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The Support and Rehabilitation of Refugees – Personal Opinion and Experience

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Abstract

Life isn't meant to be easy for anyone. But some have it much harder than others. I've spent most of my life looking after people with disability and disease. And within the last decade, I've also become involved in caring for refugees. Western society is generally sympathetic to those with illness, and at least until recently, those of us responsible for their care have received recognition and usually appreciation. However, our society is much more divided when it comes to refugees. Opinions vary widely and there has been significant resistance to accepting refugees into the UK and some other western countries. Supporting them, even in their own country can generate adverse comments or criticism, sometimes from unexpected quarters. This article is a reflection on my role in supporting refugees both here, and more often abroad. I describe my experience and achievements, along with the challenges we have faced. I invite comments and constructive criticism, because I believe it is important to share and exchange opinions and experience without rancour.

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Introduction

By way of introduction to the topic, allow me to quote ***Home***' a poem written by Warsan Shire, a Somali-British refugee:

> *'No one leaves home unless home is the mouth of a shark.*
> *You only run for the border when you see the whole city running as well.*
> *Your neighbours running faster than you, the boy you went to school with*
> *who kissed you dizzy behind the old tin factory is holding a gun bigger than his body,*
> *you only leave home when home won't let you stay.*

> *No one would leave home unless home chased you, fire under feet, hot blood in your belly.*
> *It's not something you ever thought about doing, and so when you did -*
> *you carried the anthem under your breath, waiting until the airport toilet*
> *to tear up the passport and swallow, each mouthful of paper making it clear that*
> *you would not be going back. You have to understand,*
> *no one puts their children in a boat unless the water is safer than the land.*
> *who would choose to spend days and nights in the stomach of a truck*
> *unless the miles travelled meant something more than journey.'*

Supporting Refugees in their Own Country

Syria and Iraq

One of my friends and medical colleagues, Deiary Kader, had escaped to England as a refugee from civil war in northern Iraq. In 2014 he asked me to join him on a mercy mission back to his own country. He is a surgeon and regularly returned to undertake operations for those who needed life or limb-saving surgery. He realised that many of those seeking medical support needed a physician rather than an operation, so he invited me along. Many Syrians were fleeing persecution in their country then, and large numbers of them had crossed into Kurdistan and were housed in Refugee Camps there. Sadly, ISIS had also chosen the same time to make an appearance, so we delayed our arrival for 6 months. In that time, we collected and shipped over 100 large cases of winter clothing for the refugees, as winter is harsh, and the Syrians had fled wearing only what they could carry. The clothes arrived in time for winter, and we set off the following spring.

We divided our time between treating the Syrian refugees fleeing from President Asad and the locals who were resisting the incursions of ISIS (Figure 1). The refugee camp was only a few miles from the city of Mosul which ISIS occupied and even back in our base at Erbil, we needed an armed escort to move around. The refugees were wearing the clothes we'd sent and many of the children were in poor health, most suffering malnutrition. We saw very few men under the age of 50 as they were either on the front line or had been detained at the border. Fear was in everyone's eyes, and often that was all we could see as all the women wore the hijab. We did what we could for their physical ailments, but we were powerless to influence their mental health which was affected as a result of both post traumatic stress disorder (PTSD) and the ongoing uncertainty of what the future held for them.

Figure 1. Our team in the Syrian Refugee Camp in 2015

Having spent most of my career working for the NHS as a front-line hospital physician, I felt increasingly drawn towards working overseas. Although I'd volunteered abroad previously in Sierra Leone and Cambodia, both countries with a recent legacy of devastating civil conflict, my time in Iraq had a profound effect on me. I couldn't forget the fear on the faces of the children. But for the next two years, I had to stay at home. This period was more challenging at a personal level. My parents' health had deteriorated in tandem with each other, and I spent much of my spare time looking after them. I was also heavily involved in working, teaching and training junior doctors in my hospital and in supporting young people who had asked for my help with their nascent careers. However, by the summer of 2017, my parents had sought refuge in a more celestial establishment, while my youngest had just graduated from university, joining her older siblings in gainful employment. I felt less constrained by economic and family commitments.

