Mother and child in Goma.
PHOTO: STEVE EVANS /2009

HEALTH

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HEAL AFRICA

It's a three-day odyssey from Sydney to Goma, which lies in the heart of the African continent – the last leg of the journey is a four hour road trip through Rwanda.

Goma lies on the Equator, 5,000 feet above sea level. It is on the shores of beautiful Lake Kivu and in the shadow of the active volcano Nyiragongo. National Geographic described Nyiragongo and Goma as: 'the most dangerous volcano in the world in the most dangerous city in the world'.

In 2002, when Nyiragongo last erupted, a third of Goma was swallowed up by lava and the scars are still visible in the city streets. Wooden-plank houses in the new suburbs perch precariously on rough beds of lava rock, while riding in a vehicle on some of the lava-based roads feels like riding a mechanical bull. Few buildings in this city of a million people are as high as two stories.

The Democratic Republic of the Congo (DRC), formerly Zaire – and before that the Belgian Congo – has had a troubled and tragic history. When the genocidal conflict in Rwanda spilled over into the eastern part of the DRC in 1994, nine nations became involved, and as many as 20 armed groups imposed a reign of terror. Close to six million people died and hundreds of thousands of women were raped in what has been called the deadliest war since World War II.

All too often, civilians are still caught up in raids when villages are burned and looted. And 20,000 UN peacekeepers remain deployed in the area. However, the value of their contribution is often questioned by local Congolese.

Moreover, on my last visit in August 2011, UN troops were caught smuggling coltan – Congo's precious mineral resource – across the border into Rwanda.

Few reports on the suffering of the Congolese are published in our media, partly because Australia has no diplomatic relations with the DRC and it is difficult and expensive to get into the country ($408 for a visa for a month).

These days it seems rape is a given in war, and in Eastern DRC rape-torture has become a weapon of war – it has been said that it is more dangerous to be a woman in this country than to be an armed soldier. Rape-torture of women, including mutilation, is designed to demoralise whole communities. Women are the ones who do the work that keeps the villages viable: cultivating the fields, collecting water and fire wood, making the home, raising the children, and caring for the sick and aged. When women fear to go about these essential tasks, village life collapses.

The DRC conflict, which is over the control of land, has displaced an additional million people around Goma. Large tracts of fertile hills, which once were cultivated by the villagers, are now pastures for one man's cattle. Large areas of forest, the traditional home for the Pygmies, are now being cut down for charcoal production. Rich deposits of

One third of Goma (pop. around 600,000) was covered in lava in the 2002 Mount Nyiragongo eruption; rebuilding continues.
PHOTO: JOHN TULL

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gold, copper, and especially coltan, are being mined by foreign companies.

The DRC is resource rich, but its weak and distant central government, burdened by repayments of foreign debt, provides little in the way of public services for the population in the east. Even in Goma city, water and power are regularly cut off, and roads are notoriously bad, often more a series of potholes than a road.

People have to pay to be admitted to the public hospital and to go to the public schools, while most people live on less than $2 a day and are lucky to eat once a day. The DRC ranks in the lowest six nations on the UN's Index of Human Development.

In this context, the HEAL Africa Hospital (HAH), funded by international aid agencies, serves the poorest members of the community. The hospital has 160 beds, an outpatient department, and a far-reaching network of community health and palliative care programs.

In 2009, I contacted the hospital outlining my extensive international/cross-cultural experience in mental health and offered to conduct counselling workshops for staff – specifically for those working with rape survivors.

In the DRC, women and children are gang raped, often with sticks or even the barrels of weapons. This can cause rupturing of the walls between the vagina and/or the bowel and the bladder, so that they are left incontinent, and sometimes pregnant or HIV positive.

The hospital outreach staff go into villages and refugee centres to locate these women and bring them back for testing, treatment, and surgical repair of traumatic fistulas. Women are also given the opportunity to learn some skills, such as sewing, or to take literacy classes, while they are undergoing treatment.

In 2009, I met 80 women waiting for fistula surgery in transit wards – some needing multiple surgeries.

On my first visit, my main objectives were to develop rapport with the staff and identify their priorities. It soon became obvious that not only were staff subject to vicarious traumatisation in their work with survivors of unimaginable atrocities, but most of them had themselves experienced severe and multiple trauma.

The head counsellor, for example, lost her entire extended family when 700 families were massacred in the Masisi region on one day in 1997. Also on that day, the chaplain, who works with me as an interpreter, had gone to Masisi to rescue his younger siblings. They escaped the slaughter with only minutes to spare, running for their lives with the invading troops in pursuit.

When the volcano erupted in 2002, the chaplain and his family, like other members of the staff, lost everything but the clothes on their backs. The coordinator of the hospital's program for children living with HIV has suffered the murder of her father and sister. In addition, while she was in labour with her third child, her two older children, aged six and seven, were forced to watch for two hours while her husband was tortured to death.

