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Prevention and response to CEFM through ASRH and GBV programming in MENA

Background and Purpose

In efforts to prevent child, early and forced marriage (CEFM) and to scale up a region-wide response, CARE MENA has sought to strengthen their programming by understanding and integrating approaches to address the connection between CEFM, adolescent sexual and reproductive health (ASRH), and Gender Based Violence (GBV). In addition to portraying barriers to such integration, the goal of this research is to understand solutions for effective CEFM prevention and response strategies through ASRH and/or GBV programming in the MENA region.

There were two objectives in conducting this research:

1. To map existing ASRH and GBV programming with adolescents in the MENA region
2. To gather evidence from published and grey literature, including program evaluations and reports, to better understand the linkage between integrated ASRH/GBV programming and its impact on prevention and response to CEFM

The information was collected from external informants and CARE personnel in Syria, Lebanon, Jordan, Iraq, Turkey, and Yemen. A desk review of documents and studies was also completed.

PROGRAMMATIC APPROACHES IN MENA

There were very few ASRH and GBV programs discovered with explicit goals to prevent child marriages and few designed specifically for underage brides and mothers. For these few initiatives in the region that are centered around prevention of CEFM (such as CARE Jordan's COMBI) or meeting the needs and fulfilling the rights of married adolescent girls (such as the Young Mothers Clubs of CARE Syria), we looked for how GBV, protection, and SRHR are integrated into the programs.

GBV and protection services

CEFM is a type of GBV, but also one that makes adolescent girls more vulnerable to other kinds of GBV. In GBV and protection services, there is global guidance¹ on case management of CEFM for girls at risk of imminent marriage and those already married, although country-specific guidelines vary in how thoroughly they address cases of CEFM, with few having specific directives to case managers. Adolescent girls rarely report impending marriages and are more likely to seek assistance after experiencing violence from their spouses. Often caseworkers focus on mitigation by providing psychosocial support, referrals for SRH care, and information on marriage and birth registration, including a girl's rights in divorce.

ASRH and SRH services accessed by adolescent girls

Sexual and reproductive health services play an important role in preventing and mitigating CEFM where adolescent girls – married or otherwise – are underserved in terms of SRH services. For example, there is no information about unmarried girls seeking contraception, although access to contraception is only limited in policy by age and/or marital status in two of the six countries in this investigation (Jordan and Iraq).² While data is lacking, it's assumable that few married girls use family planning. The most common approach to ASRH is the provision of information and education in safe spaces, though mobility restrictions limit many girls' access.

There are few SRH services and programs that are designed for adolescents in conflict-affected communities in MENA. Because of safety issues, the exception to this finding are SRH education websites used as "virtual safe spaces," giving adolescents information about SRH without being identified.

Life skills for adolescent girls/ Safe Spaces for women and girls

Life skills programs, proven to reduce child marriage rates³, are crucial for adolescent girls in that they can help empower them socially, economically, interpersonally, and psychologically and promote their ability to make their own choices on education, marriage, and pregnancy. Life skills education has been in addition, these programs effectively deliver SRH and GBV to adolescents.⁴

There are several life skills modules being used in group-based platforms within designated safe spaces for women and girls, which allows for the integration of services in case management, health, education, and skills building. Informants were unanimous that safe spaces are essential for reaching and empowering adolescent girls.

In MENA, there are a group of closely related life skills curricula that have borrowed from each other in adaptations to new settings, each of which include content on SRH while most also address GBV and CEFM explicitly. These include:

- Iraq Adolescent Girls' Toolkit (UNFPA and UNICEF)
- Girl Shine (IRC),
- My Safety, My Wellbeing (IRC) and an adaptation for married and engaged girls referred to as the Tailored Life Skills Package for Early Marriage (WRC)
- Adolescent Mothers Against All Odds (including Young Mothers' Clubs) (CARE).





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Engaging men and boys

Men's and boys' engagement in SRH and GBV prevention is a less common programmatic approach in MENA and primarily takes place in an unstructured way, such as through occasional community sessions targeted to males, such as household heads or community leaders. CARE has been a leader in piloting interventions that involve fathers, through the COMBI project and the Positive Fatherhood pilot. Other examples include a curriculum for Syrian refugee men in Lebanon from the Danish Refugee Council and Women's Refugee Commission that aims to engage fathers of adolescent girls to prevent CEFM, but it is fairly new.

CHALLENGES

The evidence on what works in humanitarian settings for adolescent girls is lacking, though there are recent initiatives to fill this gap, such as identifying key research gaps, and leveraging resources, mobilizing funds for research to improve programming, and building organizations' capacity for quality research.⁵

Adolescent girls are especially hard to reach during times of conflict in MENA, when the usual restrictions on their mobility are heightened and they face greater risks of violence. In many locations, married girls have greater freedom of movement than unmarried girls, though this is not true everywhere, and married girls are more likely to have limited time for seeking health and GBV services and participating in programs.

