United Nations Population Fund

GBV AoR
Whole of Syria

HEALTH CLUSTER
Turkey Hub

Listen, Engage and Empower

A strategy to address the needs of adolescent girls in the Whole of Syria

Acknowledgements

Thanks goes to Sarah Martin and Kristine Anderson who drafted the strategy. Thanks also go to the adolescent girl steering committee comprised of Hala Al Khair, Widad Babikir, Christine Bethke, Nadine Cornier, Francesca Crabu, Pamela Di Camillo, Margherita Maglietti, Jennifer Miquel, Nada Naja, Alice Rosmini. Thank you to Valentina Volpe for her contributions. Consultations with GBV and RH actors in Gaziantep and Damascus were pivotal to developing the strategy as well as all those who agreed to be interviewed to inform this strategy.

Lastly and most importantly, thanks go to the adolescent girls who were willing to share their stories and guide the development of this strategy.

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Acronyms

AoR	Area of Responsibility
ASRH	Adolescent Sexual and Reproductive Health
CCSAS	Clinical Care for Sexual Assault Survivors
CFS	Child Friendly Spaces
CMR	Clinical Management of Rape
CTP	Cash Transfer Programmes
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-based Violence
HNO	Humanitarian Needs Overview
IM	Information Management
IPV	Intimate Partner Violence
IRC	International Rescue Committee
KAP	Knowledge-Attitude-Practice
NGO	Non-governmental Organisations
RH	Reproductive Health
SADD	Sex and Age Disaggregated Data
SRH	Sexual and Reproductive Health
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WGSS	Women and Girls' Safe Spaces
WCC	Women Community Centres
WHO	World Health Organisation
WoS	Whole of Syria
WRC	Women's Refugee Commission

Introduction

The 2017 Syria Humanitarian Needs Overview (HNO) identified adolescent girls—defined as girls aged 10-19 –as a particularly vulnerable group to sexual violence and to child marriage leading to early pregnancy. Based on these findings and consultations held by the Gender-Based Violence (GBV) Area of Responsibility (AoR) and the Reproductive Health (RH) working groups of the Whole of Syria (WoS), the need for a strategic framework that would address the specific needs of adolescent girls in Syria focusing on RH and GBV was identified.

This strategy intends to strengthen and expand upon existing programming for adolescent girls in Syria, through the cross-border programming managed from Gaziantep, Turkey and from Jordan and those managed from Damascus, Syria. It is based upon the findings of a review of literature on adolescent girls in emergencies and the findings from a series of consultations with humanitarian actors working on existing programming in protection, GBV, and RH, including some programmes with adolescents, in Syria, in the region, and globally. It presents the four primary objectives that form the pillars of this strategy to better respond to the needs of adolescent girls inside Syria, with the justification for the focus and a list of activities.

Audience and Intended Use

This strategy is targeted to the following audiences:

- GBV and RH and youth coordinators and programme managers;
- Humanitarian organisations carrying out protection and health programming inside Syria;
- Members of the Health Cluster/sector, specifically RH partners;
- Members of the GBV AoR (sub-sector, sub-cluster, reference groups);
- Members of the Youth task force; and
- Other humanitarian and non-humanitarian actors that could contribute to adolescent girls health and wellbeing in Syria.

Methodology

Based on the 2017 HNO findings and the development of the 2017 Syria Humanitarian Response Plan (HRP) development, SRH and GBV coordinators and youth specialists agreed to develop a joint strategy addressing the specific needs of adolescent girls with a specific focus on SRH and GBV. UNFPA hired two consultants to support the development of a strategy. An adolescent girl technical steering committee[1] comprised of ten GBV and RH and youth specialists and coordinators from the Syria, Turkey and Jordan hubs of the Whole of Syria supported the consultants to develop the strategy.

This strategy is underpinned by a literature review on the impact of humanitarian emergencies on adolescent girls with a focus on the protection risks and developmental and reproductive health needs faced[2]. Over 45 pieces of programmatic literature focused on adolescent girls from global emergencies were examined, including evaluations and lessons learned as well as the available tools for adolescent girls programming.

1 The adolescent girl steering committee was comprised of the Whole of Syria GBV coordinator and GBV coordinators from Turkey, Jordan and Syria hubs, the UNFPA RH Humanitarian Advisor, UNFPA Jordan cross-border team leader and the UNFPA RH and youth specialists from the Syria hub.

2 Literature review is available upon request.

A total of 23 semi-structured, in-depth qualitative interviews were conducted with 25 humanitarian actors involved in the Syria response. The adolescent girl technical steering committee developed the methodology, the initial target sample and questionnaire for the interview. An initial list of target respondents was developed, consisting of actors involved in RH and GBV programming, primarily cross-border programming inside Syria and with a number of individuals with expertise on programming with adolescent girls in the region. Snowball sampling[3] was used to identify further interviewees.

The themes identified in consultations were presented to the participants at a consultative workshop in Gaziantep, Turkey on June 8-9 that brought together RH and GBV coordinators from the Syria, Turkey, and Jordan operational hubs as well as members of the RH and GBV clusters of the Turkey hub. The findings of the literature review were presented and participants engaged in an exercise intended to encourage imaginative thinking about adolescent girls' needs and vulnerabilities. The draft strategy objectives were presented and several small-group based exercises took place to select and prioritise activities in support of the objectives. For more information, see the workshop report.[4]

Consultations were organised with adolescent girls using focus group discussions (FGD). In total, 374 girls were consulted across 13 governorates in 56 sub-districts in Syria.

Why Focus on Adolescent Girls?

Adolescent girls (aged 10-19) are already at a comparative disadvantage before humanitarian crises and during and after the crises, but they are too often overlooked in humanitarian response. The risks they face—including rape, abuse, early marriage, and abduction—are greater for adolescent girls compared to any other population groups. The biological and physiological differences between women and men do not explain the large-scale differences in reports of violence against girls, in access to aid and in mortality rates. Globally:

- 777,000 adolescent girls under the age of 15 became mothers in 2016[5]
- Globally, over 16 million adolescent girls become mothers annually[6]
- Worldwide, UNICEF estimates that 70,000 females between the ages of 15 and 19 die each year as a consequence of pregnancy or childbirth[7]
- Girls under the age of 15 are five times more likely to die of a pregnancy-related cause than women in their twenties[8]
- Adolescent girls who marry before 18 are more likely to have many daughters and sons and have to bear the burden of them at an early age.[9]
- Growing evidence shows that in times of humanitarian crisis, child marriage rates increase, with a disproportionate impact on girls[10]

An analysis of disasters in 141 countries noted that with regards to disaster-related deaths, the differences between

3 Snowball sampling is a non probability sampling technique that refers to the recruitment of participants through other participants identified in the study.

