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Health Workers in Sexual and Gender Based Violence (SGBV) Care for Refugees: Insights from Frontline Health and Humanitarian Professionals in Rhino Camp Refugee Settlement, Uganda

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Introduction

In the wake of the COVID-19 pandemic, a marked global increase in cases of Sexual and Gender Based Violence (SGBV) has been noted (Johnson et al. 2020). In the refugee settlements of Uganda, this is dramatically illustrated by an escalating crisis of teenage pregnancies (UN Women 2020; Diallo et al. 2023). During lockdowns, conflicts among families and couples increased and vulnerable community members, particularly children and young people, were exposed to heightened risks of abuse (Datzberger et al. 2023). For the humanitarian community, the escalation of the past years highlights the urgent need to sustainably improve SGBV prevention, care and case management in refugee settings.

Efficiently combatting SGBV is generally described as depending on the contributions and commitment of a diverse set of state and non-state actors (WHO 2020; El-Moslemany et al. 2022) and recent guidelines promote a 'whole-of-state' approach (OECD 2021) as the most promising way forward. This article focuses on the roles and challenges of health workers as one key actor in SGBV prevention, care, and case management in Rhino Camp Refugee Settlement of West Nile Subregion in northern Uganda. Not only are these health workers often the first contacts approached by survivors, but they are also tasked with providing medical and psycho-social support, as well as referral to actors in the security and legal systems (WHO 2020). Their experiences and those of their colleagues from the humanitarian community – related in 22 semi-structured interviews – illustrate how SGBV is approached today and what frontline professionals see as priorities for improvement.

The article first provides context about SGBV in refugee settings, the roles generally allocated to health workers, as well as the methodology and case study site. This is

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followed by insights into the situation and experiences of frontline health workers and humanitarian actors in Rhino Camp Settlement. Finally, recommendations from interviewees and similar studies form the basis of suggestions for how the fight against SGBV in the settlement and beyond could be strengthened.

SGBV and Refugee Populations

Sexual and Gender Based Violence (SGBV) combines the terms of Gender Based Violence (GBV) and Sexual Violence (SV) to account for the diverse and interrelated nature of these forms of violence (UNHCR 2023). Crucially, SGBV not only covers physical assault but also emotional, psychosocial, cultural, and socio-economic violence (Simon-Butler and McSherry 2019). The term is commonly used when referring to humanitarian crises and refugee settings because particularly high rates of SGBV have been observed in displaced populations (Simon-Butler and McSherry 2019) and 'SGBV tend[s] to increase during complex humanitarian emergencies' (Pérez-Vázquez and Bonilla-Campos 2022: 2). It is important to note that although many studies, including the present research, focus on women and girls, SGBV is by no means only experienced by refugees of that gender and further research into the experiences of heterosexual men and boys, as well as members of the LGBTQI+ community is needed (Araujo et al. 2019; Dolan 2014).

A significant contributor to the high occurrence of SGBV among refugee populations is the disruption experienced in situations of displacement which leads to a destabilization of social as well as professional life and relationships (Wachter et al. 2018). While there is a drastically heightened risk of SGBV across the different stages of a refugee journey, from fleeing the homeland through applying for asylum to resettlement (James 2010; Pérez-Vázquez and Bonilla-Campos 2022), the situation in refugee camps and settlements is characterized by aggravating factors such as lack of health, social and legal service provision and inability of refugees to move freely and seek help elsewhere (Al-Natour et al. 2019; Ron et al. 2022). Furthermore, the co-dependence of couples and families in a foreign situation often means that those experiencing SGBV by partners are unwilling or unable to leave those partners or to report cases (Wachter et al. 2018; Scott et al. 2013). Finally, cultural norms and beliefs normalizing SGBV have been noted in some refugee communities, particularly ones which have experienced situations of intense violence or war (Damra and Abujilban 2022; James 2010). This already alarming situation among refugee populations has been aggravated by the COVID-19 pandemic and its resulting restrictions, which further hampered free movement and access to support services (Gillespie et al. 2022).

