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International Clinicians and Academics Supporting the Refugee Journey- personal narratives from the field.

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Abstract

Life isn't always easy, 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 as a medical volunteer. 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 countries, can generate adverse comments or criticism, sometimes from unexpected quarters. This article is a reflection on my role, both as a doctor and a humanitarian, in supporting refugees. I cover concepts and discuss how these might relate to the provision and development of medical services in parallel. A short commentary on the challenges of supporting them in other countries is included. I describe my experience and achievements, along with the challenges we have faced. I invite comments and constructive criticism, as I believe it is important to share and exchange experience and perspective without rancour.

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Introduction

By way of introduction to the topic, allow me to quote the first stanza of***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. '*

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, with an NGO he had created specifically for this purpose. 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, together with nurses, physiotherapists and a trainee surgeon. This was my first direct experience of working with refugees. Many Syrians were fleeing persecution in their country then, and large numbers 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 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 had 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 by both post-traumatic stress disorder (PTSD) and the ongoing uncertainty of what the future held for them. Displacement of people by conflict reveals the need for practical help with clothing and feeding, which if provided promptly, may reduce the need for subsequent medical care. Our provision of practical support, reinforced with subsequent medical input and the training of local healthcare workers, can form the basis for effective intervention.

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 had 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.

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

Kenya and South Sudan

Den Laat Malok was eight years old. He spent his days looking after his family's goats in rural South Sudan. His big dream was to be allowed to look after the cattle too, and maybe one day exchange some for a bride when he came of marriageable age. He walked miles under the hot sun each day and slept curled up next to the animals for warmth at night. He drank their milk for sustenance and used their dung to light a fire to warn off predators. Life seemed simple and he knew nothing of politics. But then came the civil unrest after independence. Militia and men from other tribes invaded his village. They attacked and killed the men. Den didn't wait to see what they did to the women. He ran for his life. He didn't stop until nightfall. He found himself shaking with fear and hunger by a small waterhole in the bush. He was not

alone. Maybe two dozen other young people, aged from 5 to 15, mainly boys, were gathered there too. They all told the same tale. They drank the dirty water, and they walked south. Travelling by night, they slept under banyan and acacia for shade and shelter during the day. They stayed away from villages, although they heard distant screams and smelled the smoke of fires on the wind. They dug roots with sticks and fed the youngest first. The lucky ones made it to Kakuma Refugee camp on the Kenyan border. Den was one of them. Even more fortunate, he met with others from near his town of Wau who knew his family. They gave him hope. Together they gathered enough resources to move to the rural town of Kitale, where they built a shack. Then they met Sally.

As a family we had 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 restrictions forbade travel. 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 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.

Education was identified as the major need by these refugees, even above security and clothing. Many young people from South Sudan have previously had limited access to schooling and their enforced displacement into Kenya offered the opportunity to obtain an education. However, this required funding which extended into university education for several. Many refugees were 25 years old before they completed their education which we provided in tandem with their basic food and accommodation needs. Weare in ongoing discussions with the South Sudanese education department to explore how readily we can seek to integrate our school into the wider scheme of improving education for all in that country and promote equality and ease of access for girls and certain minority groups within their society. Their lives have been forever changed by what they have endured. But with support, they now have real prospects for the future.

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 had met on her gap year. Leah explained that she had 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. Once we had 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 18.

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 cost 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.

In Uganda, street children are often locally displaced by a breakdown in social structure catalysed by loss of parents to disease, allied to economic failure resulting in profound poverty. Again, our main focus has been to provide an education in the context of a safe and secure environment, exploring the potential for rehabilitation once they felt able to contribute to society locally. 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!' However, our discussions with Uganda's Social Services are proving difficult and require prolonged negotiations to overcome a series of administrative hurdles. It is not yet entirely clear how many of these obstacles are necessary aspects of practical planning, as opposed to the need to 'persuade' regional organisations to accept our invitation and proposals.

