ACQUIRE Report

Traumatic Gynecologic Fistula: A Consequence of Sexual Violence in Conflict Settings

May 2006

A Report of a Meeting Held in Addis Ababa, Ethiopia,
September 6 to 8, 2005

Addis Ababa Fistula Hospital
EngenderHealth/The ACQUIRE Project
Ethiopian Society of Obstetricians and Gynecologists
Synergie des Femmes pour les Victimes des Violences Sexuelles

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Most importantly, we recognize the many women and girls who courageously endured the hardship and atrocity that resulted in traumatic fistula.

Acronyms

ACORD	Agency for Cooperation and Research in Development
ACQUIRE	Access, Quality, and Use in Reproductive Health
ADRA	Adventist Development and Relief Agency International
AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral
CARE	Cooperative for Assistance and Relief Everywhere
COMSED	Cooperation for Medical Services and Development
DOCS	Doctors On Call For Service
DRC	Democratic Republic of Congo
EC	emergency contraception
ESOG	Ethiopian Society of Obstetricians and Gynecologists
FGC	female genital cutting
FGM	female genital mutilation
FP	family planning
GBV	gender-based violence
HIV	human immunodeficiency virus
IDP	internally displaced person
Lib-SWAA	Liberian Society for Women Against AIDS
MAP	Men as Partners
MCH	maternal and child health
MOH	Ministry of Health
MSF	Médecins Sans Frontières
MW	midwife
NGO	nongovernmental organization
ob/gyn	obstetrician/gynecologist
PHR	Physicians for Human Rights
REDSO	Regional Economic Development Services Office
RH	reproductive health
SFVS	Synergie des Femmes pour les Victimes des Violences Sexuelles
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
SWAA	Society for Women and AIDS in Africa
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
USAID	U.S. Agency for International Development
WDP	Women's Dignity Project
WHO	World Health Organization

Executive Summary

The condition of *obstetric fistula*—a vaginal tear resulting from prolonged obstructed labor—has garnered a great deal of attention on the international reproductive health agenda, but until recently, little focus has been placed on *traumatic gynecologic fistula*—an injury that can result from violent sexual assault, often in conflict settings. Many service providers who care for women or children in areas experiencing civil war or other conflicts have seen clients with traumatic fistula, but expertise on the condition remains scattered, and sharing of strategies and tools to address the issue has been limited.

To learn more about the issue, the Addis Ababa Fistula Hospital, EngenderHealth/The ACQUIRE Project,[1] the Ethiopian Society of Obstetricians and Gynecologists (ESOG), and Synergie des Femmes pour les Victimes des Violences Sexuelles (SFVS) cosponsored the first-ever conference on traumatic fistula in Addis Ababa, Ethiopia, from September 6 to 8, 2005. Participants included fistula surgeons, health and social workers, psychologists, activists, and lawyers from 12 African countries where traumatic fistula is known to exist, as well as global humanitarian and public health experts (see Appendix 1 for a list of the meeting participants).

In anticipation of the meeting, The ACQUIRE Project conducted a review of the literature to uncover what is currently known about traumatic fistula,[2] and the findings were shared with all meeting participants.

The meeting consisted of participatory panels, small group work, and recounting of expert testimony (see Appendix 2 for the meeting agenda). The goals of the meeting were to:

- Share current knowledge on the magnitude of traumatic fistula.
- Discuss existing programmatic interventions.
- Identify key successes, challenges, and gaps related to clinical, psychosocial, community, policy/advocacy, and referral and related issues.
- Synthesize lessons learned, develop recommendations to address the identified gaps, and develop country-specific strategies to address traumatic fistula.

During the course of the meeting, experts discussed the challenges, progress, and lessons learned from programs that are addressing traumatic fistula and violence against women. Some of the primary challenges identified include:

- Political advocacy. The lack of awareness of traumatic fistula has resulted in a low level of commitment to the issue at the policy level. Meeting participants expressed the great need to provide decision makers with information and advocacy materials. Additionally, the lack of

[1] The ACQUIRE Project (Access, Quality, and Use in Reproductive Health) is a cooperative agreement funded by the U.S. Agency for International Development (USAID) that works worldwide to advance and support reproductive health and family planning services, with a focus on facility-based and clinical care. EngenderHealth manages ACQUIRE in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA).

[2] To access this document (EngenderHealth/The ACQUIRE Project. 2005. Traumatic gynecologic fistula as a consequence of sexual violence in conflict settings: A literature review. New York: EngenderHealth/The ACQUIRE Project), go to: http://www.engenderhealth.org/ia/swh/mcftraumatic.html.

information about the magnitude of traumatic fistula serves as a barrier to effective advocacy and efforts to raise awareness of the condition.

- Legal systems. In many countries in conflict or postconflict, legal systems are not in place to ensure that survivors of sexual violence have legal recourse and the opportunity to bring their perpetrators to justice. Where legal systems do exist, conflict can severely weaken the rule of law, allowing sexual violence to occur with impunity.
- Clinical care. Further training opportunities for service providers are greatly needed. In most countries, a lack of knowledge and skills hinders the provision of quality fistula repair services. Health facilities often lack the materials and equipment necessary for fistula repair. Insufficient financial, material, and human resources pose serious barriers to the provision of fistula services.
- Psychosocial care. Women who have traumatic fistula have needs that cannot be met by clinical services alone. Survivors of sexual violence require a range of psychological and counseling services that are often unavailable or inadequate due to a lack of financial support, counseling skills, and human resources. Even where these services do exist, fistula care providers may not be aware of the importance of referring clients to this care.
- Referral systems. Establishing functional referral systems is a major challenge. Often, both clients and members of the communities in which they live lack knowledge about services and clients' rights. A further difficulty is the limited availability of surgical and counseling services. Moreover, assailants may intimidate clients so that they become afraid to access services. A woman's fear of discrimination and social stigma may also inhibit her from seeking referrals for other services.
- Financial resources. A lack of political commitment to traumatic fistula very often translates into extreme resource gaps for fistula repair and rehabilitation services. A lack of consistent funding often means that health facilities and nongovernmental organizations designed to provide critical care are unable to sustain those services.
- Gender issues. Gender inequality and misogynistic attitudes and practices lie at the root of traumatic fistula. Changing attitudes and behaviors that can lead to sexual violence is a great challenge and will require extensive work and a long-term effort.

Meeting participants developed a set of programmatic recommendations and country-specific strategies for managing traumatic fistula (see Appendix 3). Some of the strategies identified include:

- Carry out needs assessments to identify existing gaps in the provision of traumatic fistula services.
- Conduct studies on the magnitude of sexual and gender-based violence and traumatic fistula and present the findings to all key stakeholders.
- Sensitize all stakeholders—including government, civil society, religious groups, and community members—on traumatic fistula, its causes, and its means of treatment.
- Mobilize community leaders and women's groups, and lobby for change among key decision makers.
- Train health and auxiliary personnel to manage traumatic fistula.
- Equip health centers and ensure adequate supplies, materials, and medicine for fistula treatment and rehabilitation.
- Establish and/or strengthen rape crisis centers.
- Establish national working groups on traumatic fistula to develop workplans and collaborative activities.

- Conduct training sessions for the media on how to address sexual and gender-based violence, obstetric fistula, and traumatic gynecologic fistula.
- Findings from the review of the literature and the meeting of experts reveal that women who have experienced traumatic fistula have needs that cannot be met by clinical services alone. Interventions must be holistic and multisectoral, with involvement of the health care, social, educational, and legal sectors, among others.

Introduction

Global awareness of the condition of *obstetric fistula*—a vaginal tear resulting from prolonged obstructed labor—has increased, but less is known about *traumatic gynecologic fistula*—an injury that can result from violent sexual assault, often in conflict settings. Brutal rape (by one or more assailants or by the use of gun barrels, beer bottles, or sticks) can result in a tear, or fistula, between a woman's vagina and her bladder or rectum, or both. Women with traumatic fistula are unable to control the flow of their urine and/or feces, and they find it impossible to keep themselves clean.

As survivors of violent sexual assault, women with traumatic fistula may have sustained additional physical injuries and are at an increased risk for unwanted pregnancy and sexually transmitted infections (STIs), including HIV. Often divorced by their husbands, shunned by their communities, and unable to work or care for their families, survivors must also cope with the psychological trauma caused by rape.

Fistula can be surgically repaired if trained surgeons and quality postoperative care are available. Long-term and comprehensive counseling, rehabilitation, and advocacy services are also critical to ensure that a woman's psychological wounds are healed and that her perpetrator is brought to justice.

A Landmark Event to Address Traumatic Gynecologic Fistula

A partnership including the Addis Ababa Fistula Hospital, EngenderHealth/The ACQUIRE Project (which stands for Access, Quality, and Use in Reproductive Health), the Ethiopian Society of Obstetricians and Gynecologists (ESOG), and Synergie des Femmes pour les Victimes des Violences Sexuelles (SFVS) brought together a group of experts on traumatic fistula and related issues for a three-day meeting on traumatic gynecologic fistula in conflict settings. Experts from 12 African countries gathered in Addis Ababa, Ethiopia, from September 6 to 8, 2005, to create a shared base of knowledge, to discuss current and best practices, and to begin to form a collegial network of professionals working on traumatic fistula at the clinical, psychological, social, and legal fronts throughout Africa.