Health Workers as First Responders to SGBV

That health workers play a key role in refugees' SGBV management is generally acknowledged (Pérez-Vázquez and Bonilla-Campos 2022; James 2010). As has been noted for locations with large-scale refugee populations (Rodella Sapia et al. 2020;

Chowdhury et al. 2022), health workers are generally the first points of contact for survivors of SGBV outside of family and friends. In refugee settlements, health workers contribute to prevention and awareness raising, act as first responders and accompany survivors through psychosocial counselling, referrals to other relevant actors and in legal proceedings (WHO 2020). While the involvement of health workers is therefore undoubtedly crucial, studies have shown that there is often a knowledge and practice gap that makes care and service provision fall short (Umubyeyi et al. 2016). Many refugee survivors of SGBV are hesitant to approach health services as they find it difficult to trust authorities – particularly ones from foreign communities – following traumatizing experiences of violence and war (Damra and Abujilban 2022). It is therefore essential for health workers to approach survivors in a nonjudgmental, culturally sensitive manner that takes account of the complexity and diversity of experiences and situations (Pérez-Vázquez and Bonilla-Campos 2022). This task is complicated in low resource humanitarian settings by a lack in infrastructure and psychosocial support, as well as difficult accessibility to health centres (Scott et al. 2013).

Origin of Data and Methodology

This article uses research data gathered for a doctoral project exploring the peacebuilding potential and contributions of frontline health workers in Rhino Camp Refugee Settlement. The research project is carried out under the University of Leicester's Doctor of Social Science (DSocSci) programme, in partnership with Muni University, Uganda, and the local Nongovernmental Organization (NGO) PALM Corps. Its focus is on the experiences of grassroots health and humanitarian professionals rather than upper management in urban centres and organizational headquarters. This is to allow voices from the frontlines to contribute their lived experiences, propose actions for improving health workers' contributions to peacebuilding and – in the case of the present paper – for strengthening SGBV care and case management. The general methodological approach is that of Ethnographic Peace Research (EPR), with its focus on social interactions and grounding in local realities (Millar 2018: 11). The research data was gathered on a total of 18 days of field visits to one health centre in Rhino Camp Settlement over a six-month period and in 22 expert interviews with frontline health and humanitarian professionals.

West Nile Subregion's Refugee Settlements, Rhino Camp, and the crisis of SGBV

Overall, Uganda, an East African country with a population of roughly 45 million, is today (2024) host to around 1.6 million displaced people (UNHCR 2024a). Situated in the northwestern corner of the country, West Nile's geographic location explains its importance as one of the great refugee-receiving regions of the world. Its districts border on the Democratic Republic of the Congo (DRC) in the West and on South Sudan in the North. Both these countries have been suffering from ongoing conflicts in large parts of their territories in recent years (Wamala 2016; Fiske and Shackel 2015). The

Sudan/South Sudan conflicts have resulted in the displacement of several million people since 2013. Today, roughly 2.3 million South Sudanese refugees reside in neighbouring countries, about 950,000 of them in Uganda (OCHA 2024; UNHCR 2024b). Of these, around 650,000 live in the six settlements and the wider sub-region of West Nile (Destrijcker et al. 2023; UNHCR 2024b). The DRC has also seen the large-scale displacement of populations from conflict areas, but refugee numbers in the subregions' settlements are much smaller, only making up a few percent in most settlements. Rhino Camp Settlement, the site of the present research, currently has a total refugee population of around 161,000 (UNHCR 2024b).

Reflecting the sheer number of refugees and the long-term nature of their displacement, West Nile's refugee settlements have little in common with what is usually understood under the more widely known term 'refugee camp'. While camps are generally temporary structures that provide shelter for large numbers of people in small areas, settlements are more permanent establishments, much more extended geographically, and are closer in nature to other villages of the region (Inhetveen 2010; Krause 2014). However, this is not to say that life in the settlements is easy. West Nile sub-region has higher rates of Multidimensional poverty than the country does on average (84 percent versus 70 percent nationally) and its population – both refugee and national – is still for the vast majority engaged in subsistence agriculture (Destrijcker et al. 2023; UNICEF 2020).

Beyond these general hardships, SGBV has long been regarded as one of the major issues affecting Uganda's refugee settlements (Okello and Hovil 2007; Araujo et al. 2019). It has been noted that the special care and protection needed for those who have travelled to West Nile in situations of heightened vulnerability, such as unaccompanied children or single-parenting mothers, is lacking, leading to these groups experiencing particularly high incidence of SGBV (Odwe et al. 2018; Cohen et al. 2021). With the educational system being overburdened, many children in the settlements also lack school education and instead work from a young age. This leads to unsafe behaviour, including with regards to sexual experiences and health (Mugumya et al. 2020).