4 Available upon request.

5 Elisabeth Presler-Marshall and Nicola Jones (2017), Family Planning the adolescent imperative, ODI GAGE Policy briefing https://www.odi.org/sites/odi.org.uk/files/resource-documents/11646.pdf

6 Ibid

7 Progress for Children, UNICEF 2008

8 15. AbouZahr C. Global burden of maternal death. In: British Medical Bulletin. Pregnancy: Reducing Maternal Death and Disability. British Council, Oxford University Press, 2003:1–13. See: www.bmb.oupjournals.org

9 State of the World Population 2013 http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf

10 See Girls Not Brides on child marriage in humanitarian crises https://www.girlsnotbrides.org/wp-content/uploads/2016/05/Child-marriage-and-humanitarian-crises-June-2016.pdf

women and men were linked to women's and girls' economic and social standing[11]. The study also noted the large differences between sexes were largely the result of existing inequalities; compared to their female peers, boys were given preferential treatment during rescue efforts; and women and girls suffered more from shortages of food and economic resources after a disaster[12]. It is well documented that males are much more likely to benefit from programming geared towards youth[13], nutrition[14], and education[15].

In Syria, assessments found that while women and girls were at high risk of GBV, certain groups were perceived to be at higher risk than others. Adolescent girls were perceived to be at higher risk of sexual violence, child marriage, and sexual exploitation through the form of serial temporary marriages[16].

Necessity of Consultation with Adolescent Girls

One of the guiding principles of working with adolescents is to ensure the participation of adolescents themselves, as adolescents have the right to express their views in all matters affecting them[17]. The right to participation is relevant to the exercise of all other rights, within the family, the school, and the larger community context. Participation is an underlying value that needs to guide the way each individual right is ensured and respected; a criterion to assess progress in the implementation process of adolescents' rights; and an additional dimension to the universally-recognised freedom of expression, implying the right of the adolescent to be heard and to have her views or opinions taken into account.

Adolescents have the right to participate in programmes that target them. As demonstrated by many programmes in development settings, adolescents' involvement in the design and implementation of programs as well as in programme monitoring are key to ensuring that programmes are both acceptable and accessible to them and that their needs are being met. In addition, adolescent involvement in programme evaluation can guide the development of future programming. Adolescent participation at all stages of the programme cycle can lead to more relevant programming, strengthen programme outcomes and contribute to meaningful partnerships between adolescents and adults. Adolescent participation remains essential in crisis settings, even though the favourable conditions that encourage adolescents' participation - including time, funding and commitment - might be limited by the emergency circumstances.

Adolescent girls' participation should also be integrated across the humanitarian programming cycle because humanitarian responses risk misunderstanding how girls' social isolation and their time-poor daily routines restrict their ability to attend traditional programming. Too often, adolescent girls are engaged by humanitarian actors only in an ad-hoc fashion, after realising the subpopulation was not accessing services or engaged in activities publicised for children or adults[18]. Participation of adolescents from data collection to design of programmes and monitoring and evaluation of programmes is endorsed in this strategy and promoted throughout, also ensuring the participation of adolescent girls with disabilities.

11 Women's Refugee Commission (WRC) (2014) I'm Here: Adolescent Girls in Emergencies: Approach and Tools for improved response.

12 WRC (2014).

13 Population Council (2010) Girl Centered Program Design: A toolkit to Strengthen and Expand Adolescent Girls Programmes.

14 Coalition for Adolescent Girls (2012) Missing the Emergency: Shifting the Paradigm for Relief to Adolescent Girls.

15 Guttmacher Institute (2017) The Sexual and Reproductive Health Needs of Very Young Adolescents Aged 10–14 in Developing Countries: What Does the Evidence Show?

16 Serial temporary marriages refers to women and girls being married multiple times through a series of Islamic marriage agreements that allow husbands sexual access to their wife.

17 As outlined in the Convention of the Rights of the Child.

18 WRC (2014).

Guiding Principles for Working with Adolescent Girls in Humanitarian Settings

The GBV guiding principles[19] include:

- **Survivor-centred approach:** A survivor-centred approach creates a supportive environment in which the survivor's rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. A survivor-centred approach is based on the following guiding principles:
- **Safety:** The safety and security of the survivor and her/his children is the primary consideration.
- **Confidentiality:** Survivors have the right to choose to whom they will or will not tell their story, and information should only be shared with the informed consent of the survivor.
- **Respect:** All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.
- **Non-discrimination:** Survivors should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation or any other characteristic.
- **Rights-based approach:** A rights-based approach seeks to analyse and address the root causes of discrimination and inequality to ensure that everyone, regardless of their gender, age, ethnicity or religion, has the right to live with freedom and dignity, safe from violence, exploitation and abuse, in accordance with principles of human rights law.
- **Community-based approach:** A community-based approach ensures that affected populations are actively engaged as partners in developing strategies related to their protection and the provision of humanitarian assistance. This approach involves direct consultation with women, girls and other at-risk groups at all stages in the humanitarian response, to identify protection risks and solutions and build on existing community-based protection mechanisms.
- **Humanitarian principles:** The humanitarian principles of humanity, impartiality, independence and neutrality should underpin the implementation of the Minimum Standards and are essential to maintaining access to affected populations and ensuring an effective humanitarian response.
- **'Do no harm' approach:** A 'do no harm' approach involves taking all measures necessary to avoid exposing people to further harm as a result of the actions of humanitarian actors.

19 IASC (2015) Guidelines for GBV in Humanitarian Action.

Findings of the Literature Review and Consultations

Highlights of Literature Review on Vulnerabilities of Adolescent Girls[20]

Adolescence, being the onset of puberty and sexual maturation, is a period of rapid physical, social, emotional, and cognitive changes. In some contexts, very young adolescent girls experiencing puberty are perceived as being old enough to begin sexual relations, marry, and bear children. This is also a time where the gender norms shift and what it means to be a woman begins to exert control over girls' lives. Pre-existing harmful gender norms are often enforced as a means of exerting power and dominance over adolescent girls.[21] How adolescents process these messages will affect their behaviours and ultimately shape their sexual and reproductive health outcomes.

