**Addressing Sexual Violence Against Refugee Women**

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**Addressing Sexual Violence Against Refugee Women (ASVARW)**

JUST/2015/RDAP/AG/VICT/9328

**NEEDS ANALYSIS REPORT**

**UK Report**

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## National context

***Refugee and asylum-seeking routes***

In the UK, there are two main routes that refugee and asylum-seeking (RAS) women[[1]](#footnote-1) may follow:

1. Arrive in UK seeking asylum (or – in the case of trafficked women – arrive illegally and claim asylum once here). These women will present and claim asylum either at the ‘port’ of arrival in the UK (e.g. London Heathrow airport, Port of Dover), or at the government Asylum Screening Unit in Croydon, South London. At this first stage, they attend a basic ‘Screening Interview’ with government immigration officers – they have to give the reason for their asylum claim and personal details including identity, country of origin, what documents they have and biometrics are taken. They are issued with an Application Registration Card. Some disclose GBV/SV at this stage (for some this may form – or link to - the basis for their asylum claim), but there is no screening or asking about GBV by immigration officers. They will subsequently have a substantive interview, called an ‘Initial Interview’. Basic information from the first interview is checked to ensure a consistent account, they have to provide evidence to back up their claim and show that they are in need of protection and cannot be returned to their country of origin. Their claim is decided by a caseworker, based on whether they qualify as a refugee under the terms of the 1951 UN Convention (have reason to fear persecution based on race, religion, nationality, membership of a particular social group, or political opinion, or can’t be kept safe by their country). Those granted refugee status are given permission to remain for 5 years, can work and access benefits – after that, they can apply for ILR. Some people not granted refugee status are given permission to remain – a small number humanitarian protection (5yrs), other discretionary leave to remain for limited time period. Initial asylum decisions are supposed to take place within 6 months but almost never happens – frequently up to 2 years just for initial decision (FLP014). The percentage of applicants granted refugee status in recent years has ranged 25-37%. They can appeal a refusal decision and this decision is made by an immigration judge at a tribunal hearing. In recent years, the proportion of appeals allowed (reversing original decision) has ranged 25-35%. A-S are not allowed to work of claim mainstream welfare benefits. They can apply for support, in the form of accommodation and cash – the latter is £36.95 per person per week. In 2015 there were 32, 414 applications for asylum in the UK. Frequent countries of origin are: Afghanistan, Iran, Bangladesh, Eritrea and Pakistan. Recently, there have been more from Sudan, Iraq, Syria, Bangladesh and India too. Around 30% of asylum applicants are women – though it’s 50% for certain countries (e.g. China, Gambia, Nigeria, DRC, Somalia, Uganda and Zimbabwe).
2. Come to UK under an official government refugee resettlement programme. These women will have been screened and granted refugee status before entry to the UK, usually in refugee camps and with the assistance of the UNHCR. There are currently three government refugee resettlement programmes:

* the Syrian Refugee Programme (most recent and high-profile). Established in 2014, the UK government had pledged to take 20,000 Syrian refugees by the end of the Parliament in 2020.[[2]](#footnote-2) As of December 2016, they had taken 4,414. Most of the refugees have been families (and 49% are children), although there have been some single individuals too. Overall, 51% are men and 49% women – however, 66% of those single individuals resettled were women. The most common reason for acceptance was as survivors of torture or violence (55%), followed by having legal or physical protection needs (25%, specific medical needs (8%), or were women and girls at risk (6%).[[3]](#footnote-3) Eligible refugees are screened from camps in Lebanon and Jordan, and then referred by the UNHCR. The Home Office then conducts second stage vetting. Accepted refugees are referred to local authorities around the UK who are able to accept or reject the referral. The participation of local authorities is voluntary. As of September 2016, 175 local authorities had registered for the scheme. Local authorities must provide a package of support. Refugees are given a five year humanitarian visa.
* the Gateway Resettlement Programme. Applications are made to UNHCR in-country, who refer suitable applicants to the UK immigration authorities. The GPP resettles groups of refugees from a small number of countries each year. In 2015 a total of 652 refugees were resettled (the maximum under the route is 750 per year); the main countries of origin were Somalia, Ethiopia, DRC and Iraq. Support is again co-ordinated by local authorities and involves a 12 month tailored integration package.
* the Mandate Resettlement Programme resettles refugees from around the world who have a close family tie in the UK who can accommodate them. The refugee is usually the spouse, minor child, parents or grandparents over the age of 65 of someone who is settled permanently in the UK. People therefore arrive individuals or in small family units; in 2015, 18 refugees were resettled under the MRS. There is no government package of support – support and orientation is assumed to be provided by the family members.