Professionals interviewed for the research named cultural norms as one of the main factors leading to cases of SGBV. Either abuse is not seen as such when it takes place within the family, or young girls are being pushed towards entering relationships at an early age to avoid shame for the family:

> So, culturally there are things that is taken as, […], as something that is normal. Like, I would say, violence is normalized. Yeah? 'Cos culturally, there is no rape, there is no marital rape. [Women's Rights Organization Coordinator, Arua]

One local researcher explained that some representatives of refugee groups defend what would in Uganda be considered underage marriages as unproblematic or even encouraged within their own cultural norms:

> [T]hey comfortably said in their country, when a girl reaches 15, she's practically available to be married off. Which is as opposed to Uganda, where the minimum age was 18. [Human Rights researcher, m]

In recent years, the COVID-19 pandemic and resulting limitations to movements and organized activities in schools and at work have further aggravated the situation in Rhino Camp. One specialist for gender work explained the increase in SGBV cases in part with a shift in gender roles:

> COVID exposed a lot of these gendered impacts. [...] Whereas the men used to look at themselves as the bread winners and heads of households - you know that comes with a lot of power, right? So, in Uganda there was total lockdown, no going anywhere. Only food vendors or market vendors were allowed to, to go out and sell. And you find out that majority of market vendors are women. So, these women became sole bread winners. [...] And to secure, or keep their positions, men used violence. [NGO Field Coordinator, f]

With regards to younger members of the refugee communities in the settlements, research carried out during the pandemic by the Nordic Africa Institute has shown that lockdowns left 'girls in close proximity to perpetrators within homes and neighbourhoods, and [...] unable to access help' (OCHA 2021). The lack of education on Sexual and Reproductive Health and Rights (SRHR) during the pandemic, and parents giving their daughters in marriage at an earlier age because of financial hardship, are additional key factors in a marked increase in teenage pregnancies (UNFPA 2021). These findings were confirmed in interviews with protection officers working in Rhino Camp Settlement:

> The lockdown kept girls and boys idle in the community since they don't have a lot of garden work and other activities, they were looking for what to do. So, at the end they started engaging into sexual activities which threw them into problems, like the teenage pregnancy. [Child Protection Officer, m]

The widespread poverty in the settlement, aspects of local culture that normalize different forms of violence, and the additional strive experienced in the COVID-19 pandemic therefore all contribute to a complex and volatile situation for health workers engaging with SGBV survivors.

Health Workers' Roles in SGBV Care: Experiences of Health and Humanitarian Professionals in Rhino Camp

Health worker's activities and responsibilities with regards to SGBV in Rhino Camp Refugee Settlement can broadly be separated into three distinct categories which are looked at in more detail in the following. They are, first, outreach and campaigning; second, medical and psychosocial care; and, third, referral and support in legal action.

1. *Outreach and Campaigning*

Health workers themselves saw their most important role in engaging with the community and informing about the negative impacts of SGBV. In the case study health centre, health workers thus lead on 'outreach' to discuss issues of SGBV with communities, both through campaigns at the centre itself (Figure 1) and visits to villages within the catchment area. One nurse described the need to remind all those in a family to do their part as a key message to prevent family violence and SGBV:

> [N]ormally when people don't understand their roles in a home, that is where the issues of conflicts comes in. So, the information you give them is to ensure that each person understands their role. The children, do they know their roles in the home? The mother, the woman does she know her role in the home? As a father, do you know your role? What roles are you supposed to play in the home? So, that one, when you make them understand it very well, it will be OK. [Nurse, f]

The health workers' role here is one of an authority figure and role model that promotes a supportive family life. Health workers see themselves as having to work with the whole family to maintain an equilibrium in which all family members play their respective roles well. Rather than in a human rights-based model in which individual rights and formal justice processes are prioritized (McGranahan et al. 2021), this promotes collective values and the upholding of family units as the priority. This is consistent with advice given to survivors which encourages reconciliation rather than confrontation, as outlined in the following sections.

Figure 1. Banner for a campaign against SGBV in the health centre (July 2022). Images © Roman Gnaegi.

