

Traumatic Gynecologic Fistula as a Consequence of Sexual Violence in Conflict Settings: A Literature Review

Prepared for the meeting “Traumatic Gynecologic Fistula: A Consequence
of Sexual Violence in Conflict Settings,” Addis Ababa, Ethiopia, September
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Executive Summary

This literature review surveys the landscape of information on traumatic gynecologic fistula in conflict settings. It was prepared to stimulate discussion at the upcoming meeting *Traumatic Gynecologic Fistula: A Consequence of Sexual Violence in Conflict Settings*, to be held September 6–8, 2005, in Addis Ababa, Ethiopia. This meeting will be sponsored by the Regional Economic Development Services Office for East and Southern Africa (REDSO), U.S. Agency for International Development (USAID).

Traumatic gynecologic fistula is an injury that occurs due to direct traumatic tearing of the vaginal tissues, as a result of violent sexual assault, including rape, mass rape, and the forced insertion of objects into a woman's vagina. A woman or girl who sustains this injury is rendered incontinent of urine and/or feces. Together with the horrible physical consequences of her condition, she must also bear the psychological sequelae of sexual assault, as well as the double social stigmatization due both to her unpleasant incontinent state and to her socially undesirable status as a victim of sexual assault.

Stories of brutal rape of women and girls have emerged from a number of African nations where political conflicts have led to the systematic use of rape as a weapon of war. Based on the research conducted for this review, the Democratic Republic of Congo appears to have the largest number of women suffering from traumatic gynecologic fistula. Reports have emerged in Rwanda, Sierra Leone, and Sudan, but there is little information as to whether they are sporadic cases or are indicative of a larger problem. While the limited documentation of traumatic gynecological fistula cases may suggest that this is not a significant issue, it may also reflect the challenges in assessing the magnitude of the problem.

Medical and psychosocial care are being delivered to women with traumatic fistula in eastern Congo, while in other countries, efforts to assist these women may exist but appear not to have been documented or not to be available in the published literature. Some women and girls with traumatic fistula likely obtain care, including surgical repair, via programs for obstetric fistula repair (where such programs exist). However, women with fistula are often shunned by their communities and may be unwilling to make themselves known or come forward for treatment. Moreover, women who have been raped often remain silent for fear of reprisals from their aggressors. For these and other reasons, many more women with traumatic fistula may go undetected and without surgical repair, counseling, and other services, needlessly suffering the lifelong consequences of this injury.

The upcoming meeting in Addis Ababa is the first-ever gathering of individuals and organizations from various African nations who work on the issue of traumatic gynecologic fistula. This meeting comes at a time when evidence suggests that rape is increasingly used as a weapon of war in armed conflicts in Africa (RHRC, 2004). It is critical to begin a dialogue around this issue, in an effort to improve understanding of the problem, including its magnitude, and to share interventions currently being used to

address it. By bringing together participants with expertise on various aspects of this problem, the meeting will seek to collaboratively analyze the successes and challenges of, and identify any gaps in, current interventions, as well as develop a comprehensive strategy for addressing these gaps. Findings from this meeting, which will be presented in a meeting report, may also serve as important advocacy tools to increase awareness of this condition and to address the legal issues pertinent to survivors of sexual assault in conflict settings. It is imperative that the needs of these women and girls, who have endured untold suffering and blatant violation of their human rights, be addressed appropriately.

Traumatic Gynecologic Fistula as a Consequence of Sexual Violence in Conflict Settings: A Literature Review

Introduction

While the condition of obstetric fistula has garnered some attention on the international reproductive health agenda, little focus to date has been given to traumatic gynecologic fistula, an injury that arises not from trauma associated with childbirth but instead from trauma associated with violent sexual assault. Such systematic assault against women and girls in conflict settings has led to an increased prevalence of traumatic gynecologic fistula in recent years. Expertise on this issue remains scattered, however, and no coordinated creation and sharing of strategies and tools has yet occurred.

In an effort to address this issue, EngenderHealth, through the ACQUIRE Project, is convening a meeting of local and international nongovernmental organizations (NGOs), emergency relief agencies, health care service-delivery organizations, human rights groups and organizations working specifically in conflict settings, clinicians, and interested donors, all of whom have expertise to lend on the issue of traumatic gynecologic fistula. The meeting will be held September 6–8, 2005, in Addis Ababa, Ethiopia.

This literature review was prepared in an attempt to survey the landscape of information on traumatic gynecologic fistula. The information herein was collected by querying individuals and organizations working on this issue, who were identified both through extensive networking and through Internet searching. In particular, the Google search engine (<http://www.google.com>) was heavily used to search for information on the condition of traumatic fistula and on the organizations working in this area. The objective was to gain insight into the magnitude of the problem and to learn more about past and ongoing interventions to address this condition. While efforts were directed toward producing a comprehensive review, only information that was currently available via personal communication or published literature is included. Therefore, this review, which was necessarily done in an opportunistic fashion, may be missing key information from some countries, institutions, or individuals. However, as a general overview of the issue of traumatic gynecologic fistula, it is hoped that this document will help stimulate discussion at the meeting in Addis Ababa.

Background

What is traumatic gynecologic fistula?

In the context of reproductive health, the term “fistula” may bring to mind *obstetric* fistula. This condition, most often a result of prolonged, obstructed labor, is an abnormal communication that develops between a woman’s vagina and her bladder and/or rectum,

rendering her incontinent of urine and/or feces. This tragic childbirth injury has severe physical, psychological, and social consequences for a woman.