Because information about traumatic fistula is lacking among the larger reproductive health and relief communities, The ACQUIRE Project conducted a literature review to gather existing information on traumatic fistula in advance of the meeting. The review of the literature uncovered stories of brutal rape of women and girls 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 (DRC) appears to have the largest number of women suffering from traumatic gynecologic fistula. Reports also have emerged from Rwanda, Sierra Leone, and Sudan, but there is little information to confirm whether they are sporadic cases or are indicative of a greater problem. Although the limited documentation of traumatic gynecologic 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, but it is not known if other countries have services to assist these women. If they do, their efforts 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).[3] 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 women with traumatic fistula go undetected and without surgical repair, counseling, and other services, needlessly suffering the lifelong consequences of this injury.

"[We] must begin to fight the culture of impunity that condones the behavior resulting in traumatic fistula."

—Andrew Sisson, REDSO

The meeting on traumatic gynecologic fistula provided a valuable opportunity to hear from experts on gender inequality and sexual violence in conflict settings, as well as to develop a comprehensive strategy to address the multifaceted needs of women and girls with traumatic fistula. Andrew Sisson, director of the U.S. Agency for International Development's (USAID's) Regional Economic Development Services Office for East and Southern Africa (REDSO), stated that an estimated one in three women worldwide has been physically or sexually abused by one or more men at some point in their lives. Sisson told the story of a 6-year-old girl in the presurgery ward at the Doctors On Call For Service (DOCS) Hospital in Goma, DRC:

> *"…She had been ripped from her mother's arms as they sat in their yard at dusk. Suddenly a group of five militiamen came in shooting. Her mother begged the men to take her in exchange for her daughter, but they refused. They had come for the little girl. The child was found the next day, in her school, her tiny legs tied to two benches. She was bathed in blood. While the doctors in Goma said her daughter would survive, the mother lamented that she could never marry…. She feared the girl would never be able to forget the horrific violence done to her."*

Justine Masika, director of SFVS in the DRC, recounted seeing a 1-month-old survivor of rape. She noted that the perpetrators are often armed, and may be members of the militia or the military; in some cases, members of a woman's family. Ruth Kennedy, liaison officer from the Addis Ababa Fistula Hospital, stated, "Some [women] will never be cured. We need to have in place an alternative for those so wrecked and so hopeless they can no longer think for themselves and provide for them a haven of hope."

Meeting Objectives

The meeting had four specific objectives:

- To share current knowledge on the magnitude of traumatic fistula
- To discuss existing programmatic interventions
- To identify key successes, challenges, and gaps related to clinical, psychosocial, community, policy/advocacy, and referral and related issues
- To synthesize lessons learned, develop recommendations to address the identified gaps, and develop country-specific strategies to address traumatic fistula

[3] EngenderHealth/The ACQUIRE Project. 2005. *Traumatic gynecologic fistula as a consequence of sexual violence in conflict settings: A literature review.* New York: EngenderHealth/The ACQUIRE Project. Available at http://www.engenderhealth.org/ia/swh/mcftraumatic.html.

Magnitude and Programmatic Interventions

Definition of Traumatic Gynecologic Fistula

All types of fistula are caused by trauma. Traumas that can cause fistula include obstetric trauma (e.g., labor, instrumental delivery), gynecologic surgery such as hysterectomy or surgery for laxity of the pelvic genital tissues, instrumentation of the bladder, impalement from accidents such as falls or animal gorings, malignancy or radiation of the genital tract or rectum, inflammatory bowel disease (e.g., Crohn's disease), infections such as tuberculosis, and cultural injuries (e.g., Gishiri cutting, female genital cutting [FGC], or foreign bodies inserted into the vagina). Sexual violence, including rape, defilement, or forcible insertion of objects into the vagina, is the major cause of traumatic fistula.

For the purposes of the meeting, traumatic gynecologic fistula (hereafter "traumatic fistula") was defined as **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 postconflict settings.**

Experts stressed that "conflict" can occur within households, and not only as a result of war. Ruth Kennedy, from the Addis Ababa Fistula Hospital, suggested that "we need to be clear that the war that is taking place is in the woman's vagina—that is what has become the battlefield—and we need to take action and not get caught up in semantics about what is and is not a 'conflict setting.'" Organizations should not let semantics obscure the need to provide quality services for women with obstetric and traumatic fistula and those with severe perineal tears. Although the classifications and causes may differ, the end result of incontinence remains the same.

Overview of Sexual and Gender-Based Violence (SGBV) in Conflict Settings

The United Nations High Commission for Refugees (UNHCR) has declared sexual violence, gender-based violence (GBV), and violence against women "violations of fundamental human rights that perpetuate sex-stereotyped roles that deny human dignity and the self-determination of the individual and hamper human development. They refer to physical, sexual, and psychological harm that reinforces female subordination and perpetuates male power and control."

Further, the UN General Assembly's 1993 Declaration on the Elimination of Violence Against Women, Article 2, notes: "The acts of violence specified in this article include: spousal battering, sexual abuse of female children, dowry-related violence, rape including marital rape, traditional practices harmful to women such as female genital mutilation [FGM], nonspousal violence, sexual harassment and intimidation, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state such as rape in war."

The actions and policies of national and international governing bodies, corporations, and the military, as well as the media's reinforcement of harmful social norms, all contribute to a culture of violence. Local customs and practices can also lead to violence.

Several factors exacerbate SGBV in conflict settings:

- Increased militarization and decreased respect for international law
- Undermining of international institutions such as the UN and the International Criminal Court
- Debt, structural adjustment programs, deepening poverty and inequalities, and corresponding conflict
- Diminished ability of the state to provide basic services, including health care, education, and justice

SGBV is inevitably worse during times of war. Accountability decreases at multiple levels, and sexual violence becomes a way to intimidate and silence women activists and community leaders. It is often used as an interrogation tool, as a way to humiliate women and demonstrate their powerlessness, as well as an act of genocide. Women are often abducted and used as sex slaves and as unpaid labor for the military.

Emerging international legal strategies may prove to be effective in addressing SGBV. For instance, UN Resolution 1325 calls for the inclusion of a gender analysis in all UN conflict-related programs to ensure a focus on the prevalence of SGBV in conflict settings. Increasingly, the provision of psychological and physical health services is considered to be an integral part of emergency assistance and postconflict reconstruction. After the conflicts in the Balkans and Rwanda, international tribunals and the International Criminal Court designated violence against women "a crime against humanity."

Finally, recent research has begun to demonstrate the efficacy of working with men to challenge patriarchal and misogynist practices. In South Africa, for instance, EngenderHealth has been collaborating with local cooperatives, institutions, and government agencies to implement a successful Men As Partners (MAP) program, aimed at changing established beliefs, attitudes, and behavior, promoting transformations in social norms, mobilizing men to take action in their communities, and advocating for increased government commitment to positive male involvement.

Harsh Realities in Two Countries

DRC

Justine Masika, director of SFVS in eastern DRC, recounted several stories about women with traumatic fistula:

> *"We met a woman of 80 years who had been raped by seven armed men. Left in [the] bush, she was found two weeks later by a hunter who brought her to a village, where they had no means to cure her, so they brought her to Goma. The woman had no money for treatment, and died as a result. We saw another woman who'd been raped and whose husband and eldest son were killed. When she exposed the perpetrators, they returned to her home and cut off her lips."*

In response to this violence, SFVS was established in February 2003 as an SOS service. It now consists of 80 human rights and women's associations working to assist survivors of sexual violence and the poor. Its goals are to provide medical, social, and legal aid, and to organize women to fight against sexual violence.

Burundi

Burundi has experienced conflict for more than a decade. Its economy has collapsed, and nongovernmental organizations (NGOs) have reported more and more cases of mistreatment of women across all 17 provinces. As a result, the organization Seruka was founded to treat survivors of sexual violence and to provide services that address the whole spectrum of clients' needs, from medical and psychological to social and legal. The Seruka Center aims to provide services in a way that avoids further stigmatization of clients, especially in light of the fact that in Burundi, rape is often socially accepted, occurring not only in areas with a large military presence, but also in private households.

The Seruka Center includes a 20-bed hospital that is open 24 hours a day, seven days a week. It is one of only four centers in the country that treats rape survivors. Nurses are carefully trained to approach clients with empathy and respect. They make confidentiality a priority, and follow strict rules for internal and external communication, using codes in place of clients' names in every unit.

Since the beginning of 2005, the center has treated an average of 124 rape survivors per month, a distinct increase from the previous year. Forty-one percent of the clients were between 19 and 45 years old; almost 50% were minors between the ages of five and 18. Approximately half of the girls and women were raped by someone they knew—most by a single perpetrator, and one-quarter by more than one assailant.

Seruka has faced numerous challenges, such as getting medical certificates signed and recognized by the proper legal authorities. The organization has also had difficulty securing antiretroviral (ARV) treatment for clients with HIV. Nevertheless, in January 2005, the Ministry of Health (MOH) officially declared sexual violence a priority in Burundi.