In addition, the UK Government has committed to resettle 3,000 refugee children affected by the conflict in the Middle East over the course of this parliament under the Vulnerable Children’s Resettlement Scheme.[[4]](#footnote-4) This also discharges the Government’s commitments under the Dubs amendment and the Dublin III treaty to resettle several hundred refugee/asylum-seeking children from the Calais camps (these are time-limited commitments).[[5]](#footnote-5) Resettlement of child refugees is done via a National Transfer Scheme (and overseen by a dedicated team in the Home Office), which allocates children out to local authorities.[[6]](#footnote-6)

**nb: the UK Prime Minister has called a general election for 8 June 2017. It is unclear until then whether and what changes to RAS policy and law may follow.**

***Identifying ‘reception centres’***

As the national overview shows, there are not national ‘reception centres’ for refugees. Refugee women (and children) accepted to the UK under any of the government refugee schemes are officially welcomed by local authorities and provided with (at varying levels) a package of support. The specific support/arrangements and key professionals involved are likely to vary at a local level. Importantly, refugees are dispersed around the UK, with almost all local authorities receiving (small numbers of) refugees.

For asylum-seekers, those awaiting an initial decision may be accommodated in initial centres (i.e. fewer places), but once they have an initial decision they, too, may be dispersed to different local authorities across the country. All asylum-seekers will at some point ‘pass through’ the immigration offices in Croydon (with a few exceptions) to have their initial (substantive) interview; thus this is a place where screening/asking/intervention could take place. However, this is a very specific (official, policed, and often challenging and traumatic) context for a-s.

In addition, there are many (local and national) voluntary organisations working to support RAS – both recent arrivals and those who have been in the UK longer. These may be good locations to access and offer support to RAS women. Note: some of these organisations may have an ‘official’ role in receiving refugees (e.g. contracted by local authorities to provide support services); others will be purely voluntary.

***Profile of RAS women***

Women with refugee status may acquire this as a result of successful (usually very lengthy) application via the asylum system; those arriving under a resettlement programme will arrive with it. This means there are three groups of women at any point:

* Asylum-seeking women
* Recently-recognised refugees (acquired refugee status through the asylum system)
* Resettled refugees.

Interviews confirmed that the profile, routes through the immigration system, experiences in the UK and access to services vary considerably depending on whether women go through a refugee resettlement programme (small numbers) or the asylum-seeking process. Transition between AS and R is traumatic and retraumatises women (Mental Health, FLP007).

**Legal issues**

There has been a shift in legal and judicial responses to SVA since 2003. The judiciary now has a wider understanding of why RAS women may not divulge SVA in their first meeting to immigration officers (this was not the case before 2003). This shift has percolated down to Home Office, because if the Home Office has had to change its practice as it keeps losing cases on appeal (for not believing women’s testimonies of sexual violence) (Interview with immigration soliciitor, FLP004)).

Women’s immigration status (if not secure i.e. recognised refugee) often means they are not able to access key public services including SV and housing support (e.g. refuge, IDVA, ISVA). This can be a huge barrier both to professionals/services asking about status and also to women’s willingness to disclose/ability to access services.

One particular issue is that where asylum-seeking women disclose GBV/SV at the screening interview (first contact with immigration officials), anything they say can automatically form part of their later claim – and so if they later alter the basis of their claim or there is any discrepancy between what they say at the screening interview and later account, this can work against them. This is a reason that both immigration lawyers and the Home Office immigration officials were previously nervous about a project to introduce routine asking about GBV/SV at this immigration interview stage. On the other hand, the ‘real life’ argument was made that women DO disclose at this stage, and thus (a) it is important to offer some support at that point, even if only signposting them to SV support services, and (b) it might be better to get specialists involved earlier, so the experience of disclosing is less traumatic for women and the interview process runs smoother for all involved.