Perhaps even more tragic is that this same type of injury can also result from direct traumatic tearing due to violent sexual assault and rape. This kind of fistula, termed *traumatic gynecologic fistula*, often results from particularly violent sexual assault and may be caused by forced sexual intercourse (by one or more assailants) or by the forcible insertion of objects (for example, guns, bottles, or sticks) into a woman's vagina.¹

While the causes of traumatic gynecologic fistula (hereafter referred to as “traumatic fistula”) differ from those of obstetric fistula, many of the consequences are similar. Incontinent of urine and/or feces and carrying an unpleasant odor, women with fistula are often shunned by their husbands and their communities. Rape survivors face the additional shame of having been sexually assaulted, which often results in social stigmatization. As victims of violent sexual assault, women with traumatic fistula may have sustained additional physical injuries. They also face the psychological consequences of this brutal act (for example, depression and posttraumatic stress disorder) and are at an increased risk for unwanted pregnancy and sexually transmitted infections (STIs), including HIV. Rape during armed conflicts plays a significant role in spreading HIV and exacerbating the already-raging HIV/AIDS epidemic.

Rape is a form of gender-based violence (GBV) that has increasingly been used as a weapon of war in armed conflicts in Africa (RHRC, 2004). GBV refers to any harm that is perpetrated against a person's will that exploits distinctions between individuals of different sexes (or even of the same sex). While men and boys are also victims of GBV, women and girls are typically most affected (RHRC, 2004). Sexual violence during conflicts aims to destabilize populations and destroy bonds within communities and families, advance ethnic cleansing, express hatred for the enemy, or supply combatants with sexual services (RHRC, 2004). Sexual violence perpetrated against women and girls is an important health and human rights issue. Traumatic fistula is only one of the many horrific consequences of GBV that is associated with armed conflicts.

Though this review focuses on traumatic fistula in conflict settings, the violent sexual assault of women and girls outside of armed conflict (as in the case of domestic violence and child abuse) can also lead to this condition. Cases of women who have acquired traumatic fistula as a result of domestic violence have been documented in places such as Ethiopia (Muleta & Williams, 1999) and India (Sharma, 1991). In the United States, a four-year-old girl acquired traumatic fistula as a result of sexual abuse (Parra & Kellogg, 1995), and such events have undoubtedly transpired in many other locations. While some reports exist, the frequency of such occurrences is unknown.

Given the etiology of traumatic fistula, the comprehensive treatment of women with traumatic fistula must address the serious physical, psychological, and social

¹ For the purposes of this review, gynecologic fistulas that result from other causes, such as trauma from penetrative traffic, domestic, or animal accidents (goring) are excluded, as are infection and irradiation injury.

consequences of sexual violence. A thorough physical examination, counseling, and testing for pregnancy and for STIs are all critical in addressing the wide range of needs of women who have suffered traumatic fistula in the context of sexual assault. Traumatic fistula, like obstetric fistula, can usually be surgically repaired through a delicate and often complex operation. While the success of the surgery depends on a number of factors, the large majority of traumatic fistula cases are amenable to repair. In terms of surgical management, repair of traumatic fistula may not require the preoperative wound healing period that is often necessary for repair of obstetric fistula. However, the management of a rape victim's psychological needs may require a considerable amount of time, to support a woman toward her full recovery.

Rape as a weapon of war

In conflicts worldwide, rape has long been used as a cruel and dehumanizing weapon of war. Accounts of brutal rape have emerged from a number of African countries, including Burundi, the Democratic Republic of Congo (DRC), Liberia, Rwanda, Sierra Leone, and Sudan, where thousands of women and girls—as old as grandmothers and as young as toddlers—have suffered brutal sexual violence at the hands of military and rebel forces. Rape is often accompanied by other forms of physical and nonphysical violence. In some instances, women and girls are abducted and kept as sex slaves and are raped repeatedly, often by multiple assailants. Men and boys are also victims of sexual violence.

Following World War II, the International Military Tribunal at Nuremberg declared rape to be a crime against humanity. However, only as recently as 1998 was sexual violence punished as a war crime and rape punished as an act of genocide, by the UN International Criminal Tribunal for Rwanda. Since then, in 2001, the International Criminal Tribunal for the former Yugoslavia also began prosecuting rapists (Human Rights Watch, 1998). In his recent report on women, peace, and security, the Secretary General of the United Nations called upon the international community to “recognize the extent of the violations of the human rights of women and girls during armed conflict” and to take action accordingly (UN Security Council, 2004).

Accounts of sexual assault associated with conflict have also surfaced in the recent past from Angola, Bosnia and Herzegovina, Chechnya, Haiti, India, Kosovo, Mozambique, Pakistan, Peru, Serbia, Somalia, northern Uganda, Zimbabwe, and others. Internally displaced persons or refugees, such as the Somalis in Kenya, the Burmese in Bangladesh (Human Rights Watch, 1995), and now the Sudanese in Chad, are also vulnerable to sexual violence. When instances of sexual assault are particularly violent, such as in the case of gang rape or insertion of sharp objects into the vagina, women and girls are susceptible to developing traumatic fistula due to tearing of pelvic tissues. In the DRC, fistula from violent sexual assault has become so commonplace that doctors are now recording this injury as a crime of combat (Wax, 2003).

A number of accounts of women suffering from traumatic fistula have emerged from the DRC. An article in *The Nation* magazine presented an account of a 70-year-old woman who was raped by militiamen in the DRC, developed a fistula as a result, and hid in the

forest for three years out of shame and fear of the rebels. She recently underwent fistula repair surgery (Goodwin, 2004). Reports in *BBC News* and the *News Telegraph* recounted the story of Vumi, a young woman who was raped by 15 men and then, thanks to the goodwill of passersby, eventually arrived at the Doctors On Call for Service (DOCS) Hospital in Goma. However, despite six attempted fistula repair surgeries, she remains incontinent (Blair, 2004; Martens, 2004).