Programming Experiences in Six Countries

Chad

Magnitude of traumatic fistula

In an 18-month pilot of the national fistula program conducted in 2002–2003 in Chad, an estimated 456 fistula repairs were recorded, a number thought to underrepresent the actual incidence in the country. Since the beginning of the project,, the program has treated 520 clients with fistula— 476 of these were women from Chad and 44 were refugees from Darfur or the Central African Republic. Among the 520 cases, eight were traumatic fistula. Fifty percent of all cases were found in girls eight to 15 years of age; rectovaginal fistula was found in greater numbers than other forms of fistula.

In all cases of traumatic fistula but one, the fistula was due to sexual violence. In one case, the fistula resulted from the forced insertion of fingers or a stick into the woman's vagina. Fistula due to unsafe abortion was also reported.

Successful interventions

Work to address the problem of fistula began in Chad when a team from the Addis Ababa Fistula Hospital was invited to operate on fistula clients in Adre, Abeche, and N'Djamena. After supporting the training of two Chadian doctors at the Addis Ababa Fistula Hospital, the United Nations Population Fund (UNFPA) began to implement a fistula program in Chad. Today, N'Djamena has a functioning fistula

"The national fistula strategy should address the different types and causes of fistula, including sexual violence."

—Dr. Mahamat Koyalta, Hôpital de la Liberté

care and treatment unit that has worked with Hôpital de la Liberté to conduct surgical fistula repairs, but a smaller unit is also needed to serve a rural area. The government of Chad has organized information days and seminars to raise awareness about fistula and to engage and involve communities and decision makers. As a result of these advocacy efforts, the government is developing a national strategy to eliminate fistula.

Partnership has been crucial in Chad's fistula program; for example, internally displaced person (IDP) camps have provided a venue for coordination between NGOs and other agencies, such as UNHCR. Chad is beginning to address the problem of sexual violence and the resulting issues and needs of survivors. With a national fistula program under way, awareness of the issues and advocacy for survivors of sexual violence must now be integrated into programming strategies that address the different types and causes of fistula, including sexual violence.

Challenges

The following challenges to addressing traumatic fistula in Chad were cited:

- The fistula crisis remains a social injustice in Chad; the causes of fistula have been identified and solutions exist, but real political will and involvement are lacking.
- Shortages of resources, training, and available health services hinder programs.
- Advocacy efforts are needed to raise awareness among opinion leaders and decision makers in the government and parliament.
- An official protocol is required to aid in determining the causes and classifying traumatic fistula in Chad.

DRC

Magnitude of traumatic fistula

Though clinical workers have identified traumatic fistula in eastern DRC, it is difficult to gather precise figures on the magnitude of the problem, because the only data available are facility-based clinical statistics.[4] Since many women with traumatic fistula do not seek treatment at a health facility, a significant number of cases are likely to go undetected and therefore unrecorded.

> **"One reason I have been so happy to be part of this…is because I had thought that we were just suffering alone."**
>
> *—Dr. Longombe Ahuka, DOCS*

The DOCS fistula program began in April 2003. At the outset, only traumatic fistula was repaired, because time and resources were limited and because treating survivors of sexual violence was made a priority. In the first year, 95% of the fistula cases treated were traumatic in origin. By 2004, the rate of traumatic fistula cases decreased to 55%. In the past two years, DOCS Hospital in Goma received over 3,550 rape survivors and performed 600 fistula repair operations. Approximately 68% of these operations were for traumatic fistula.

Successful interventions

The DOCS program acknowledges that women with traumatic fistula need comprehensive treatment in addition to surgical repair and is working to develop a holistic approach to helping these women. One major focus is the provision of psychological services. DOCS works with an

[4] For further information on the magnitude of traumatic fistula in the DRC, refer to: EngenderHealth/The ACQUIRE Project. 2005. *Traumatic gynecologic fistula as a consequence of sexual violence in conflict settings: A literature review*. New York: EngenderHealth/The ACQUIRE Project.

organization called "Heal My People," which seeks out sexual violence survivors and provides psychological and emotional support. The center also treats women without traumatic fistula but with other complications of sexual violence (e.g., 10–30% of the women treated there have genital complications).

The following recommendations were made for future programming in the DRC:

- Traumatic fistula programs should include a component of "family mediation" between the survivor and other members of her family, and they should establish links with other projects working to reconstruct communities that have been damaged as a result of conflict.
- Fistula programs can help women become more autonomous through vocational training.

Guinea

Magnitude of traumatic fistula

A study carried out at the District Hospital of Kissidougou in Lower Guinea Conakry from 1998 to 2000 examined 52 fistula cases, of which 34 (65%) were obstetric fistula and 18 (35%) were traumatic fistula. Of the women treated, 38 were from Guinea (four of whom were IDPs) and 14 were refugees (10 from Sierra Leone and four from Liberia). Eighteen clients reported having been raped. In Guinea, underreporting of traumatic fistula is common because of the shame, social ostracism, and stigmatization associated with rape.

> **"The more a woman is independent, the more she can climb the ladder of a society dominated by men."**
>
> *—Dr. Pascal Manga, Maternité Sans Risque de Kindu*

Among the clients with traumatic fistula, most (41%) were between the ages of 16 and 20 years. Ninety-one percent of the women had lived with their husbands before the fistula developed. After they developed the condition, 44% of the women reported being abandoned by their husbands and 6% identified themselves as not married.

Successful interventions

Of the 18 fistula clients who had been raped, 10 were treated for STIs before surgical repair. All of the rape survivors received psychological counseling prior to surgery. Thirteen of the women with traumatic fistula underwent successful surgical repair, and two reported some improvement after the operation; unfortunately, three women remained incontinent after surgery. All of the women remained in the hospital for 15 days after surgery and all received both nursing and psychosocial counseling. Two months after the surgical intervention, the women received follow-up examinations at the refugee camp.

The following recommendations were made for future programming in Guinea:

- Advocacy efforts are needed to ensure that laws penalize the perpetrators of rape.
- Security guards should be sensitized to the issues of rape and traumatic fistula.
- Within 72 hours of a rape, interventions should aim to prevent STIs and pregnancy and to administer ARVs for HIV prevention.
- Sensitization and awareness-raising activities among communities—particularly those that border Sierra Leone and Liberia—must be initiated to ensure that survivors of sexual violence are evacuated and brought to health centers in a timely manner.

Liberia

Magnitude of traumatic fistula

The exact magnitude of traumatic and obstetric fistula in Liberia is unknown. Rape is highly stigmatized in Liberia and is not openly discussed, which could account for the lack of reported cases. Additionally, surgeons with the ability to treat fistula are based only in urban areas, although it is likely that most fistula cases occur in rural areas.

Successful interventions

Many gaps remain in traumatic fistula programming in Liberia. Mercy Ships has provided fistula repair services, but little else has been done. The Liberian Society for Women Against AIDS (Lib-SWAA) is establishing a center for the provision of counseling and legal services for rape survivors. It is hoped that more women will seek care once they are confident that the center can provide help.

Challenges

The following challenges to addressing traumatic fistula in Liberia were cited:

- Underreporting of rape and traumatic fistula is a major challenge to developing successful programs.
- Rape is not openly discussed; documented cases of rape exist but are not recognized as valid by local authorities.
- A myth exists that having sexual intercourse with a virgin can prevent or can cure HIV/AIDS.
- Perpetrators of sexual violence often go unpunished.

"Given that this is how rape is treated, who would want to come out and report it, especially if they have a fistula?"

—Hh Zaizay, Lib-SWAA

Uganda

Magnitude of traumatic fistula

In northern Uganda, where for nearly 20 years civil war has killed more than half a million people and displaced almost two million, no specific data document the magnitude of traumatic fistula. The Agency for Cooperation and Research in Development (ACORD) conducted a study based on visits to health facilities and on examination of police records. ACORD found no reports of fistula due to sexual violence, but rape and defilement of young girls were reported. Rape and sexual abuse are common among women living in IDP camps, where security and protection are lacking. Women and girls are forced to travel long distances outside of the camps to work in the fields, which places them at great risk for rape by bandits, soldiers, and rebels who demand sex in exchange for "safety." The Lord's Resistance Army has been reported to abduct children for use as sex slaves and child soldiers; in some cases, male children are forced to commit sexually violent crimes.

In 2004, in a camp of 63,000 people, 83 cases of "rape and defilement", 221 assaults, and 78 cases of domestic violence were reported.[4] These numbers are likely underestimated, since statistics are generally based on reported incidents of abuse, and survivors are often reluctant to report.

Harriet Akullu, a rural research coordinator/team leader from ACORD, shared a personal account from a child she had met. The boy stated:

> *"…Madam, do not send me home, I do not want to go back home and be with my mother. I have done too many things in the bush against women. No one will forgive me if they learn…There was this one time when we found some women in a*

[4] Taken from Pabbo (northern Uganda) camp health unit and police records.

rural market. Some of them ran away and we shot them. The elderly ones could not run so our commander ordered them to lie on their back and spread their legs apart. They complied. He then ordered us, the juniors, to pick cassava stems from a nearby garden, which we did. He asked each one of us to get a woman and push the cassava stem through their private parts…We were made to push the cassava stems until all of them were dead..."