Adolescent girls are already at a disadvantage globally in non-crisis situations. Emergencies compound existing vulnerabilities and create new risks. In Syria, these vulnerabilities are further aggravated by reduced freedom of movement for girls. Adolescent girls affected by humanitarian crises often have to assume leadership roles in the family. They take on disproportionate levels of the household burden, care for younger siblings, and manage households in the absence of parents who may leave home to find work, or who they may have lost. These activities are inherent to emergencies and adolescent girls often shoulder serious responsibilities for the sake of duty or survival.[22]

Adolescent girls may themselves become a means of survival for families - foregoing meals, engaging in unsafe livelihoods, or marrying early to relieve financial responsibilities. These actions further isolate them from friends, school, community, and the networks of aid that might support them. In humanitarian settings, child-bearing risks are compounded for adolescents, due to increased exposure for child marriage, forced sex, increased risk-taking and reduced availability of and access to relevant and appropriate sexual and reproductive health information and services.

Adolescent girls are also often invisible during humanitarian emergencies,[23] rarely consulted in programme design, and their needs are often overlooked.[24] The lack of access to services is often a function of adolescent girls' limited mobility within communities and the usual public distribution of these services. Due to this invisibility, humanitarian aid typically neglects adolescent girls as a population[25] and they are rarely consulted in programmes.[26] Humanitarian actors have an obligation to analyse the specific challenges adolescent girls face in emergencies, to provide them with access to services, support, and safe spaces, and to lessen the factors that make them more vulnerable. Currently, most programming is blind to the needs of adolescent girls.

Adolescent girls also face many violence-related risks, including sexual violence, harmful traditional practices and human trafficking.[27] Reports state that females aged 14 to 21 years are at greatest risk of sexual violence in Syria.[28] Adolescence is a critical time to lay the foundation for positive sexual and reproductive health outcomes.[29] The biological and physiological differences between women and men do not explain the large-scale differences in reports of violence against girls, in access to aid and in mortality rates. Girls tend to receive the maximum benefit when the programmes they participate in are girl-only because they feel free to open up, express themselves, ask any questions and take on leadership roles that they might not otherwise. Girls tend not to feel as safe, comfortable, or in control in public spaces or in mixed company as their male contemporaries — and often culture dictates

20 This section presents highlights from the full literature review, which is available upon request.
21 WRC (2014)
22 Coalition for Adolescent Girls (2012)
23 Coalition for Adolescent Girls (2012).
24 WRC (2014).
25 Coalition for Adolescent Girls (2012)
26 WRC (2014)
27 WRC (2014)
28 VOICES https://www.humanitarianresponse.info/en/operations/whole-of-syria/document/gbv-voices-wos-hno-2017-booklet-format
29 Guttmacher Institute (2017)

that they defer to males.

In the Middle East, adolescent girls face similar challenges to what has been documented globally. The recent and on-going conflict in Syria and its subsequent displacement has disproportionately affected adolescent girls. There is also a significant gap in the humanitarian response for girls, specifically those between 10 to 14 years old. They are unable to access age-appropriate psychosocial, educational or recreational activities offered by Child Friendly Spaces (CFSs) as they are too old, while Youth Friendly Spaces are often crowded with young men or, and they are too young for Women's Community Centres.[30] [31] [32]

Findings of the Consultations

GBV and RH Risks Faced by Adolescent Girls in Syria

Adolescent girls inside Syria face a host of GBV risks that threaten their health (both physical and mental) and wellbeing and hinder their access to the services they need to cope with these threats. The findings of consultations with humanitarian actors inside Syria reflect global documentation on the variable impacts of emergencies on adolescent girls. **Adolescent girls often lack mobility to move safely and freely outside the home. This compounds their social and emotional isolation, prevents access to services, and contributes to mental distress.**

Adolescent girls expressed feeling an enormous amount of **stress and pressure** on their lives, because of the crisis but also specifically because they worried about their parents not having employment and the financial pressures on their families. The continuous displacement that some of them experience also caused a lot of stress because it meant they faced very high rental payments. Moreover, adolescent girls said they experienced stress because they knew their parents were concerned for their safety, while they also expressed fear of men harassing them outside their homes. They expressed tensions with their parents because of traditional view that *'girls should not do certain things'* (e.g. activities outside the house). Their lack of basic needs - such as not enough food, water or adequate shelter or access to services - further increased the pressure they felt. Lastly, they discussed how much time it took to carry out their household chores (i.e. preparing food, cleaning) to support their families, alongside time for schooling.

I feel that I am bursting with good intentions, yet I cannot unleash them because my parents won't allow me. They tell me that their daughter shouldn't be so outgoing. (Tartous sub-district, Tartous governorate)

Another quote from an adolescent girl also demonstrates the stress and pressure they can feel: *I am afraid of having a heart attack, as my friend did, because of sadness. (Damascus city, Damascus governorate)*

Because of the stresses above, adolescent girls said they therefore felt an increased pressure to marry early, which invariably meant having children very young too. They recognised that dropping out of education could help them better support their families. However, they also recognised all the responsibilities that came with marriage such as additional housework and caring for children, as well as movement restrictions imposed by their families (i.e. parents, husband).

Since I left Aleppo and came here, everything has changed. My parents are more concerned for me, and they even made me quit school. (Tartous sub-district, Tartous governorate)

Most of my friends are getting married while they are still at school, and I feel that my parents are encouraging me to do the same. My mother keeps telling me that my ultimate goal in life should be marriage and becoming a housewife. (Tartous sub-district, Tartous governorate)

30 The Kurdistan assessment found that girls between 10-14 years were falling between the gaps of CFS, Youth Friendly Spaces and Women Community Centres.

31 UNFPA and UNICEF (2016) Adolescent Girl Assessment Report: Kurdistan, Iraq.

32 UNFPA and UNICEF (2016) .

Child marriage is not new to Syria. Before the conflict, 13% of Syrian women aged 20 to 25 were married before 18[33] which was linked to cultural practices and social norms, never the less, today many Syrian interviewees attributed an increase in child marriage to the breakdown of the educational system and high rates of poverty that compel families to marry girls as a way to increase their income and reduce the number of family members in need of food and care.. Parents, they explained, may also see marriage as a way to "protect" daughters from violence, including sexual violence. Although parents may recognise that child marriage is not the best outcome, they feel it's the only viable option for coping with their economic status – a predicament that was echoed in the 2017 HNO Voices report.