Newspaper articles also told the stories of Nyagakon (Wax, 2003), Rosette (Walsh, 2003), and Thérèse (Nolen, 2005), others who suffered from the horrifying ordeal of traumatic fistula. For example, Nyagakon was violently raped while eight months pregnant, and besides sustaining a fistula, she lost her baby as a result (Wax, 2003). Cases of women who developed traumatic fistula as a result of sexual assault are also cited in a report on sexual violence in the DRC by Human Rights Watch (2002) and in a recent report on sexual violence in South Kivu prepared by two Congolese NGOs and International Alert (RFDA, RFDP, & International Alert, 2005).

Documentation of fistula as a direct consequence of violent sexual assault

Increasingly, fistula is being cited as one of the potential consequences of violent sexual assault, particularly in conflict situations, where violent rapes tend to occur more frequently and systematically. A number of organizations refer to this condition in their reports and publications on GBV. The list below presents some of these references. These documents do not necessarily provide specific cases of women with traumatic fistula (which are discussed elsewhere in this review), but at least acknowledge it as a potential outcome of sexual assault:

- An online publication by the UN Office for the Coordination of Humanitarian Affairs lists fistula as one of the physical effects of war on women's health and well-being (IRIN, 2004).
- In a Human Rights Watch report on the Rwandan genocide, fistula is mentioned as one of the possible consequences of sexual violence (Human Rights Watch, 2004).
- In an Amnesty International online publication, fistula is similarly mentioned as a "socially-isolating injury...resulting from violent rape...which can be rectified by surgery if the woman can get access to a suitable hospital" (Amnesty International, 2005).
- Another report by Amnesty International, on sexual violence in Liberia, mentions fistula as one of the possible consequences of rape, while not providing evidence of such cases (Amnesty International, 2004b).
- In a 78-page publication by the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Refugees (UNHCR) on the clinical management of rape survivors, fistula is mentioned once, in the context of "Examination of the genital area, anus and rectum" for rape survivors, where it states: "If indicated, do a recto-vaginal examination and inspect the rectal area for trauma, recto-vaginal tears or fistulas, bleeding and discharge" (WHO & UNHCR, 2005).
- A statement by Thoraya Ahmed Obaid, Executive Director of the United Nations Population Fund (UNFPA), to the UN Security Council lists the injuries and medical

and psychological consequences of sexual violence, one of which is fistula (Obaid, 2004).

- An Amnesty International report on Darfur mentions fistula in the context of rape (Amnesty International, 2004d).
- The RHRC mentions traumatic fistula in the GBV section of an online publication on *Reproductive Health for Refugees Basics* (RHRC, 2004). Among a number of statistics on the prevalence of GBV, the document states that doctors in the DRC are classifying vaginal destruction as a crime of combat. They cite the *Washington Post* as their reference (most likely Emily Wax's 2003 article).
- An article in the *Yale Daily News*, later published in the *Sudan Tribune*, also mentions fistula as a potential physical injury resulting from sexual abuse (Spicyn & Sweetser, 2005).

Magnitude of the Problem and Current Interventions

While it is evident that the rape of thousands of women and girls has occurred in conflict-related sexual assaults, no clear estimate of the prevalence of traumatic fistula exists in any country. While on the one hand this may mean that the overall magnitude of this problem is limited, it may also reflect the significant challenges that inhibit the proper assessment and documentation of the magnitude of the condition.

Awareness of traumatic fistula and its etiology may be lacking. Political insecurity in conflict settings often makes field assessments difficult. Governments may limit the ability of local and foreign organizations to openly address the issues of rape and sexual violence. Women with traumatic fistula are often shunned by others in their communities and may be unwilling to make themselves known or to come forward for treatment. Also, women who have been raped often remain silent, for fear of reprisals from their aggressors.

Thus far, insight into the magnitude of the problem of traumatic fistula is very limited. Reports generally provide individual accounts of women suffering from traumatic fistula. Estimates of magnitude can only be based on information from facilities, which can specify the number of women with traumatic fistula who have presented for treatment. However, such facility-based approximations likely underestimate the extent of this condition, since many affected women may be reluctant to seek medical attention and since facilities to assist these women may not exist where needed. Furthermore, estimates of the number of women and girls raped in a given conflict situation do not necessarily shed light on the potential prevalence of traumatic fistula.

Democratic Republic of Congo—Magnitude

Currently, the majority of the accounts of traumatic fistula have emerged from the DRC, where armed conflict in eastern Congo has led to tens of thousands of women and girls suffering from sexual violence (Amnesty International, no date). Despite the signing of a peace agreement in 2002, sexual violence, particularly in eastern Congo, continues today (Human Rights Watch, 2005). Traumatic fistula is reported to be a significant problem mostly in the eastern and central parts of the DRC (Ahuka, 2005), in the provinces (North

Kivu, South Kivu and Maniema) most affected by the past and ongoing armed conflict (Amnesty International, 2004a). Reports of this condition in the DRC have been numerous and have included personal accounts of several women who developed traumatic fistula as a result of violent sexual assault (Blair, 2004; Goodwin, 2004; Martens, 2004; Nolen, 2005; RFDA, RFDP, & International Alert, 2005; Walsh, 2003; and Wax, 2003).

A handful of professionals have conducted research into the crisis of sexual violence and traumatic fistula in the DRC. In a report on sexual violence in North Kivu province in the DRC (Kalume et al., 2004), 973 victims of sexual violence were identified over a period of six months. A study of 100 of these women revealed that 17 suffered from postviolence fistula. A study published in the *Congo Medical Journal* that was conducted in Kindu, the capital of Maniema province (central Congo), demonstrated that among 2,010 victims of sexual violence seen at Maternité Sans Risque de Kindu over a two-year period (2002–2004), 36 suffered from traumatic fistula—28 from vesicovaginal fistula (VVF), two from rectovaginal fistula (RVF), and six from both VVF and RVF (Manga, Choma, & Kawaya, 2004). Further, there are likely many more women suffering from traumatic fistula in other parts of the province that are at a distance from Kindu or are less accessible due to the ongoing armed conflict (Manga, 2005).