Successful interventions

Lakor Hospital, the regional referral hospital in Gulu, has a fistula repair program, and all major health units in the region handle reported cases of rape. Isolated programs address reproductive health issues but they do not explicitly address SGBV. ACORD is active in research and programs promoting dialogue on issues such as rape of women by soldiers. Other programs are directed toward monitoring and documenting incidences of human rights violations, including rape, in IDP camps. Additional programs are needed in the camps to improve security and promote health, education, referral systems, and information services.

> "**Social services alone will not end the problem of traumatic gynecologic fistula; we need to address the issue by starting with our policies and advocacy.**"
>
> *—Harriet Akullu, ACORD*

Challenges

The following challenges to addressing traumatic fistula in northern Uganda were cited:

- The military poses challenges to collecting data on SGBV, sometimes threatening activists.
- An overwhelming distrust of authorities and the police prevails among the local community.
- Fear of stigmatization (e.g., often social sanctions place blame on the survivor) and fear of reprisals from their attackers inhibit women from reporting SGBV.
- Harsh investigations of SGBV cases pose a particular challenge: Court negotiations can last for months, during which time the survivor's name and the details of her ordeal are made public.
- The boundary between what is recognized and defined as SGBV and what is considered a normal interaction between a man and a woman is blurred.
- Communities are not aware of the policies and procedures for reporting SGBV.
- Reporting can be costly (e.g., travel costs).
- IDP camps lack culturally appropriate services for survivors of SGBV; for instance, if a woman seeks services at a health post, it is likely that a man will examine her.
- Cultural beliefs and practices—such as the common belief that having sexual intercourse with a young girl rejuvenates a man's sexual capabilities—further endorse rape as an acceptable behavior.

Sudan

Magnitude of traumatic fistula[5]

In a 2004 UNFPA-supported assessment of obstetric and traumatic fistula services throughout Sudan, most cases were found in the two main fistula repair centers: the Abbo Center in Khartoum and El Fashir Hospital in Darfur. Although it is clear that fistula occurs in other parts of the country,

[5] For further information on the magnitude of traumatic fistula in Sudan, refer to: EngenderHealth/The ACQUIRE Project. 2005. *Traumatic gynecologic fistula as a consequence of sexual violence in conflict settings: A literature review*. New York: EngenderHealth/The ACQUIRE Project.

many people do not know that fistula can be treated. As a result, women do not report to hospitals and therefore are not included in prevalence rates. In Darfur, all of the factors associated with an incidence of traumatic and obstetric fistula are present, including violence, poor antenatal care, and a lack of trained health care workers and ambulances. With the conflict in Darfur, even basic transportation systems have deteriorated. Therefore, it is likely that many more women with fistula are hiding in the villages and not coming forward for treatment.

The Addis Ababa Fistula Hospital has operated on over 100 southern Sudanese women who were initially flown to Lokichokio Hospital in Kenya by the Red Cross. Many women want surgical repair, but access to and availability of services are limited. At present, the only way women from southern and western Sudan can receive fistula repair is to go to Chad or Kenya.

Successful interventions

Since 2003, UNFPA has supported a fistula program in Sudan that enables surgeons to train at the Addis Ababa Fistula Hospital. In west Darfur, Save the Children is active in programs that support emergency and essential obstetric care, as well as antenatal care. These services represent far more than what is available in the rest of Darfur.

Surgeons at the largest hospital in west Darfur, Geniena Hospital, have begun to perform simple fistula repairs. Three hundred cases of fistula were recorded from 2003 to 2004, approximately 150 per year. However, the surgeons select only the least complicated cases for surgical repair, and no services are available to address the psychological and social rehabilitation issues faced by their clients.

Challenges

The following challenges to addressing traumatic fistula in Sudan were cited:

- Women with fistula are not aware of services and therefore do not seek treatment.
- Few providers are trained in fistula repair.
- Services that address psychological and social rehabilitation issues are not available.
- Transportation systems and referral systems do not function.

Critical Related Issues

Around the globe, GBV takes many forms and has many outcomes. The gender discrimination that underpins traumatic fistula can equally lead to other forms of GBV, which must therefore be considered in conjunction with traumatic fistula.

Female Genital Cutting/Female Genital Mutilation

The prevalence of FGC/FGM in Somalia was discussed during the meeting. Dr. Abdulcadir Giama, of Cooperation for Medical Services and Development (COMSED), reported that 99% of the women and girls in Puntland, Somalia, are subjected to infibulation (excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening). Approximately 1% of infibulated Somali women have a Sunna-type cut, which involves removal of the prepuce and the tip of the clitoris, whereas 98% have the more extreme Pharaonic-type cut, which involves removal of all genitalia and full infibulation of the vagina.

FGC/FGM commonly leads to any of numerous early and chronic complications including urinary tract infections, tetanus, gangrene, and death from shock due to hemorrhage. Further, women who have experienced FGC/FGM typically suffer dysmenorrhea (pain during menstruation) and dyspareunia (pain during sexual intercourse). The negative psychological and emotional effects of FGC/FGM on girls and women are profound, as illustrated by the Somali example that after marriage, the homes where couples spend their honeymoons are built far from the villages so that others are not forced to hear women screaming from the pain of penetration on their wedding night.

Service providers and activists cite a variety of theories regarding the causal link between FGC/FGM and fistula. Although FGC/FGM can increase the risk of hemorrhage and infection during childbirth, evidence is lacking on whether all forms of FGC/FGM serve as causal factors in the formation of fistula. However, experts believe that infibulation and the traditional medical practice of the Gishiri cut, or vaginal cutting, which is practiced in northern Nigeria, can contribute directly to fistula.

Child Rape

Though the global prevalence of child rape is unknown, one study suggests that worldwide, 40 to 47 percent of sexual assaults are perpetrated against girls age 15 or younger.[6] Any number of factors may play a role in this form of violence, including dysfunctional family dynamics, previous abuse of the abuser, a sense that child rape is normal behavior, widespread and worsening poverty, increased crime and insecurity, alcohol and substance abuse, and absent parents. Certain cultural factors may also come into play, such as the practice of early marriage, and the widespread belief that sexual intercourse with a baby or small child (or virgin) will change the abuser's HIV status from positive to negative.

For the children who survive this abuse, the consequences are often devastating. Physically, they are at an increased risk for STIs, including HIV, and for unwanted pregnancies, which can lead to

[6] Heise, L. 1993. Violence against women: The missing agenda. In: Koblinsky, M., Timyan, J,, and Gay J, ed.. *The health of women: A global perspective*. Boulder, CO: Westview Press.

unsafe abortions and other physical injuries, such as fistula. Young women may suffer infertility and experience pelvic pain. Survivors also face the psychological effects of the trauma, including posttraumatic stress disorder and depression, which may lead to suicidal behavior. The long-term mental health implications are profound: Anxiety, low self-esteem, and withdrawal from friends are common. The social consequences include the increased risk for dropping out of school, engaging in high-risk sexual practices, and worsening poverty.

Dr. Julius Kiiru, a fistula surgeon from the MOH in Kenya, noted the importance of providing emotional support and appropriate counseling to child survivors of rape, including referral for long-term counseling. Dr. Kiiru also advised that when a rape has occurred, it is critical not to destroy any legal evidence, to report the crime to the nearest police station, and to ensure that surgical and medical treatment are made available, including services to prevent STIs, including HIV/AIDS, and pregnancy. Education on issues regarding child rights, abolishing harmful traditional practices, improving the legal protection of children, and legislating for harsh penalties against child rape are all critical factors in the effort to eliminate this form of violence.

Domestic Violence

Violence in the home affects large numbers of women worldwide. While the incidence of domestic violence is high, programs have shown that it is possible and effective to reach out to men and to ask them to consider their relationships with women and other men and to consider how their actions affect these relationships. This approach acknowledges the role men play in domestic violence, as well as that contemporary gender roles constrain men's lives and contribute to this violence.

> **"Domestic violence and SGBV are about men controlling women's lives."**
>
> *—Dean Peacock, EngenderHealth/ The ACQUIRE Project, South Africa*

There is a great need to resocialize men, many of whom have observed GBV in their homes or communities. For instance, in Uganda and South Africa, many young men are socialized to resolve problems through violence and they do not learn other methods of handling conflict. In conflict settings, for example, crimes are often committed by young children seeking revenge after witnessing a parent being raped or killed. Men and boys are also sometimes forced to commit acts of violence against women. Successful interventions to address sexual and gender-based violence in the home must begin with educational efforts, followed by the institution of programs that mobilize youth to speak out against violence and that teach men alternative means of handling conflict.

Dean Peacock, program manager from EngenderHealth/The ACQUIRE Project's South Africa office, proposed several interventions to address domestic violence:

- Prioritize the safety of survivors and the accountability of batterers.
- Engage men as partners in prevention efforts.
- Promote prevention across the "Spectrum of Prevention," which includes:
  - Influencing policy and legislation
  - Mobilizing the community
  - Strengthening organizations
  - Fostering coalitions and networks
  - Educating service providers and key stakeholders
  - Promoting community education
  - Strengthening individual knowledge and skills

Strategies for Successful Programming

Quality of Care: Key Components of Programming

The care, treatment, and support of women with traumatic fistula differ from the management of other survivors of sexual violence in one significant way—the treatment required for the fistula, which may entail one or more operations to repair the injury. The other aspects of treatment are generally the same as those required for the larger community of women who endure sexual violence during conflict.