**Context of abuse**

GBV is a global phenomenon. RAS women are relatively even more powerless than other women in the UK, and as such are at risk of GBV. In terms of RAS experiences of GBV in the UK, interviews showed that there was a wide range of experiences/journey stories, and the particularities varied depending on the country of origin. We note that the groups and communities that those we interviewed worked with will to some extent reflect their local population/community demographics – so in developing training will need to be mindful that other areas or services might work with slightly different profiles of RAS women.

Women were abused in one or more of the following contexts:

* In country of origin – including domestic and sexual violence/harasssment (commonly cited), FGM (especially African countries), forced marriage, dowry violence and HBV (esp South Asian countries), forced prostition or sexual exploitation (Eastern European countries, esp Ukraine, Moldova, Albania; also Vietnam, Brazil and Nigeria cited). Many LGBTQ women face further abuse, for example rape as “sexual correction” is socially sanctioned in some African countries.
* In war (country of origin/transit countries – especially Africa, Syria/Jordan, and Sri Lanka)
* During the journey. Some of them may have a safe passage, but most experience sexual exploitation in transit. There are more young men than women in refugee camps, this inevitably poses a risk to women. One interviewee cited Dover port immigration officials as saying that 100% of women arriving through the Calais camp had been raped.
* Trafficked to/around Europe was very common (esp Eastern European countries, Nigeria, some Far East)
* Within the UK/ongoing. When they have reached their destination, many experience sexual exploitation and trafficking, for example from landlords. Example of A-S women ‘sofa surfing’ then finding they have to have sex to ‘pay back the favour’ of a place to stay.

Most of these forms/contexts applied to both A-S and R women, with the exception that women arriving under refugee resettlement route were less likely to have been trafficked to the UK or experience such ongoing abuse/vulnerability/exploitation when here (because they had a legal route).

***Specific forms of GBV and reasons for seeking asylum***

* Attacks including rape and disfigurement in the context of war and conflict, and during migration.
* Murderous attacks by family members, or in the context of terrorism and ethnic cleansing.
* Sexual violence within the family or within the context of sex trafficking (pimps or clients)
* Rape as a “sexual corrective” for LGBTQ women
* Sexual and gender based violence against LGBT communities leading to particularly gay men seeking asylum. Specific abuse within family and communities against transgender people who are transiting. These can often be successful in asylum cases.
* FGM (Somalians, Eritreans, some other African countries)
* Sexual mutilation as part of civil war.
* Honour based Violence
* Trafficking: sexual exploitation and sex slavery, forced into prostitution (range of reasons: poverty, low education, low status of women in country of origin). Immigration solicitors often deal with trafficking cases. Trafficking “almost always means there’s potential for an asylum claim” (FLP014 – immigration lawyer). esp Nigeria/other African countries, Albania, Moldova, Ukraine, Zimbabwe. Albanian and Ukrainian girls especially (FLP010) with “boyfriends” who become their pimps. Increasing prostitution/trafficking from Far East – e.g. Vietnamese women sold to traffickers in Moscow and brought to London (Lewisham).
* Trafficking/forced prostitution
* Honour based violence and forced marriage – Pakistan
* Domestic violence from husbands/family members (all nationalities; mentioned as specific issue in Sri Lankan community, where there are also issues about men and alcohol – FLP010).

Interviewees identified trafficking as a very common experience amongst the A-S women group – but, this may reflect (a) that there is a national mechanism for identifying and referring trafficked women to support services (the National Referral Mechanism, or NRM), and/or (b) that trafficking is a legal basis for an asylum claim – therefore, it may be that this group are just more visible to services (or at least the services we interviewed), and because the trafficking experience is so directly related to how/why they are in the UK.

Whilst there were a wide range of experiences of GBV/SV amongst RAS women, they did not in all cases form the basis of women’s claim for asylum / refugee status. For instance, trafficking, or being a member of a clearly defined minority group (e.g. LGBTQ women, especially in countries such as Uganda where being gay is illegal) might relate to their claim, whereas many women might claim on other groups (e.g. torture, war, political persecution) but also have experienced GBV/SV. So, the way in which SV/GBV experiences were related to the RAS status and the ‘visibility’ of SV/GBV as part of their narrative varied.

In addition to SV/GBV, other reasons for seeking asylum included:

* Political persecution (Chinese, Sri Lankans, Nepalese, Turkish)
* Civil war (Syrian refugees, Somalians, Eritreans)
* Homophobic attacks – often successful claims for asylum (Mental Health, FLP006)
* Torture (Sri Lankans and others) - though often sexual violence/rape in this context, e.g. women have experienced it in prison whilst detained for political activities (FLP010). Many Sri Lankans come to UK with paid agents (not trafficked).