An unpublished study conducted at DOCS Hospital in Goma (eastern Congo) found that among 76 women with urogenital fistula studied over a one-month period, 39.4% had sustained fistula as a result of rape (specifically, collective rape and/or assault associated with forcible insertion of foreign elements into the vaginal cavity). The authors believe that these numbers represent merely the tip of the iceberg in terms of women suffering from this condition (Ahuka et al., unpublished).

In attempting to assess the magnitude of traumatic fistula, it is important to accurately determine the cause of a woman's fistula, to exclude women who developed fistula as a result of prolonged obstructed labor. At DOCS in Goma, some women who came for fistula repair surgery claimed to have sustained their fistula as a result of violent rape. Further inquiry during counseling revealed that the women had not actually been rape victims but had concocted the story thinking it was the only way to obtain free services. Subsequently, DOCS held an awareness-raising campaign to clarify that their services were available for both obstetric and traumatic fistula patients (Eagleton, 2005).

Democratic Republic of Congo—Current Interventions

The majority of surgical repairs of traumatic fistula take place at three hospitals in the DRC (Ahuka, 2005). These are DOCS Hospital in Goma (North Kivu province), Panzi Hospital in Bukavu (South Kivu province), and Maternité Sans Risque de Kindu Hospital in Kindu (Maniema province). Outreach efforts to identify and counsel victims of sexual violence and refer them for necessary medical care have been undertaken by the Center for Victims of Sexual Violence (Christian Relief Network [CRN], 2004a; CRN, 2004b; CRN, 2004c) and by other organizations.

The Pole Institute in Goma focused an issue of its quarterly magazine on GBV in North Kivu province (Pole Institute, 2004). This informative publication includes a comprehensive overview of how the needs of survivors of GBV are being addressed in Goma and other parts of North Kivu province. It also describes a collaborative effort organized by the U.S.-based organization DOCS, the Federation of Protestant Women, and a group of Congolese human rights and women's associations (the latter group of associations together are known as the *Synergie des Femmes pour les Victimes de Violences Sexuelles*, or SFVS), one that addresses both the medical and psychosocial needs of women and girls who suffered GBV during the intense conflict in the DRC. Female lay outreach counselors work to identify women who are victims of violence, to give them moral and psychosocial support and to refer them for medical care (at DOCS Hospital and elsewhere), when necessary. During the first several months of this endeavor (which began in March 2003), a number of women with traumatic fistula were identified (Pole Institute, 2004). In May 2003, only 12 women were waiting at the DOCS center for fistula repair surgery; by January 2004, 132 surgeries had been completed, 80 women had gone home cured, and 60 were waiting for surgery (DOCS, 2004). The majority of these cases were traumatic fistula, while some were obstetric in origin (Ahuka, 2005).

In the province of South Kivu, Panzi Hospital in Bukavu also performs fistula repair surgeries. In 2002, inhabitants of Shabunda, in eastern Congo, who suffered from traumatic fistula were flown by Médecins Sans Frontières to Bukavu for fistula repair surgery (Markandya & Lloyd-Davis, 2002). Last year, of the 357 fistula repair surgeries performed at Panzi, roughly 12% were for fistulas that were traumatic in origin, while the remaining were for obstetric fistula (Stanton, 2005; Mukwege, 2005). Between January and June this year, of the 165 fistula cases operated at the same hospital, approximately six cases were traumatic fistula (Mukwege, 2005).

The *Maternité Sans Risque de Kindu* in Maniema province (central Congo) has also been performing fistula repair surgeries for women with traumatic fistula and anticipates identifying more cases once they start searching outside of the capital, in the interior of the province (Manga, 2005).

Rwanda

The UN estimates that between 250,000 and 500,000 women and girls were raped during the conflict and genocide in Rwanda in the 1990s. A February 2005 report by BBC News indicated that the UK's Department for International Development (DFID) granted £4 million to improve care and access to antiretroviral treatment for women who survived the Rwandan genocide and had been raped and often infected (deliberately) with HIV (Wooldridge, 2005). However, fistula is not mentioned at all in this report. A report by Amnesty International on Rwanda mentions that as a result of the brutal sexual violence during the genocide between 1990 and 1994, "many women were left with permanent health complications such as fistula" (Amnesty International, 2004c). The research conducted for this review has thus far revealed evidence of only two specific cases of traumatic fistula in Rwanda, each of which may or may not have been a result of conflict-related sexual violence (Théobald, 2005).

Sierra Leone

A civil conflict in Sierra Leone between 1999 and 2001 led to the sexual assault of many women and girls. A report by Human Rights Watch (2003) tells the story of a young girl who developed both VVF and RVF as a result of brutal gang rape. A report by Physicians for Human Rights cites the example of a 16-year-old girl who was gang-raped and who suffered from VVF as a result (Physicians for Human Rights, 2002). The U.S.-based International Medical Corps (IMC) was involved in assisting women with traumatic fistula, by providing surgical repair services. IMC sent a Sierra Leonean doctor and nurse to an intensive fistula training course in Nigeria. Following this training in the fall of 2001, 321 patients have been screened in Sierra Leone, and 86 operations have been performed (IMC, no date). It is unclear from the online publication whether these surgeries were performed on women with traumatic fistula or whether women with obstetric fistula are included in these numbers. Furthermore, it is unclear whether this program is still in operation.