Kenya and South Sudan

As a family we'd previously enjoyed short periods of working in India and Africa, as well as a longer stint in New Zealand. So, when Sally, the daughter of one of my colleagues, contacted me in 2017 to ask if I could assist some young refugees from South Sudan who had made the thousand-mile overland trek on foot to Kakuma refugee camp in Kenya, I was

intrigued. Sally had met them soon after their arrival during her gap year and she had promised to try to support them in their endeavour to find a home and an education in their adopted country. She wondered if I could help with the provision of medical and practical care for them, and this seemed like the opportunity I was waiting for.

The children had fled South Sudan during the repression which followed the establishment of an independent South Sudan. These 38 youngsters, aged 3 to 16 at the time, had recently resettled from the refugee camp to the town of Kitale, in northern Kenya. They had euphemistically christened their overcrowded hut ‘Hope House’. Sally and I spent a week with them in summer 2017 establishing their priorities and helping to secure their future education and nutrition. They also had several healthcare issues, most of which I was able to address with the aid of our rudimentary Swahili. It was hard not to admire their resilience, energy and firm faith. They are all from the Dinka tribe, a tall and very dark-skinned group, and have maintained their traditional cultures around food, religion and social interaction, while thriving in the educational system available in Kenya. However, this costs money, and they had very limited finances to cover this. So, we agreed to help with the food and rent for Hope House and fund the refugees through further education. Many of these young men and women are highly intelligent and were extremely motivated to complete their education in Kenya and return to South Sudan to play an important role in establishing their new country.

I have visited them every year except for 2020 when covid reared its ugly head. They have maintained their sense of purpose and of fun (Figure 2). They continued to insist that they wished to return home to South Sudan eventually, to share their newly acquired knowledge with the children there. Hence, with the approval of the South Sudanese education authority, in 2019 we purchased land in Juba in South Sudan to use as a base for their relocation. In 2022 we visited local schools and planned the structure, timeline and cost involved in building the school they envisaged in South Sudan. We planned for the repatriation of the Hope House residents back to their own country when they complete their own education in Kenya and have started building a day school for the local children in Wau. We have already constructed 5 classrooms during the first half of 2023 and the school should be fully open by the start of next year (Figure 3). The Hope House graduates will invest their educational attainments into the local economy which will benefit from their newly acquired skills and education to help the young country realise its potential through education and leadership roles. Our intention is to turn the tragedy of forced migration through conflict into triumph by using the education these young people acquired in Kenya to educate their countrymen, while also ensuring they have a sustainable income.

Figure 2. The South Sudanese refugees from Hope House in Kenya in 2022

Figure 3. The new school which we have built in Wau, South Sudan in 2023

Uganda

While we were at Hope House in 2017, Sally was contacted by a friend from Uganda whom she'd met on her gap year. Leah explained that she'd recently rescued 12 boys, all under the age of 12, from the sewers where they'd been living as

street children to shelter from the police in Mbale who beat them if they caught them above ground. They were mainly AIDS orphans, and some were addicted to glue sniffing. I guessed the request and prepared my excuses. I explained that there was no way we could travel on to Uganda as we had neither visas nor yellow fever vaccination certificates, both of which were essential. Sally smiled and arranged for us to leave by motorbike at midnight. The next morning, I found myself surrounded by frightened young faces, which hadn't seen soap for many months. I spent the day learning about life underground and what had led to such an existence. Leah has a heart of gold, as well as a very persuasive tongue. She translated the boys' responses to our many questions. They told me that education was their only route out of poverty and that they valued this even above the other priorities we'd identified. They were refugees in their own country from a life that otherwise offered petty crime, grinding poverty and a cycle of deprivation. I was asked to assess and treat their many medical problems, and once we'd gained their confidence and improved their health, Sally, Leah and I calculated what the cost of providing ongoing support for these twelve lads would be until they were old enough to be independent. Eventually we committed to establishing a Charity locally to accommodate, clothe, feed and educate these young men until the age of eighteen.

