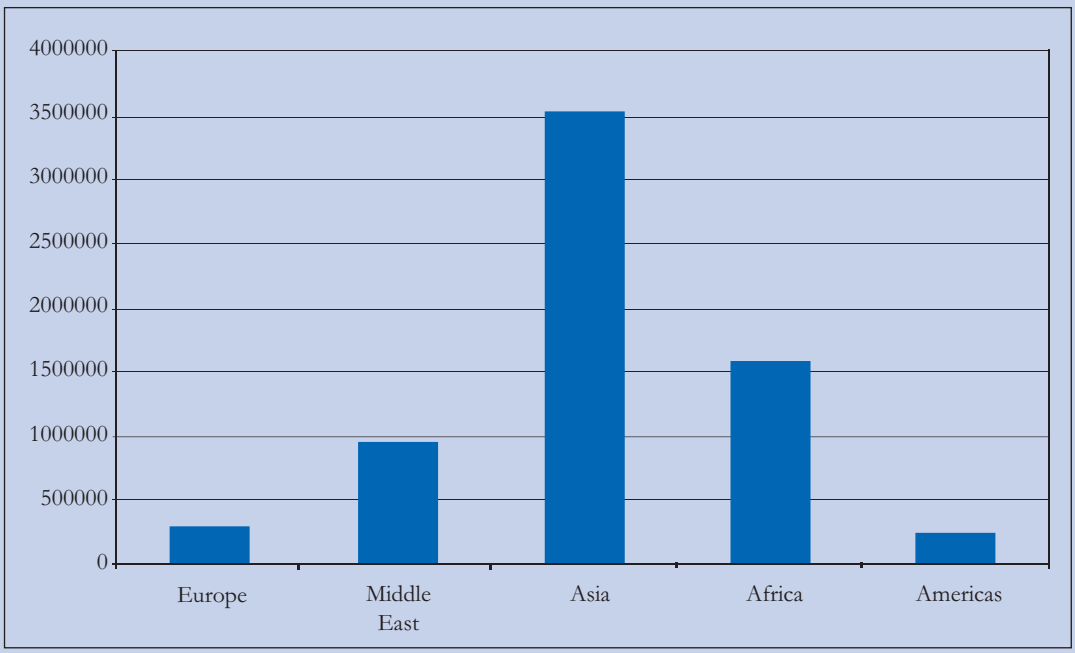
Beyond these aggregate numbers, the question is: who is killed in military operations? Murray *et al* (2002) examine the age and sex distribution of battle deaths. According to their data, men aged 15–29 are most likely to be killed, but women make up nearly a quarter of all battle deaths. Their estimates also suggest that battle deaths are almost equally split between military and civilian fatalities.

Total war deaths

Table 2.1 presents data on battle deaths and total war deaths for some African wars. The percentage of battle deaths in total deaths is generally low, ranging from about 3 percent to 30 percent. Although this is a large range, these numbers indicate that deaths from military operations usually constitute only a small proportion of total war deaths. Estimates of total war deaths have large margins of error and no comprehensive dataset exists to date.

Estimating total war deaths is a difficult exercise. A number of epidemiological studies have attempted to do so using

Figure 2.1: Battle deaths, 1960–2005



Source: UCDP/PRIO armed conflict dataset.

household surveys — which are difficult or impossible to carry out in war zones. These micro surveys, usually carried out towards the end of a war or once the war is over, rely on recalled data. One example is the work by Coghlan *et al* (2006), in which the researchers try to estimate the number of deaths from the war in the Democratic Republic of Congo during 1998-2004. The estimated total death toll was about 3.9 million, making the war the deadliest war since the end of World War II (Coghlan *et al* 2006). The latest estimates (as of mid-2008) put the estimated war death toll (excluding battle deaths) at 5.4 million.

Legacy effects

Wars affect people's lives long after the fighting has stopped. Wars do not only kill, they also cause disability due to injury or increased disease burden. One of the diseases that affects Africa disproportionately is HIV/AIDS. The disease is contracted through sexual transmission or contamination of a person's blood with the virus (through needle transmission, for example). Buvé, Bishikwabo-Nsarhaza, and Mutangadura (2002) provide an overview of the spread and effect of HIV-1 infection in sub-Saharan Africa. By the end of 2001, the HIV-1 adult

Table 2.1: Battle and total war deaths in selected African countries

Country	Period	Battle Deaths	Total Deaths
Algeria	1991–2002	90,200	—
Angola	1975–2002	160,500	1.5 million
Burundi	1990–2002	6750	200,000
Congo, Brazzaville	1993–2002	9791	—
DRC	1998–2008	—	5.4 million*
Egypt	1992–98	1347	—
Guinea-Bissau	1998–99	—	1,850
Liberia	1989–96	23500	150000–200000
Morocco	1975–89	13,000	—
Mozambique	1967–92	145,400	0.5–1 million
Nigeria	1967–70	75,000	500,000–2 million
Sierra Leone	1991–2000	12,997	—
Uganda	1981–91	107700	—

* This figure excludes battle deaths.