Legal frameworks and uncertainties limit options for addressing CEFM in most of the countries in the review. Refugees face restrictions, including their right to work and use services in some locations; marriage before 18 is legal in all or some circumstances in most of the countries; women's and girls' rights are not equally enshrined everywhere; and temporary or exploitative marriages in some locations are leading to higher rates of divorce and/or greater vulnerabilities among married girls.

Moving Forward

Understand adolescent girls and ensure their meaningful participation: Applying the socio-ecological model can help programs recognize barriers and enabling factors for adolescent wellbeing at multiple levels. Programs need to reflect the complexity in adolescent girls' lives, especially for those with multiple vulnerabilities.

Be specific in guidance for outreach staff, case managers, and legal advisors: Supplement existing inter-agency protocols and/or revise CARE's internal protocols for case management to detail actions to take in preventing and responding to cases of CEFM. Although the global guidance in the [Interagency GBV Case Management Guidelines](#) provides a starting point, ensuring local relevance will likely require broad consultations or workshopping in each setting.

Foster staff transformation across programs and operations: Gender-transformative programs require CARE and peer staff to critically reflect on gender and power and their personal role in pursuing gender justice. For CEFM programming, important topics include girls' rights to bodily autonomy and self-determination, sexuality, marriage, fertility and contraceptive use, family honor, violence against women and girls, and decision-making in the family. The Social Analysis and Action (SAA) toolkit, used in the AMAL project in Syria, could be expanded to health care providers in other countries to examine their assumptions about adolescent girls' needs and rights to decision-making about their sexual and reproductive health.

Ensure health care service providers are equipped to counsel adolescent girls and their family members: A significant effort needs to be made to find well-qualified trainers to work with providers for quality and adolescent-responsive SRH services. Health care providers and facilities should also create spaces that bring adolescent leaders and community members together to define what 'adolescent-responsive' means locally and collaborate on shared action plans. Adolescents should be involved in regular feedback to providers and facilities in order to hold them accountable.

Expand access to safe spaces and life skills programs for adolescent girls, married and unmarried: Life skills interventions are not equally accessible and inviting to all girls, who face variable restrictions on their mobility and differing needs for content. CARE should consider options for scaling up or scaling out successful programs

like the Young Mothers' Clubs in NW Syria and/or groups using curricula from other organizations.

Improve mechanisms for coordination with other agencies: Humanitarian coordination mechanisms are usually organized around sectors rather than subgroups in the population affected by a crisis. As such, issues with cross-cutting drivers and multi-sectoral solutions receive less attention and effort. Effective CEFM prevention and mitigation will require greater collaboration across sectors and organizations beyond GBV clusters and Areas of Responsibility.

Strengthen partnerships with local groups in CEFM prevention and mitigation: Civil society groups for women, girls, and youth that have survived or been born out of an emergency make great partners for outreach and have local expertise on adolescent girls, where they live, how they spend their time, and what issues they face. Likewise, volunteer groups such as community protection committees or community health boards can serve as liaisons.

Invest in evaluations and research: CARE should think strategically about what kind of evidence would best make the case for strengthening programmatic links and build monitoring and evaluation systems that capture data accordingly. This might include patterns in service utilization, referral completion, awareness of CEFM as a form of GBV, unmet need for family planning among married adolescents, and shifts in attitudes or social norms using tools such as CARE's SNAP.

ENDNOTES

- 1 Examples include: Interagency Gender-Based Violence Case Management Guidelines and Interagency Guidance Note: Prevention of and Response to Child Marriage, Kurdistan Region of Iraq
- 2 Reproductive Health Policies 2017 Data Booklet. United Nations Economic and Social Affairs.
- 3 GAGE Rigorous Review: Girls' clubs, life skills programmes and girls' well-being outcomes. Rachel Marcus, Nandini Gupta-Archer, Madeleine Darcy and Ella Page. Overseas Development Institute. September 2017.
- 4 Girl Shine Part 2: Life Skills Curriculum. International Rescue Committee. 2018. Related resources: Part 1: Advancing the Field, Designing Girl-Driven Gender-Based Violence Programming in Humanitarian Settings; Part 3: Girl Shine Caregiver Curriculum; and Part 4: Mentor and Facilitator Training Guide. Available here: <https://resourcecentre.savethechildren.net/library/girl-shine>
- 5 Child marriage in humanitarian settings: Spotlight on the situation in the Arab region. UNFPA, UNICEF, CARE, Terre des Hommes, Women's Refugee Commission, and University of Bedfordshire. 2018. Page 7.