2. *Medical and Psychosocial Care*

In Rhino Camp Refugee Settlement, the so-called 'referral pathway' (Figure 2) outlines different actors' roles in managing SGBV cases and places health workers explicitly as first responders, tasked with both providing medical and psychosocial care. When survivors of SGBV attend the health centre, health workers saw their main responsibility in providing immediate medical care, then reporting to police:

> They're reported here at the health workers. We manage them, then we report back to police. Because now, gender-based cases, they first report to the [health] facility. Because that is emergency first, then other things can follow after. [Lab Technician, m]

While there is confidence that health workers can provide competent medical care, their ability to provide the complex psychosocial care needed for survivors is often put in question. One officer from an NGO in the mental health field voiced his doubts openly:

> [W]e have trained the health workers. But you find if it is a nurse or midwife and so the person may not be having much experience on mental health. But it

> is the psychiatric nurses and the psychiatric clinical officers who have specialized in mental health. [...] The nurses may be having some basic information on mental health, but it will not help much, yeah. [NGO Field Officer, f]

This perceived shortcoming is crucial since not receiving qualified psychosocial support can lead to severe adverse outcomes for survivors in the short- medium- and long term (Rodella Sapia et al. 2020). In fact, the appropriateness of health workers' behaviour in their encounters with survivors was called into question by some interviewees. One NGO officer specialized in women's rights showed outrage regarding what some survivors had reported to her on their treatment by health workers:

> A first respondent has to be the most sensitive person you can run to and you feel like 'this is my safe haven I can run to'. But when you get to them and they're shouting? They're shouting at the patients, they're shouting at the survivors. 'I am already traumatised, I have been raped and you're asking me these questions of 'did you enjoy?' or you're asking me questions of 'what time did it happen?'. Like, 'why would it even happen to you?', 'I didn't choose this!'. So, there's no selection of words among these people. [NGO Field Coordinator, f]

Health workers themselves also freely identified shortcomings in SGBV care and counselling. In many cases, particularly during the COVID-19 pandemic, they felt that they had insufficient time to spend on a survivors' needs. The lack of specialised psychosocial support workers on-site – and the difficulty of accessing them in a timely manner – was one issue brought up regularly in discussions:

> Yeah, we have some special people who do that [psychosocial care], most especially the psycho-social team. But literally what we do, they always come when it is now late hours. 'Cos at most times the patients meet the nurses first, the doctors, maybe the clinicians. So, the time we reach calling the psycho-social worker, it might be up to day three or day two. [Nurse, m]

The lack of support and feeling of being left alone also extended to the health worker's own wellbeing. Several health workers reported in interviews that they faced open hostility and violence from community members when working with survivors of SGBV. One nurse contrasted this to the expectations she had from her education, stating that only the field experience could teach her to deal with such difficulties.

> We were trained. But now, some of the issues you get them in the field. What they tell you in class may not be like what you face in what, in the community. Like this one was being highly 'communicative' and somebody can slap you anytime when they get annoyed. They beat you up. [...] Yes. They can even spit on you. Just like that. [Nurse, f]

Figure 2. Billboard outlining the 'referral pathway' outside the health centre. Images © Roman Gnaegi.

Health workers thus find themselves regularly overwhelmed with the dual expectations of having to provide medical and psychosocial care and see themselves as lacking both appropriate training and support through other professionals in the care for SGBV survivors. Similarly, other professionals working in the field doubt their readiness to fulfil the allocated tasks appropriately.

3. *Referral of Cases and Support in Legal Action*

Health workers are also charged with linking up SGBV survivors to other actors on the referral pathway, both for their 'Safety and Security' and legal support. In theory, this clarity in role allocation for health workers is very laudable. However, the importance given to the health centre in the referral pathway raises the question of accessibility for survivors. Protection professionals on the ground saw both the remoteness of many communities and the short timeframe within which evidence would have to be gathered as important impediments in this regard:

> You find a woman is raped from a different place - because [there is] no transport to go to police, to go to health facility. [...] you see, the evidence is lost within seventy-two hours. Somebody will not be able to report and lose-instantly give up. And maybe clean herself and we lose the case. But if we had these health facilities close to these people and transports available, we'd be

> able to see that women will be [...] helped very well. [Child Protection Officer, f]

For the case that survivors do reach health centres, the World Health Organization (WHO), together with the Ministry of Health of Uganda, has made a concerted effort in recent years to train health workers on how to approach SGBV reporting, albeit in a limited number of locations (WHO 2020). For instance, a selection of health workers was trained in how to fill in the crucial 'Police Form 3' which is needed to prosecute for SGBV. However, major issues remain, as WHO (WHO 2020:12) itself freely states. The extensive list of problems includes, among others, that 'patients are being charged to support the costs of health care providers who have to pay for their own transport to attend court hearings', 'court hearings can take 11 months to eight years requiring a health worker to be available to attend all times', and, maybe most troublingly, 'health care providers live in the same communities within which the violence has happened; thus giving evidence in court can put them in danger from perpetrators, making them afraid for their personal safety'.

