

Traumatic fistula: the case for reparations

by Arletty Pinel and Lydia Kemunto Bosire

As a conflict strategy, women are often sexually assaulted using sticks, guns, branches of trees and bottles. Women's genitals are deliberately destroyed, some permanently. Traumatic fistula often results. As with victims of torture and other grave human rights abuses, there exists an obligation to restore the women to health as far as possible and to provide reparation for their violations.

Traumatic fistula is an abnormal opening between the reproductive tract of a woman or girl and one or more body cavities or surfaces, caused by sexual violence, usually but not always in conflict and post-conflict settings. It is a result of direct gynaecological trauma, usually from violent rape, mass rape and/or forced insertion of objects into a woman's vagina. Brutal rape can result in genital injury and the formation of a rupture, or fistula, between a woman's vagina, her bladder, rectum or both.

Traumatic fistula compounds the psychological trauma, fear and stigma that accompany rape – with the same risk of unwanted pregnancy, vulnerability to sexually transmitted infections (STIs), including HIV, and diminished opportunities to marry, work or participate in the larger community. Women with fistula are unable to control the constant flow of urine and/or faeces that leak from the tear. Often, affected women are subsequently divorced, shunned by their communities and unable to work or care for their families. Long-term medical complications for the survivors of violent rape may include uterine prolapse, infertility and miscarriages.

Medical personnel have observed cases of traumatic fistula in the conflict and post-conflict countries of Burundi, Chad, Democratic Republic of Congo, Sudan, Burundi, Rwanda and Sierra Leone. It has also been reported in other countries such as Ethiopia, Guinea, Kenya, Liberia, Somalia, Tanzania and northern Uganda. However, the exact prevalence of fistula remains unknown. Data collection is difficult in conflict

and post-conflict settings, in part because victims fear further attacks and stigma and because of lack of awareness regarding the availability of fistula repair services. These are compounded by poor healthcare infrastructure and ongoing insecurity. The absence of data affects the capacity of stakeholders to grasp the real magnitude of the problem. Researchers can only determine the extent of traumatic fistula by the numbers of women reporting to repair centres and health facilities for treatment.

In many cases, expert surgeons trained in fistula repair can mend the damage. The average cost of fistula surgery and post-operative care for one woman is approximately \$300. Post-operative care of women should include trauma counselling, rehabilitation and physical therapy. Healing, especially of psychological wounds, takes time. Some women – especially those who have had foreign objects forcibly inserted into their vagina and/or rectum – are unable to heal even after repeated surgery, and are left permanently scarred.

When women's bodies become a battleground, conversations about reconstruction and national reconciliation cannot have meaning for those affected – either directly or indirectly – until there is an acknowledgement of the gross violations of the rights of the affected women and until affected communities are made whole again, insofar as this is possible. The public act of destruction of a woman's anatomy is symbolic to the tearing apart of the social fabric, one that damages the family, and can only fuel revenge and further conflict. In thinking

about accountability, stakeholders cannot neglect the condition of these women on whose bodies the worst violence of war is expressed.

Brussels and reparations

The Brussels Call to Action – agreed at the International Symposium on Sexual Violence in Conflict and Beyond in June 2006¹ – asked stakeholders to “recognise the right and ensure access to material and symbolic reparation, including restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition for all survivors” of sexual violence. Reparative measures are important for assuring the woman that she is a rights-bearing citizen and that the violation of her rights to life and a life of dignity cannot be tolerated.

The first necessary intervention is restoring the women's functions by treating the fistula and stopping the incontinence. This means supporting the treatment centres that provide surgery, as well as ensuring such provisions as anaesthesia, blood transfusion and trained personnel. Often, the same surgical resources used in fistula repair can also be used in carrying out Caesarean sections and other routine operations that are essential to reduce the gender-based imbalance in healthcare access that leads to high rates of maternal mortality. This intervention also includes raising awareness in affected communities about availability of repair services.

