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I. **Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ACTED</td>
<td>Agency for Technical Cooperation and Development</td>
</tr>
<tr>
<td>CFS</td>
<td>Child Friendly Spaces</td>
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<tr>
<td>CP</td>
<td>Child Protection</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally Displaced Person</td>
</tr>
<tr>
<td>IRC</td>
<td>International Rescue Committee</td>
</tr>
<tr>
<td>KRG</td>
<td>Kurdistan Regional Government</td>
</tr>
<tr>
<td>MMU</td>
<td>Mobile Medical Unit</td>
</tr>
<tr>
<td>NFI</td>
<td>Non Food Item</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>NRC</td>
<td>Norwegian Refugee Council</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual Reproductive Health</td>
</tr>
<tr>
<td>SGBV</td>
<td>Sexual and Gender Based Violence</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’ Emergency Fund</td>
</tr>
<tr>
<td>VAW</td>
<td>Violence against Women</td>
</tr>
<tr>
<td>WCC</td>
<td>Women’s Community Centre</td>
</tr>
<tr>
<td>YFS</td>
<td>Youth Friendly Space</td>
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II. Executive Summary:

This report to assess the specific needs and challenges of adolescent girls in Iraq was commissioned by UNFPA and UNICEF in Iraq in May 2016. The goal of the assessment was to identify the key challenges adolescent girls face, in particular, related to Gender Based Violence (GBV) as well as identifying the gaps in service provision to meet the needs of adolescent girls. The assessment was carried out primarily in the Kurdistan Region of Iraq (KRI) with consultations throughout other locations in Iraq. Data collection for the assessment included focus group discussions (FGD) and key informant interviews (KII) with beneficiaries and service providers. Two workshops, one in Dohuk and another in Sulaymaniyah were also conducted.

Adolescent girls are particularly vulnerable to multiple forms of violence and have limited support systems and access to information. The recent and ongoing conflict and displacement has disproportionately affected adolescent girls. The majority are out of school, experience growing levels of sexual violence, abductions, sexual harassment, child marriage, sexual exploitation and abuse and have restrictions placed on their movement by their families.

The assessment found that girls between 10-14 years were falling between the gaps of Child (CFS), Youth Friendly Spaces (YFS) and Women Community Centres (WCCs). Girls between 10-14 years are been left behind, not receiving life-saving information that is critical for girls at this age and the technical capacity of staff to implement such activities was limited. Girls aged 10-14 years were deemed too young for WCCs, too old for CFSs and some were unable to access YFSs due to their age or because these spaces were mixed with boys.

There was a gap in case management services for adolescent girls, with Child Protection (CP) and Gender Based Violence (GBV) actors not adequately equipped to deal with such cases. Ongoing development of capacity in this area is taking place with a scale up on trainings on topics such as Caring for Child Survivors.

The assessment found that outreach and awareness raising was not tailored to the needs of adolescent girls and was mainly reaching girls who already have access to services. A significant focus of outreach and awareness raising that targeted girls took place at schools, without consciously addressing certain barriers faced by girls who were restricted from leaving their homes.

Education and teaching environments were identified as challenging for girls. Many reported being mistreated and beaten by teachers and identified poor quality of teaching. This provided an added reason for parents to remove their girls from school.

Adolescent Sexual and Reproductive Health (ASRH) information was identified by health professionals, non-governmental organisations (NGO) and mothers of adolescent girls as important. Non health staff lacked capacity to provide this information to girls and needed further training in order to feel equipped to give basic ASRH information to adolescent girls.

The assessment provides detailed findings and recommendations to improve the quality and availability of services for adolescent girls. Although the assessment was heavily focused on KRI, recommendations are not limited to KRI and should be used to inform programming across Iraq.
1. Background and Overview

1.1 Background

Iraq’s crisis has been driven by massive waves of displacement caused by armed conflict. From January 2014 to June 2016, more than 3.3 million internally displaced persons (IDP) were forced to flee their homes and have been dispersed across 105 districts and 3,836 locations in Iraq. The situation of displaced families is dire. 85% of displaced people are in debt (mostly unpayable), leading families into impoverishment. In numerous neighbourhoods, including in Dohuk, Erbil, Sulaymaniyah and Kirkuk, families are relying on negative, even irreversible coping strategies. Food consumption within the most vulnerable families is declining and, child labour and child marriage are on the rise. 40% of all displaced families still require urgent shelter support, among whom 645,000 people are surviving in unfinished and abandoned buildings, makeshift collective centres and spontaneous settlements. Horrific violence, mass executions, systematic rape, and torture are being used against communities in areas controlled by Islamic State of Iraq and the Levant (ISIL). Gender-based violence (GBV) is widespread and devastating. Families who are displaced frequently lack documentation and restrictions on their movement are commonplace in certain areas.

1.2 Overview of the current situation for adolescent girls in Iraq

Adolescent girls are particularly vulnerable to multiple forms of violence and have limited support systems and access to information. The recent and ongoing conflict and displacement has disproportionately affected adolescent girls. The majority are out of school, experience growing levels of sexual violence, abductions, sexual harassment, child marriage, sexual exploitation and abuse and have restrictions placed on their movement by their families. Limited opportunities for education remain a major obstacle. Additionally, many families are afraid to send their girls to school for security concerns, and girls continue to be at risk of GBV and early marriage as a coping strategy.

Child marriage is reportedly on the increase in the current crisis. Key findings from the 2014 Interagency Child Protection Assessment indicate that child marriage was one of the most common forms of GBV reported by key informants (24.06%). Even prior to the onset of the recent conflict, child marriage was a risk for girls and this has been documented as prevalent among Syrian refugee girls. Financial motives and to protect girls from violence and harassment are commonly cited reasons. The amended Law on Personal Affairs No. 188/1959 sets the minimum age of marriage at 18 years, however, it allows for the marriage of children between the ages of 15 and 18 if approval of their legal guardians is obtained. The Kurdistan Regional Government (KRG) raised this age to 16, but it remains below the global standard of 18 years.

Learnings from successful interventions indicate that education is a powerful way to prevent child marriage, especially keeping girls in school through secondary grades. Iraqi women aged 15-54 years old have low level of education, 22% were unable to read and write and this percentage increases by age. More than one third of these women have not completed more than primary school. The illiteracy rate among women in Kurdistan (32%) is higher than other governorates (19.6%). Country-wide enrollment figures at primary level remain relatively high at 89%. However, a significant drop-out rate is evident after this level. Only 52% of Iraqi boys and 44% of Iraqi girls of secondary school age attend school. Levels of educational attainment is even lower among IDPs.

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3. MCNA II, REACH
5. UNFPA Safety audit assessment in Baghdad, 2014
6. Inter-Agency Child Protection Assessment Erbil, Sulaymaniyah and Duhok Governorates Kurdistan Region of Iraq, July - August 2014
7. Are we listening? Women affected by the Syrian Crisis, IRC, 2014; We just keep silent, UN Women, 2015
8. Child Protection in Iraq – A Situation Analysis, the Outreach Practice Unit at the American University of Beirut, July 2015 [Unpublished]
9. Iraq Woman Integrated Social and Health Survey (I-WISH) Summary Report, March 2012
In March 2016, an Adolescent Girls Taskforce\textsuperscript{11} was set up in Iraq comprising of United Nations (UN) agencies, GBV and Child Protection NGOs working with girls. The taskforce was established as a short term forum to complement the previous work of the child marriage taskforce and other ongoing initiatives. It focuses on

- Identifying issues and concerns affecting adolescent girls.
- Recommending and developing programming responses to address needs.
- Field testing tools and resources developed.