It is important to note that these shortcomings have been identified at a national level, while health care provision in the refugee settlements is generally seen as particularly precarious (Mwenyango and Palattiyil, 2019; Kwiringira et al., 2018). Unsurprisingly, interviewees pointed to severe issues with the referral pathway and a lack of efficiency in accompanying survivors of SGBV. A Protection Officer from a local NGO described the problem of health workers not sitting in the same coordination meetings with others working on the problem of SGBV:

> Actually, we have these different sectors. We have sector working group meetings. But they don't, like, work together. When there is a safety working group [...] we just go and discuss some protection issues. Education is separate. Health is separate. [Child Protection Officer, m]

In the end, because of this lack of coordination, many victims of SGBV never see any significant action taken after an attack, when somewhere in the referral pathway the cases fail to proceed. What results is a lack of trust by survivors of SGBV in the system and the functioning of the referral pathway. When asked about the efficiency of the pathway, one Gender Protection Officer working in Rhino Camp Settlement showed considerable frustration about this:

> To me ... yes, at certain point it works well, at a certain point there are hinderances. Especially when it comes, like, to confidentiality, when it comes to the timely feedback, response. That is where majorly the issue is. Untimely feedback or no feedback at all [...]. I will give an example. As me, as [a gender protection officer], I can identify a case, which I can't manage. You transfer it, you refer it to the focal partner, to proceed with it. But you'll find the survivor is coming back to you, asking you 'what happened? You referred me there,

> nothing was done'. [...] You find the survivor comes back biased and keeps quiet. [Gender Protection Officer, f]

Finally, some health workers – just like many other members of the public – regard SGBV between partners as essentially a family issue to be resolved outside of the court system. One experienced nurse described her role as being one of de-escalating the situation whenever possible:

> Even if sometimes they come with the aim of issues to go to the police, but as they are here with you, you keep talking to them. Like, if it is a woman, you ask 'how many children do you have?'. She might tell you, 'I have eight'. And then, 'In school?', 'Some are, some are not'. [...] So, you bring to her idea, 'do you think this idea of taking this man to police is something that is going to work for you?'. You pose the question then, for her to think. You don't decide. So, the next day you also come. Meanwhile you encourage this man to be coming also, to check on this woman. [...] Of course, now, during that process when he is coming, you also encourage them to begin communicating. So, as the woman gets treatment, they can also be reconciling. By the time they are discharging, they have forgotten about the issues of police. So, they go home amicably. [Nurse, f]

While such a stance must be regarded as problematic from a human rights-based perspective, it must be understood both within the cultural norms of the West Nile Subregion and the limitations of the referral system and legal pathway. Health workers see solutions within and between families as a preferable outcome to legal battles which can put family members and themselves at risk of retaliation in a context of limited state authority and protection for survivors (see also Liebling et al. 2020; WHO 2020).

Health workers in Rhino Camp Refugee Settlement therefore act within the constraints imposed by difficulties of accessibility and appropriateness of health services, local cultural norms, and survivors' as well as their own vulnerability. This casts doubt on whether they can confidently and competently support survivors of SGBV.

Health and Humanitarian Professionals' Suggestions for Improvement

Interviewees contributed different opinions on how SGBV care and case management could be improved. The need to provide more education and training in mental health and social care was highlighted. This would enable health workers to be better and more understanding first responders in cases of SGBV and ideally reduce the reliance on care interventions from international NGOs which continue to provide many services in the settlement to this day:

> Our lives nowadays rotates around NGOs but what if they leave? So, can this also go back to the institutions of learning. They start from the institutions of learning. I feel it would be better that way. Because while they are practicing, they're already practicing not just the art of humanity, but they're having their sensitivity of 'it's not OK to happen. It's just not OK.' [NGO Field Coordinator, f]

Another core theme among suggestions was that the current system around the referral pathway is too confusing and that the roles of state ministries, NGOs and other 'partners' are not understood clearly enough. Health workers feel like they are largely excluded from processes, despite being tasked as first responders in the pathway. This is likely due to many actors not understanding that health work is intricately linked with SGBV care:

> Now our challenges have been especially, like, those partners [...], you know for them, they assume, like, their programmes are not health related. [...] So, if those other partners could come together and we do these things together, that would be one of our biggest achievements in order to bring peace in our communities. [Clinical Officer, m]

Lastly, an urgent need voiced by health workers was to generate greater understanding in the community for health workers' involvement in SGBV care and conflict resolution. Health workers feel left alone with this task and as illustrated in the previous section, even face violent pushback at times:

> The community needs to be sensitized more. Where if they are sensitized on the prevailing situations- you know some people think their problem is beyond control, is unmanageable [...] but once you talk to them and bring them into common understanding and continuously guiding them, then the health workers have the role fulfilled. Not only the health workers, the religious leaders, the government officials, the police, the law itself, they all have to play parts.
> ***So, sort of all of society needs to understand the value of this work.***
> Exactly. [Nurse, m]

Beyond the institutional support that is needed, health workers therefore also depend on a fundamental understanding of the community – from refugee and host community members to the police that is charged with offering them protection – of their roles and responsibilities in the management of the SGBV crisis.

Discussion

The reflections by health workers and their humanitarian colleagues are largely consistent with other research on SGBV care in refugee settings. For example, Kwiringira et al. (2018) confirm that traditional justice and alternative dispute

resolution mechanisms are often seen as preferred options to the legal system in Ugandan refugee settlements as they promise faster processing, financial compensation, and the affirmation of traditional power structures in refugee communities. They also identify a lack of trust in the health system and insufficient specialized training for health workers as major issues to be remedied. The problem of services not being sufficiently geared towards the needs of refugee survivors of SGBV, as highlighted by the respondents, is discussed in similar terms by Pérez-Vázquez and Bonilla-Campos who identify 'a clear gap between what these women require and the support they are receiving from their family/community and the services initially designed to support them' (Pérez-Vázquez and Bonilla-Campos 2022: 10). Finally, the lack of coordination and unified 'push' in SGBV care is reflected in research and policy recommendations such as those by Sithole et al. (2018) who assessed a similar SGBV response structure to Rhino Camp's 'referral pathway' and call for a stronger adaptation of programmes to local realities. Setting up a referral pathway and allocating a crucial role for health workers in it is thus insufficient when the contextual limitations are not considered.

Therefore, health workers need both additional training and protection mechanisms to confidently carry out their role in SGBV management. More fundamentally, however, the experiences and recommendations raise issues of coordination and participation that are common to humanitarian and refugee contexts. The SGBV response in Rhino Camp Settlement is shown to be fragmented due to the great number of partner organizations involved and insufficiently adapted to local realities. This can only be remedied through improved participation via the inclusion of health workers in fora and decision-making bodies where SGBV is discussed. Although it is impossible to conclusively lay out or anticipate all obstacles faced by health workers in carrying out their SGBV-related work, a continuous engagement with them on a strategic level will allow to learn and adapt to changing circumstances. Better inclusion of health workers in a SGBV-response that has an expanded leadership of national and local actors (Raftery et al. 2022) would be beneficial for the coordination of the referral system. It would lead to a more unified response to SGBV and allow for local adaptation, both crucial elements for increasing the sustainability of interventions.

Conclusion

Health workers in Rhino Camp Refugee Settlement and comparable situations necessarily fulfil an important role in combatting SGBV. Although the role of health workers in this field has been acknowledged in some specialist literature, and although the referral pathway in the settlement allocates them specific tasks, the general understanding of what their contributions are or should be is not as advanced. On one hand, health workers are key partners for the state and humanitarian actors to educate on SGBV and to create positive dialogue within communities. On the other, their lack of integration in planning processes and the inefficiency of the referral pathway keep them from reaching their full potential in supporting survivors of SGBV. The

insufficient support for health workers was starkly highlighted during the COVID-19 pandemic when SGBV cases in the refugee settlements rose sharply and the need for qualified care and support became particularly important.

Offering stronger support for health workers in dealing with SGBV in Rhino Camp Refugee Settlement and other humanitarian settings is a necessity to achieve better results in this difficult field. This should take the form of improved training and security for health workers and, crucially, better integration in the referral pathways and all-sectors responses to SGBV. If in this way a supportive environment is created, health workers have the potential to contribute significantly towards helping refugee survivors of SGBV on their path of recovery and finding justice.

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