As I heard these and so many other stories, I marveled at the resilience of these people. I was amazed that they managed to achieve anything in the chaos and unreliability of life in the region.

Subsequently, in every workshop I have devoted time to discuss self-care and mutual support strategies. For example, I introduced a form of gentle dance exercise; encouraged their wonderful a cappella singing groups; and gave each woman a supply of scented hand lotion and taught them techniques for hand massage. Of course, I advocated they use all of these activities with the patients, too.

Sharing of food is also an important aspect of any training in Africa and I always provide substantial refreshments at morning tea and a generous main meal for lunch.

In the first workshop, with 22 counsellors over six days, my objective was to identify models of work already in use in the hospital by posing a case history that was based on composite stories from real cases. I asked participants to discuss the case in small groups, and then to role-play a first interview with the patient. Participants fell into two groups.

The first group tended to be concerned primarily with a survivor's spiritual life. In role-play I observed that they usually advised the player taking the role of the raped woman that her experiences were no

Women outside the HEAL Africa Hospital. PHOTO: BARBARA FERGUSON/ 2011

worse than those of thousands of other women. Consequently, they urged them to give thanks that they were alive, to forgive the perpetrator and to get on with their life.

Initially, I took issue with this method. However, given the limited resources and time for counselling so many survivors, I came to recognize the practicality of the approach.

Rape survivors often find themselves blamed, even rejected by their husbands and families, and shamed and isolated due to their physical disability. I was assured that women are helped by the realisation that they are not alone. Moreover, unlike other women who have suffered similarly, they are getting treatment and the opportunity to gain some practical skills for moving on in their lives.

I was reminded of some Vietnamese boat people I interviewed in the 1980s: they said that after they had survived a perilous sea voyage, rape, and robbery by Thai pirates, they felt that they had plumbed the depths of their personal strengths and as a result were confident that they could face anything life threw at them.

The second group of counsellors had had some training in the model widely practised in the 'maisons d'ecoute' – rape counselling centres, literally 'listening houses' – where women are encouraged to share their stories. Undoubtedly, it is essential that survivors are able to tell other people what has happened to them, to be believed, to have the enormity of the horror they have endured recognised and their need for justice acted upon.

Children stand near a camp overlooking Lake Kivu in Kibati, 5km north of Goma. There are over a million displaced people in the war-torn province of North Kivu. PHOTO: LIONEL HEALING / AFP/ 2009

As far as justice is concerned, there have been some advances since my first visit in 2009. At that time the culture of impunity for the rapists meant that even when a woman knew she had a right to complain to police – which was rare – and even when a man or group of men were apprehended, all too often the evidence or the perpetrators disappeared before a sentence could be imposed.

Additional resources have now been provided, more police given training in taking evidence, and mobile courts travel to the scene of the attacks facilitating convictions.

As far as strategies to help survivors, however, I had some doubt that the simple repetition of trauma stories was a sufficient means to promote recovery for the women.

A sociologist, who had interviewed rape victims ten and 15 years ago told me in a personal report that she found they had remained as distraught as if the attack had just happened. Another person suggested that some of the more highly publicised stories became more and more horrific with every re-telling.

The most recent literature in the field also suggests that repeated rehearsing of the traumatic event serves to reinforce the distressing memories, stimulates harmful stress hormones and plunges the person back into the state of terror and helplessness experienced at the time of the attack.

In some cases this made the women more vulnerable to further attacks – especially since many women have no alternative but to return to the situation where they were raped.

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In this case, what they need are strategies to keep themselves safe, and groups of survivors can help each other by sharing information of this nature. It may also be that due to the overwhelming emotions and confusion at the time of the attack that some women have confused memories of what actually took place. And hearing what happened to other women can even create false memories of their own experience.

Whether or not this is true, in subsequent workshops, in 2010, I suggested a model of work that moved on from re-telling the traumas, and I asked counsellors to assess its usefulness in their work.

This model, a Brief Intervention for Trauma Symptoms (BITS), was developed by Dr Steve Stathis, a psychiatrist based in Brisbane. Briefly, it suggests four aspects of treatment.

The first one is to provide information about the complex consequences of trauma which will help the person understand that their reactions are normal given what they have experienced – this is a form of psycho-education.

A second is to allow a person to express what has happened to them and, most importantly, identify specific symptoms that are affecting their daily functioning – a brief trauma narrative. Of course, this is also essential for the counsellor's understanding of the person's needs.

The third aspect of the model involves cognitive restructuring to help the person move from self-blame and shame to be able to place the blame on the perpetrator. I was able to link this with the hospital's Women Stand-Up Together program. It involves a number of centres throughout the province, where women gather for training about their rights and also to learn skills in sewing, small-animal husbandry and agriculture.