Sudan

Although there are currently many barriers to estimating the prevalence of sexual violence in Sudan, Amnesty International believes that incidents of rape and other forms of sexual violence are widespread (Amnesty International, 2004d). A recent briefing released by Médecins Sans Frontières reveals that between October 2004 and February 15th, 2005, alone, the organization treated 297 rape victims, of which 99% were women. This report also provides personal accounts of many women who were raped, but does not mention traumatic fistula in any context (Médecins Sans Frontières, 2005). Although there is no information on the prevalence of traumatic fistula in Sudan, a recent news briefing by the UNHCR (Le Breton, 2005) mentions that Sudanese refugees were obtaining fistula repair surgery in Abeche Regional Hospital in neighboring Chad. At the time, two-thirds of the 20 Sudanese refugees who had a fistula repaired had been raped by Janjaweed militia. These repairs, performed by surgeons from N'Djamena, were funded by the UNHCR and UNFPA (Le Breton, 2005). Further inquiry into this matter revealed that of the Sudanese refugees whose fistulas had been repaired, only two (a 10-year-old and a 17-year-old) had sustained their injuries as a result of sexual violence (Koyalta, 2005).

Other African nations

Among Somali refugees, two cases of traumatic fistula were observed in the refugee camps in northeast Kenya over the last several years. While one appeared to have resulted from first sexual intercourse, the other was reported (by the victim) to have occurred as a result of rape (Ginzel, 2005).

In Liberia, sexual violence has been rampant, as indicated in a report by Amnesty International (2005). In this report, researchers assert that sexual assault has included violent rape and gang rape of women of all ages, and that this violence has increased since 2003. Reports by the United Nations Development Programme (UNDP), the IRC, and other local and international NGOs (mentioned in Amnesty International's report) also provide clear evidence of sexual violence, with the UNDP report indicating that from

60% to 70% of the Liberian population suffered from some sort of sexual violence. Liberian refugees in Sierra Leone are also cited as having suffered sexual violence (Amnesty International, 2005).

Based on these reports, it seems likely that the condition of traumatic fistula has affected women and girls in Liberia. However, due to political insecurity in the country, organizations have had trouble collecting data from the field. Perhaps further research could reveal whether women in Liberia suffer from traumatic fistula and what can be done to address this problem. Similarly, further inquiry into recent conflicts in Angola, Burundi, Mozambique, northern Uganda and other nations where sexual violence has occurred during conflict may yield additional insights into whether the condition exists in any of these places.

Conclusions

Armed civil conflicts around the world have led to suffering and death for countless children, women, and men. Sexual violence in particular tends to affect mostly women and girls, who are often terrorized in a dehumanizing attempt to subjugate and oppress both their communities and the women themselves. Many victims of sexual violence continue to suffer, often with minimal recourse to medical, psychological, social, and legal aid. Without appropriate treatment, women and girls who have developed traumatic fistula must deal with the lifelong physical, psychological, and social consequences of both their sexual assault and their debilitating condition. Therefore, efforts to address this issue in conflict settings, where the overall prevalence of traumatic fistula is expected to be higher, are essential. It is also critical to provide care appropriate for women who are survivors of sexual violence, as surgical repair of fistula alone cannot address their needs.

This review provides an overview of what is known about traumatic fistula in conflict settings around the world. Though limited in scope by the lack of documented evidence, it will serve as a foundation for discussion around the issue of traumatic fistula. At the September 2005 meeting in Addis Ababa, more information on this issue will be gathered from the various participants, and this information will be compiled in a meeting report. Participants will be asked to share information and expertise to improve understanding of the magnitude of the problem in different regions, to determine what kind of surrogates might be used to estimate the prevalence of traumatic fistula (such as rape and sexual violence in general), and to estimate what proportion of sexual violence victims develop a traumatic fistula.

Besides the surgical needs of women with this condition, participants will also discuss the psychological effects of sexual violence and the support needed by women who have suffered sexual violence and traumatic fistula. Interventions and programs to address traumatic fistula, as well as their successes and challenges, will also be vetted in detail. By bringing together a number of organizations and individuals with expertise on various aspects of this problem, gaps in current interventions will be identified and a comprehensive strategy for addressing these gaps will be developed collaboratively. Findings from this meeting may also serve as important advocacy tools to increase

awareness of this issue and to address the legal issues pertinent to survivors of sexual assault in conflict settings.

For now, this preliminary literature review makes it clear that future efforts to address this issue should include increased surveillance to assess whether this problem exists, in all countries where systematic sexual violence has occurred during conflict. Furthermore, the information herein confirms the crucial need to begin a collective discourse, which will lead to positive action to ameliorate the condition of women and girls with traumatic fistula.

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Annotated Bibliography

Ahuka, O. L., et al. Unpublished. Fistules uro-genitales a l'est de la republique democratique du Congo: une 'epidemie'? Analyse des facteurs etiologiques pendant une guerre civile.

The following is an abstract provided with the article by the authors.

Most urogenital fistulas (UGF) are caused obstetrically by dystocias found in rural regions of developing countries. In many cases in the eastern Democratic Republic of Congo (DRC), however, UGFs are caused by rapes that occur as a result of the numerous armed conflicts in the region.

Through our study, we wanted to expose the complexity of the etiological factors of this pathology as we found it in our daily practice. This prospective study was conducted at DOCS Learning Center (Goma) and at the reference hospital of Mweso in the North Kivu within a period from the 1st to the 31st of March, 2004.

We conducted our study on 76 women aged 16-70 years old, all of whom suffer from UGFs. Our outcomes show that rape without pregnancy is directly responsible for UGF in 39.4% of all cases (collective rape and/or associated with forcible insertion of foreign elements into the vaginal cavity). Other factors caused by the war comprise 28.8% of the cases. Combining these results, the conditions created by the civilian war are either directly or indirectly the cause of 68.2% of UGF cases. This rate is far greater than the 25% rate that represents the obstetrical cause of UGF within these armed conflict areas.

Moreover, it is noted that 80.2% of our patients are not over 30 years old, with an average of 27.22 ± 10.36 years old. 46.7% of cases in our series are primiparous or nulliparous.

As for the pathology duration, it averages 26.68 ± 22.47 months. It is important to signal that 97.8% of cases occurred within the last five years. This length corresponds to the duration of the civilian war in the DRC (August 1998 to June 2003), a correlation that clearly indicates that the incidence rate observed in this pathology is directly related to the conditions created by the war.