The Adolescent Girls Taskforce identified multiple challenges and gaps related to adolescent girls in Iraq, including growing levels of sexual violence, abductions, sexual harassment, child marriage, exploitation and abuse. Women and girls have restrictions placed on movements and are increasingly isolated, in particular adolescent girls. It was identified that current GBV and child protection service provision was insufficient to meet the needs of survivors in general\textsuperscript{12}, let alone the specific needs of adolescent girls. In May 2016, as part of the development of an Iraq Adolescent Girls Toolkit, an assessment was carried out to identify key concerns affecting adolescent girls to inform resource development. This assessment highlighted a significant gap in the humanitarian response for girls, specifically those between the ages of 11 to 14 years old. This age group in particular is unable to access age appropriate psychosocial, educational or recreational activities offered by numerous actors through existing Child (CFSs) and Youth Friendly Spaces (YFSs) and Women’s Community Centres (WCCs). Furthermore, in assets building exercises carried out with key stakeholders at workshops in Dohuk and Sulaymaniyah, partners identified this age group as the most critical group to reach with information and activities related to their situation and needs.

There are currently 3.3 million IDPs and over 240,000 refugees living in Iraq\textsuperscript{13}. Even though 60\% of refugees and 90\% of IDPs live in non-camp settlements, there is a heavy focus on providing assistance in camp settings, resulting in a vast inequality of access to services and resources\textsuperscript{14}. Given the isolation and lack of information and access to services that adolescent girls face in emergencies, those who are living in non-camp settings in Iraq are particularly vulnerable, invisible and hard to reach. The humanitarian response for this particular group should be prioritised. The assessment highlighted that women and girls were sometimes unable to access services and when there were services available, some were not aware of what the services exactly were. Outreach strategies heavily focused on schools, therefore only engaging a specific segment of girls. It was also noted that there was a lack of adolescent friendly information and strategies to explain services to girls.

Adolescent girls between the ages of 10-19 years, are at a comparative disadvantage before, during and after crises. This transitional period between childhood and adulthood is also when girls begin to assume adult roles, but without key skills, capacities and networks that enable others to safely navigate forced displacement\textsuperscript{15}. The assessment identified girls between the ages of 11-14 years in Iraq are in great need of specialised services and information to meet their particular needs. It is essential that humanitarian actors collectively account for adolescent girls, to ensure girls are able to safely access life-saving information, services and resources.

Humanitarian actors, working across all clusters, but particularly education, health and protection, should strengthen their capacity to work more effectively with this sub-population to ensure that their needs, which are often overlooked, are met.

\textsuperscript{11} UNICEF, UNFPA, UNHCR, NRC, IMC, Al Messala, ACTED, WRO, IRC, GBV and Child Protection sub clusters
\textsuperscript{12} Adolescent Girls in Iraq Presentation Adolescent Girls Taskforce, March 2016
\textsuperscript{13} Humanitarian Response Plan Iraq, 2016
\textsuperscript{14} Multi-Cluster/Sector Initial Assessment Report: IDPs Response in Iraq, province of Ninewa and Erbil, Save the Children, 2015
\textsuperscript{15} I’m Here: Adolescent Girls in Emergencies. Women’s Refugee Commission, 2014
2. Assessment Methodology:

This assessment was conducted to identify the specific needs and challenges of adolescent girls. The assessment was carried out in KRI from 19 April to 2 May 2016 and the overall purpose was to understand the specific needs of adolescent girls and identify current gaps in services provided to adolescent girls to inform the adolescent girls’ toolkit design. Partners and staff from outside of KRI were also consulted but the assessment was primarily focused on KRI.

The key objectives of the assessment were to:
- Conduct a review of existing tools and approaches used in Iraq and regionally to provide a foundation for the Iraq adolescent girls’ toolkit.
- Conduct an assessment including focus group discussions with adolescent girls, parents and other key stakeholders including social workers, teachers and GBV and Child Protection partners
- Identify existing partners, key external stakeholders (including gatekeepers and other organizations) and target groups to enhance programme implementation and coordination.

<table>
<thead>
<tr>
<th>Key Actions</th>
<th>Allocated Timeline</th>
<th>Outputs</th>
</tr>
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<tbody>
<tr>
<td>Conduct a review of existing tools and approaches used in Iraq and regionally to provide a foundation for the Iraq adolescent girls’ toolkit.</td>
<td>10 days</td>
<td>Desk review was conducted based on available global, regional and national documents, reports and assessments from UN Agencies, Ministries and Non-Government Organisations (NGOs). This included information on the situation of adolescent girls (i.e. GBV risks, child marriage, gender dynamics in Iraq among IDP and refugee groups). Existing tool-kits and curricula implemented for youth were also reviewed.</td>
</tr>
<tr>
<td>Conduct an assessment including focus group discussions with adolescent girls, parents and other key stakeholders including social workers, teachers and GBV and Child Protection partners.</td>
<td>6 days</td>
<td>Key informant interviews were conducted with stakeholders from UNICEF, UNFPA and staff from national and international NGOs and Government Ministry staff. Workshops were carried out with UNFPA/UNICEF partners in Dohuk (11 NGOs/Directorates) and Sulaymaniyah (6 NGOs) to identify the needs of adolescent girls and gaps in programming. (Dohuk ½ day, Sulaymaniyah 1 day). FGDs with adolescent girls between 11-19 years were conducted across Erbil and Dohuk in camp and non-camp settings, among refugee, IDP and host community groups. The majority of participants were adolescent girls who were attending school and not married (accessing particularly vulnerable groups of adolescent girls proved to be difficult during the assessment). FGDs with mothers of adolescent girls were conducted across Erbil and Dohuk in camp and non-camp settings, among refugee, IDP and host community groups.</td>
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<thead>
<tr>
<th>FGD Breakdown</th>
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<tbody>
<tr>
<td>Location</td>
<td>Girls</td>
<td>Women</td>
</tr>
<tr>
<td>Baharkha IDP Camp</td>
<td>27</td>
<td>2</td>
</tr>
<tr>
<td>Darashakran Refugee Camp</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Baharmandan (non-camp)</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Domiz Refugee Camp</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Sharia IDP Camp</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Sharia (non-camp)</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>105</td>
<td>38</td>
</tr>
</tbody>
</table>

105 girls aged between 11 to 19 years old and 38 mothers of adolescent girls [143 in total] were consulted during the assessment across six locations [Erbil: Darashakran Refugee Camp, Baharkha IDP...
Camp, Baharmandan Non-Camp setting; Dohuk: Sharia IDP Camp, Sharia Non-Camp Setting, Domiz Refugee Camp]. Staff from Government Ministries, International and National NGOs were also consulted16.

**Definition of scope:** The assessment included IDPs and refugees in camp and non-camp settings with an unintentional focus on those who live in camp settings due to limitations in time and locations where partners were implementing programming. A small number of host community women and girls were also consulted. The main focus was adolescent girls aged 10 -19 years. The assessment was conducted in Dohuk and Erbil, with a workshop in Sulaymaniyah for partners, and skype discussions with a small number of staff from the Baghdad Governorate.