Sources: Lacina and Gleditsch (2005); Coghlan et al (2006); UCDP/PRIO armed conflict dataset; and Human Security Brief (2007).

prevalence rate in the region was estimated at 8.4 percent. Estimated prevalence rates for other regions were much lower: the Caribbean region had the second highest prevalence rate of 2.2 percent, while all other regions had prevalence rates of less than 1 percent. The discussion on why Africa is more severely affected than any other region focuses on two explanations: war and poverty. Wars are conducive to the rapid spread of HIV. Soldiers facing the risk of losing their lives weigh the risks of contracting HIV against stressful situations and dangers related to war. Civilians are often subjected to human rights abuses, including sexual violence. Some women find themselves in abject poverty, which may lead them to use commercial sex to survive. In general, displacement during war weakens social cohesion and relationships — which may lead to promiscuity. As stated above, poverty is another reason for the high prevalence rates. Poverty seems to increase the gender imbalance. Although women are more at risk of contracting HIV, it seems that they cannot demand condom use from their partners. Buvé, Bishikwabo-Nsarhaza and Mutangadura (2002) conclude that populations in many parts of Africa are becoming trapped in a vicious HIV-poverty cycle.

War also leaves people traumatized. Most of the victims of civil war are civilians, who are subjected to, or witness, war-related traumatic events such as shootings,

killings, rape, torture and murder of family members. A random household survey of residents and internally displaced persons in Freetown, the capital of Sierra Leone, in 1999, showed that almost every respondent had been exposed to conflict. Fifty percent of the respondents had lost someone close to them, and 41 percent had actually witnessed the death of this person. Torture had been witnessed by 54 percent, executions by 41 percent, amputations by 32 percent, and public rape by 14 percent. The witnessing of such events can lead to serious psychological stress.

War ruins a country's economy, including the health sector. Post-conflict governments have insufficient revenues to spend on the health sector, which faces enormous demand. Yet, donors are often reluctant to fund improvements in the health sector until they are certain that peace can be sustained.

Regional spillover effects due to disease

Most of the total war deaths are attributable to communicable diseases and not to violence. Nationwide public health programmes for disease control and prevention cannot be carried out during civil war. This has implications for the health of the citizens in the country at war; however, the negative health effects of civil war go beyond borders. For example, Uganda has not reported any wild cases of polio since 1996, but it has to continue mass immunizations in border regions for fear that the disease will spill over from Sudan and the Democratic Republic of Congo (Wendo, 2002).

A further well documented example of civil war being a major impediment to the eradication of endemic diseases is the case of Dracunculiasis, or Guinea worm disease. The worldwide campaign to eradicate dracunculiasis began at the U.S. Centers for Disease Control and Prevention in 1980. At that time, there were an estimated 3.5 million cases in more than 20 African countries. Thanks to the regional eradication program the incidence of the disease was reduced by 98 percent. Most of the remaining patients were in Southern Sudan because the campaign could not be completed during the civil war in the south. During the temporary "Guinea Worm Cease-Fire" in 1995, health workers were able to distribute cloth water filters to villagers as part of the regional eradication programme. This distribution of more than 200,000 filters was considered a tremendous success. Distribution of filters continued after the temporary cease-fire. It was estimated at the time that it would take three to five years to completely eradicate dracunculiasis after the end of the war. Until then, the cost of the disease to Sudan and her neighbours would be substantial: About $2 million per year to maintain the eradication programme in Sudan, and the cost of maintaining surveillance to detect cases exported from southern Sudan to other regions of the country and to neighbouring countries. All of these costs could have been avoided if the eradication programme had not been hampered by the civil war in southern Sudan.

Regional spillover effects due to displacement

In contrast to death figures, it is easy to obtain internationally comparable data for displaced persons. The United Nations High Commission for Refugees (UNHCR) collects and publishes worldwide data. In 2006, it listed about 33 million people 'of concern' to the UNHCR. These people 'of concern' are defined in three broad categories: about 10 million refugees, 13 million internally displaced persons (IDPs), and 10 million others (asylum seekers, returned refugees/ IDPs and stateless persons).

