Obstetric and Traumatic Gynecologic Fistula in Sierra Leone: A Call for Empowerment

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Reflecting on the medical tragedies of the world, a group of rural Haitians asked, “is every human being not a person?” (Farmer 2005:218). This question compellingly brings to bear the plight of those plagued by unnecessary suffering, debilitation, and death as a result of preventable or controllable illness; these people, the ones who needlessly suffer, are stripped of their personhood and often of their humanity (Sen 2005:xi). Thousands of women in Sierra Leone unnecessarily suffer from either obstetric fistula or traumatic gynecologic fistula, the most serious and debilitating non-fatal health outcomes of obstructed labor and sexual violence respectively (AbouZahr 2003:9). A fistula-affected woman is destined to live a life of incontinence, often in isolation, unless treatment can be procured. Sierra Leone, a small country in West Africa, reports one of the highest rates of obstetric fistula and is hypothesized to also have one of the highest rates of traumatic gynecologic fistula in the world (ACQUIRE 2006:1, 7). The increased presence of obstetric and traumatic gynecologic fistula in Sierra Leone cannot be attributed to insufficient health care alone but must be considered in light of historically characteristic social norms and cultural practices. The degree to which obstetric fistula and traumatic gynecologic fistula are present in Sierra Leone may be articulated as a human rights violation through notions of gender inequality, notions that have been exacerbated in times of war and post-war political and economic instability. As such, any approach to the prevention and treatment of obstetric and traumatic gynecologic fistula must extend outside of the confines of medicine and work to empower girls and women to challenge traditional notions of gender and childbirth in Sierra Leonean society.

At least seventy-five thousand girls and women worldwide sustain an obstetric fistula in childbirth each year (Roush 2009:e21). Somewhere between seventy-six and ninety-seven percent of obstetric fistulas is the product of obstructed labor (Narcisi et al. 2010:342). In

obstructed labor, the soft tissues of the girl or woman's vagina, bladder, and rectum are compressed between the fetal head and the maternal pelvic bones. As increasing contractions force the fetal head tighter and tighter into the maternal pelvis, the blood supply to the aforementioned soft tissues is first constricted and then effectively stopped. The result is then widespread ischaemic injury, injury that leads not only to massive tissue damage throughout the maternal pelvis but often to fetal death from asphyxiation. The dead fetus, after maceration, is then expelled through the vagina, if not removed via caesarean section, and days later, a slough of necrotic tissue follows, leaving a fistula, a hole (Wall 2006:1203). The hole forms in the vaginal wall communicating into the bladder, leaving a vesico-vaginal fistula, or the rectum, leaving a recto-vaginal fistula, or both (AbouZahr 2003:8; Melah et al. 2007:819). A fistula-affected woman, then, is destined to continuous involuntary leakage of urine, feces, or both, depending on the fistula's location, unless treatment can be procured.

In Sierra Leone, as elsewhere in Africa, the practice of child marriage is commonplace. In order to lessen their financial burden, parents will often marry their daughter young, ensuring her virginity, in exchange for a more substantial bride wealth (Nour 2006:1645). Once married, assuming menarche has already been reached, a girl is expected to bear children quickly in order to secure her identity, status, and respect as a woman in the community (Nour 2006:1645). The circumstances of child marriage, then, would suggest that many girls entering marriage are from poor families. Chronic undernutrition and malnutrition, often associated with poverty, preclude a girl from reaching adult size by menarche (Miller et al. 2005:289). Thus, a girl entering child marriage is often subject to pelvic immaturity; that is to say, her pelvic bones are not ready for childbearing and delivery (Nour 2006:1646-1647). Pelvic immaturity often results in cephalo-

pelvic disproportion in childbirth, leading to obstructed labor and ultimately obstetric fistula (Muleta et al. 2010:950).