## Context of the interviews

***Centres/services addressed :***

We interviewed a combination of front-line professionals (i.e. working directly with RAS women) from different types of service/professional discipline, and ‘second-tier’ professionals (i.e. those working in policy or at management levels in services):

*15 Frontline professionals:* Health (2 - GP, Nurse in sexual violence clinic); Mental Health (4 – one psychotherapist in a mental health service for women, one psychotherapist working in trauma service, 2 psychotherapists working in specialist service for RAS women and SV); ISVA (1), IDVA (1); Immigration lawyers (2): Housing (2 – one generic housing charity, one refugee housing charity); Outreach/therapeutic work with RAS (3).

*4 Second Tier professionals:* Politician (1 – local MP, also chairs national parliamentary group on RAS women); Policy managers in national refugee charities (3).

***Topics covered in the interviews (key-words):*** *sexual violence, legal rights, testimonies, trauma, impact, gender, FGM, trafficking, domestic violence and abuse, homophobic violence, forced marriage, honour-based violence, political persecution, torture.*

# Training needs of the persons interviewed

Most interviewees liked/agreed with the proposed 4-theme training. Some said that one theme was less relevant for them – e.g. GPs thought legal/institutional issues less relevant; as did RAS youth worker/facilitator. They suggested some specific content which is captured in the tables below. After the tables, we have included a text summary which incorporates the proposals in the tables together under the 4 training themes.

We also set out our proposal for the development of the training as modular units in the UK, which can be flexibly delivered to different beneficiaries, and via different mediums.

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| **Training needs** | **Beneficiary** | **Proposals** | **Notes** |
| Making referrals | Nurses and GPs (NHS) | Online information/training/resources that professionals can refer to |  |
| Impact of SVA/not to use culture as an explanation of SVA/GBV | Judges  Housing officers (voluntary sector) |  |  |
| What is GBV | Housing (voluntary sector)  Plus: services which specifically work with RAS women | (For housing), online training for volunteers nationally and locally would also be helpful + short training with team. | (For housing), short training with their team (2 hours max) – on awareness of GBV. Accompanied by handbook and raising awareness. They would be happy to host it on their website (Housing FLP005). |
| Why women may change their story – nature/impact of SVA/PTSD | Mental health  Immigration officials  RAS support services  GBV support services |  | *“We also could benefit from cultural training at a group level – we work on a 1:1 basis so sometimes not aware of cultural differences. So training on ‘social, cultural and anthropological (e.g. migrants’ countries of origins and journeys; experiences of gender based violence; specific issues for female migrants)’ would be helpful*”(Mental Health, FLP006) |
| Legal issues and international contexts | Mental Health  GBV services  Housing |  | *“We have to sometimes write a short letter to support asylum claims and don’t know enough about local contexts and international law”* (Mental Health, FLP007).  Understanding the impact that women’s different immigration status may have on their ability to access services – understanding how they act as barriers |
| Sexual Violence | Frontline services for RAS women | Half day training for volunteers | *It would be helpful to have training on sexual violence but it has to be at two levels:*   * *SV within families* * *SV within war, conflict and transition.*   *We need different responses to both.*  *We have 30 + staff and volunteers and we would value a half day training (10 am to 1 pm).*(Frontline service RAS women FLP013) |
| Cultural issues and how they meditate GBV | All FLPs – but especially immigration officers, health |  | Needs to be better awareness of cultural issues, e.g. xenophobia – and the cultural contexts of abuse: e.g. understanding how women see their own sexuality and its implications in their cultural context.  Good to focus on different forms of GBV and potentially on variations by route/journey in.  Understand how women conceive of / name (or don’t) their own experiences – e.g. may not consider themselves to have been raped  Understanding cultural context of abuse (e.g. extreme shame/taboo) |
| Managing individual conversations | GPs/health  All FLPs  Immigration and housing |  | Building confidence in how to ask about SV (and refer/signpost)  Avoiding repeatedly asking women the same questions; recognising and avoiding triggering/re-traumatising questions  How to use narrative and therapeutic approaches/questions (e.g. open questions, mirroring, not screening but allowing women to tell own stories) – basic counselling and coaching skills, to avoid guilt/shame/blame  Building relationships of trust to facilitate disclosure |
| Spotting the signs of abuse and trauma | Health  Immigration officials/housing officials  (All FLPs) |  | Understanding signs and effects of trauma (e.g. blankness, vagueness, forgetfulness) – esp important for officials making judgments about women’s credibility  Understanding re-traumatisation |
| Managing referrals and signposting | All FLPs |  | Where to look for services (local and national)  How to refer/signpost  What is the right level of support needed by women  Understanding issues of eligibility e.g. women with no recourse to public funds (who may not be able to access services like refuge, IDVA, ISVA) – and finding ways around this!  What to do if the woman doesn’t want / refuses help |
| Understanding women’s needs/hierarchy – and thus at what point screening is appropriate | GBV services  RAS services  (Other FLPs) |  | Understanding Maslow’s Hierarchy of Needs – what, and in what order, women prioritise needs and how this might affect disclosure/help seeking- e.g. housing – safety – children – debts – sexual health all might come before disclosure/help seeking for the SV.  ‘*When women arrive they want accommodation, food, shelter’* (FLP004 Soliciter*). – i.e. they may not want to disclose at this point?*  Timing of asking about GBV is key (Housing Charity FLP016)  “*It is hard to ask when another organization is the gatekeeper. (women may talk about SVA) after several days/weeks when the woman is comfortable”* (Housing charity FLP005)  *There is more silence about rape, women don’t want to speak about it. It is the elephant in the room. Women need to feel safe with the staff before they speak about these issues* (Frontline service for RaS women, FLP013)*.* |
| Integration post-crisis (especially for refugees) |  |  | Generally gaps in service provision for those with refugee status (i.e. not asylum-seekers), though they have access to more services.  Especially around integration into local communities – support, English language classes. |
| Understanding different GBV experiences, routes/journeys, and differences by country of origin | All FLPS |  | Training on different experiences of GBV and their impacts/signs  Training on different routes/journeys to UK and implications  Training on differences by country of origin/nationality  Implications of all these for women’s needs/services/status |
| Impact of subject on professionals involved | All FLPs |  | Understanding secondary trauma for FLPs hearing these experiences  Importance of peer support/clinical supervision etc for FLPs working with RAS women/SV |