Integrated programming must involve the following stakeholders:

- Individual service providers who have been trained to respond
- Health systems, however they may be functioning at the time of conflict
- Communities at large and specialized community groups (such as SFVS in the DRC)
- Justice systems at the local, national, and international levels

The ability of stakeholders to respond to the needs of survivors of sexual violence—and the type of response—is contextual, depending on the nature and extent of the conflict. Context may dictate the availability and accessibility of resources needed by survivors of sexual violence, regardless of their willingness or ability to seek care. In some conflicts, health systems, facilities, and providers continue to function and may be able and willing to provide care. In others, care must be provided through external services or camps established to respond to the needs of refugees or IDPs. In addition to these context-specific characteristics, the time at which a client is able to present for care and treatment is unpredictable.

Drawing on the work of the CHANGE Project and EngenderHealth, there are six core elements of care that women with traumatic fistula have the right to receive:

- Information
- Privacy and confidentiality
- Dignity, comfort, and expression of opinion
- Informed decision making
- Access to services
- Safe services

By keeping these rights at the forefront of their work and mission, providers offering interventions will maintain a sense of service to their clients.

Providers' Roles, Attitudes, and Skills in the Treatment of Traumatic Fistula

The clinical management of traumatic fistula is similar to that of obstetric fistula, although in some cases there is less direct tissue injury in traumatic fistula than in the generally more complex childbirth injury. Thus there may be fewer tissue defects and, therefore, less scarring. However, forced insertion of foreign objects into the vagina (e.g., gun barrels, bottles, or sticks) can in some cases cause the tear to be more complicated than a fistula caused by obstetric complications. In

addition to the surgical treatment, physicians must institute specific investigations, including STI (especially HIV) and pregnancy tests.

Some meeting participants suggested that the long-term psychological impact of traumatic fistula may be a more complex problem than the physical pathology (assuming that the fistula is repaired). Common issues that can be addressed through counseling include the loss of interest or pleasure in daily activities, self-isolation, insecurity and anxiety, and rejection by family and society. The principles of management that should be used by counselors are based on empathy for the client and unconditional acceptance of her, reflection on feelings, availability, and the assurance of confidentiality. Therapy can also include education for people who are involved in the client's life, as well as for members of the larger community. Although referral to proper medical attention is key, a comprehensive approach that includes a complete synergy of medical and psychological care and social assistance is critical.

There are several ways to improve the clinical treatment of traumatic fistula in conflict zones where equipment and supplies may not be readily available. Meeting participants suggested that a provincial-level referral site is needed for complicated cases coming from peripheral sites. The referral site also would serve as a training center for providers and as a supervisory body for peripheral sites. At a minimum, such a site would employ an obstetrician/gynecologist (ob/gyn), a surgeon, an anesthetist, a certified nurse, and social workers with experience in fistula management. Services to address traumatic fistula would be integrated into the general referral center for each district. Ideally, district hospitals would have a fistula management unit staffed with trained personnel.

Training Issues

Clinical Care

A variety of issues and challenges arise in the training of service providers (physicians, nurses, social workers, counselors, and assistants) who treat and care for traumatic fistula clients. While in some cases fistula surgery can be a relatively simple procedure for the experienced surgeon, the surgeon may also encounter a whole spectrum of technical difficulties, as some cases are very challenging to repair.

Training in the repair of traumatic fistula must begin with an overview of the anatomy of the female bladder, uterus, vagina, and rectum. A good light source and essential equipment are necessary to diagnose traumatic fistula. Some possible complications include tissue necrosis and sloughing, strong retraction with the removal of sutures, persistence of a foreign body, and unsuccessful repair.

Dr. Yves Bagale, a surgeon at Panzi Hospital in Bukavu, DRC, discussed the case of a woman whose entire urogenital system had been destroyed by bullets. Speaking from the perspective of a trainer, Dr. Bagale noted that, depending on the case, traumatic fistula can be different from obstetric fistula due to the level of fibrosis that is present, especially after the introduction of sharp instruments or weapons.

Panzi Hospital has a multidisciplinary team of service providers that includes psychologists, nurses, doctors, gynecologists, and surgeons. At present, six doctors are training in fistula repair techniques. Training includes several components, including a clear understanding of the anatomy of the urogenital system, as well as surgical techniques for fistula, including repair, reconstruction, and palliative care. A trainee will be supervised in general vaginal surgery and will then move on to simple repair surgery and, ultimately, more complex interventions and palliative procedures.

The main challenges to adequate and efficient training are the absence of thorough teaching about traumatic fistula in national universities, the scarcity of French literature on the issue, and the underestimation of the prevalence of traumatic fistula due to stigmatization.

Counseling

Kabekatyo Muliri, from the DOCS program *"Gueri Mon Peuple"* ("Heal My People") in the DRC, trains counselors and outreach workers in caring for women with traumatic fistula. At DOCS, the primary functions of counselors are to provide psychosocial care for survivors of sexual violence and to initiate family mediation and socioeconomic support for community reintegration. Because traumatic fistula and sexual violence are low priorities to the government, DOCS recruited 40 women counselors and has worked with them since 2002. These counselors were identified by the community to receive three months of special training as outreach workers for women with traumatic fistula.

DOCS notes that because women with traumatic fistula are so stigmatized that they hide in shame, it is important to preselect counselors who are known in the community and who are discreet, wise, and compassionate. A counselor must respect the survivor, protect her confidentiality, and help her regain her dignity. A primary aspect of training is to ensure a standardized approach to counseling traumatized clients. Once a counselor is trained in that technique, the focus is on facilitating emotional healing, helping women to have faith and hope that their situation will improve. Counselors are also trained to refer clients for other services as needed, in a manner that protects client confidentiality.

DOCS implements different strategies to address specific issues such as what to do in a rape situation, how to initiate a legal process, and how to sensitize the local community to protect its women and girls. DOCS addresses these issues through conferences and seminars for trainees, school campaigns, and radio interviews to raise awareness.

Garnering Political and Policy-Level Support

During the course of the meeting, *advocacy* was defined as the process of trying to change, create, and/or implement policies, laws, and practices. Different forms of advocacy include meeting with and educating government and other officials, providing clear options for advocacy measures, educating the public, and creating social demand for change.

> **"We need peace at home, we need justice, and the authors of this violence must stop."**
>
> *—Cathy Furaha, SFVS*

Seven key steps of advocacy, as tailored to the issue of traumatic fistula, were outlined:

1. **Identify the problem and consider the strategy and tactics for resolving it.**
   The problem of traumatic fistula requires treatment, education, and protection for survivors, as well as prevention for women at risk, medical and judicial reforms, and prosecution of perpetrators.

2. **Get the facts—gather and analyze information on the issue.**
   Conduct a literature review, focusing on surveillance and epidemiologic research, obtain facts from the sources, and develop dialogues with other agencies.

3. **Determine what needs to be achieved and develop benchmarks and objectives.**
   Set concrete and achievable objectives such as providing treatment and support, improving community understanding and medical and judicial response, addressing the atrocities that lead to violent sexual assault, eliminating stigmatization and discrimination, and promoting zero tolerance for violence against women.

4. **Identify key decision makers.**
   Identify who has the power to make change, including international agencies, government officials, community and tribal leaders, and donors.

5. **Build alliances and coalitions.**
   Build alliances with agencies working on different aspects of traumatic fistula (e.g., those working on clinical treatment, on reducing the prevalence of rape, and on documenting and adjudicating rape and sexual violence).

6. **Create an action plan.**
   This involves seven steps:
   - Begin with a clear description of the specific problem and objectives.
   - Identify the key decision makers and activities.
   - Assess what resources are required.
   - Determine the responsible persons or organizations.
   - Establish a time frame.
   - Develop expected outcomes.
   - Implement, monitor, and evaluate the action plan.

7. **Implement, monitor, and evaluate.**
   Additional issues and challenges related to advocacy work around traumatic fistula may include:
   - Collaborating with religious groups can be extremely beneficial, but also challenging, as religious leaders have been perpetrators of crimes in some settings.
   - Survivors may refuse services because hearings are public. Parents may need to represent child survivors.
   - Efforts to obtain compensation for survivors of sexual violence have not been very effective.

A DRC Case Study in Advocacy

As a result of the conflict in the DRC, crime and violence are rampant, and the rule of law is almost nonexistent. Cathy Furaha presented the key constraints affecting the efforts by SFVS to legally assist survivors of sexual violence:

- A great shortage of workers with legal skills exists, magistrates are often ineffective, and there are few lucrative opportunities for lawyers. As a result, perpetrators in the villages are not brought to justice.
- Magistrates in the DRC are not aware of international texts and laws, so they continue to use outdated laws.
- Great ignorance exists among the population about issues of justice.
- Courts and tribunals are often insufficient in number and are not located in accessible areas.
- Some perpetrators of sexual crimes are themselves police or military personnel.

Despite these challenges, a number of NGOs are working with survivors and justice agents to improve the judicial system. Villages sometimes establish their own tribunals, with support from NGOs, which can assist in such cases. As a result of advocacy efforts, it is now possible to propose new laws in parliament, which could result in more stringent legislation against SGBV.