This program commenced in October 2017, and after five years the boys are almost unrecognisable (Figure 4). They look healthier and feel happier and live in a large house we bought in 2019. Leah, wanting to name it after us both, called it Kelah House. Our Charity also supports 4 adults (and their families) who help look after the boys. The costs of both food and rent rose dramatically so we purchased some land nearby to grow our own food. We have also been able to help provide food for those people who were most affected by the famine that ravaged rural Uganda during the pandemic and remains an issue due to the conflict in Ukraine. Four of the original boys have been able to return to their extended families nearby, although we continue to fund their education. Others who have no family or whose placements broke down, remain at Kelah, along with some recent new recruits from the streets. Last year, we spent several days planning and talking to each of the children individually to understand their hopes for the future. Although all have seized their educational opportunity, some of the boys have struggled academically because of prior trauma and noxious substances. These lads want to be apprenticed to mechanics and carpenters which we can facilitate. The four brightest boys are keen to continue through secondary school and beyond. We discussed their future, and they are keen to explore the opportunity of becoming social workers. Given their lived experience of homelessness, they are well placed to work within services designed to break the cycle of deprivation and poverty that produces this. Such an approach would also facilitate our ambition to amalgamate Kelah House into Uganda's Social Service network in the future, thereby securing its place in continuing to support vulnerable children. This way we can achieve long term sustainability without long term financial dependency. This could allow them to use their own early life experiences as street children to help and support other children who are at risk of being abandoned too. That would be a great way of 'paying it forward!'

Figure 4. The Street Children from Kelah House with Leah in 2019

Other Parallel African Initiatives

Refugees are often a product of economic or political instability. To a degree, this is difficult to predict and therefore prevent. However, a lack of education and the absence of health care can both contribute towards, as well as result from, the chaos that often precipitates the need for mass migration of people in an unplanned way. We therefore felt that working with refugees and ‘firefighting’ the consequences of their displacement was more likely to be effective and sustainable if it were to be combined with an effort to understand and improve education, socio-economic conditions and health care provision in their locality.

In 2017, I was also invited to join a project with Glasgow University to examine the prevalence and socio-economic effects of arthritis in Tanzania. I was asked if I’d like to undertake the field work and train local health care workers in the diagnosis of rheumatic disease. The project was based around Kilimanjaro, a place I’d dreamed of visiting since childhood. I spent that autumn in Tanzania and became increasingly involved in helping to teach the clinical undergraduate curriculum to local medical students at Kilimanjaro Christian Medical Centre (KCMC). In Spring 2018, I took four international medical students to KCMC for their clinical elective studies. They shared my loftier ambitions and we analysed and later published our physiological responses to ascending to the summit of Mount Kilimanjaro (Figure 5) [1]. I spent the summer teaching medical students there and the autumn teaching medical trainees from both Tanzania and the UK. Our project field work began in Spring 2019, and I spent a month teaching and training the local team. This work has continued to expand exponentially.

Figure 5. Renee, Paul, Gill, Zoe, Billy, Kate and myself: the Kilimanjaro Climbing Team in 2018

In early 2020 we expanded the training program for new members of our research team. We succeeded in documenting the case mix and prevalence of rheumatic disease in Tanzania [2], while also allowing for assessments of the socio-economic impact of arthritis in the Kilimanjaro area [3]. I continued to work across the spectrum of general medicine locally at the same time, helping with teaching and advising on complex and serious clinical cases, while also undertaking peripheral clinics in remote rural areas where there were no experienced medical staff on hand to support the juniors. Covid interrupted our program for a year and moved all our work to a remote platform.

During this period, I worked fulltime supporting National Health Service (NHS) hospital inpatients in the UK. When the pandemic eased sufficiently for us to resume face to face support for people in East Africa, I was invited by a Scottish charity to assess the medical needs of people living in poverty in Zambia. I took two younger colleagues whom I'd supported during their training and early careers, and we spent a month in early 2022 working around Zambia providing general medical care at our own expense. The highlight for us was the final week spent camping on a peninsula on the edge of the lake created by flooding the Zambezi River and visiting people on the islands by boat each day. Our clinics were held under baobab trees, and we had to navigate past crocodiles and hippos on our daily commute (Figure 6).