Some adolescents are particularly vulnerable. For example, divorced and widowed girls face considerable social stigma. Adolescent girls who are married without documentation (known as "zawaaj 'urfi," or "civil marriage") have no proof of marriage and no proof of paternity for their children, which makes them unable to claim rights in the event that their husband dies or leaves them. Additionally, intimate partner violence (IPV) of married adolescent girls is common. *"I've witnessed a lot of domestic violence. If she is young and she does not know how to behave in the community, for example, speaking with male relatives or other males in the community, she will be punished."*[34]

Adolescents lack autonomy and control over their physical health that compounds their emotional distress as they undergo significant developmental changes. Most adolescent girls both lack and crave information about the physical and psychosocial changes that they undergo during adolescence. For example, many do not obtain information about menstruation from their mothers so they need a space to learn and discuss these changes.

Service Environment for Adolescent Girls in Syria

The consultations suggest that adolescent girls often do not exercise full control over decision-making regarding their physical and reproductive health, as husbands, mothers-in-law, and other family members are usually involved in decisions regarding family planning and childbirth. It is generally more acceptable for married adolescent girls to obtain RH services, but they are usually accompanied by someone else who makes decisions regarding their physical and reproductive health. Conversely, unmarried adolescents' girls have difficulty accessing RH services and clinics due to mobility difficulties and disapproving attitudes of service providers (doctors, nurses, clinic staff, cleaners) as well as family members that stigmatise unmarried girls and women seeking reproductive health information and services.

Most respondents agreed that if the girl is under 15, married or single, she would normally need to and have someone accompany her such as her mother or older sister to use RH services and she would rarely come alone. For public services, they also need a national ID card to access these services but most people under 15 do not have this. Service providers struggle to reach to married adolescent girls saying, *"We need to know how to attract those age ranges. We very much need trainings for the staff to attract adolescent girls and understand what are sensitive ways to deal with them."* However, girls under 15 do not usually require parental authorisation to attend informal education programmes if they can get there by themselves. Those are opportunities to reach them that should be considered.

Services available for adolescent girls largely revolve around Women and Girls' Safe Spaces (WGSS). Most WGSS activities rarely target adolescent girls specifically but group adolescent girls in with adult women. The few programmes that do specifically target adolescent girls are small in scope. The curricula used by one Gaziantep-based partner are adapted from the manual "Thinking, Feeling, Behaving: An Emotional Education Curriculum for Adolescents," while another uses an existing IRC curricula for engaging girls through drama and the "My Safety, My Wellbeing" curriculum that has a progressive curriculum for younger and older adolescent girls and for caregivers. According to the partners, the girls have appreciated the programmes (particularly sessions that disseminated information on bodily and emotional changes during adolescence as they did not receive

33 UNICEF, State of the World's Children: Adolescence: An Age of Opportunity, 2011
34 Respondent

this information from their mothers). Working with parents and caregivers has been more difficult. Parents and caregivers—along with other members of communities—have shown some reluctance to change their views on traditional, prescribed roles of adolescent girls' roles. Working with the community to sensitise them to the needs of adolescent girls and the need for such projects has proved difficult. Partners recognised the importance of working with parents and caregivers and the need of developing a context appropriate approach.

Girls are generally able to attend WGSS by themselves, but can only attend regularly if the WGSS are within easy walking distance and in areas where it is acceptable for girls to move about freely. Only girls who can find the time and permission to leave their household responsibilities behind for a few hours per week can attend the sessions. The strengthened links between the health and GBV sectors has also helped strengthen the linkages between RH services in medical centres, hospitals and mobile clinics with GBV services. It has resulted in more service providers making referrals to and between the WGSS and RH clinics. Effective referrals of adolescent girls particularly depend on the distance between the facilities and the availability of a staff member who can discreetly accompany the girl. Humanitarian actors are aware of the high rates of child marriage, but most programmes focus on awareness raising among parents and caregivers regarding the risks. This approach, while valuable, does not deliver tangible solutions for parents who cannot afford to support their daughters.

Partners report that adolescent girls have expressed an interest in the following topics:

- Life skills including sessions on parenting, adjusting to married and widowed life, and improving communication with husband, in-laws and parents;
- Literacy and other activities such as tajwiid (Quranic recitation) and vocational training to help their families economically, if a woman is widowed. Others asked about domestic agriculture (cultivating plants, flowers, etc.).
- Formal Education: Married girls wanted to finish their studies in order to help their children in education. They also expressed a desire to get a license or degree because most of them lose the opportunity to go to school and get the degree. Informal education programmes are not as important to them as formal education.
- Informal Education: Unmarried girls and adolescents prefer strengthening their language skills and taking computer courses.

Reproductive Health

In general, the consultations found that there are no consistently followed procedures for obtaining parental authorisation for health services among health actors in Syria. Medical providers have the most "face-time" with married adolescent girls and see cases of early pregnancy and childbirth as well as domestic abuse and rape. However, they lack a "gender lens" and do not all have the capacity (and, according to some, the time) to deal with GBV, particularly when overstretched medical facilities do not have any psychological support services (PSS) attached. Knowledge of where to refer survivors is also limited.

Widespread clinical management of rape (CMR) services inside Syria are still lacking, although there have been a number of trainings, implementation of checklists, provision of post-rape kits and adaptation of global protocols[35] to local standards. Provision of survivor-centred services remains challenging. Doctors may provide services to rape survivors solely to detect pregnancy, and/or conduct a "virginity examination[36]" by examining (and possibly repairing) the hymen. In this sense, their treatment of survivors often mirrors stigmatising social norms from their society and contributes to stigmatisation of rape survivors. Many doctors still need to be equipped to appro-

35 WHO Clinical Management of Survivors of Rape guidelines and protocol

36 The WoS GBV AoR is developing a guidance note for doctors to inform health professionals on how virginity testing goes against survivor-centered principles.

priately interact with survivors of sexual violence, provide psychological first aid (PFA) and learn how to make referrals. Unsurprisingly, doctors and other medical service providers seem overwhelmed and suffering from their own stress and burnout. In addition, the risk of vicarious trauma and compassion fatigue that can affect untrained services providers, can lead to further inappropriate responses while dealing with GBV survivors.

There are some contradictory findings around family planning from the field consultations. In one view, family planning has become more controversial since the conflict began.There are also perceptions that disseminating messaging on family planning is "imposed" or is invasive of personal privacy and choice. Conservative armed groups also may attempt to police family planning practices or influence usage of family planning, even though Islam permits many kinds of birth control. Yet several respondents stated that there was a greater desire for family planning in some areas (including in areas controlled by extremist actors), as people did not wish to care for more children during a crisis situation. Some medical facilities provide counselling on family planning. There is some demand and some women come with their husbands (who also need counselling) and their mothers-in-law.