Data Collection

Efforts to set up programs for advocacy, education, treatment, and prevention of traumatic fistula and sexual violence often fail because of a lack of clear documentation of the incidence and prevalence of the condition and associated SGBV. In each country, the magnitude of traumatic fistula, rape, and violence in general has been difficult to establish from existing data sources; some data come from clinics and/or IDP camps, but these figures likely represent only "the tip of the iceberg." Collaboration between groups from different sectors is needed to collect relevant information. One participant suggested using USAID's President's Emergency Plan for AIDS Relief (PEPFAR) design for studying HIV/AIDS information systems as a possible model for collecting data on traumatic fistula and SGBV.

Establishing Linkages to Family Planning, HIV/AIDS, and Other Services

Participants discussed the importance of ensuring family planning (FP), if desired, for survivors of traumatic fistula and GBV, and of incorporating FP into fistula programming. However, linking traumatic fistula and FP services presents many challenges. In some settings, emergency contraception (EC) is provided immediately after rape, but when women report rape late, EC is ineffective. Furthermore, as has been reported in the DRC, women with traumatic fistula frequently conceive before they seek surgical repair. Providers are therefore unsure of how to appropriately offer FP services.

Managing Traumatic Fistula

Meeting participants divided into small groups to discuss key issues and challenges to managing traumatic fistula. Groups were organized according to five themes:

- Clinical management
- Psychological and counseling issues
- Social/community interventions
- Political advocacy
- Referral systems

An overview of the key issues outlined by these small groups follows.

Clinical Management

Challenges

Lack of available facilities, appropriate materials and equipment, trained personnel, and functional referral mechanisms present major challenges to effective clinical management of fistula. History taking and diagnosis of traumatic fistula must improve at the facility level, particularly for traumatized women and children. Other challenges involve the many concurrent injuries that survivors of sexual violence sustain, their tendency to delay reporting the assault, as well as their need for confidentiality, counseling, and possibly legal services.

Strategies and Interventions

Some strategies proposed include:

- Conduct a study of functional models such as mobile surgical clinics.
- Establish a functional treatment site that works with peripheral surgical sites.
- Ensure timely client referral and counterreferral.
- Provide adequate training for doctors, midwives, nurses, and social workers.
- Establish a consistent supply of equipment.

Psychological and Counseling Issues

Challenges

Some of the primary challenges in the provision of psychological and counseling care are the lack of providers trained in counseling survivors of SGBV and the absence of standards for counseling traumatic fistula clients. Furthermore, in conflict settings, it can be difficult to ensure confidentiality and privacy for SGBV clients, as well as to maintain continuity of care in providing the long-term psychological and emotional counseling they may need after fistula repair.

Strategies and Interventions

Some strategies proposed include:

- Develop standards and guidelines for counseling traumatic fistula clients. (EngenderHealth is exploring ways to incorporate traumatic fistula counseling in an obstetric fistula counseling training curriculum currently under development.)
- Ensure that counseling programs offer or refer clients to medical and legal services to meet a diverse array of survivors' needs, with a specific focus on STI and HIV/AIDS testing, in a manner that protects client confidentiality.
- Establish fistula repair services that offer or refer women to counseling during the preoperative, intraoperative (i.e., during the hospital stay), and postoperative periods.
- If possible, provide counseling services for perpetrators as well as for survivors of sexual violence. (In some situations, providers might serve as mediators between survivors and assailants.)
- Rely on counselors who are known in the community and who are discreet, wise, and compassionate.
- Work with counseling programs to build the capacity of communities to address sexual violence.

Social/Community Interventions

Challenges

Documenting evidence of rape and sexual violence is often a challenge because of the sociocultural barriers to reporting. In some cultures, communities will deny that rape occurs. In such communities, victims fear revealing themselves as survivors of rape because of the stigmatization and sensitivity that surround the issue. Further, sexual violence often takes place within the family, which, when revealed, can cause entire families to be stigmatized; therefore, cover-ups are common. Survivors of sexual violence are often marginalized and of low socioeconomic status. Because there is little community understanding of the issue, and because its magnitude is underestimated, these survivors may experience feelings of isolation, shame, and discouragement.

Strategies and Interventions

Some strategies proposed include:

- Establish a baseline of available social and community services.
- Institutionalize a referral system or an outlet for survivors of sexual violence (e.g., the national lawyer's association, or an anonymous hotline) to be accountable for referring clients and for following up with them.
- Establish or support holistic systems and support care centers to meet the many needs of women.
- Empower communities to be aware of sexual and reproductive rights.

Political Advocacy

Challenges

On the political level, a number of challenges to addressing traumatic fistula were cited, including the low socioeconomic status of women and the fact that the perpetrators of violence are often people in power. Without documented evidence of traumatic fistula and SGBV, efforts for advocacy and raising of awareness at the policy level often fail. The result is a lack of knowledge about the problem and a lack of commitment to providing solutions. For example, in many settings,

the time it takes for due process of law for a man accused of rape is excessive, a factor that discourages reporting. Community-level advocacy can also be difficult in conflict settings, where the army is often the government, and where resistance to advocacy is met at very high levels, often with violence.

Strategies and Interventions

Some strategies proposed include:

- Empower community members by informing them of their rights.
- Collect critical baseline data from the community, health service providers, and the government.
- Use the media as a valuable tool to raise awareness.
- Engage in advocacy efforts at both the local and international levels to influence policy in ways that facilitate tangible outcomes for survivors.
- Partner with various groups to address the underlying issues and root causes of violence (e.g., work with men and work with the international court system to explore joint advocacy opportunities).
- Participate in forums at the national level to pursue sponsorship of policies that support survivors of SGBV (in situations in which national governments are not inclined to protect their citizens, international courts and policymakers need to play a role).

As in any intervention, the long-term goals of advocacy efforts must include promoting the rights of women and involving men to examine the root causes of GBV.

Referral Systems

Challenges

Establishing functional referral systems is a major challenge. Often, both clients and members of their communities lack knowledge about services and clients' rights. Gaps in the scope of necessary services also pose a challenge. Survivors of sexual violence may have limited physical and social access to service providers. Further, assailants may intimidate clients, and local tradition can sometimes inhibit women from reporting sexual violence and seeking needed services.

Strategies and Interventions

Some strategies proposed include:

- Streamline social support and referral systems by institutionalizing a referral system and, if possible, an outlet for reporting sexual violence.
- Where the infrastructure is intact, establish a hotline through which clients can be referred for services.
- Whenever possible, integrate social support services into existing services and mechanisms.

Country Action Plans

Meeting participants were divided into small groups and were asked to draft country-specific action plans to address traumatic fistula. Though the time available did not allow development of full action plans, participants will use the draft plans as models for their work.

Participants developed action plans for interventions that ranged in time from nine months to five years and that addressed a variety of issues, including the need to improve the clinical management of traumatic fistula, to increase advocacy and sensitization efforts, to strengthen referral systems, to improve the application of laws, and to engage men as active partners in reducing GBV and traumatic fistula.

Although the draft action plans differed significantly according to the individual situation and the needs and available resources in each country context, the following issues arose in every group during the development of the plans and subsequent discussions:

- The need for more information on the magnitude of traumatic fistula in all settings
- The need to improve the clinical management of traumatic fistula
- The need for enhanced advocacy efforts at all levels (from community to government) and for information and tools to assist in these efforts
- The need for coherent uniform processes and output indicators for developing and monitoring traumatic fistula interventions

See Appendix 3 for the draft action plans for each country or group of countries.

Conclusions

The first formal meeting of its kind, the conference on traumatic fistula held in Addis Ababa, Ethiopia, in September 2005 provided a forum for the issue of traumatic fistula to be brought to the public's attention and for dedicated professionals from around the world to exchange ideas and experiences.

During the course of the three-day meeting on traumatic gynecologic fistula, participants shared stories of horrific violence; of traumatic fistula—and associated SGBV—occurring not only in conflict settings but also in homes, and "not only by rampaging soldiers, but also by husbands, uncles, brothers, fathers, and grandsons…," as Mary Ellen Stanton of USAID commented. Yet despite such horrors, the meeting presented some "glimmers of hope," such as the South African examples of attitude transformation among former GBV assailants, and of raising awareness of domestic violence; the focus on love and compassion provided to clients at the Addis Ababa Fistula Hospital; the examples from around the world of the prosecution of some assailants; and the extraordinary dedication of those surgeons and other providers represented at the meeting.

It is clear that the challenges to eradicating traumatic fistula are formidable: We need to care for victims, address the bigger challenge of prevention, and ensure security for girls and women in conflict settings. More broadly, we need to challenge the culture of impunity, including protecting women with the law, punishing perpetrators, eliminating harmful traditional practices such as FGC, and protecting children from witnessing and becoming victims of sexual violence.

As a practical matter, we need to find a balance between integrating issues of traumatic fistula into other areas of work and integrating SGBV-related issues into existing obstetric fistula programming, where it exists. "It is my hope," shared Cathy Furaha of SFVS, "that we shall not stop at this, but that our efforts will continue after the meeting." It is our responsibility, as a global community working on this issue, to move this agenda forward.