Figure 6. Louisa, Catherine, Sukie, Vincent, Dan and I on our Zambian daily commute in 2022

In June 2022 I accepted an invitation to facilitate the development of clinical services in Zanzibar. I spent the days teaching and undertaking outpatient and inpatient consultations of complex cases, and the evenings helping prepare a report for the Health Ministry. We defined the priorities in teaching, developing, and delivering care for those with auto-immune disease for 2 million people living on the islands of Unguja and Pemba. We proposed a timeline for service development which we costed, and which the health minister promised to implement. I've been back to develop our work

into outreach community hospitals this summer and will return regularly to extend our work to Pemba and commence clinical research. We now also hold regular case-based discussions online and have built up a sizeable database and teaching portfolio.

Over the last few years, we have been able to develop links across five countries in East Africa, facilitating the development of much needed clinical services for communities who had very little access to medical care. In Tanzania we have shown that non-communicable disease (NCD) accounts for the great majority of inpatient medical admissions and that rheumatic disease is one of the commonest disorders within the community [4]. These data were supported by the finding that a quarter of our clinical consultations in Zambia and Kenya related to musculoskeletal disease [5]. In Tanzania, our NIHR project work revealed a high prevalence of MSK disorders in adults living in villages around Kilimanjaro, while children were affected far less frequently [6]. Other initiatives have included working with the Departments of Psychology at both KCMC and UK universities to recognise and address the rapidly expanding burden of mental health issues among young people both home and abroad [7]. Our further research project will build on physical, psychological, and socio-economic aspects of illness in Africa, but formal academic output is not the only important measure of our success [8].

Clinical service development must continue apace and our work in East Africa supports this by training local health care workers and empowering them to lead the way in promoting future health care provision. This has incorporated the teaching and training of African students and staff at all levels across several countries, while also recognising the importance of ensuring both political and economic support for these initiatives. The infrastructure around health care provision in these countries has traditionally focused on preventing and treating infectious disease, so education around the detection, diagnosis, and management of NCDs at all levels is an essential element in this process and requires significant investment. Given the worldwide economic situation, external investment in promoting the health of developing countries is unlikely to increase soon, so ongoing input from non-government organisations, charities and motivated individuals remains essential [9]. Much of my income from my NHS work goes to fund our continuing efforts in East Africa.

I have also worked with a couple of international global health charities at their request to share knowledge and contacts for refugees in East Africa, with a view to improving access to treatment for malaria and other neglected tropical diseases there. I've also provided medical support for organisations who care for refugees trapped in Immigration and Detention centres, via Reprieve and Amnesty. This work spans every continent, including the UK. Trying to link all these initiatives together with other organisations elsewhere is an essential aspect of planning a sustainable and independent future for East Africans. I could not have achieved any of this alone and I am indebted to my family, and to many good friends and colleagues around the world, for their practical help and financial and personal support during what has proved a challenging period of time.

Commentary

The medical, psychological and social consequences for those trapped as refugees, either in their own countries or abroad, can be difficult to fully appreciate. We have however gained an insight into the challenges refugees face when

applying for permission to stay in the UK. My family and I work with an organisation locally to raise awareness of the terrible conditions in which women are kept while awaiting their applications for UK asylum to be processed. They are separated from their family members and kept isolated in a detention centre surrounded by barbed wire and guards. Inevitably, not everyone appreciates the efforts we make. We have received unwanted contact and persistent harassment over several years, attempting to inhibit our voluntary work. Recently two women attended our organisation's public consultation event locally to claim that I only support refugees to gain access to vulnerable people. The organisation had already been warned about this pair's previous behaviour, and promptly reported them to the police for causing unfounded alarm and distress. It seems that even the best motives can be subject to misrepresentation and that, through helping others, one can be left feeling very vulnerable too. When combined with the very real physical dangers, emotional upset and financial issues, the challenges associated with undertaking such voluntary work must not be under-estimated. It is not for the faint-hearted and requires persistence and endurance as well as a thick skin. But family, friends and faith are very sustaining, especially when combined with fitness and a sense of fun. Despite the challenges, if you want to learn more or be involved, feel free to contact us via email (cliveryton@gmail.com) or our website: www.clivekelly.org

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