**Limitations to the assessment:** The assessment was limited due to numerous factors, especially as a result of the narrow time-frame with insufficient time to identify and reach specific groups. Moreover, specific groups were not successfully reached, i.e. girls in non-camp settings, out of school, not accessing services, married adolescents and adolescent mothers. This in itself is an indicator that these particular groups are hard to reach. Male gatekeepers (fathers, brothers, community leaders) were also not consulted during the assessment, a significant limitation, given their influence on adolescent girls. The number of mothers consulted was low, due to miscommunication of objectives of FGDs or prior planning for FGDs been limited. Geographically, the assessment was heavily focused on KRI, with limited information regarding the issues and concerns in other areas of Iraq.

### 3. Assessment and recommendations summary:

<table>
<thead>
<tr>
<th>Key Findings</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>- Girls between 10-14 years17 were falling between the gaps of Child (CFS), Youth Friendly Space (YFS) and Women Community Centres (WCCs).</td>
<td>- Girl friendly services, addressing the specific needs of girls 10-14 years should be incorporated within existing spaces. - Sessions should be separated by age where possible.</td>
</tr>
<tr>
<td>- Focused psychosocial activities for girls were available and adapted from regional and global toolkits but with limited training and follow up for staff who were implementing psychosocial activities for girls. - Recreational activities were enjoyed by girls but there was a need to provide some groups of girls with dedicated recreational spaces for sports.</td>
<td>- Staff should be trained on how to deal with GBV disclosures in group settings. - Girls should be consulted on activities they want to participate in. - There should be a focus on recruitment of more female facilitators/staff to be able to provide sessions in a girl friendly environment.</td>
</tr>
<tr>
<td>- Tailored activities for adolescent girls specifically developed and adapted for girls in Iraq, was limited to very few organisations. - Girls between 10-14 years were being left behind, not receiving life-saving information that is critical for girls at this age. Technical capacity of staff to implement such activities was limited.</td>
<td>- Tailored activities that build girls skills in decision making, problem solving, protecting themselves from GBV and seeking assistance and support should be incorporated across partner organisations. - Staff ability to facilitate such sessions should be expanded.</td>
</tr>
<tr>
<td>- There was a significant gap in case management for adolescent girls, with Child Protection (CP) and Gender Based Violence (GBV) actors not adequately equipped to deal with such cases.</td>
<td>- Case management specifically through and adolescent girls lens needs to be addressed by GBV and CP partners through additional training, coaching and mentoring.</td>
</tr>
<tr>
<td>- Mobile activities were limited in the Iraq context, especially with regards to group psychosocial activities.</td>
<td>- Develop and roll out guidelines on how to conduct mobile services in communities that cannot reach a static space, including entry and exit strategies.</td>
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</table>

16 Please see Annex 1 for list of organisations and individuals consulted
17 While the assessment targeted 11 to 19 year olds, existing literature and lessons learnt for adolescent girls programming globally recommends targeting girls from aged 10 years and above.
| **- Outreach and awareness raising** was not tailored to the needs of adolescent girls and was mainly reaching girls who already have access to services. | **- Further training for partners on identifying particular groups of vulnerable girls, how to explain services to girls and how to reach vulnerable girls.**
| **- Lack of tailored outreach strategies across partners to reach the most vulnerable groups of girls.** | **- Build staff capacity on how to develop a successful outreach strategy to reach girls.**

| **- Child marriage was identified as a protection mechanism. Key issues contributing towards child marriage (such as meeting basic needs) requires more attention.** | **- The Interagency Child Marriage Guidance note\(^\text{18}\) to be followed up on and partners encouraged to follow the guidelines and implement recommendations from the guidance note.**

| **- Education and teaching environment was challenging for girls. Many reported being mistreated and beaten by teachers and reported poor quality of teaching.** | **- Established referral mechanisms in schools whereby children can report cases of harassment and abuse through social workers or focal points.**
| **- Establish separate shifts for girls and boys should be encouraged in locations where this is a barrier to access.**

| **- Health: ASRH information was identified by health professionals, NGOs and mothers of adolescent girls as important. Non health staff lacked capacity to provide this information to girls.** | **- The UNFPA model on adolescent friendly health services should be rolled out. Specific issues related to the roll-out, including resources and overseeing the process should be addressed.**
| **- Clinics should provide outreach and information sessions in places where girls feel comfortable. This information should be given separately to women and girls.**
| **- Advocate for the discontinuation of the ID for registration as this may be a barrier for access for girls.**

| **- Non-Food Item distributions were, in some cases not based on a needs assessment of the community and therefore not taking into consideration the specific needs of adolescent girls.** | **- Carry out needs assessments with different groups in the community, preferably separately for adolescent girls, and conducted by a female facilitator.**

| **- Privacy and consent regarding taking photos of girls (and boys) below the age of 18 years were, in many cases not respected.** | **- Staff who are working with children or vulnerable groups should be trained on ‘do no harm’ principles and principles of consent. They should be aware of roles and responsibilities regarding documenting activities and taking photos.**

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\(\text{18} \) Interagency Child Marriage Guidance Note for Kurdistan Region of Iraq: Prevention and Response to Child Marriage, October 2015
4. Key findings and recommendations:

4.1 Girls access to and use of CFS, YFS and WCCs:

According to partners consulted during this assessment, the majority of YFSs target youth between 15 and 24 years old. The CFSs target children between 5-14 years old, however, the spaces are generally for all children between 5-18 years but are more often used by those under 14 years. WCCs generally target women and girls over 15 years old. The assessment identified that girls attending the CFSs (both in refugee and IDP settings) wanted to be separated by age and in particular did not want to be included in activities with younger children. One of the barriers highlighted by girls was that the CFSs were perceived to be too ‘childish’ for girls above 12 years old. Staff at a YFS mentioned that girls between 12 to 14 years old would try to access the YFS but were referred to the CFS as YFS generally target those above 14 years. These girls did not feel the CFS was appropriate for their age group but were not given an alternative option in some locations visited.

There was a large disparity between partners’ understanding of the needs of girls and the actual needs of girls. The majority of partners noted that there were no issues related to adolescent girls’ engagement in activities. Many reported that the number of girls attending far outweighed the number of boys for both CFSs and YFSs, especially in the refugee context. Refugees were repeatedly referred to as more ‘open minded’ in comparison to Arab IDPs. However, through consultations with refugee women and girls, they expressed the need for separated activities for boys and girls. 87% of mothers from the IDP and refugee population consulted said that mixed sessions was a reason why their daughters would not be allowed to attend a YFS or CFS. For many mothers, the main reason was related to age, as opposed to specific activities for girls and boys. Whereas for girls, the issue was more specifically related to certain activities such as sports, Adolescent Sexual and Reproductive Health (ASRH) or life skills sessions. For example, girls attending a YFS in Domiz Refugee Camp explained that they did not feel comfortable attending with boys who were above 13 years old. For girls who were already able to access the space, they explained that they did not mind being mixed with boys for certain activities but they wanted a girl only space where their friends could also join them (those girls whose parents don’t allow them to come because it is mixed). Where girls did feel comfortable in mixed sessions, they still preferred for boys to be of a similar age to them and some felt intimidated by older boys. Mothers from one refugee camp in Erbil mentioned that they would not send their daughters to the YFS if it was mixed. They feared this would create problems such as potentially bringing shame upon the family through engaging in relationships or because people in the community may talk about their daughters mixing with boys.