Appendix 1: Meeting Participants

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Appendix 2: Meeting Agenda

DAY 1: September 6, 2005
Magnitude and Programmatic Interventions

Time	Activity	Person responsible	Session chair
8:00–9:00 a.m.	Registration (continued from the evening of September 5)	EngenderHealth/The ACQUIRE Project	Mary Nell Wegner, EngenderHealth/ The ACQUIRE Project (USA)
9:00–9:10 a.m.	Welcome	Wuleta Betemariam, EngenderHealth/ The ACQUIRE Project (USA) Andrew Sisson, REDSO (Kenya)	
9:10–9:40 a.m.	Opening remarks	Justine Masika, SFVS (DRC) Dr. Solomon Kumbi, ESOG (Ethiopia) Ruth Kennedy, Addis Ababa Fistula Hospital (Ethiopia)	
9:40–9:45 a.m.	Official meeting commencement	Dr. Tesfanesh Belay, MOH (Ethiopia)	
9:45–10:00 a.m.	Realities in one country: A personal journey	Justine Masika, SFVS (DRC)	
10:00–10:15 a.m.	Why we are here: Review of the agenda, objectives, and mandate for Days 1 to 3	Erika Sinclair, EngenderHealth/The ACQUIRE Project (USA)	
10:15–11:00 a.m.	Introductions	Participants	
11:00–11:30 a.m.	*Morning break*		
11:30–11:45 a.m.	Definition of traumatic gynecologic fistula (hereafter "traumatic fistula")	Dr. Joseph Ruminjo, EngenderHealth/The ACQUIRE Project (USA)	Karen Beattie, EngenderHealth/ The ACQUIRE Project (USA)
11:45 a.m.–12:30 p.m.	Overview of sexual and gender-based violence in conflict settings	Dean Peacock, EngenderHealth/The ACQUIRE Project (South Africa)	
	Understanding the context of sexual violence	Dr. Boyka Grantcharska, MSF (Burundi)	
12:30–1:00 p.m.	Q&A/discussion	Participants	
1:00–2:00 p.m.	*Lunch break*		
2:00–3:30 p.m.	Panel discussion on traumatic fistula: Programming experiences in several countries to discuss: ♦ Magnitude of the problem ♦ Successful interventions ♦ Challenges	Dr. Mahamat Koyalta, Hôpital de la Liberté (Chad) Dr. Longombe Ahuka, DOCS (DRC) Dr. Theirno Hamidou Barry, District Hospital of Kissidougou (Guinea) Hh Zaizay, Lib-SWAA (Liberia) Harriet Akullu, ACORD (Uganda) Dr. Salah Daak, Save the Children (Sudan)	Patricia MacDonald, USAID (USA)
3:30–4:00 p.m.	*Afternoon break*		
4:00–4:45 p.m.	Q&A/discussion	Participants	Dr. Biruk Tafesse, Addis Ababa Fistula Hospital (Ethiopia)
4:45–5:00 p.m.	Wrap-up/review of Day 1	Erika Sinclair, EngenderHealth/The ACQUIRE Project (USA)	

DAY 2: September 7, 2005
Strategies for Applying Successful Programming

Time	Activity	Person responsible	Session chair
9:00–9:15 a.m.	Highlights from Day 1 and introduction to Day 2	David Adriance, EngenderHealth/The ACQUIRE Project (Kenya)	Dr. Zufan Lakew, Addis Ababa University (Ethiopia)
9:15–10:00 a.m.	Critical related issues: ♦ Female genital cutting ♦ Child rape ♦ Domestic violence	Dr. Abdulcadir Giama, COMSED (Somalia) Dr. Julius Kiiru, MOH (Kenya) Dean Peacock, EngenderHealth/ The ACQUIRE Project (South Africa)	
10:00–10:30 a.m.	Q&A/discussion	Participants	
10:30–11:00 a.m.	*Morning break*		
11:00 a.m.–12:15 p.m.	Key issues and challenges in the management of traumatic fistula: ♦ Clinical ♦ Psychological and counseling ♦ Social/community ♦ Political advocacy ♦ Referral systems	Small groups	Dr. Rogaia Abuelgasim, UNFPA (Sudan)
12:15–1:15 p.m.	Groups report findings Q&A/discussion	Participants	
1:15–2:15 p.m.	*Lunch break*		
2:15–3:30 p.m.	Quality of care: Key components of programming	Karen Beattie, EngenderHealth/The ACQUIRE Project (USA)	Dr. John Kelly (UK)
	Providers' roles, attitudes, and skills in the treatment of traumatic fistula	Dr. Ambaye WoldeMichael, Addis Ababa Fistula Hospital (Ethiopia) Nancy Kana, Medair (DRC) Dr. Dominique Baabo, GESOM/SFVS (DRC)	
	Training issues	Dr. Pascal Manga, Maternité Sans Risque, Kindu (DRC) Kabekatyo Muliri, DOCS (DRC) Dr. Yves Bagale, Panzi Hospital (DRC)	
3:30–3:45 p.m.	Q&A/discussion	Participants	
3:45–4:15 p.m.	*Afternoon break*		
4:15–4:45 p.m.	Garnering political and policy-level support	Cathy Furaha, SFVS (DRC)—local perspective Dr. Julia VanRooyen, PHR/Harvard Humanitarian Initiative (USA)—global perspective	Dr. Florence Mirembe, Makerere University (Uganda)
4:45–5:00 p.m.	Q&A/discussion	Participants	
5:00–5:15 p.m.	Wrap-up/review of Day 2	Harriet Akullu, ACORD (Uganda)	
6:30–9:00 p.m.	*Evening social event in the Addis Hilton Hotel*		

DAY 3: September 8, 2005
Recommendations Moving Forward

Time	Activity	Person responsible	Session chair
9:00–9:20 a.m.	Film screening: *A Walk to Beautiful*	Participants	Dr. Ann McCauley, REDSO (Kenya)
9:20–9:45 a.m.	Gaps in quality care	Dr. Yirgu GebreHiwot, ESOG/FIGO/Addis Ababa University (Ethiopia)	
9:45–10:45 a.m.	Future directions framework: Strategies to address critical needs	Small groups	
10:45–11:15 a.m.	*Morning break* / Film screening: *Our Bodies...Their Battleground: Gender-based Violence during Conflict*		
11:15 a.m.–12:30 p.m.	Future directions framework (continued)	Small groups	Dr. Ann McCauley, REDSO (Kenya)
12:30–1:30 p.m.	*Lunch break*		
1:30–2:30 p.m.	Groups report findings, Q&A/discussion, setting priorities	Small groups	Cathy Furaha, SFVS (DRC)
2:30–3:00 p.m.	Wrap-up/review of meeting	Lauren Pesso, EngenderHealth/The ACQUIRE Project (USA)	
3:00–3:15 p.m.	Closing remarks	Mary Ellen Stanton, USAID (USA)	
3:15–3:30 p.m.	Evaluations	Participants	
3:30 p.m.	*Optional visit to the Addis Ababa Fistula Hospital*		

Appendix 3: Draft Country Action Plans

Burundi/Chad/Guinea

Problems and objectives	Key activities and decision makers	Resources required	Responsible organizations and/or persons	Time frame	Expected outcomes
Political Advocacy ***Problem*** Inadequate information for decision makers (especially politicians) on fistula-related issues ***Objective*** Sensitize key decision makers on fistula-related issues	***Decision makers*** ♦ Health ministers ♦ Nongovernmental organizations (NGOs)			Six to 12 months	Authorities and communities join the battle against fistula
Clinical ***Problem*** Fistula cases not managed well ***Objective*** Train providers to manage fistula cases better	***Activities*** ♦ Train health and auxiliary personnel to care for fistula clients ♦ Stock health centers with equipment, supplies, and medicine ***Decision makers*** Health ministries			Six to 12 months	

DRC

Problems and objectives	Key activities and decision makers	Resources required	Responsible organizations and/or persons	Time frame	Expected outcomes
Clinical ***Problem*** Insufficient material, financial, and human resources	***Activities*** ♦ Build capacity for medical coverage and care for survivors ♦ Supply equipment for rehabilitation ♦ Train service providers ***Decision makers*** ♦ Government ♦ Donors ♦ Stakeholders	Need to identify and mobilize resources		Three months to identify resources; six months to equip facilities and execute intermediate trimester and follow-up activities	♦ Structures equipped ♦ Personnel trained
Advocacy ***Problem*** Population is unaware of the problem ***Objectives*** ♦ Sensitize population and authorities ♦ Involve authorities in GBV issues	***Activities*** ♦ Sensitize community and authorities via conferences, reflection days, articles, radio programs, training service providers ***Decision makers*** ♦ Government ♦ Stakeholders ♦ Human rights NGOs ♦ Religious groups/clergy	Need to identify and mobilize resources		Identify and mobilize resources in the first months; the rest of the time used to implement and assess activities	
Psychosocial ***Objectives*** ♦ Help survivors restore their balance ♦ Help survivors reintegrate into the community	***Activities*** ♦ Sensitize survivors ♦ Mobilize resources ♦ Train providers	Need to identify and mobilize resources		Four months to identify and mobilize resources; eight months to handle cases	♦ Survivors sensitized and reintegrated ♦ Providers trained ♦ Community sensitized

Ethiopia

Problems and objectives	Key activities and decision makers	Resources required	Responsible organizations and/or persons	Time frame	Expected outcomes
Problem Lack of awareness and inefficient legal system	***Activities*** ♦ Legal literacy ♦ Information, education, and communication (IEC) ♦ Advocacy	♦ Trainers ♦ Training materials ♦ Financial resources ♦ IEC materials ♦ Advocacy kits	Coordinating body	♦ 2005–2006 (legal literacy) ♦ 2005–2006 (IEC) ♦ 2005–2010 (advocacy)	
Problem Lack of access to quality care	***Activities*** Establish and strengthen crisis centers in five regions	♦ Infrastructure ♦ Human resources ♦ Technical information	Coordinating body	2005–2009	Increased access to quality care and improved quality of life for survivors

Notes:

♦ A national coordinating body is needed to oversee the work of five fistula treatment centers in five regions of the country.
♦ Fistula centers can be reoriented and refocused to include work on traumatic fistula as well as on obstetric fistula.
♦ Lack of information and data is an issue; a functional management information system and additional research and surveys are needed.