# Training needs of services/professionals from the point of view of the persons interviewed

|  |  |  |  |
| --- | --- | --- | --- |
| **Training needs** | **Beneficiary** | **Proposals** | **Notes** |
| Basic counselling and coaching skills | All Front Line Practitioners |  | (as above) |
| Legal rights of RAS women | Reception staff in GP’s surgeries  (and general FLPs) |  | Issue is that law on RAS keeps changing so the training needs to be dynamic |
| Training on the impact of SVA on women/ should be trained to believe women/ training on rape myths | Immigration officers  Police  Housing sector (state sector)  NHS (Doctors + Reception staff) | Training should combat ‘culture of disbelief’.  Training on mental health impacts of GBV | Police should not act like immigration officers.  Home Office Staff tend to have stereotypes of what to expect from women who are victims – ethnic stereotypes and how they expect victims in general (FLP004).  Immigration officers have ‘default position of disbelief’ (2TIER001).  *“NHS does a great job but sometimes they look at RAS people as patients 1:1, so not aware of wider picture” (*Mental Health, FLP006) |
| Training on how to use religion/culture to support RAS women | Peer group training (RAS women)  *(nb. However, we feel direct training of RAS women is outside the scope of this project)* | e.g. why FGM is not a religious practice. | *“Religion/culture is seen as a problem. Women are using religion to transform their understandings of GBV”* (Solicitor, FLP004). |
| What is GBV | Health  Police  Mental health |  |  |
| Healthy relationships | RAS women  *(nb. However, we feel direct training of RAS women is outside the scope of this project)* | Training peer groups | “*There can be control at different levels. For example: some women talk about not trusting their husbands and checking their phones. This is a form of control. We need to create an understanding of abuse and healthy relationships. If women want men to trust them they also have to show trust themselves. RAS men suffer from a lot of frustration. They have lost everything, often they have witnessed GBV against wives and daughters (F. They can get frustrated, and they take it out on their wives. This triggers DVA, and leads to broken families. This is particularly an issue with Somali families. This means women are left with children, the kids don’t have a father figure and get into bad company”* (Frontline Refugee Women Charity FLP013) |

**Summary (training content and proposed approach for UK)**

**Training content**

Most interviewees liked/agreed with the proposed 4-theme training. Some said that one theme was less relevant for them – e.g. GPs thought legal/institutional issues less relevant; as did RAS outreach youth worker.