Since 2000, the number of refugees has fallen from 12.1 million to 9.9 million worldwide. However, the total number of IDPs and others of concern has risen sharply since 2002 — from 10.3 million in 2002 to 23 million in 2006. How does Africa compare with the rest of the world? Africa is home to about 12 percent of the world's population; however, 31 percent of the world's refugee population originates from Africa. Most African refugees come from the following countries: Sudan, Somalia, DRC, Burundi, Angola, Eritrea, Liberia, Rwanda, Western Sahara, and Ethiopia. Table 3.2 lists refugee numbers for these countries. Refugees from these countries make up about 28 percent of the world's refugees.

Where do these refugees flee to? Most of these refugees flee across the border to neighbouring states, that is, they do not leave the continent. The main host countries are Tanzania, Chad, Kenya, Uganda, DRC, Sudan, Zambia, Ethiopia, Algeria and Congo. Refugee numbers by country of asylum are presented in Table 2.3.

Table 2.2: African refugees by origin, 2006

Country	Refugees
Sudan	686,311
Somalia	464,253
DRC	401,914
Burundi	396,541
Angola	206,501
Eritrea	193,745
Liberia	160,548
Rwanda	92,966
Western Sahara	90,614
Ethiopia	74,026

Source: UNHCR (2006)

Table 2.3: African refugees by country of asylum, 2006

Country	Refugees
Tanzania	485,295
Chad	286,743
Kenya	272,531
Uganda	272,007
DRC	208,371
Sudan	196,200
Zambia	120,253
Ethiopia	96,980
Algeria	94,180
Congo	55,788

Source: UNHCR (2006)

With respect to the other large group of "people of concern," the IDPs, a staggering 42 percent of global IDPs were displaced in nine African countries: Uganda, Sudan, DRC, Cote d'Ivoire, Somalia, Central African

Republic, Chad, Burundi and Congo. Table 2.4 provides the figures for IDPs in Africa. Displacement often has terrible consequences. IDPs are at high risk from violence, malnutrition, and communicable diseases. A survey carried out in the Republic of Congo found that between November 1999 and January 2000 morality rates were more than 5 per 10,000 and that malnutrition was the principal cause of death among the displaced. A third of all children in one camp in Brazzaville were suffering from global acute malnutrition. *Médecins Sans Frontières* treated more than 10,000 cases of acute malnutrition (Salignon *et al* 2000).

Table 2.4: Internally displaced persons in Africa, 2006

Country	IDPs
Uganda	1,586,174
Sudan	1,325,235
Democratic Republic of Congo	1,075,297
Côte d'Ivoire	709,228
Somalia	400,000
Central African Republic	147,000
Chad	112,686
Burundi	13,850
Rep. Of the Congo	3,492

Source: UNHCR (2006)

Box 2.1: Violence, displacement, and death in West Darfur, Sudan

The current violent conflict in Darfur began in earnest in February 2003, resulting in an estimated 190,000 refugees, who fled to Chad, and about 1 million internally displaced persons (IDPs). Between April and June 2004, *Médecins sans Frontières* (MSF) carried out a survey of IDPs in Darfur, to provide a basis of appropriate assistance. IDPs were surveyed in a two-stage household-based cluster survey: First, four sites were chosen in West Darfur; Second, in these four sites, a number of randomly chosen households were interviewed. The survey showed that IDPs lived either in clearly identifiable camps or had mixed with the resident population. Each head of household was asked to recall deaths since 2003. The age and sex of the dead people were noted, as were the causes (violence, medical, or other) and location (in the village, in flight, or in the camp). Crude mortality rates were estimated based on survey data. Crude mortality rates were extremely high in the "village and flight" period and violence-specific mortality rates accounted for most mortality during this period. The UNHCR rates situations with crude mortality rates above 1 death per 10,000 persons per day as an emergency situation. Mortality rates ranged from 1.5 to 9.5 in the different sites. In comparison, the non-emergency rate in the sub-Saharan population is 0.5. During the "camp period", mortality rates decreased to between 1.2 and 5.6, in other words, they were still well above the emergency benchmark. The survey also showed that men were at far higher risk of being killed. Separations and disappearances were also common, mostly affecting men. High mortality and family separations amount to a demographic catastrophe. The age and sex pyramids for these four sites are skewed because of the missing or dead men. The case of Darfur seems exceptional because of the high percentage of violent deaths in total deaths. However, as with other violent conflicts, the victims are mostly civilian and the displacement leads, not only to excess mortality and loss of livelihoods, but also to long-term dependence on aid.

Source: Depoortere et al (2004).