While the practice of child marriage was salient before the beginning of the Sierra Leone civil war in 1991, the practice assumed a new measure of brutality during the war as child brides became bush wives. During the course of the eleven year war, thousands of women and girls were abducted by rebel forces and confined among their ranks for extended periods of time (Denov 2006:320). A girl's first experience of rape and sexual abuse almost always coincided with her abduction. The rape of an abducted girl was often performed by several men and could go on for days; at some point, one man would step forward, claiming the girl as his "wife" and thereby "saving" her from future rapes (Coulter 2009:126-127). This "heroic" act mandated the girl's loyalties to her "savior", subjecting her to life as a bush wife. Although bush marriages are not socially or culturally sanctioned, a girl forced into this type of marriage was expected to assume the responsibilities of a traditional wife; she not only performed domestic tasks, such as cooking, laundering, cleaning, and farming, but also remained at her "husband's" disposal sexually (Bélair 2006:555-556; Coulter 2009:240). A bush marriage, however, needs to be seen for what it truly is, a form of sexual slavery (Bélair 2006:557). Many, if not all, girls entering bush marriages were subject to routine sexual violence and exploitation by their "husbands" and their "husbands'" superiors. A girl impregnated by her "husband" and subsequently allowed to carry the child to term was at the same risk for obstetric fistula as a girl entering into a child marriage before the war (Bélair 2006:555). As previously noted, many obstetric fistulas are the product of obstructed labor; however, fistulas, formally known as traumatic gynecologic fistulas, may also arise as the product of sexual violence, namely rape, defilement, or the forcible insertion of objects into the vagina (ACQUIRE 2006:3). As with obstetric fistula, a girl affected

by traumatic gynecologic fistula is sentenced to continuous involuntary leakage of urine, feces, or both, depending on fistula location, either vesico-vaginal, recto-vaginal, or both (ACQUIRE 2006:1). Thus, the practice of sexual violence within bush marriages compounded a young bush wife's risk for sustaining a fistula.

The end of the Sierra Leone civil war did not signal the end of child marriage or even bush marriage. In fact, there has been an increase in child marriage and sexual violence post-war (Jones 2010:102). Due to limited post-war economic opportunities, the practice of child marriage remains commonplace (Reis 2007: 180). Since a girl is considered to be an economic burden on her parents, there is an incentive to marry her at a young age, effectively eliminating the burden (Nour 2006:1645). In light of the post-war economy, it may be hypothesized that the age at which girls are now married is decreasing, as parents, under post-war circumstances, look for ways to alleviate their financial burdens. Young girls are the prime targets not only for child marriage but also for post-war sexual violence. Unlike women, girls are "smaller, weaker, [and] more easily overpowered and intimidated" by men who have been effectively stripped of their weaponry post-war (Jones 2010:102). If impregnated, girls forced into child marriage or victimized through sexual violence are at risk for obstetric fistula from obstructed labor, the latter also at great risk for traumatic gynecologic fistula.

Underlying child marriage, bush marriage, and sexual violence, to a varying degree, are notions of gender, and therefore gender inequalities. The normative gender model in Sierra Leone, in which men are superior to women, is based on the polarization of men and women with regard to their positions and roles in society (Coulter 2009:58). Of women it is often said that "there is no such thing as an unmarried woman" (Coulter 2009:74). This statement, articulating the notion that bride wealth is paid in exchange for a woman's reproductive and

productive labor, underlines the two primary roles of a woman in Sierra Leonean society: wife and mother (Coulter 2009:74-75). A “good wife”, then, is one who obeys her husband (Reis 2007:192). This notion is particularly poignant with regard to bush marriage, as a “good wife” fulfills her obligation to have sex with her “husband” even if she does not want to, but the notion also resonates with child marriage (Reis 2007:192). In both instances, the superiority of men in marriage is clearly evident, as the girl, the wife, in fulfilling her obligations to her husband, relinquishes control over her personhood, body, and reproductive health. Thus, it is the girl’s incapacity to refuse her husband’s sexual advances and thus protect her physical and emotional well-being that characterizes the gender inequality in Sierra Leone. The gender inequality can be further articulated through the notion that a “good woman” is one who quickly bears children after marriage (Coulter 2009:74-75; Nour 2006:1645). For a girl entering a child marriage especially, this gendered responsibility inherently places her in a position of great risk with regard to her reproductive health.