The war atrocities are therefore a direct cause of UGFs in the conflict area of the eastern DRC. Clearly, the rape victims who come into the hospital center only comprise a small percentage of the millions of other victims who cannot be reached due to the insecurity of the country. We call for a conscious stand and responsibility of all individuals to erase this curse.

Amnesty International. [no date given]. Democratic Republic of Congo: The struggle for health care and justice for rape survivors. Retrieved from <http://web.amnesty.org/actforwomen/stories-15-eng>, March 16, 2005.

Note: The “reconstructive surgery” referred to in this document, given the context, appears to be fistula repair surgery.

This online document outlines the situation of rape survivors in eastern DRC. Armed groups are believed to have raped tens of thousands of women in brutal attacks. Women who survive rape incur a number of injuries and illnesses, and many of them require reconstructive surgery. However, treatment for these women is very limited. In fact, only two small hospitals, including Panzi Hospital in Bukavu, have the resources to perform reconstructive surgery for rape survivors. Prospects of judicial redress are also limited, though local women’s and human rights organizations have responded, with no action taken by the government and minimal action by the international community. However, rape survivors are determined to lead by example and challenge social stigma and government inaction.

Blair, D. 2004 (December 27, 2004). Congo militiamen wreak havoc with rape as a weapon. *News Telegraph*; retrieved from <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2004/12/27/wcongo27.xml&sSheet=/news/2004/12/27/ixworld.html>, February 23, 2005.

Vumiliya Tembeyaona is one of the many women in the DRC who is suffering from incontinence due to vaginal fistula. Having been raped and tortured by 15 men, she was left unconscious until passers-by helped her reach a clinic, and eventually DOCS Hospital in Goma, where she now lives. Three surgeons at DOCS hospital have performed numerous delicate fistula surgeries and have helped 2,400 women with fistula. Despite peace deals between Congo’s warring factions, the numbers of fistula patients have not diminished. Armed militia groups continue to inflict misery on the innocent, in a nation where anarchy reigns and the strong prey upon the weak. Miss Tembeyaona, who still suffers from incontinence after six operations, is surrounded by women who have survived horrific ordeals. The attackers of 21-year-old Migisha Ntenganya fired a bullet into her vagina.

Christian Relief Network. 2004a. The sexual violence continues. Retrieved from <http://www.crn.no/page?id=1518&key=12408>, February 9, 2005.

In eastern DRC, Mama Jeanne's orphanage has now started taking in victims of sexual violence. Mama Jeanne has taken courses on how to meet the needs of these women, and she shares her skills with women's groups in Masisi. She also cooperates with DOCS, a hospital in Goma with surgeons who specialize in surgery for victims mutilated as a result of brutal rapes. She has referred 15 women who have been operated on, some of whom have required up to four operations to become normal again.

Christian Relief Network. 2004b. Assist victims of sexual violence. Retrieved from <http://www.crn.no/page?id=1518&key=11988>, February 9, 2005.

According to Amnesty International, fighters in the DRC have raped at least 40,000 women over the last six years. Many women never recover from the physical, psychological, and social effects of the assaults, due to their lack of access to health care and psychological care and due to social stigma. Christian Relief Network (CRN) supports local initiatives to reach and assist victims who would otherwise be left without assistance. In Goma, eastern DRC, CRN supports Mama Jeanne's Home for Victims of Sexual Violence, where victims receive aftercare, counseling, and follow-up. Mama Jeanne also supervises 30 outreach counselors who go from village to village to seek out victims of sexual torture and provide the necessary care and referral. In an effort to increase access to medical health care, CRN also supports medical treatment and fistula repair surgery for victims. While only two hospitals in eastern DRC can perform fistula surgeries (Panzi in Bukavu and DOCS in Goma), CRN is rehabilitating Pinga Hospital in Masisi, to increase the capacity and competence of the hospital to treat victims of sexual violence.

Christian Relief Network. 2004c. 14 women to get surgery. Retrieved from <http://www.crn.no/page?id=1518&key=12985&mode=print>, February 9, 2005.

During the week of December 17, 2004, 14 rape victims were brought down from the Masisi Mountains to Goma for fistula surgery at the DOCS hospital. The CRN/CEPAC's (Communauté des Églises de Pentecôte en Afrique Centrale) Center for Victims of Sexual Violence provides counseling and care while the women are in Goma, and the surgeries are supported by CRN's donors and the Norwegian Ministry of Foreign Affairs.

Doctors on Call for Service (DOCS). 2004. Healing for women victims in Congo. Retrieved from <http://www.docs.org/VVFLeafletMarch04.pdf>, February 9, 2005.

Rape is being used as a weapon of war in eastern DRC and is leaving thousands of women injured with vesicovaginal fistulas. The surgery to repair a fistula is delicate and often complex and is available free of charge at the DOCS Learning Center. Affected women also receive care for physical and emotional trauma. In May 2003, only 12 women were waiting at the DOCS center for fistula repair surgery; by January 2004, 132 surgeries had been completed, 80 women had gone home cured, and 60 were waiting for surgery. While many DOCS physicians and nurses are volunteers from the United States, Congolese physicians are also being trained.

HRW. 2003. 'We'll kill you if you cry': Sexual violence in the Sierra Leone conflict. Retrieved from <http://hrw.org/reports/2003/sierraleone/sierleon0103.pdf>, February 28, 2005.