However, there has also been a tradition of the promotion of family planning in urban areas like Damascus with Syrian Family Planning Association clinics supported by International Planned Parenthood Federation since the 1970s. The family planning programme is the most successful part of RH services in these areas. Regardless of the attitudes, family planning messaging and programming inside Syria requires sensitivity to the cultural context and a careful approach. It was suggested by experts to emphasise messaging with the communities and patients on the advantages of birth-spacing and not on limiting the number of births, particularly when targeting mothers-in-law and husbands.

There are few opportunities to reach married adolescent girls regarding family planning, because they usually seek care only when they are pregnant. Perinatal care (antenatal and postnatal) is a window of opportunity to inform adolescent girls and family members about family planning benefits and options.

There has been work linking health and GBV, to integrate GBV into health programmes, and to make GBV services and referrals smoother between health facilities. Actors find it is most helpful when a WGSS is within walking distance of a clinic.

There have been some successes in working with mothers and adolescents by teaching the engaged and married adolescent girls about menstruation and puberty and providing sex education. One provider said that mothers seem relieved to pass on this task to professionals and also that mothers learned more about their own bodies as well when they attended the sessions. She added that staff members are always worried about the security of providing this information but that they didn't anticipate any challenges as in some of the very conservative societies. People are shy, but grateful. Everything is disclosed to the parents and the parents are likewise grateful.

Globally, the collection, analysis, and usage of data to identify and respond to the distinct needs of adolescent girls is inadequate. Sex and age-disaggregated data (SADD) is often only collected in the form of M/F and under 18/over 18. This is also true in Syria. Humanitarian actors are not currently looking at more precise disaggregation that would enable comparisons between the differential access to and experience of services among adolescent girls, or among other demographic cohorts. For many, adolescent girls are not treated as their own unique demographic group, but are grouped in with "youth" or with "women and girls." Data collection appears to be focused on providing information for donors and reports, rather than as a tool to improve programming. Very few, if any, actors were actively including adolescents in their data gathering or analysis or programme design.

Capacity and Remote Management

The challenges of remote management in the WoS context have been well-documented[37] and revolve around the difficulty of obtaining and retaining qualified staff, transferring technical knowledge, ensuring quality of services, and mitigating the high level of risk faced by field staff. These challenges apply to protection and RH programming, and deeply affect the ability to transfer advanced technical knowledge for staff, or identify and recruit the less visible populations for interventions.

37 See Kimberly Howe, Elizabeth Stites, and Danya Chudacoff, "Breaking the Hourglass: Partnerships in Remote Management Settings—The Cases of Syria and Iraqi Kurdistan," 2015 Feinstein International Center.

Humanitarian actors in the WoS context are often generally aware of obvious risks faced by adolescent girls (some more acutely aware than others), or tend to generalise that all programmes are around child marriage. There is a lack of in-depth awareness of the contrasting needs of young adolescents versus older ones, even among protection actors who work with adolescent girls. Training on GBV and case management is often basic and it is difficult to follow-up on the application of concepts learned in actual work, although capacity building is on going. There is a need for more in-depth training of GBV case management with specific reference on how to deal with adolescent girls. Likewise, there's a need to implement detailed curricula for group activities tailored on adolescent girls that looks at the individual needs of married and unmarried girls. Also the need to develop approaches on how to work with parents and caregivers was identified. Urgently, there is a great need for the sensitisation of doctors, midwives, other healthcare service providers, and clinic staff to the vulnerabilities of adolescent girls in order to address the problematic attitudes that hinder adolescent girls' access to medical care. RH actors need more specialised training and support supervision including whatever new research and information regarding these groups of girls is available.

Opportunities and Challenges for Implementation

Implementing this strategy will have to take into account the operational constraints inherent in the Whole of Syria approach. There are opportunities that can be built on, while some threats to the strategy must be taken into account.

There have been significant efforts at capacity building, which have resulted in a higher number of NGOs with basic GBV knowledge. The efforts at integrating reproductive health and GBV have also been somewhat successful as there are better referrals between these two sectors. There is also interest from partners in working in GBV, reproductive health, and adolescent care. There are functioning WGSS that are well attended and it is acceptable for married girls to seek RH services. There is demand from adolescent girls for formal and informal education, programming in WGSS and vocational activities. Additionally, there are many resources available to support adolescent programming as well as functioning refugee programmes where the cross-border response can share and receive support on lessons learned from programmes.

However, there are significant challenges that may impact the implementation of this strategy. The humanitarian response is still quite gender-blind and the needs of adolescent girls have fallen through the cracks. Both humanitarians and communities have limited recognition of the specific needs of adolescent girls. There is limited use of SADD and analysis of existing data to measure impact. Strong traditional gender norms still dominate in parts of Syria and are mirrored by the service providers working in these areas. Service providers are also under enormous stress and pressure as they are members of their community, and experience the same stress and possible displacement. Turnover can be high. The operational environment in all three areas of Syria, Jordan and Turkey poses security, political, logistic, and cultural challenges to reaching adolescent girls, particularly isolated ones. Short funding cycle and donor priorities can also pose challenges in implementation.

Timeline

This strategy is for three and a half years initially and activities are focused on immediate (June –December 2017); intermediate (2018); and long term (2019-2020). Due to the changing nature of the crisis, the strategy will be reviewed at the end of 2018.

Aim of Strategy

The aim of this strategy is to empower Syrian adolescent girls through the provision of humanitarian assistance to allow them to achieve equal rights and control over their lives, to make the choices that they want and to lead meaningful and happy lives.

Objectives

In November 2011, the Coalition for Adolescent Girls held a consultation where experts in humanitarian response, child protection, and gender collectively articulated the urgent need for new humanitarian strategies around adolescent girls[38]. The resultant Call to Action outlined six main actions to shift the paradigm around inclusion of adolescent girls in humanitarian response. They included:

- Reinforce what we know and identify what we must learn.
- Prioritise a learning agenda.
- Increase donor engagement to target adolescent girl populations at the funding level.
- Build capacity in the humanitarian sector to target adolescent girls.
- Consider adolescent girls. Engage them. Enable them to lead.

The Whole of Syria Adolescent Girl strategy is designed to link to the broader efforts of the global Call to Action and is aligned to other ongoing initiatives in the Arab States, such as the UNFPA-UNICEF regional accountability framework of action to end child marriage 2017-2019, elaborated within the framework of the UNFPA-UNICEF global joint programme to end child marriage and developed around 5 major areas: 1) adolescent girls' capacity to express and exercise their choices, 2) positive and conducive social norms, 3) quality and cost-effective girls-centered services, 4) national laws, policy frameworks and mechanisms promoting adolescent girls' rights, 5) generation and use of robust data and evidence to inform programme design, track progress and document lessons on girls' programming.