Kenya and Tanzania

Problems and objectives	Key activities and decision makers	Resources required	Responsible organizations and/or persons	Time frame	Expected outcomes
Legal ***Problem*** Law enforcement is poor and is applied inconsistently ***Objective*** Reform and strengthen laws and ensure consistent application	***Activities*** ♦ Mobilize community leaders and women's groups ♦ Lobby for change among decision makers ***Decision makers*** ♦ Governments ♦ Parliament ♦ Public sector ♦ Private sector ♦ Legal reform sector	♦ Human resources ♦ Financial resources ♦ Media ♦ Data collection	♦ Hospitals ♦ Programs ♦ Responsible ministries ♦ Donors ♦ Local organizations ♦ International organizations	One year	Strong laws and mandatory sentencing for rape and sexual violence
Clinical ***Problem*** ♦ Lack of referral systems ♦ Lack of services (e.g., physical, psychological, social, legal) and their inability to function appropriately ***Objective*** Ensure availability of proper services	***Activities*** ♦ Identify existing services and centers ♦ Conduct needs assessment to identify existing gaps ♦ Train service providers in all categories ♦ Improve infrastructure (e.g., ensure privacy and confidentiality) ♦ Monitor and evaluate services ***Decision makers*** Responsible ministries (e.g., health, justice, social services)	♦ Human resources ♦ Financial resources	♦ Hospital in charge ♦ Project in charge (e.g., WDP in Tanzania) ♦ Service providers ♦ Responsible ministries ♦ Donor agents ♦ Local organizations ♦ International organizations	Two years	Satisfied clients

Liberia

Problems and objectives	Key activities and decision makers	Resources required	Responsible organizations and/or persons	Time frame
Problems ♦ Gender inequalities ♦ Inadequate allocation of resources for women's health and SGBV ***Objectives*** Reduce SGBV and obstetric fistula: ♦ Increase public awareness of the problems of gender inequalities, SGBV, and obstetric fistula ♦ Support key stakeholders in developing the knowledge, skills, and commitment necessary to address the issues ♦ Engage men as active partners	***Activities*** ♦ Conduct a feasibility study on the magnitude of gender inequalities, SGBV, and obstetric and traumatic fistula in hospitals and with service providers for presentation to key stakeholders ♦ Convene a two-day consultative forum to increase awareness of the problems of (and relationships between) gender inequalities, SGBV, and obstetric and traumatic fistula leading to the development of action plans for implementation by key stakeholders ♦ From this consultative forum, convene a working group to support various stakeholders in implementing their action plans ♦ Possible action plan activities: train all relevant media in addressing SGBV and obstetric and traumatic fistula, and train the police services and army ***Decision makers*** ♦ The Office of the President of Liberia ♦ The Legislature ♦ MOH ♦ Ministry of Gender and Development ♦ Ministry of Justice ♦ Media ♦ UN system ♦ International donors ♦ National and international NGOs ♦ Religious and community leaders ♦ Association of Female Lawyers in Liberia	♦ Human resources and logistics to collect data on the magnitude of the problems ♦ Resources required to convene a series of meetings ♦ Media coverage/airtime ♦ Training modules: on men and gender equality; on SGBV for service providers; and on ob-gyn for institutions, hospitals, and medical staff ♦ Government resources	Lib-SWAA	Consultative forum in November to December (possibly as part of the launch of 16 Days of No Violence Against Women Campaign); working group to meet monthly; full group to meet every six months to discuss compliance and implementation of action plans

Somalia (Puntland)

Problems and objectives	Key activities and decision makers	Resources required	Responsible organizations and/or persons	Time frame	Expected outcomes
Problems ♦ No government ♦ Almost no social services, including basic health and MCH services ♦ No functional structures or trained providers to treat traumatic fistula ***Objectives*** ♦ Develop a minimal level of service for ob-gyn care ♦ Have a trained midwife for obstetric emergencies in a MCH center every 300 km centered around Galkayo Medical Center (GMC), Galkayo ♦ Initiate mobile surgical clinics to treat fistula	***Decision makers*** ♦ Local government in Puntland ♦ Local and international NGOs ♦ GMC management	♦ Financial resources ♦ Training programs ♦ Training materials (e.g., books, equipment) ♦ Skilled human resources ♦ Appropriate equipment and supplies	♦ Local government in Puntland ♦ NGOs (COMSED, Galkayo Education Centre for Peace and Development [GECPD]) ♦ GMC management	Three months to contact GMC management, local NGOs, and government; six months to develop training programs; implement programs and train doctors and midwives begin pilot project at GMC and a few satellites	♦ Decreased maternal/child mortality and morbidity (obstetric fistula) ♦ Improved quality of life for women

Note: The situation in Somalia differs from that of some of the other countries, due to Somalia's total lack of government. The region is divided into three areas. This action plan starts with Puntland, an area where some social services exist. (In the southern area, no social services are available.)

Sudan

Problems and objectives	Key activities and decision makers	Resources required	Responsible organizations and/or persons	Time frame	Expected outcomes
Advocacy ***Problem*** Lack of information on the magnitude of traumatic fistula (In the past six years, no cases of traumatic fistula were documented in Sudan.) ***Objective*** Estimate the magnitude of traumatic fistula in Darfur	***Activities*** Meet with stakeholders to bring them on board ***Decision makers*** ♦ MOH (including state and federal) ♦ Humanitarian Aid Commission (government body responsible for all NGO activities) ♦ UN agencies ♦ NGOs in the field	♦ Human resources, including technical experts to conduct situational analysis, and providers, especially midwives (In Darfur, there are 1,000 midwives.) ♦ Financial resources (according to recommendations of experts)	UNFPA as coordinating agency for medical complications of GBV and traumatic fistula	Six months	♦ Identified number of fistula cases, classified by cause, geographic location, and age ♦ Documented incidence of sexual violence in Darfur (dependent on political approval)
Political advocacy ***Problem*** Lack of information for the government on traumatic fistula as a consequence of sexual violence ***Objective*** Raise awareness of policymakers to acknowledge traumatic fistula as a result of sexual violence(in order for services to be put in place)	***Activities*** ♦ Advocate among government to promote survey of traumatic fistula in Darfur ♦ Inform government of the underlying causes of GBV as part of survey ♦ Advocate for service providers, community leaders, and public to report traumatic fistula cases ***Decision makers*** ♦ MOH ♦ All government agencies ♦ UN agencies ♦ NGOs				

Northern Uganda

Problems and objectives	Key activities and decision makers	Resources required	Responsible organizations and/or persons	Time frame	Expected outcomes
Problems ♦ Lack of awareness about traumatic fistula and availability of services ♦ Little understanding of the magnitude of the problem ♦ Missing infrastructure and resources ***Objective*** Reduce incidence of sexual violence, especially rape, and resulting traumatic fistula	***Activities*** ♦ Develop network with agencies and individuals interested in supporting issues around traumatic fistula ♦ Conduct situational analysis to determine the magnitude of traumatic fistula and the resources needed to manage it ♦ Develop advocacy strategies and campaigns ***Decision makers*** ♦ First Lady Janet Museveni (who has already shown interest in obstetric fistula) ♦ MOH (including hospitals like Mulago, referrals in the north) ♦ Universities (Makerere and others) ♦ Military ♦ United Nations Children's Fund (UNICEF) ♦ UNFPA ♦ Save the Children ♦ Local District Directorate of Health Services ♦ ACORD ♦ WHO ♦ USAID ♦ UNHCR ♦ EngenderHealth/The ACQUIRE Project ♦ Swedish International Development Cooperation Agency (SIDA) ♦ Association of Women Lawyers (have legal aid projects)	♦ Human resources ♦ Financial resources ♦ Logistics	EngenderHealth/ The ACQUIRE Project	Three months to set up in-country meeting; six months to conduct situational analysis and develop tools; three months to disseminate information; one year to implement programs	♦ More and more women in IDP camps accessing legal redress and surgical repairs ♦ Significant reduction in incidence of sexual violence in camps ♦ Move toward adoption of more appropriate policies