This 79-page report by Human Rights Watch (HRW) documents sexual violence perpetrated against thousands of women and girls during the armed conflict in Sierra Leone between 1991 and 2001. Rape in wartime is an act that targets sexuality and serves a military and political strategy. The victims of sexual violence, young and old alike, suffered brutal individual and gang rape, rape with objects (including weapons, sticks, and burning wood), and abduction and sexual slavery at the hands of rebel forces. The Revolutionary United Front (RUF), the Armed Forces Revolutionary Council (AFRC), and a splinter group of the latter, the West Side Boys, were responsible for most of the crimes of sexual violence in Sierra Leone. In addition to the adult men, child combatants also raped civilians. A limited number of documented cases have also revealed members of the progovernment Sierra Leone Army (SLA) and Civil Defense Forces (CDF), as well as UN and ECOMOG (Economic Community of West African States Monitoring Group) peacekeeping forces, as perpetrators of sexual violence. HRW demands accountability for the unimaginable human rights abuses committed in Sierra Leone.

Vaginal fistulas are briefly mentioned during this report. The first mention is in the section "Sexual Violence Against Women and Girls During the Civil War," under the subheading "Sexual Violence Committed by the Rebel Forces." A personal account is given by a 16-year-old who was gang-raped both vaginally and anally by 10 RUF rebels and who developed a fistula directly as a result of her brutal gang rape. She had an operation in 2000, which did not work, and in 2001 got

a catheter. Still in pain and with a vaginal discharge problem, this young girl has nightmares and feels discouraged. A young 9-year-old girl who was cared for by a nurse after being raped appears to have had recto-vaginal fistula, although the circumstances are not clearly described in the report.

The other mention of fistula is in the section “Effects of Sexual Violence” under the subheading “Health.” Fistulas as a result of rape are mentioned as health problems caused by sexual violence, among other health problems (such as transmission of HIV and other sexually transmitted infections (STIs), unwanted pregnancies, complications when giving birth, trauma, prolapsed uterus, and mental health issues).

International Medical Corps (IMC). 2004. Sierra Leone National Obstetric Fistula Intensive Training, Research, Surgery and Recovery Center in Freetown, Sierra Leone (proposal).

Note: In a needs assessment conducted by IMC in Sierra Leone in 2003 (for UNFPA), they noted that although they initially were treating women with traumatic fistula, most cases of fistula arose from complications of labor, rather than from sexual violence. Perhaps this proposal is a result of that assessment. Note that they refer to both traumatic and obstetric fistula as obstetric fistula.

Problem Statement: Childbirth among young girls in Sierra Leone can lead to a devastating injury known as obstetric fistula, which leaves the victim incontinent of urine and/or feces. Fistula sufferers may also sustain nerve damage and other physical consequences, and are often ostracized from their families and from the societies in which they live. Sexual violence during conflict and unsafe reproductive health practices such as female genital cutting have created a new class of fistula sufferers in Sierra Leone. IMC has experienced a steady influx of fistula patients who are unable to cover the costs of their fistula repair surgery.

Background Information: IMC is dedicated to saving lives and relieving suffering for vulnerable populations around the world through intensive training and support for health and development workers living in countries that have experienced complex emergencies. IMC’s initial response in 1999 to the Sierra Leone conflict included provision of a number of health services, including fistula repair. Initial funds for treating women with fistula

allowed IMC to train two local surgeons and several nurses and aides. While hundreds of women still require fistula repair surgery, funding has been withdrawn and local capacity to treat these women is dismally low.

Proposed Intervention: IMC seeks to conduct obstetric fistula surgeries by working with the Ministry of Health Services (MOHS) to train surgeons, nurses, and aides in the treatment and care of obstetric fistula patients, while also benefiting from the help of international experts. A new Obstetric Fistula Intensive Training, Research, Surgery, and Recovery Center will have an operating theater, recovery wards, and a hostel for trainees and for preoperative and postoperative patients. IMC will collect biomedical and socioeconomic data on fistula patients to inform future programming. The MOHS and local stakeholders will be included in every aspect of this program. IMC will also receive referrals for advanced cases from Mercy Ships International. IMC will continue to participate in and hold meetings with international organizations and experts.

Kalume, M. A., et al. 2004. La violence sexuelle a l'est de la RDC en periode de conflit. Particularités et conséquences médicales. *Congo Medical Journal* 8(13):1176–1182.

The following is a summary provided with the article:

Over the last three years, humanitarian organizations and local observers reported exacerbation of sexual violence against women and children in Eastern Democratic Republic of Congo. Faced with these alerts, a number of authors proposed to assess the magnitude of this human rights violation in North Kivu province to bring out its characteristics and medical consequences.

The authors noticed the following: 973 victims of sexual violence had been identified over a period of six months; the sample was made of 100 victims referred during the first three months. The victims' age ranged from 3 to 73 years; those from rural areas were mostly young mothers; in addition to vaginal penetration, some perpetrators from rural areas forced foreign bodies into the genital organs of their victims and inflicted the most barbarous acts, such as the violent beating, tying up, or killing of relatives. More severe in rural than in urban areas, rape was followed with severe medical consequences such as miscarriage, unconsciousness, vesicovaginal fistula, even rectovaginal fistula; other common consequences included pelvic inflammatory diseases and HIV/AIDS.

This is a true woman hunt for sexual reprisals, because the victim is captured either at home or in supply places (market, fields, water points) and sometimes in the street; rape is collective and serial, in the open, perpetrated in most cases by armed men. These poor women and girls, displaced, driven from their homes or families for some, are almost without assistance from their local communities.

Le Breton, G. 2005 (March 17). UNHCR, UNFPA fund surgery for refugee and local women in Chad. Office of the United Nations High Commissioner for Refugees (UNHCR) news story. Retrieved from <http://www.unhcr.ch/cgi-bin/texis/vtx/news/opendoc.htm?tbl=NEWS&id=4239519f4>, May 26, 2005.