As such, the objectives are as follows:

Objective 1: Generate knowledge, data and evidence on the needs of and varying impacts on adolescent girls to inform programme design, track progress and document lessons on girls programming

Globally, most humanitarian funding, programming, and policy strategies do not target adolescent girls specifically but group them in with women or children, as is also the case in the WoS response. There is a growing body of information on how to reach and target adolescent girls in humanitarian settings, and how to design programmes to best serve them. Linking to the Call to Action that emphasises the need "to reinforce what we know and identify what we must learn," the WoS response will improve evidence around adolescent girls including through ensuring that tools and practices around data collection, data analysis, and programmatic learning are adolescent-friendly. The collection and analysis of Sex and Age Disaggregated Data (SADD) must be improved. It must be analysed to enable an understanding of the impacts (or absence of impact) of programmes on adolescent girls. Much of the data collection takes place in schools or in WGSS, and consequently there is a lack of information on the most "invisible" adolescent girls—those that reside in rural areas, are confined to their homes, girls with disabilities and generally go unnoticed. Additionally, knowing that participation of girls in all cycles of programming improves effectiveness, it is critical to improve the participation of girls in data collection.

Linking to the Call to Action to prioritise a learning agenda, we must also increase our understanding of the variable needs of the different sub-groups of adolescents - according to their age, their marital status, their education, their living condition. Adolescent participation and engagement from this point will help build programmes that are relevant, adapted and acceptable, and which grow their confidence at the same time.

38 Coalition for Adolescent Girls 2012.

Monitoring tools will be adapted to ensure feedback from adolescent girls on the services that are provided. All learning will be disseminated through the coordination bodies and forums in Syria. Additionally, the coordination bodies will work with adolescents to amplify their voices and make sure they are heard.

Most adolescent girls expressed the wish to have employment and education in the future, which would empower them to escape financial pressures. Furthermore, they gave examples of activities they would like to do, such as sports and music, and skills they would like to learn. Several also mentioned the wish for more women to participate in society and express their opinions. Below are some recorded examples of adolescent girls' wishes:

We would like to change all "community traditions" and the way women are stereotyped by the community. (Adolescent Girl from Daret Azza sub-district, Aleppo governorate)

I wish to have equality in rights and duties between males and females. I want to move freely. (Adolescent Girl from Busra Esh-Sham sub-district, Dar'a governorate)

I hope that streets will be organised and lit. (Adolescent Girl from Saraqab sub-district, Idleb governorate)

I wish girls could complete their study. (Adolescent Girl from Mseifra sub-district, Dar'a governorate)

I would build schools, hospitals, places for playing, and protect children from unexploded mines. (Adolescent Girl from Maaret Tamsrin sub-district, Idleb governorate)

We would also like this war to end and for the displaced people to go back home. Too many mothers have seen their children gone abroad. They want their children to come home, and for their families to reunite. (...) My wish is that my father would come back so that he and my mother could hug me forever, and that everyone in this country would be happy again. (Adolescent Girl from Nawa sub-district, Dar'a governorate)

If I could do anything, I would abolish all the factions in the judiciary. There would be real authority and a governor who defends the rights of women, takes their side, supports them, consults them and protects them from violence. This is not in my hands - it is up to the rest of the world. (Adolescent Girl from Badama sub-district, Idleb governorate)

I hope women will be represented and heard in the community council, according to our rights. I hope those who break the law will be punished, and we can have women centres like the ones we have now. (Adolescent girl from Saraqab sub-district, Idleb governorate)

Objective 2: ***Promote holistic adolescent friendly RH and specialised GBV services to address the needs of adolescent girls.***

Consultations with service providers revealed an urgent need to address the attitude of service providers towards adolescent girls. Negative attitudes identified were around adolescent girls' access to RH services including access to family services. Many service providers also seemed to have positive attitudes towards child marriage for girls. These attitudes, as discussed above, create barriers for adolescent girls to access services.

While it is always the intention of women and girls safe spaces to be adolescent friendly, WGSS and GBV actors recognised that more can be done to reach all adolescent girls and ensure the spaces are welcoming and tailored to their needs. In order to address these attitudes and create adolescent girl friendly services, SRH services providers will be trained on the specific needs of adolescent girls and their rights. Women and girls safe spaces social workers, as well as managers will also be trained to ensure that women and girl safe spaces are adequately

tailored to the needs of adolescent girls, that adolescent girls are consulted in the running of these safe spaces and that activities offered also respond to the specific needs of adolescent girls.

Consultations with adolescent girls confirmed that the activities provided at women and girls safe spaces were very positive. While mentioning areas of improvement (e.g. having more diversity in courses, being able to keep equipment, expanding the infrastructure of centres etc.), the girls described how they had benefitted from the centres by feeling emotional relief, gaining a new sense of hope for the future and feeling respected by staff members.

A very good example of adolescent friendly services is also when adolescent girls report feeling empowered in their community by 'having a voice' (in particular as a result from awareness sessions and life skills courses).

This centre is special for women and girls. It makes them feel that they are the owners of the community and that they have value and feel that they are strong. (Adolescent Girl from Atareb sub-district, Aleppo governorate)

We felt a positive change in our life. We filled our free time with useful things. When we get out of the house to come we feel that we have an aim to achieve in our life. (Adolescent Girl from Suran sub-district, Aleppo governorate)

In most locations, adolescent girls mentioned a lack of medication and access to health services. In particular specialised medical staff, such as obstetricians, would be located solely in bigger cities and were therefore hard to access. While adolescent girls mainly gave examples of how this impacted older family members (e.g. those in need of regular diabetes medicine or heart disease medication), they described how the lack of these services in combination with increased financial pressures on their families impacted them emotionally and caused constant stress.

I am married and in my first pregnancy. I was extremely worried about having a premature birth because there is no doctor nor is there any infrmary in the village. Therefore, I went to stay at my parents' house because it is close to the hospital where they have a doctor. (Adolescent Girl from Al-Hwash sub-district, Homs governorate)

Objective 3: Increase adolescent girls' access to appropriate reproductive health services, GBV specialised services and empowerment activities.

This objective is linked to the Call to Action to target adolescent girls, consider them, engage them, and enable them to lead.