We think we can fold all the proposed specific topics in the tables above into 4 thematic modules as proposed by the project. We think there will be most content in module 2 (*Social, cultural, anthropological)* and module 3 (*Managing conversations with women)*, the latter which we think should be practically focussed on training a range of FLPs on how to manage those conversations/disclosures/basic therapeutic techniques around narrative conversations and open questions (rather than on encouraging screening, which we conclude from the interviews is problematic for several reasons including the practicalities of getting women to disclose (especially to officials such as immigration/police/housing), and the possibility of re-traumatising by asking). We think we would need to bring in some outside expertise in developing and delivering this module (only).

[NB: We have a document which summarises all the topics in the tables under the 4 themes, which we can share with partners on request, but thought too much detail for this NAR].

**Possible existing materials/sources of expertise**

Interviews showed that there is existing expertise and some content: for instance, some services we spoke to are specialists in working with RAS and SV – could we draw on some of these people for developing training content/potentially delivering some training, especially around asking/screening, how to speak to (traumatised) RAS women, and how to make referrals (these are specialist and skilled topics to train on and would benefit from FLPs with experience in practice). In particular, the modules on **managing individual conversations** and (less importantly) **making referrals** I (Lis) would like to bring in expert support for.

**Proposal: development of modular training, delivered via varied mediums**

We propose that, rather than offering a set of 4 sessions to the same audience over several days, the way forward is to break training into modules which can be offered to different groups (e.g. some to the same groups, some to only one).

A modular approach would enable us to deliver the training in different contexts – e.g. in a mixed group in Bristol/London; by attending existing service/team meetings or training slots and delivering on their sites. One thing to consider is that we may positively want to train mixed groups of professionals together, and how this can be achieved.

Our other proposal is to use a range of media – some in-person training, and some online (training and tools/resources). Need to think how online would be hosted/delivered, and whether ‘live’ (e.g. trainer in real time via webinar or skype; or online interactive guides; or just putting information or tools online).

Flexible forms of delivery are both practical in terms of recruiting participants (many interviewees did not think they would be able/willing to attend training of more than a few hours – though it will vary by profession/level of relevance to their day to day jobs), and a more targeted use of our training offer (beneficiaries have differing starting levels of knowledge and interest).

‘Train the Trainer’ model possible – then beneficiaries can cascade to colleagues?

**Beneficiaries**

Multiple key FLPs were identified (see tables). There are perhaps two core groups:

1. SV/DV/GBV services (e.g. refuges, IDVA, ISVA) which come into contact with RAS women but are not knowledgeable/confident in understanding their experiences/needs (e.g. IDVA and ISVA services, rape support services). Interviews showed that, with the closure of many specialist RAS services, many of the women are ending up in these more ‘generic’ services (e.g. 2TIER005 – generic orgs are having to pick up a lot of work with RAS women as refugee sector being closed.
2. RAS services who are not specialist in SV/GBV

Then, other key front-line professionals were identified:

* Housing officials (e.g. NASS. Migrant Helpline processes initial claims for NASS support. Note that the major housing contracts for asylum are just being recommissioned)
* Health (GPs – but which? Perhaps practices in areas with high BME/RAS populations?). Specific challenge to asking/disclosure is time-limited appointments; GPs would welcome training on spotting signs of SV/trauma. Some have had (useful) training on spotting signs/how to ask/how to refer on DV and some on FGM – but not on other forms. Understanding whether specific forms of abuse are linked to particular countries of origin/experiences.
* Mental health services (e.g. therapists and counsellors – start with those working in trauma/with RAS women?)
* Immigration solicitors/lawyers (the wider field of all lawyers is too large, and we now have contact with immigration lawyers and they are interested in the field/training)

Potentially, also:

* Social workers;
* Peer advocates (e.g. young refugees or A-S supporting others – though this may be non-core group for this project);
* Churches (FLP010) and perhaps mosques – 75/80% of their African clients are Christians and active at church. Churches also provide food banks and emergency housing for destitute women.