Girls aged between 10 to 14 years are clearly falling through the gaps, too old for CFSs and too young for YFSs and WCCs. Their access to such spaces is further diminished by combining boys and girls in activities. For many girls, mixed spaces were not an option, especially after the age of 11 or 12 years old. Although a Women’s Centre may be more appropriate for some girls, in many centres, activities for women and girls take place together and are not age disaggregated. Generally, girls under 15 years are unable to access these spaces. Even when they are able to access, they are included in activities that have generally been designed for women.

Recommendations:
- CFS, YFS and WCC should establish girl friendly spaces to ensure that the specific needs of adolescent girls are being met and to increase access to girls who are otherwise unable to access existing services. Dedicating girl only days (or mornings/afternoons) within youth spaces or specific adolescent girl friendly activities for girls in child friendly spaces should be considered for low resource centres. Specific considerations for girl only spaces where there are girls and boys who attend above the age of 10 years should be considered. Separate age appropriate activities for women and girls should be offered within Women’s Centres.
Female staff should be available to facilitate activities with girls. Mixed spaces is a major barrier to engaging girls across both refugee and IDP settings.

Age restrictions for YFSs and WCCs should be reviewed. WCCs should consider opening up their services to girls younger than 15 years old. For example, in Dohuk, where one NGO is operating, girls from the age of 11 years are accessing girl specific activities, using a curriculum developed for refugee girls in Lebanon. The curriculum learning sessions are being tailored to the needs of the adolescent girls they access in Iraq.

YFSs should consider specific activities for girls between 10 to 14 years. CFSs need to do more to attract girls of this age, through dedicated days, afternoons or mornings for this age group.

Targeted outreach strategies to engage girls in this age group should be developed and implemented.

A regular feedback mechanism needs to be set up for adolescent girls to give ideas and opinions on activities, access and management of spaces they attend. Regular consultations with girls will enable partners to understand the situation of girls and equip them to adapt to the needs of girls and respond with appropriate and relevant interventions. Girls at a YFS in Erbil mentioned that they were previously consulted and requested to give their feedback on certain activities. This was something they appreciated and enjoyed being part of.

4.2 Psychosocial and recreational activities:

A number of organisations provided recreational activities for girls and boys, with some also introducing focused psychosocial activities covering topics such as ASRH, life skills, GBV and resilience etc. Recreational activities were available in many WCCs, CFSs and YFSs and consisted of a number of creative activities that girls enjoyed participating in.

Psychosocial Activities:

Resources for psychosocial activities had generally been adopted or adapted from regional or global materials that covered topics related to issues girls and boys in Iraq face. However, in some cases, staff were not trained on the implementation of these toolkits and resources, and therefore, the quality of information being given and staff ability to respond to some of the sensitive issues arising was limited.

Feedback from girls during one FGD who had been participating in a tailored life skills programme had repeated the information they had learnt during one of the sessions related to ASRH, and the information was incorrect. This could be due to staff not fully understanding the information themselves or the message not being communicated clearly in an age appropriate manner, highlighting the need for further training for staff when giving information on sensitive or complex topics.

Some packages that covered sensitive information related to ASRH, GBV and life skills were conducted for male and female youth over 14 years, meaning that girls specifically between the age of 10-14 years old and in need of critical, life-saving information, were not being reached. Those giving information related to GBV were, in many cases not trained on how to deal with group GBV disclosures. Where information was given in youth friendly spaces on ASRH, male and female youth (particularly in refugee settings) were mixed together when receiving this information, which is likely to cause girls not to be comfortable and open to discuss ASRH issues in front of male peers or facilitators. When asked how comfortable youth feel during these particular sessions, facilitators explained that girls and boys request to be separated, and the solution has been to separate them within the same room as opposed to holding separate sessions for them.

Packages that have been developed for the region and understand the cultural sensitivities specify that when necessary, it is acceptable to separate boys and girls. However, some staff were not aware of the details of such packages and therefore were unaware of the cultural considerations outlined in these resources. In some YFSs and WCCs, adolescents, youth and adults would be mixed in the same sessions. For example, in one location, ASRH, GBV and life skills information was provided to women
and girls between the ages of 13-26 years. The need for appropriate age segregation was identified to ensure that the specific needs of younger and older adolescents is addressed appropriately.

Recreational activities:
In a number of locations, both IDP and refugee, girls requested girl only recreational spaces for sports. For IDP girls, this meant a space that was covered and private where they could play sports. Existing spaces were dominated by men and boys, and many girls were not able to access them due to fear of harassment or community perceptions of girls playing sports in public. Refugee girls also mentioned wanting to be involved in more sports. One group mentioned that they were excluded from sports because they were girls and the sports coach instructed them to watch the boys play sports instead. Other girls preferred to have a girl only space for sports as they did not feel comfortable with boys over 13 years old.

Recommendations:
- Staff should be provided with gender and GBV training, regardless of whether they are a GBV organisation or not. Training and awareness on gender sensitivity and needs will enable staff to further cater for these groups.
- One of the biggest gaps identified was in partners’ ability to respond to GBV disclosures in group settings. A number of partners are providing information to girls and facilitating activities with girls where the likelihood of a GBV disclosure in a group setting is high. Staff were also unequipped to deal with girls who discuss harmful practices or negative coping mechanisms. Those working with groups, where there is a likelihood of GBV disclosure in group setting, need to be trained on how to respond to this particular situation, confidentiality and referrals and to ensure they do no harm.
- For some activities, girls and boys are put together to discuss sensitive issues related to ASRH. Cultural sensitivity should be applied and girls and boys should be consulted as to whether they prefer to do these activities together or separately. Girls and boys should not be obliged to attend mixed groups if they are not comfortable.
- Female facilitators should be provided for girls wherever possible as it will help to reduce barriers and allow girls to feel more comfortable expressing sensitive issues.

4.3 Tailored activities for adolescent girls:
The lack of tailored activities and interventions that respond to the specific needs and issues related to adolescent girls came out during this assessment. Whilst some organisations were providing focused psychosocial activities specifically for adolescence, there was an overall gap, specifically in activities and programming that address girls’ skills and knowledge related to ASRH, financial literacy, leadership, decision making and support networks for girls between the ages of 10-14 years old, adapted to the Iraq context.

This was partly due to a lack of understanding on the need to implement such activities to target girls, as well as limited technical capacity, financial constraints, and lack of qualified staff to provide such activities – particularly female staff. Although during the workshops in Dohuk and Sulaymaniyah, it was identified that building assets for girls between 10-14 years was especially important.

Staff felt that by the age of 14 years old, girls should have key skills in negation and problem solving and they should know some basic self-defence. They should know about their bodies and who to turn to if they experience violence. Staff also felt that girls should have effective communication skills by 14 years old. They felt that activities that address these key points should be carried out with girls from an earlier age than is currently being done.