Adolescent girls offer multiple assets to their families and communities and to protect and enhance these assets, adolescent girls need humanitarian programmes that break their isolation, address their needs, and build their capacities. Programmes that engage adolescent girls to build strong social networks, relationships with mentors, and leadership and life skills have succeeded in protecting adolescent girls from a variety of risks, from early marriage to physical violence, during all phases of emergencies.

"The location, timing, and cultural context for programmatic activities affect whether different segments of adolescent girl populations can engage them. Programme managers must think creatively about how to enable

all adolescent girls to participate, as well as take on appropriate leadership roles in the community over time. Managers in the field must target adolescent girls for participation in suitable programmes, confirm and monitor their participation, and modify programmes as necessary to ensure their continued engagement, especially to help them gain access or to accommodate the other responsibilities in their lives. Programme implementers must simultaneously maintain sensitivity to the needs and perceptions of other community members to avoid potential backlash.[39]"

Through the consultations and the consultative workshop, it became evident there is enthusiasm and support with many of the local partners to begin programming. But answering the "how?" still needs to happen. The literature review and interviews with key informants revealed a number of tools, both global and contextualised for the Syrian context (both for refugees and in neighbouring countries) that can be used[40].

Consultations with adolescent girls also revealed the lack of knowledge adolescent girls had about their reproductive health. For example, while discussing menstruation, adolescent girls mentioned using 'perfume to cover their smell'. In one discussion in Damascus city, adolescent girls discussed that 'according to customs and traditions' one should not shower while menstruating and also wait for three days before having a shower after one's period.

Adolescent girls also mentioned the barriers they face to come to seek services or come to centres. These included the lack of childcare available, in particular for small children of adolescent girls, having to work or being harassed by men on the way to the centre. Other barriers linked to the crisis include distance to the service delivery point, checkpoints on the way, or inadequate locations (e.g. in crowded area and therefore more likely to be targeted, or where transportation is too expensive). Lastly, adolescent girls expressed restrictions from family members (including from husbands) due to 'social conventions' (i.e. girls should do housework and not leave the house).

> *My children are still very young, so I cannot come here sometimes. (Adolescent Girl from Al-Hwash sub-district, Homs governorate)*

There is a need for both adolescent-friendly services and adolescent-specialised services within the Syrian context. The difference is illustrated in the box below. The activities proposed will focus on both increasing the existing programming to make it more adolescent friendly, primarily in the reproductive health sector and introducing tools for adolescent programming (particularly in the women and girl safe spaces and community centres).

Adolescent-Friendly: Ensuring that services that can be used by different ages (such as RH services) are affordable, acceptable, convenient and accessible from the perspective of adolescent girls.

Adolescent-Specialised: Services designed specifically for adolescent girls, engaging them in the design, implementation, monitoring and evaluation of the programme.

Objective 4: Engage with other actors to ensure needs and consideration of adolescent girls are part of the response.

The Call to Action instructs donors to engage in funding programmes targeted towards adolescent girls as they are often not visible to the aid community, and the current culture of relief and emergency response does not

39 Coalition for Adolescent Girls (2012).

40 Please see literature review and resource list

place value on reaching adolescent girls as a distinct population. Within the Whole of Syria context, the target of this advocacy and influencing must be broader and include current actors within the humanitarian community including donors, other humanitarian clusters who engage with adolescent girls, international and local aid agencies, and service providers – particularly those working on reproductive health and GBV programming.

This objective is also linked to the Call to Action to build capacity to target adolescent girls in the humanitarian community. Humanitarian services for adolescent girls typically reside within a variety of sectors (health and education). This approach may miss many adolescent girls who are unmarried, not in school, and with restricted freedom of movement. Other sectors should therefore become more involved in understanding the needs of adolescent girls and addressing this problem. This will require some cultural conversion within humanitarian networks, as well as reinforcement of technical capacity in organisations that work with adolescent girl populations. Advocacy with donors, awareness raising with other sectors, programming that addresses knowledge, attitude, and practice of other service providers will be needed.

This is particularly important, as across the governorates, adolescent girls mentioned not having adequate and sufficient food, shelter or employment opportunities. They also mentioned the lack of clothes and expensive prices of clothes, which their families could not afford any more. Furthermore, the lack and high costs of sanitary towels and tampons were mentioned in most locations where adolescent girls were consulted on this topic. Girls described how fathers would not give them money for these purposes and how they would come up with alternative solutions, such as using baby pads and pieces of cloth. Some girls had received sanitary towels through humanitarian aid distributions.

We moved to three houses in one month simply because of the increasing rent prices. Eventually, we were forced to live in a tent that is unfit for purpose, with no water or electricity. (Adolescent Girl from Suran sub-district, Aleppo governorate)

The financial situation is bad because of the war. Clothing is scarce, especially since my father died. (Adolescent Girl from Harim sub-district, Idleb governorate)

I cannot afford to buy sanitary towels because they are expensive and there are many girls at home. Therefore, we use pieces of cloth. (Adolescent Girl from Al-Hwash sub-district, Homs governorate)

Table of Actions

	Action	Target	Timeline	Responsible
Objective 1: **Generate knowledge, data and evidence on the needs of and varying impacts on adolescent girls to inform programme design, track progress and document lessons on girls programming**				
1.1	**Review current data collection tools** of GBV and RH sectors and agree on standardised tools to collect SADD, both for routine data collection and surveys	All GBV and RH service providers, with a focus on actors with adolescent-specialised programmes	2017	GBV, RH and Youth Coordinators and bodies
1.2	**Collect the minimum common set of SADD** on a routine basis (through the Health Information System - HIS) and through the Protection 4Ws	RH service providers and protection members	Beginning of 2018	GBV, RH and Youth Coordinators and bodies
1.3	Ensure Protection Focus Group Discussions for Humanitarian Needs Overview **capture information from of adolescent girls**	GBV Coordination, GBV IMO, GBV service providers	2018	GBV, RH and Youth Coordinators and bodies
1.4	**Modify** existing GBV monitoring tools to collect adolescent girl specific data and feedback	UNFPA M&E staff and programme staff	Immediate	GBV, RH and Youth Coordinators and bodies
1.5	**Improve the analysis** and programmatic use of SADD through coaching and building capacity of RH and GBV humanitarian actors to understand the differential impacts of programmes on adolescent girls and to plan for future interventions	All GBV and RH service providers	Immediate	GBV, RH and Youth Coordinators and bodies
1.6	**Launch a baseline Knowledge Attitude and Practice Survey** (KAP) around adolescent girl services with RH and GBV providers	RH and GBV services providers in northern Syria and Southern Syria	2018	SRH coordination
1.7	**Conduct research** into using social media to reach adolescent girls (or parents) according to age and marital status, building on the results of the KAP survey	Adolescents and parents	2018	SRH coordination
1.8	**Improve the systematic documentation** and sharing of programmatic lessons learned across the RH and GBV sectors from those working with adolescent girls.	RH and GBV partners working with Adolescent girls	2018-2020	RH and GBV coordination
1.9	**Document stories and capture voices** of adolescent girls	Humanitarian community	2018-2020	GBV coordination groups