Notions of gender inequality are, of course, not circumscribed by marital relations but are extend to familial relations at large. In Sierra Leone, it is commonly understood that a girl is “always *of* or *for* someone else” (Coulter 2009:58). Girls are thus seen both as inferior to men and as the property of men. This construction of girls provides the rationale for the pervasiveness of bush marriages and sexual violence. In subjecting a girl to sexual violence, a man is both reinforcing the gender hierarchy and displaying his masculinity (Mackenzie 2010:207). In Sierra Leone, the objectification and demoralization of girls and women gave power to the rebels during the war, while simultaneously endangering the girls and women’s reproductive health, placing them at an increased risk for obstetric and especially traumatic gynecologic fistula.

Political and economic instability, which intensify the existing gender inequalities in Sierra Leone, may thus be seen as prominent factors contributing to the pervasiveness of child marriage, bush marriage, and sexual violence. The connection between economic instability and child marriage is likely the most salient as parents primarily consider child marriage for their daughter in times of economic distress. The relation between political and economic instability and bush marriage and political and economic instability and sexual violence, then, is best articulated through the framework of gender inequality. The Sierra Leone civil war can certainly be characterized by political instability, which continued post-war with the added burden of socioeconomic decline (Henry 2005:446). The practice of bush marriage and sexual violence can thus be understood as a man's struggle for control in a seemingly uncontrollable world. While a man had and continues to have little to no control over the rampant societal and economic instability characterizing wartime and post-war Sierra Leone, a man could essentially "control" a girl through bush marriage or sexual violence, asserting his power and his masculinity. The lack of control associated with political and economic instability may thus prompt a man to seek control in other aspects of life, namely interpersonal relationships, thereby placing victimized girls at risk for obstetric and traumatic gynecologic fistula.

Through the practices of child marriage, bush marriage, and sexual violence, a girl is subjected to an increased risk for sustaining a fistula, either obstetric or traumatic gynecologic, and her right to life is severely restricted. The participation in any one of these practices effectively eliminates a girl's control over her personhood, body, and reproductive health and, as consequence, threatens her right to "life, liberty, and security of person", as dictated in Article 3 of the Universal Declaration of Human Rights. If a girl or woman sustains a fistula, either as the product of obstructed labor or brutal sexual violence, her rights are further limited as

opportunities for education, social engagement, and economic and political empowerment are no longer available to her (Jones 2007).

With a large proportion of obstetric fistulas in Sierra Leone resulting from cephalo-pelvic disproportion, accessible operating rooms, with the resources and personnel necessary to perform cesarean sections, must be part of any approach to the prevention and treatment of obstetric and traumatic gynecologic fistula (Farmer 2005:158). While accessible and functional operating rooms are certainly an important facet, their presence will only cater to the medical management of obstetric and traumatic gynecologic fistula. An anthropological perspective, in addition to the already present biological one, permits the articulation of fistula not only as a medical condition but also as a human rights violation grounded in notions of power and social inequality. Rights violations necessarily need to be seen as symptoms of deeper pathologies of power, as they are intimately linked to social inequalities that determine who will suffer from abuse (Farmer 2005:7). In Sierra Leone, the increased presence of obstetric and traumatic gynecologic fistula can be readily tied to practices of child marriage, bush marriage, and sexual violence. These practices largely arise from socially and culturally embedded notions of gender, whereby girls are not only inferior to men but also the property of men. In times of political and economic instability, gender inequalities are exacerbated, as men struggle for power and control in a seemingly uncontrollable world, often exerting that power and control over girls. The solution to the high presence of obstetric and traumatic gynecologic fistula cannot end with the establishment of well-supplied hospitals or even the procurement of reliable, trained staff. The solution must come from within Sierra Leonean society, from the resolve of girls and women speaking and acting against historically held notions of gender and childbirth.

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