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19 Key Informant Interview with one partner in Dohuk, identified that as a result of gender training, staff were better able to tailor their response to girls, to ensure girls were able to access activities tailored to their needs.
One of the partners consulted in Dohuk attended a gender training and as a result were able to identify a gap in girls attending between the ages of 12-17 years at their centre. Targeted community mobilisation techniques enabled them to identify the issues and engage a higher number of girls within this age group. They also provided tailored sessions to girls based on their needs and requests including sessions on puberty and menstruation, hygiene and how to protect themselves

**Recommendations:**
- Develop and roll out a guidance tool for staff across relevant sectors/cluster on how to set up effective adolescent girls’ programmes to reach vulnerable groups of girls outlined below.
- Development and roll out of a set of sessions that help build assets for girls, especially to mitigate, respond and prevent GBV for GBV, CP and others who work with adolescent girls.
- Build capacity of staff working across all sectors/clusters to respond effectively to the needs of adolescent girls through existing programme structures and mechanisms - see below for further details.

**4.4 GBV Case management for adolescent girls:**
A 2014 report by UN Women advised that great caution should be employed before programmes that encourage young women and girls to speak out and disclose GBV experiences as it could place them in danger. Furthermore, the report indicated that there were low levels of disclosure by women and girls of incidents of violence against them, which could possibly indicate a gap in refugees’ (and IDPs) understanding of what services are available to them. Given the more tailored approach that needs to be adopted with adolescent girls and the sensitivity involved in explaining case management services to girls, the lack of adolescent girl friendly information specifically on case management, could be limiting help seeking among adolescent girls who have experienced GBV.

Anecdotal evidence collected in the camps and through partners during the assessment suggests that women and girls may be reluctant to disclose cases of GBV due to concerns of confidentiality being breached. A recent GBV assessment by UNFPA further emphasises the importance of confidentiality. The assessment found that women do not report violence by family members, because they are ashamed, fear repercussions or are concerned with protecting husbands or family members. They are predominantly scared of stigma and shame tied to the status of being identified as a GBV survivor. Therefore, coming forward to disclose GBV to access services with a lack of assurance over confidentiality could be a significant barrier for women and girls. The report by UN Women also found that women ranked confidentiality as the most important criteria in enabling access to services and protection, but generally felt that this was not provided. The GBV assessment report identified confidentiality as a barrier for GBV survivors seeking help, stating that there was a ‘failure to provide confidentiality’. The report highlighted that rooms in Primary Health Clinics (PHC), hospitals and police stations often do not allow for a confidential space for disclosure of GBV. Disclosing GBV in front of family members or strangers can be distressing and dangerous for survivors. Confidentiality can be breached at several points through multi-sector response system. Given the sensitivity of GBV in this context and risks to survivors’ safety, this issue is crucial to address with GBV partners.

This assessment found that many partners consulted need to strengthen their capacity to effectively provide GBV case management for children, especially those 13 years and below. The referral pathways are at times unclear, with Child Protection actors stating that they refer these cases to GBV partners and GBV partners referring them to Child Protection. The quality of case management services and response time for referrals was highlighted as an issue between GBV and Child Protection.

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20 We Just Keep Silent: Gender Based Violence Against Syrian Refugees in The Kurdistan Region of Iraq, 2014
21 An Assessment of GBV: UNFPA by Dr. Aysel Vazirova, 2016
22 We Just Keep Silent: Gender Based Violence Against Syrian Refugees in The Kurdistan Region of Iraq, 2014
23 An Assessment of GBV: UNFPA by Dr. Aysel Vazirova, 2016
actors. GBV partners openly identified the need for further capacity building and coaching/mentoring to better respond to the needs of child survivors.

There is a lack of adolescent girl friendly information, specifically regarding case management, with girls in some locations not fully understanding the purpose of case management. Partners are generally unfamiliar with techniques and approaches related to delivering case management information to girls. Issues related to consent need to be clarified among staff. Approaches towards consent varied between partners and across locations, especially for girls below 14 years. Some partners would not accept consent from a trusted adult as an option even though this is recommended in the child protection case management Standard Operating Procedures (SOP) and global guidelines. Providing information on case management must also include whether girls will be able to consent for themselves or if they will need to gain consent from an adult. Furthermore, some partners were conducting home visits and intervening with perpetrators, which is a risk to women, girls and staff.

The physical spaces at some centres/spaces need to be assessed for suitability for case management. Some centres did not have a separate case management room, or rooms were not located in a private area, so those entering for case management were visible to people outside and within the centres. This is also a concern for partners providing PSS and case management services through mobile teams outlined below.

**Recommendations:**

- The quality of case management needs to be addressed through an adolescent girls’ lens including further training on confidentiality, understanding of issues related to consent, and improved knowledge of up to date referral mechanisms.
- CP and GBV partners need to identify who is best placed to deal with case management for girls (and boys) prior to making referrals. They should be aware in advance so not to delay the process.
- CP staff need to further build their capacity for dealing with child survivors, both in terms of technical capacity and coverage. GBV partners also need to build their technical capacity in dealing with younger survivors who may feel more comfortable accessing a WCC as opposed to a CFS.
- Staff need to become familiar with concepts related to do no harm, specifically linked to confidentiality. This is crucial for case workers/social workers. There should be a mechanism for women and girls to report complaints when they believe confidentiality has been breached.
- Staff need to be aware of GBV guiding principles and trained on safety issues related to home visits and dealing with perpetrators as it can cause risk to women, girls and staff themselves.
- Centres offering case management need to be provided with clear guidelines on how to establish a case management or listening rooms.

Some suggestions taken from the Lebanon Sexual and Gender Based Violence (SGBV) Case Management Standard Operating Procedures (SOPs) include:

<table>
<thead>
<tr>
<th><strong>Outside the space:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non stigmatizing name of the centre/space.</td>
</tr>
<tr>
<td>2. Safe and well-lit.</td>
</tr>
<tr>
<td>3. Integrated in community.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Inside the space:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sufficient number of rooms, at least 3 rooms – a counseling room, a room for staff (for self-care and confidential discussions), a reception/waiting area, and a bathroom.</td>
</tr>
<tr>
<td>2. Group activities room – depending on the function of the centre.</td>
</tr>
<tr>
<td>3. Safe data storage.</td>
</tr>
</tbody>
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24 Sexual and Gender Based Violence (SGBV) Case Management Standard Operating Procedures (SOPs), Lebanon, 2014
4. Appropriate imagery.

**Inside the counseling room:**

1. Soundproof room that can be locked.
2. Supplies for other forms of expression.
3. Access to water.
4. Window suggestions: there should not be a window that is visible – or there is a risk that someone could be watching. Curtains or blinds can be used to ensure privacy.

4.5 Mobile approaches:
As noted previously, a significant allocation of services visited during the assessment were focused on camp settings. There were also a number of static centres in non-camp settings, however, partners conducting mobile services is limited and even where mobile activities do exist, some are focused on providing one to one support, instead of group psychosocial support. This was identified in workshops in Dohuk and Sulaymaniyah, where some CP and GBV partners were providing arts, crafts and informal discussions with girls on an individual basis as staff had mentioned that it was not easy to identify spaces to carry out mobile services for groups.

One non-camp centre had more women participating from the host community than the IDP community that it was expected to reach. Many IDPs who were able to access the centre were either living in the surrounding area or could afford transportation. When asked where the vulnerable women and girls are, especially those in need of such a centre, the partner explained that the centre was far from those women and girls, who could not come without transportation or financial support. A centre close to a Yazidi non-camp settlement was positioned where it could be easily accessed by the community. Women and girls felt comfortable accessing the space available, however, they mentioned that they had not received any other services from NGOs. They mentioned that if they needed a doctor or a specific service, they would go to Dohuk or to the camp. This prevented them from accessing additional services due to distance and cost. They explained that non-food item (NFI) distributions were only available inside the camp.