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

Methods

It must be admitted that this was never intended to be a structured scientific article. However, aspects of it do have a semblance of structure in that we connected a sequence of humanitarian and medical trips to East Africa on the common stem of a program to understand, support and empower local leaders to improve access to basic education, nutrition and safety. We did this in the knowledge that improvements in health care outcomes should follow. In some of the projects described, more specific scientific approaches were adopted and these are described and referenced for our medical work in Tanzania, Zambia and Kenya in the next section. In particular, our work in Tanzania was structured and supported by an NIHR grant and details of the methodology are referenced. As for the humanitarian work in Uganda and Kenya, this was opportunistic and really rather random. I claim no scientific basis for our actions, other than human instinct and empathy.

The origin of refugees

Refugees are often a product of economic or political instability. To a degree, this is difficult to predict and therefore prevent. There are many structural processes which can contribute towards conflict, and may precipitate people into leaving their country, or to great hardships if they stay. Unfortunately, people in the Global North are very much implicated, with certain conflicts serving to our advantage economically or politically. While the time and place of individual conflicts may be hard to predict, there may be many factors that could reduce them. 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.

It has been observed that the reasons for forced migration have become more complex and that governments are responsible for politicising and transforming the refugee label, precipitating resistance to refugees [1]. In France, disease can facilitate residency applications for refugees, demonstrating how humanitarianism can be politicised [2]. In Holland the conflict between state and NGO agenda for the deportation of refugees has caused concern [3], while the policing of migratory flows into ‘fortress Europe’ may feel more like capture than rescue of refugees [4]. As an Irishman working in England, I am very conscious of the long colonial history of certain countries, and the often-adverse effects on the citizens of those territories that have been invaded and ‘colonised’. People forcibly removed from the land of their birth against their will as slaves or ‘offenders’, then forced to settle in foreign countries, were the predecessors of today's refugees, some of whom are still exploited as modern-day slaves in a variety of often undesirable roles.

There are 17 internationally agreed global sustainable development goals (GSDG). These include the need to end poverty and hunger, ensure health, education and gender inequality. And to improve access to water, sanitation, renewable and reliable energy and to employment. Our work recognises the links between poverty, illness and lack of education. By focussing on improving and equalising access to educational access, in tandem with providing the means for the sustainable provision of nutritious food and clean, we aim to also improve health care outcomes and increase the chances of long-term employment. Giving refugees control over their own destiny must always be a major aspect of the planned infrastructure.

Other African Initiatives

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 would 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) [5]. 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 [6], while also allowing for assessments of the socio-economic impact of arthritis in the Kilimanjaro area [7]. 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 full-time 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

Recent further developments

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. Just today, we've finished writing a medical paper describing for the first time the prevalence and clinical features of lung disease as a complication of rheumatoid arthritis in East Africa.

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 [8]. These data were supported by the finding that a quarter of our clinical consultations in Zambia and Kenya related to musculoskeletal disease [9]. 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 [10]. 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 [11]. 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 [12].

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 [13]. Much of my income from my NHS work goes to fund our continuing efforts in East Africa.

Strength and limitations

This article was originally intended as a descriptive piece for a magazine rather than a scientific journal article. Its obvious weaknesses are the lack of a clear scientific objective and the absence of a premeditated methodology. However, its appeal lies in the strength of creativity and compassion that working together with others for the common good has created, and the opportunities that this shared experience can catalyse in ourselves and others for the future further benefit of those less lucky than ourselves.

Commentary

The Equality, Diversity, Inclusivity and Justice (EDIJ) agenda is being applied in a much wider global setting now. This is usually appropriate but far from universally realised. There are still many people who have access to none of these components, leave alone to all of them. Human conflict is at the root of much of this failure and until we learn to live together, respect and accept each other for whom we are and what we do, it remains inevitable that inter-personal differences will obscure attempts to apply EDIJ universally. If we are to realise the core values and aims of WHO and achieve the global SDGs, people of every creed, colour and orientation must set aside their differences and work together for the greater good of all.