The fourth aspect consists of symptom management where the person is assisted to identify the personal strengths that have allowed them to survive and then build on these to recover. The model was very positively evaluated by the 11 members of the counselling staff who attended the workshop. Unfortunately, it is difficult to know the extent to which they are implementing it in their work, or are training others to use it.

A second series of workshops was given on my visit in 2010, which I called "Protect the Little Children", in which 26 staff members, who work with children in the hospital's community health programs and programs for families living with HIV, participated.

In 2009, I had learnt that while children suffer sexual assault and incest, as well as war-trauma, their needs were often overlooked. I introduced the usual experiential exercises to enhance communication skills and elicit the types of issues the participants were facing in their work.

I also gave mini-lectures on child development, explored the nature of traumatic events, and of the life-changing impact of such events on a child's physical health, their ability to learn, to handle their emotions and form relationships throughout life. This material was new to the participants and highly valued. The issues raised prompted me to plan a special "train the trainers" workshop for my visit in 2011.

For this workshop I chose four staff members from different programs at the hospital – a program coordinator, a nurse-psychologist, a counsellor, and a chaplain – to explore the Tree of Life model for severely traumatised children. I knew them all well from previous workshops and had seen their commitment and capacity in action.

The model uses the tree and its component parts as a way for children to think about their lives: their roots, their strengths, their aspirations and the people who knew and had supported them in the past.

The idea is that by identifying these positives, they are more likely to look at the difficulties they experience from a place of strength and safety and

focus on the future rather than the past.

I sent the material explaining the model ahead so that participants were familiar with the content. On the first day of the workshop we reviewed the material on child development from last year's workshop. Then, in preparation for the following day when we would trial the model with a group of children, we went through the process of drawing our own tree of life, and explaining it to one another.

This proved to be an emotional session as the participants had all experienced more trauma in their lives than the average Australian could imagine. However, sharing their experiences and their coping strategies resulted in a strengthening of their relationships with one another.

The following day, nine children arrived to take part in the trial of the model led by the HAH staff. The children all know me quite well from previous visits so were not distracted by my presence as an observer.

Three of the children were from families living with HIV, one was an orphan living with a sick grandmother, one was fatherless and the other was often quite sick as a result of her disease. Two of the children are children of HAH staff and four are orphans from the Pygmy (displaced forest dwellers) village that I have been establishing outside Goma.

The venue for the workshop was the guest house where I stay in Goma and most of the activities with the children were out on the lawn under a pergola. The many trees in the garden provided inspiration for the tree theme and the children entered into the activities with enthusiasm. They were also eager to explain their drawings.

An orphaned Pygmy boy, who had become selectively mute since his parents were murdered last year, filled his page with a sturdy palm tree, clearly identified several people as supporters and happily told us his goal was to become a pilot.

An orphaned Pygmy girl drew a tiny, bent tree in the corner of her page. This child walks with a limp after nearly losing her left foot to a long-neglected infection earlier in the year. Clearly, her tree represented her sense of her own disability and insignificance. She had only one "support" leaf on her tree – which had my name written on it.

The children ranged in age from six to 15 years so we needed to allow for physical activities that related to the theme. Everyone joined in for interpretive dance portraying the trees growing from tiny seedlings to mature trees standing strong in the rain and storms. After this activity children were asked if children, like trees, also experience difficulties and dangers. They were soon talking about the losses in their lives, although they were not pressed to talk about their own experiences.

One child told how his father was murdered on the day he was born. He said, "I am told he was a handsome man and I look like him – but I really want to see my father".

Several other children echoed the longing to know a dead parent and to have something tangible to remember them by. These families have few possessions and no photographs to share. One of the Pygmy orphans talked about what it was like "living life like a nomad", never knowing a safe haven until the past few months since the new village had been built for her people.

Not every child spoke in this session and attention was riveted on those who did. One parent later reported a conversation with their child indicating that he had been surprised to learn that other children felt just as he did about the loss of their father.

In the model, the final session allows the children to share strategies for feeling safe and dealing with their fears. Some of the older children had already talked about key people who helped them, and who were a resource for all of the children: they mentioned teachers, the hope created by the opportunity to go to school, the medicines provided by HEAL Africa Hospital, pastors who helped destitute families and the comfort found in prayer and faith in God.

It is a privilege to work with the staff at the HEAL Africa Hospital and to contribute in some small way to their task of alleviating the suffering among this traumatised population.

Eastern Congo: Rape-torture of women, including mutilation, is designed to demoralise whole communities. Women work to keep villages viable: cultivating the fields, collecting water and fire wood, making the home, raising the children, and caring for the sick and aged. When women fear to go about these essential tasks, village life collapses.

PHOTO: WALTER ASTRADA