Given the number of IDPs and refugees that live outside of camp settings and the lack of funding available to partners, adopting mobile approaches could provide a viable alternative or complement existing static programming. Taking into account the restrictions placed on adolescent girls and the extreme isolation that many experience, it is necessary to rethink existing approaches to gain further access to these groups.

**Recommendations:**

- Many girls who are extremely vulnerable and isolated are not be able to reach static, existing spaces due to unfamiliarity with staff and centres. There may be a lack of trust and reluctance to send girls, compounded with other issues related to distance and stigma. Additional resources should be allocated for mobile services. In order to reach isolated vulnerable adolescent girls, it’s important that activities target them in the places that they have access to, such as local community halls, schools or identified safe spaces within walking distance.
- Guidelines should be developed on how best to conduct mobile services and these should be and should be rolled out with staff trained on key techniques and concepts.
- Mobile GBV/CP and mobile medical units (MMU) and other services should be coordinated to ensure communities receive comprehensive and integrated services.
- Mobile activities should strive to conduct group psychosocial activities and not be limited to one to one sessions.

4.6 Outreach and awareness raising:
The 2014 report by UN Women indicated that GBV services were identified as focused on raising awareness, and the alternatives that were presented to women were so risky that the women felt that
they would be in a worse situation, if they followed the advice offered. For example, the report indicated that women were encouraged to move freely, go out and come home whenever they want without anyone (even their husbands), having the right to ask where they have been. During this recent assessment, a number of partners mentioned their heavy focus on awareness raising, especially related to GBV. Given the added challenges related to working with girls and their limited agency over decision making, such an approach would reduce girls’ ability to access services and would not be appropriate for girls and could potentially cause harm.

One partner indicated that they go door to door to give information about the services offered and provide a ten minute presentation on Violence against Women (VAW). They stated that they faced resistance from men in particular, and when they want to engage adolescent girls. This is particularly challenging as parents can be suspicious of their services. Partners are prone to transmit key messages to the community on child marriage and the importance of education. Yet when the community expresses the root causes (i.e. not able to access education due to lack of documentation or limited income), some staff are not fully equipped to tackle these issues in a meaningful or comprehensive way that will address the issues they are raising awareness about.

Many partners are predominantly reaching girls who already have access to services, with no targeted strategy to reach vulnerable groups such as understanding the groups they currently access and identifying vulnerable/invisible groups that are not being reached and working with wider communities to try to engage these girls. A number of partners mentioned that a main entry point for outreach is schools. Door to door visits are also conducted, but some partners are not able to communicate key information about services in an adolescent friendly way, and are also unsure of how to approach gatekeepers. Community outreach coverage is limited and/or not strategic in some locations. During one field visit, a woman who lived two tents away from a women’s centre explained that she was unaware of the services available at the centre that she passed by each day. The 2016 GBV assessment report further reinforced the point, that services are mainly reaching those who already have access. One participant during assessment stated that “most women are not here (“safe space”), they never come here, and they are not stepping outside of their tents”, the opinion came from FGDs participant in Dohuk and was supported by many in the group.

Recommendations:

- Staff need to be trained on how to explain services to adolescent girls and how to talk about GBV services in the community, without creating stigma for groups accessing services.
- Staff should be familiar with the importance of trust building and discussing issues of access with parents.
- Explicitly identifying safe spaces where girls will not be mixed (date/time of girl only spaces) and emphasising sessions and activities that parents will approve of is crucial.
- Ensuring that staff are familiar with the issues in a specific location before giving blanket awareness raising sessions and disseminating key messages is important.
- Targeted outreach for vulnerable girls outlined in 2015 interagency child marriage guidance note i.e. girls in non-camp settings, out of school, not accessing services, married adolescents and adolescent mothers.
- Train staff on approaches that should be undertaken to expand the reach to more vulnerable groups of adolescent girls.

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25 We Just Keep Silent: Gender Based Violence Against Syrian Refugees in The Kurdistan Region of Iraq, UN Women, 2014
26 An Assessment of GBV: UNFPA by Dr. Aysel Vazirova, 2016
4.7 Child Marriage:
For 11 to 18 year old girls, assessments have shown child marriage to be the major risk factor preventing them from enrolling in school and continuing their education. The 2015 Interagency Child Marriage Guidance Note for Kurdistan Region of Iraq states that there are girls who are particularly vulnerable to child marriage, which includes those who live in economically vulnerable families, those who are out of school or those who have never attended school and IDP and refugee children. However, through the assessment, it was apparent that the practical implementation of the Guidance Note was limited with those consulted. Partners were predominantly reaching girls who attend school through their activities and services, whilst girls at higher risk of child marriage are not actively targeted through outreach.

Both girls and mothers, when asked what they think a suitable age for marriage is said approximately 18 years and above. When asked what age girls are actually getting married, women and girls explained that girls are getting married much younger due to many issues. Mothers in camps explained that this was mainly to get girls outside of the camp so that they can have a better life or because the situation is difficult and they cannot support them so marriage is a better alternative. Yet in one location (among refugees and IDPs from a certain socio-economic class) mothers explained that girls were marrying later due to parents being more educated about child marriage. In Domiz Camp, the prevalence of child marriage was not clear for partners, with three different actors stating it varied from not common to very common, again highlighting a disconnect between staff understanding and the situation on the ground. Girls listed a number of reasons why girls might get married at a young age. Aside from parents forcing girls to marry, other reasons included girls being in love, girls wanting to escape from their current situation or because there were no other options for them (e.g. school, training). Staff from two different refugee camps mentioned that there was a high divorce rate among girls and this created a lot of stigma and potential for more violence among girls.

Recommendations:
- In order to reduce the risk of child marriage, it is important to meet the basic needs of families. Families must be able to feed, clothe, house, and protect their children in order for there not to be a perceived benefit in marrying their daughters at early ages.
- Married girls and adolescent mothers need to be targeted through specific interventions that meet their specific needs. These groups in particular will find it incredibly difficult to access services and when they do, are usually accessing activities/information with women, which doesn’t take into consideration specific issues related to their age and their situation. Programming should not only focus on prevention, but also on responding to the existing needs of these girls.
- Programmes addressing child marriage need to be comprehensive and inclusive of health, education and/or livelihood opportunities; teaching life-skills and decision-making; and/or fostering economic literacy. In particular, barriers to accessing school (distance, language, curriculum, fees), as well as other education and skills programming, is a major factor contributing towards girls not accessing education and families resorting to child marriage.
- Education, livelihoods, health, and protection clusters are all critical to discussions and planning around preventing and responding to child marriage. Although interventions may most often be designed by those working on GBV, much of the implementation and monitoring needs to be done by other actors.

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27 Education Cluster Iraq Dashboard, June 2015.
4.8 Education:
Many families are afraid to send their girls to school due to security concerns\textsuperscript{31} and in a recent Save the Children report\textsuperscript{32} youth spoke about physical punishment at school, unprofessional or untrained teachers, and education equivalency recognition documents not being recognised outside of the Kurdistan Regional Government (KRG). Both youth and their parents identified education as one of the key drivers in their decision-making about leaving Iraq according to the Save the Children report.