Sixty Chadian and Sudanese women in eastern Chad are receiving first-class fistula repair, thanks to a project by UNHCR and UNFPA. Two surgeons from N'Djamena are performing the surgeries, with funding from UNHCR and UNFPA. The women had developed vesicovaginal fistula either through obstetric causes or due to violent rape. Two-thirds of the 20 Sudanese refugees undergoing fistula repair, including a 10-year-old girl, had been raped by Janjaweed militia. However, due to the taboo surrounding rape, many rape survivors do not come forward with their medical ailments. Women who have been raped are viewed as second-class citizens and are often shunned by their societies and their husbands. Some of the women who have been repaired at Abeche Regional Hospital prefer to stay and help other women affected by fistula, rather than return to the refugee camps.

Martens, J. 2004 (January 24). Congo rape victims seek solace. *BBC News*. Retrieved from <http://news.bbc.co.uk/1/hi/world/africa/3426273.stm>, February 23, 2005.

The war in Congo, now coming to an end, has brought untold suffering to many. A young girl named Vumi suffers from vesicovaginal fistula, an injury that leaves her incontinent. This type of fistula, a hole between the bladder and the vagina, is normally an injury occurring during prolonged obstructed labour, but Vumi and countless others like her have suffered this injury as a result of violent rape and the forcing of objects into their vaginas. Jeanne Banyere (Mama Jeanne) is part of the Women's Protestant Federation that cares for victims of sexual violence in eastern Congo and brings them to a nearby hospital run by DOCS (Doctors on Call for Service). There, Dr. Longombe Ahuka performs fistula surgeries and laments the savagery that he has seen. In addition to the injuries

sustained by the women, 24% of his patients have also tested positive for HIV. While the women in Congo have faced unimaginable horrors, the opportunity to undergo fistula repair surgery may restore their dignity.

Nolen, S. 2005. 'Not Women Anymore...' The Congo's rape survivors face pain, shame and AIDS. *Ms. Magazine* (Spring); retrieved from <http://www.msomagazine.com/spring2005/congo.asp>, May 11, 2005.

Thérèse Mwandeko is one of many women waiting at Panzi Hospital in the Democratic Republic of Congo for fistula repair surgery by Dr. Denis Mukwege. Having saved money for an entire year to pay for transport to the hospital, she is overjoyed with a feeling of hope once she arrives. Thérèse was the victim of a violent gang rape, in her case by Rwandan militia soldiers. Amnesty International researchers believe that the scale of rape in the DRC is higher than anywhere before, though actual numbers are yet to be determined. Due to the stigma surrounding rape, rape survivors in Congo are often shunned by their husbands and communities. An estimated 30% of women raped in Congo are infected with HIV. Dr. Jean-Yves Mukamba, director of a hospital in Kibombo, struggles to treat these women with an almost nonexistent stock of medical supplies and no assistance from Kinshasa.

Despite the peace deal signed in 2002, the country does not look as if war has ended. Infrastructure is lacking, militiamen still roam freely in the forests, and many people have lost their homes and possessions. Legal assistance for Congolese is negligible, and perpetrators of violence are yet to be held accountable. The UN mission in Congo is unable to provide adequate assistance, and to add to this, UN peacekeepers were recently alleged to be contributing to sexual violence in the country.

Pole Institute. 2004. An open wound: The issue of gender-based violence in North Kivu. *Regards Croisés Quarterly Magazine 11* (August); retrieved from <http://www.pole-institute.org/documents/regard11bis.pdf>, June 12, 2005.

This issue of the quarterly magazine of the Pole Institute is focused on gender-based violence in North Kivu province. In addition to information on traumatic fistula, this magazine describes the various aspects of GBV that must be addressed, including counseling, social support, advocacy, legal recourse, and the position of the local authorities on this issue.

Walsh, D. 2003 (November 25). 'How can human beings do that to each other?' Rape joins plunder of diamonds and gold as a hallmark of Congo's bloody conflict. *The Independent Online Edition*; retrieved from <http://www.rense.com/general45/congo.htm>, February 23, 2005.

In what some aid workers are calling a "war against women," 23-year-old Rosette was violently raped and now suffers from vesicovaginal fistula that leaves her incontinent. She and dozens of other women bear their stench and wait patiently at DOCS clinic in Goma for an operation that will cure their condition. In just six months, of the 1,000 women treated, 83 required fistula repair surgery. Many test positive for HIV. The atrocities against women, both very young and very old, are unimaginable. Dr. Abuka Longombe has seen the worst of the Congo war, including people being hacked to death in their hospital beds. While Dr. Longombe says that a war crimes tribunal is needed to end the culture of impunity, for now, efforts are directed at maintaining the fragile peace between Kabila and his rebel enemies.

Wax, E. 2003 (October 25). A brutal legacy of Congo war: Extent of violence against women surfaces as fighting recedes. *Washington Post*. Retrieved from <http://www.washingtonpost.com/ac2/wp-dyn/A14059-2003Oct24?language=printer>, February 9, 2005.

Gang rape during the war in eastern Congo has been so violent and frequent that the resulting destruction of a victim's vagina is considered a war injury and is recorded by doctors as a crime of combat. Thousands of women in the DRC suffer from vaginal fistula, which leaves them incontinent and often ostracized by society. Jo Lusi heads a Congolese-run hospital in Goma that is working with the U.S.-based Doctors on Call for Service (DOCS) to provide free surgery to repair vaginal fistulas. UNICEF is building a ward for women who suffer from fistula and other effects of rape. While Jo Lusi and others attest to thousands of rape victims showing up for care, many feel that there are thousands more cases that go unheard of. Some aid groups estimate that one in every three women in Congo are victims of rape. But women are not sitting silently any more and are staging protests to bring attention to the issue.

A 30-year-old woman named Nyagakon was raped by five men while she was eight months pregnant. Her husband took her to a hospital where her dead fetus was removed, and she also suffered vaginal fistula as a result of the violent rape. After Nyagakon spent months at home, her husband took her to the Panzi Hospital in Bukavu, where she is undergoing multiple surgeries to cure her fistula. She has hope that she will finally be healed and will be able to return home.