Interviews confirmed that police are less relevant – they are less in contact with RAS women.

***Note.*** A group who were identified as core beneficiaries was immigration officials. They will be harder to access/recruit to training, unless a specific approach is made via Government contacts. We established a possible link in here, via a previous training project run by the Refugee Council for immigration officers (in partnership with the Home Office) in SV/RAS women. May be an opportunity to resurrect/develop this. HOWEVER – unlikely to get anywhere until after election on June 8.

**Other questions/issues arising**

* Any scope to work with vulnerable female migrants who aren’t RAS? E.g. FLP010 works with a lot of spouses suffering GBV/SV who have leave to remain but temporary/linked to their spouse’s visa. FLP012 – 80% of clients in project supporting South American women are Portuguese or Spanish residents but on dependent EU visas. These are in low paid jobs, suffering DV/SV and trapped in relationships as visa-dependent.
* What about over-stayers? What about abandoned wives (many have suffered DV)? (FLP010)

**SWOT Analysis**

# It aims to briefly describe the context emerged from the interviews, focusing on the aspects of strengths, weaknesses, opportunities and threats

*Note: We have completed the SWOT in relation to our (UK/CGVR) ability to deliver the training to meet the objectives of the project*

|  |  |  |
| --- | --- | --- |
| **Present** | **Strengths** (our assets to help deliver project successfully) | **Weaknesses** (our challenges to delivering project successfully) |
| CGVR has existing contacts with relevant communities and existing projects (e.g. on sexual violence, FGM) mean we have already identified an audience for training  CGVR (in particular, GG and LB) have existing subject expertise in GBV and SV  CGVR has existing experience/skills in developing and delivering training/workshops  NA interviews have identified a clear need and appetite for training amongst a range of beneficiaries | CGVR does not have expert practice or therapeutic knowledge about how to manage conversations with RAS women – or how to respond to traumatised women or deal with disclosures  Our networks and contacts are mostly in Bristol and London (pre-existing networks, areas of settlement for RAS communities and also those gained through the NA interview process) – project/training likely to focus on these areas. |
| **Future** | **Opportunities** (external opportunities to help deliver project) | **Threats** (external threats to deliver project) |
| Through CGVR networks + NA interviews we have identified other sources of existing expertise (people and skills) and resources which we can draw on in developing training (e.g. around legal routes and rights)  We have identified external practice experts on managing conversations with women, who are able to advise on content and/or deliver practical training on techniques for dealing with tramuatised women – potential to ‘buy in’ some of this expertise to deliver training.  DV/SV services who have RAS women coming through doors – willingness to be trained  Opportunity to engage Home Office/immigration officials (currently on hold, due to pending elections) in training/ improving asylum screening interview process.    Appetite for this training (esp reflecting a lack of confidence and skill in asking/referring amongst FLPs) | The asylum system is skewed to disbelief/questioning women’s credibility. This may make it difficult to engage the more official professionals (e.g. immigration officials, housing) in training.  “Decimation” of RAS voluntary sector has meant expertise lost – women going to SV/DV services instead, who don’t have RAS expertise (but this is an opportunity too, as a need for this training)  Lack of capacity in support services (esp. therapeutic) may make it hard to pick up any increase in referrals as a result of training  Dispersal of asylum-seekers and refugees around the country may make it hard to select and target the key beneficiary groups/geographic areas  Result of General Election on 8 June may lead to changes in immigration/asylum policies |

1. The same paths are true of RAS men, but this project focuses specifically on women. [↑](#footnote-ref-1)
2. It is unclear what the impact of the next general election announced recently (for 8 June 2017), will do to these targets/timeframes. [↑](#footnote-ref-2)
3. *Syrian Vulnerable Persons Resettlement Programme audit,* National Audit Office (2016): <file://ads/filestore/SPOL/Staff/_Research/Research%20Project%20Current/RQ8925%20-%20DAPHNE/Background%20reading/The-Syrian-Vulnerable-Persons-Resettlement-programme.pdf> [↑](#footnote-ref-3)
4. <https://www.gov.uk/government/news/new-scheme-launched-to-resettle-children-at-risk> [↑](#footnote-ref-4)
5. <https://fullfact.org/immigration/ask-full-fact-dubs-and-dublin/> [↑](#footnote-ref-5)
6. <http://www.local.gov.uk/refugees> [↑](#footnote-ref-6)