These issues were also raised by girls during this assessment. Girls who were able to access school said that they experience harassment to and from school, within the school itself, both by their male counterparts and by teachers. Furthermore, physical punishment in schools was pervasive and the quality of teaching, inadequate, this was not just limited to Government schools. Girls also reported that when they raised this issue to their parents, their parents threatened to remove them from school. Mothers also complained about the treatment of their children in school by teachers. The issue of poor quality education and mistreatment by teachers in school is a contributing factor to the drop out of girls. Mothers and girls reported incidents of beating, one girl described how her sister had experienced a damaged eardrum due to a teacher forcefully inserting something inside her ear. Other girls complained about being made to clean during lessons instead of learning. Girls noted that teachers were not teaching during the lessons and they were frustrated at not learning. One girl said ‘if I am not telling my mother what is happening at school, who else can help us’ indicating that they do not feel they have anyone to turn to for issues.

Additionally, girls and mothers raised issues concerning lack of teachers, overcrowding in schools, language barriers at school and in one case, girls reported that the distance to school at the camp was too far and a contributing factor to girls not attending.

Recommendations:
- Training on positive discipline and healing classrooms should be carried out for teachers.
- There should be established referral mechanisms in schools whereby children can report cases of harassment and abuse through social workers or focal points.
- Issues related to quality of teaching need to be assessed and addressed by the Education Cluster and Ministry of Education.
- Providing separate shifts for girls and boys should be encouraged in locations where mixed classes are a barrier to accessing school.
- Understand and address the root causes of barriers to education access such as providing unconditional cash transfers in parallel to key messages that encourage parents to send girls to school.

4.9 Health:
The Ministry of Health is yet to roll out the adolescent friendly health guidelines developed by UNFPA. Ministry staff reported that this was due to lack of funding and management, further exacerbated by high staff turnover inside the clinics. Some staff felt it was not a priority and therefore did not see the urgency or necessity to roll the guidelines out. One doctor from a reproductive health clinic requested more support in setting up an adolescent friendly clinic and training on how to deal with this group in particular. Some clinics hold information sessions at WCC or are connected to a WCC which makes access for girls easier, however in most cases, ASRH information was still being given for women and girls together.

Mothers mentioned that girls usually receive information on ASRH issues from them or their older sisters. They felt this information was important and it was accepted that this information could be

\textsuperscript{31} Gender-Based Violence Sub-Cluster Strategy for Iraq: 2016
\textsuperscript{32} Uncertain Futures: The impact of displacement on Syrian refugee and Iraqi internally displaced youth in Iraq. Save the Children, 2016.
given by someone trained to do this. It was also clear that staff from CFSs, YFSs and WCCs that did not have a health background did not feel comfortable giving basic ASRH information to girls. Many felt that this should be given by doctors or specialised health staff, although the information is quite basic and included in many life skills packages that are implemented in Iraq.

In most health clinics, girls who come for services need to provide the identification card of their husband or parent in addition to their own for registration. Although in some locations this is not enforced, these exemptions are not commonly known and can be a barrier for girls who want to attend clinics without approval from husbands or parents. The 2016 GBV assessment report 33 highlights added barriers and identified that for a large share of women in IDP and refugee communities visiting a doctor requires considerable effort. A woman has to a) ask permission from husband/parents; b) find someone to accompany her (often the perpetrator or people close to him/her); c) make time for a visit between home chores; d) find money; e) travel sometimes long distance (security concern and a hidden cost, very relevant for IDPs in sparsely populated, rural areas).

Recommendations:
- The UNFPA model on adolescent friendly health services should be rolled out. Specific issues related to the roll-out, including resources and overseeing the process should be addressed.
- Develop alternative approaches to accessing girls through reproductive health services. Having clinics near or attached to a WCC is a good practice that improves girls’ access to ASRH services.
- Clinics should provide outreach and information sessions in places where girls feel comfortable. This information should be provided separately to women/girls, be tailored and age appropriate.
- An assessment on barriers to ASRH should be conducted, with consultation from adolescent girls, to gain further information to improve programming.
- Advocate for the discontinuation for the need of identification from parent/husband for registration to access health services as this can be a barrier for girls.
- ASRH and hygiene information, related to menstruation needs to be prioritised for girls from at least age 10 years (or earlier), to prepare them for changes they will experience during puberty.
- More collaboration between health and protection to identify vulnerable girls. Doctors are seen to hold a position of power and have access to groups. They can use this opportunity to identify key concerns among girls and specific groups to work with. If fully aware of available services, they can also make recommendations for programming.
- Staff with access to girls should be trained on how to give basic ASRH information and awareness.

4.10 Non-Food Items (NFIs):
Women in one camp mentioned that they were receiving NFIs that were not based on their needs. In the same camp, children attending school were denied access to NFIs as they were at school at the time of distribution and when they went to collect the NFIs after school, they were told the items had all gone, later these items were being sold on. This was also identified as a reason why children were missing school, specifically during distribution times.

Outside of camps, there were complaints that services, especially distributions, do not reach people. Services should be provided outside of camps as well as inside to ensure that vulnerable groups outside camps have same access to basic assistance. Overall, it was evident that a lack of assessment to understand needs and appropriate times for distributions have a direct impact on adolescent girls as their specific needs are not being addressed, as well as an impact on the wider community.

Recommendations:
- It is crucial that the basic needs of families are met. In the absence of this, girls will at a higher risk child marriage that is used as a negative coping mechanism.

33 An Assessment of GBV: UNFPA by Dr. Aysel Vazirova, 2016
Invest in consultations prior to distribution, with consultations held separately for different groups, women, men, girls, and boys, to understand their specific needs.

Consultations for women and girls should be conducted by female staff so that women and girls feel comfortable expressing their needs.

4.11 Privacy:
Across a number of locations visited, it was observed that photos of adolescent girls were taken by staff on mobile phones with no consent requested at the time. It is possible that some had provided consent prior to sessions, however, in cases where it was the first time that girls were attending, photos were taken. Partners mentioned that for some children, consent had been obtained, but it was hard to follow up as consent was taken for videos and for others it was only photos. They noted that remembering who consented for videos or photos was not easy to track. Many staff were unfamiliar with the concept of gaining consent from a parent/guardian prior to taking photos.

Some partners mentioned that using social media as a means to connect with girls would be effective to reach those who were unable to participate in activities. However, in one Arab IDP camp, girls noted the potential negative perception in the community if the community sees them using mobile phones. Girls noted that if they were seen in public using mobile phones, or on social media, the community would gossip about them and this could bring shame to the family. None of the girls in this specific camp had personal mobile phones, some had access to a family device that they could only use indoors. Many of these girls mentioned that they did not use social media applications due to the potential stigma.

Recommendations:
- Staff who are working with children or vulnerable groups should be trained on ‘do no harm’ and principles of consent. They should be aware of roles and responsibilities regarding consent, documenting activities and taking photos.
- If possible, organisations should identify focal points to be responsible who are trained and understand issues on consent and taking photo in ways that don’t make girls feel uncomfortable or cause harm.
- Programming that relies on social media should take into consideration potential repercussions for certain groups of girls.
5. Conclusions

With the growing levels of sexual violence, harassment, child marriage, exploitation and abuse that adolescent girls are facing and current service provision unable to meet the specific needs of adolescent girls, these girls are increasingly vulnerable. Staff capacity is sometimes stretched, with technical expertise in addressing the needs of adolescent girls, limited. In addition to training, staff need coaching and mentoring on tailored interventions that will help to build girls’ skills and ability to prevent, mitigate and respond to GBV.