I have 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.

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 here and abroad. 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 towards us, and they promptly reported them to the police for causing unfounded alarm and distress. No matter how genuine one's intentions, it seems that even the best motives can be subject to misrepresentation and that, in helping others, one can be left 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. Family, friends and faith are very sustaining, especially when combined with fitness and a sense of fun. More details and images can be accessed via our website www.clivekelly.org

Lessons learned

Refugees must show considerable resilience to survive the rapid sequence of often traumatic changes in their lifestyles. Their sense of purpose, language, beliefs and culture are important in sustaining them. I would encourage orchestrated support for them which, when partnered with opportunities and support, may pave the way for an increased level of quality of life among refugees. An important element of future planning is their subsequent rehabilitation. Initially this may require psychological as well as physical support, and ultimately encouragement towards developing a sustainably independent lifestyle.

Developing sustainable change is best tackled by direct dialog with key stakeholders , preferably in person to establish trust and confidence. In practical terms, this requires the appointment of a reliable local guardian. They will likely be responsible for day-to-day decisions and the handling of any funding that is provided. This has been an essential step in our program and without the likes of Gabriel (Kenya), Leah (Uganda), Vincent (Zambia), Sanjura and Sanaa (Tanzania), working with and within the organisations involved, it could not have succeeded.

The characteristics of such projects which make success more likely include a well-developed plan and associated timeline, along with guarantees of funding which is both realistic and transparent. Sharing the responsibility for defining these with the individuals and organisations is of course essential if trust is to be developed and maintained. Key milestones are important,along with a regular review of progress. And avoidance of blame by developing a corporate sense of responsibility and sharing the pleasure of success -as well as the pain of failure.

There have been instances where our support failed to make the impact we'd hoped for. These included funding for unmarried young mothers in Tanzania and sustainable education facilities for poverty-stricken children in Madagascar. The first failure related to an unrealistic financial expectation that we could not meet, along with the fact the the mothers did not see education as their main priority. The second because of political challenges that actively discouraged inward investment in education. Both these reflected a lack of sufficiently detailed forward planning on my part. Enthusiasm alone is not enough, and its important to be realistic about how attainable one's goals are likely to be.

Summary and conclusions

I have described some challenges faced by people forced to leave the security of family and friends and adopt a dependent lifestyle, either locally within their own borders or abroad. This is rarely done through choice and is often precipitated by conflict, disease, political or economic factors. Many young people are severely traumatised by this process and require extensive support. They see education was a priority, and often as their only legal means of securing a stable future. Providing this inevitably requires cooperation with local institutions which we have learned can be a slow and arduous process. They understand the educational, socio-economic conditions and health care provision in their localities and are motivated to best invest the help provided in the most effective way. I also recommend regular online contact and annual visits where possible to maintain informed reviews around progress and priorities and renew those bonds of friendship and trust that can provide a firm foundation for the future.

Those majority who remain ‘back home’ in the Global North are still able to contribute to reductions in the ‘root causes’ of

conflict and forced migration. Sponsorship can take many forms in addition to money. Specialist advice across the spectrum of practical and professional contacts and contracts are invaluable. Letters of support and appeals for change can make a big difference when directed to selected individuals or organisations. Increasing awareness of problems and their potential solutions by airing and sharing them with friends and on social media can change hearts and minds. Supporting organisations which work to support and/or repatriate individuals is essential. And at a personal level, looking to adopt an inclusive and informed approach to developments around the world is an important step towards opening one's heart and mind. If we can't learn to forgive failings in others, what hope have we of learning from our own mistakes? Cultivating a climate of true tolerance in our own relationships is a necessary step towards using one's experiences and abilities for the benefit of others. I cannot adequately convey the huge sense of privilege that accompanies helping people in such dire need. It gives me enormous pleasure to improve other people's lives a little.

Please allow me the indulgence of concluding with the rest of the poem 'Home'

> *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.'*

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