The second element of the reparations called for in Brussels is compensation. Even as human rights activists and insurance experts continue to put a price on the damage caused by torture, rape, extra-judicial killings and other abuses, in many countries in which the problem of traumatic fistula exists compensation is not possible. However, just because ministries of finance cannot afford to compensate – and international

stakeholders are loath to do so – does not mean this is not an important principle to constantly assert.

In the absence of material compensation, symbolic reparations are important. Should we get, as we routinely do for 'orthodox' human rights abuses, an apology from the state to all the victims of fistula and other grave sexual violence, the state being the presumed protector of the violated rights? Or a memorial for all the women whose bodies have acted as alternative battlegrounds, to remind the people that such acts of shame must never happen again, to remind the women themselves that their war is not forgotten, to portray the women as heroes and survivors of great pain, to honour women rather than ostracise and blame them, and claim for them a public space to show that respect?

The third reparative element in the Call to Action is rehabilitation in the form of medical or psychological services. Women come to the few existing treatment centres wishing they were dead rather than burdened by the triple stigma of rape, incontinence from fistula and potential HIV. The hardest task is to restore to these women their dignity and convince them that their rights will be respected in future. The difficult task of psychologically rehabilitating victims must be at the heart of interventions and must be available routinely – not just to those victims prepared to testify before truth commissions and courts.

The Call to Action demands guarantees for non-repetition. This requires reform of institutions that are meant to guarantee respect for human rights and, in particular, respect for women as rights-bearing individuals. There must be an end to impunity and an inculcation of an aversion to the crimes that these women have suffered. The security sector (both regular and irregular) must understand the sanctions of perpetrating violence of this nature, as they are often the greatest aggressors.

The international community must be unified in its denunciation of any state which fails to sanction its military when implicated in traumatic fistula, as it is in its denunciation of torture. Such security forces cannot serve in peace-keeping missions. Generals of irregular forces whose men are implicated in sexual

torture ought to be accountable for torture, with all the relevant international criminal implications.

Ways forward

It is vital to:

- commission research into the causes, impact and magnitude of traumatic fistula in order to support effective advocacy and to assist in planning effective interventions
- support hospitals to enable them to offer repair services attached to their operating theatres, with equipment that can be used for improved services for women, including caesarean sections
- design interventions that include access to anti-retroviral treatments and family planning care to avoid unwanted pregnancies
- include information regarding traumatic fistula within the curricula of all military units, peacekeepers and police forces
- standardise UN and international agency emergency responses to include clinical services – including proper medical examinations, emergency contraception, fistula surgery, qualified personnel who can offer skilled obstetrical and gynaecological services, appropriate equipment, counselling and psychological care
- provide resources to strengthen health services: currently, when the annual UN Inter-Agency Consolidated Appeals Process (CAP) for countries in crisis is launched, health programmes receive less than a quarter of requested resources
- develop community systems to document atrocities and refer them to appropriate national and international legal mechanisms, with the existence of traumatic fistula as evidence
- work with communities and the media to change community perceptions and attitudes that exacerbate the stigma, discrimination and exclusion suffered by affected women

- support victims' organisations and develop programmes to integrate affected women back into their communities and to foster a supportive atmosphere for the survivors of traumatic fistula and other forms of gender-based violence.

At the heart of reconciliation is the notion of developing civic trust, where those whose rights have been violated can think of themselves as rights-bearing citizens. Addressing the needs of women deliberately torn in the throes of war must be seen as one of the first steps towards reconciliation, towards repairing a society torn apart by war and political difference. Ignoring this diminishes the impact of other interventions.

Dr Arletty Pinel (MD) (pinel@unfpa.org) is UNFPA's Chief of Reproductive Health and Lydiah Kemunto Bosire (l.k.bosire@gmail.com) is a UNFPA consultant.

For more information, see Traumatic Gynecologic Fistula: A Consequence of Sexual Violence in Conflict Settings www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/TF_Report_final_version.pdf

1. See back page.

In 2003, UNFPA spearheaded the global Campaign to End Fistula, which is working in more than 35 countries to prevent and treat fistula, and to help rehabilitate and empower women after treatment. www.endfistula.org