Girls who are not currently able to access services, are not in school, are engaged or recently married, and especially girls between the ages of 10-14 years old need to be a prioritised in adolescent girls interventions. Partners needs further support and guidance in how to reach these girls and how to respond to their particular needs.

6. Next steps:

6.1 Adolescent Girls Toolkit:

- UNFPA and UNICEF identified a need to develop more tailored interventions to respond to the needs of adolescent girls, especially to prevent, mitigate and respond to GBV and to improve their health and wellbeing that were highlighted during this assessment. As a result of the assessment and through consultation with girls, mothers and partners, the adolescent girls’ toolkit was designed and contextualised for Iraq.
- The toolkit has been designed to meet the varied needs of girls in the Iraq context, from tailored targeted interventions to longer term implementation.
  - The toolkit comprises of three components, setting up adolescent girls programme (a significant need given partners’ existing limited capacity in adolescent girl programming techniques and approaches), comprehensive curriculum addressing the needs of girls and community participation.
  - The key components of the curriculum include trust building, life skills, reproductive health, safety, financial literacy and leadership.
  - Sessions take into account literacy levels of girls, ensuring they are accessible to all.
- Training has been conducted for key staff who will pilot the toolkit and feedback will be collected regarding session content and relevance to the context from participating partners’ staff across KRI, Baghdad and Diyala Governorates.
- The Adolescent Girls Toolkit should be adopted by partners working with girls across multiple clusters. Where possible, the learning sessions in the curriculum should be implemented. However, even where it’s not possible, the basic steps in adolescent girls programming can be followed to provide service providers with information and suggestions on how to better engage with girls.
- Comprehensive programming needs to involve multiple actors engaging with adolescent girls. GBV programming alone is not enough to address the complex and comprehensive needs of girls and should include education, health and economic empowerment. Successfully engaging communities to support girls is crucial.

6.2 Adolescent girls’ toolkit follow up:

- As part of the follow up on the adolescent girls’ toolkit pilot, there is a need to provide on the job support to assess facilitators’ techniques on implementing the toolkit, as well as providing coaching and mentoring support.
- Technical support should be made available to partners to guide them through the process of setting up adolescent girl programmes, recruiting girls and facilitating the curriculum. The
provision of additional materials and adaptations for sessions on an ongoing basis to meet the needs and demands of partners is needed.

- Monthly check-ins should be organised for staff who are piloting the toolkit to identify any issues arising and recommendations on how to move forward.
- After the piloting phase, it is recommended that a review takes place to assess the success of the pilot, through partner meetings, visits, discussions with staff, girls, parents and other key gatekeepers. It’s important to identify any key issues arising with curriculum content and also to understand if specific vulnerable groups have been reached through the pilot phase.
- A workshop should be conducted to assess progress, challenges and adaptations to the toolkit, prior to finalisation. Based on workshop recommendations, the toolkit can be adapted and finalised.
- Partners should also be given the opportunity to identify supplementary gaps in skills and knowledge that they still need training on, during the workshop, time can be allocated to specific training components they need.
## Annex 1

<table>
<thead>
<tr>
<th>Government Ministries</th>
<th>UN Agencies</th>
<th>NGOs</th>
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<tbody>
<tr>
<td><strong>Ministry of Health Erbil</strong>&lt;br&gt;Janin Al Jazrawi</td>
<td>UNICEF (Erbil, Dohuk, Sulaymaniyah)&lt;br&gt;Sinéad Murray&lt;br&gt;Star Anwar&lt;br&gt;German Robles Asuna&lt;br&gt;Addul Rahman Mohammed</td>
<td>Agency for Technical Cooperation and Development&lt;br&gt;Jessica Stuart Clark</td>
</tr>
<tr>
<td><strong>Ministry of Labour and Social Affairs Erbil</strong>&lt;br&gt;Dr. Arif Heto</td>
<td>Education Cluster (Erbil)&lt;br&gt;Karly Kupferberg</td>
<td>Al Masala&lt;br&gt;Salwa Sabir&lt;br&gt;Diman Nadir</td>
</tr>
<tr>
<td><strong>Directorate of Labour and Social Affairs (Sulaymaniyah)</strong>&lt;br&gt;Vian Mohamed</td>
<td>UNFPA (Erbil, Dohuk and Baghdad)&lt;br&gt;Veronika Njikho&lt;br&gt;Ahmed Tahir&lt;br&gt;Dr Rabab Ahmed&lt;br&gt;Dr Hiba Mohsen&lt;br&gt;Hayder Mohamed&lt;br&gt;Seepal Tayeb&lt;br&gt;Suha Nimir&lt;br&gt;Dr. Hayder Ismail Al-Tawela&lt;br&gt;Y PEER: Rasty Brimo</td>
<td>Civil Development Organisation&lt;br&gt;Ashna Raof Mahood&lt;br&gt;Tania Awat Rasheed&lt;br&gt;Payam Ahmad</td>
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<td><strong>Dohuk General Health Directorate</strong>&lt;br&gt;Dr. Bakhtiar Ahmed Rashed</td>
<td>UNHCR Erbil&lt;br&gt;Mohamed Ali Elshazly</td>
<td>Harikar&lt;br&gt;Avivan Najman Rasheed&lt;br&gt;Sparwa Shmoel&lt;br&gt;Sozdar Suliman Khalaf</td>
</tr>
<tr>
<td><strong>Directorate of Health (Sulaymaniyah)</strong>&lt;br&gt;Dr Rozhgar A Saleem</td>
<td>International Rescue Committee&lt;br&gt;Dalia Amin&lt;br&gt;Shan Serwan&lt;br&gt;Didar Bahaddin&lt;br&gt;Ivana Chapcakova</td>
<td>International Medical Corps&lt;br&gt;Harriet Omina Oyombe&lt;br&gt;Nalin Ali&lt;br&gt;Vindar Abdulrahim&lt;br&gt;Zozen Mela Ali</td>
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<td>Intersos&lt;br&gt;Claudia Nicoletti</td>
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<td>Norwegian Refugee Council&lt;br&gt;Reem Shammout&lt;br&gt;Jihan Hiso&lt;br&gt;Israa Mustaf&lt;br&gt;Manal Hajin</td>
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<td>Nujeen&lt;br&gt;Nazik Barakat</td>
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<td>Save the Children&lt;br&gt;Paola Franchi&lt;br&gt;Bashir Said&lt;br&gt;Haitham Majeed</td>
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<td>Seeking to Equip People&lt;br&gt;Rana F. Ameen&lt;br&gt;Omima Mussa</td>
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<td>Tajdeed&lt;br&gt;Rusul Abid Kareem</td>
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| Raghad Abd Kareem  
| Hadeel Mohammed  
| Aklass Addullatif  
| Terre des Hommes  
| Kimi Sekhon  
| Women’s Empowerment Organisation  
| Rebwar Radha  
| Snoor Sabah Abdalla  
| Mardeen Jasim Muhammed  
| Women Rehabilitation Organisation  
| Zahar Shamal  
| Janneke Rijnart  
| NGOs participating in Dohuk Workshop  
| Harikar  
| Nujeen  
| IOM  
| UPP  
| WRO  
| SOSD (The Sinjar Organization for Social Development)  
| UPP (Un Ponte Per)  
| VOP (Voice of Older People and Family)  