	Action	Target	Timeline	Responsible
Objective 2: **Promote adolescent girl friendly SRH services and specialised GBV services.**				
2.1	Conduct specific **sessions** on adolescent friendly programming for RH working group and/or health cluster/sector meeting, using tools developed. *(Coaching and building capacity of RH actors to understand the differential impacts of programmes)*	SRH Service providers	2017-2018	RH coordinators in each hub.
2.2	Conduct **learning sessions** on the need for adolescent girl friendly sessions for protection actors *(Coaching and building capacity of GBV humanitarian actors to understand the differential impacts of programmes)*	GBV actors	2017-2018	GBV Coordinators in each hub.
2.3	**Update WGSS Training Manual** to include guidance on how to ensure WGSS is adolescent girl friendly and **conduct trainings**	WGSS staff, social workers, GBV organisations	2017	GBV coordinators
2.4	Develop materials and conduct a 2-day workshop for medical service providers on **improving knowledge and skills for caring for adolescent girls.**	RH Service providers in all operational hubs of Syria		WOS SRH Coordinator
2.5	**Training** for RH service providers on discussing basic human anatomy, physiology, and sexuality and means of discussing topics around sex with adolescents.	RH service providers, including doctors and midwives. Social workers in WGSS	First six months of 2018	WOS SRH Coordinator
2.6	Coaching and **training** to remove stigmatising language and practices around RH programming and services and promote using survivor-centred approach.	RH service providers, including doctors and midwives and collaborating with UNFPA's Y-Peer network where available.	First six months of 2018	WOS SRH Coordinator
2.7	Develop a **pool/roster of qualified**, vetted trainers inside Syria who are capable of providing face-to-face trainings with in-field staff	Trainers in all operational hubs of Syria	2018	GBV, RH and Youth Coordinators and bodies
2.8	Promote a coaching and supervision approach for service providers	RH and GBV managers	2018	RH and GBV coordinators in each hub

	Action	Target	Timeline	Responsible
Objective 3: **Increase adolescent girls' access to appropriate sexual and reproductive health services, specialised GBV services and empowerment activities.**				
3.1	Develop **adolescent girl advisory** groups to: • to give a voice to adolescent girls on their vision and needs and improve services • to acknowledge girls as resources and active participants on issues that concern them • to train and support peer educators	Adolescents	Early 2018	GBV and RH Coordinators
3.2	**Develop community advisory groups to**: • give a voice to parents and leader on their vision, fears and ideas to improve services • acknowledge community members as key stake-holders and resources on issues that concern adolescent girls • provide them with information, overcome their barriers, get their buy-in, support and participation	Parents and the community	2018-2020	UNFPA supporting field partners
3.3	Establish **young mothers groups and activities** within WGSS and WCC and recruit young mothers as a source of information for improved adolescent programming.	Adolescent mothers	2018	UNFPA and field partners
3.4	Develop **mentorship programme** with adolescent girls (using identified curricula) within the WGSS	Adolescent girls and community	2018-2020	GBV organisations
3.5	**Explore Cash Transfer Programming for**: reducing child marriage, supporting married girls and widowed girls, improving case management for GBV survivors, and working with parents to improve girls attendance in programmes	GBV coordinators; Specialised GBV actors	2018 - 2020	GBV Coordinators

	Action	Target	Timeline	Responsible
Objective 4: **Engage with other actors to ensure needs and considerations of adolescent girls are part of response / Target: education child protection and other sector**				
4.1	**Raise awareness** about the needs of adolescent girls and the importance of adolescent friendly programming with other sectors.	All humanitarian actors	Immediate	GBV, RH and Youth Coordinators and bodies
4.2	Create an **Adolescent Girl Task Force** with Reproductive Health, Child Protection, and Education to address the needs of adolescents in each hub	Sector coordinators in RH, GBV, CP, and Education	2018	GBV, RH and Youth Coordinators and bodies
4.3	**Development and sharing of check-lists**, minimum standards, lessons learned` and other tools, in order to improve knowledge of other humanitarian sectors/ actors on how to take into account the specific needs of adolescents girls in their response	Education, Child Protection, Health, WASH, Camp Management etc.	2018	GBV, RH and Youth Coordinators and bodies
4.4	**Conduct an Awareness Campaign** for the humanitarian sector centred around 16 Days of Action: Focus on Adolescent Girls	Each hub to determine priority (Education, Child Protection, Health, WASH, Camp Management)	Nov 28-Dec 10, 2017-2018	GBV, RH and Youth Coordinators and bodies
4.5	Ensure all **IASC GBV Guidelines roll-out actions** contain components on the specific needs of adolescent girls	Focal Point for IASC GBV Guideline Rollout and targeted clusters.	Link to IASC GBV guidelines programming currently happening	IASC GBV Guidelines focal point in each hub with support from IASC GBV Guidelines Reference Group

Monitoring and Evaluation

The RH and GBV coordination groups will be responsible for developing a monitoring framework for each of their hubs that is adapted to the context and specific activities.

Way Forward

The RH and GBV and Youth coordination bodies of the Whole of Syria in Damascus, Amman, and Gaziantep will lead the implementation of this strategy.

In line with the strategy's objectives, efforts will be coordinated across the three hubs of the Whole of Syria approach. The different coordination hubs will implement the strategy through a range of approaches appropriate to their respective capacities and particular context. The strategy will be linked to the coordination body strategies and work plan and partners will be involved in the revision of progresses.

Consultations will be held by the adolescent girl steering group to discuss ongoing efforts and preview future plans for implementation. Consultations will be conducted with adolescent girls to continue to provide feedback and inform prospective implementation of the strategy. Further consultation will also take place with other organisations and actors working with adolescent girls. Each coordination body will be held accountable to carry-out the objectives outlined above and to update them on a yearly basis.

This strategy will be reviewed yearly and updated as necessary to assess funding and respond to emerging challenges and opportunities.

United Nations Population Fund

GBV AoR
Whole of Syria

HEALTH CLUSTER
Turkey Hub

Date of Publication: November 2017 UNFPA Regional Syria Response hub.