Guest Editorial

Early marriage and pregnancy among Syrian adolescent girls in Jordan; do they have a choice?

International humanitarian agencies and member states have adopted and begun implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), aiming to reduce preventable deaths, ensure health and well-being and expand enabling environment. The strategy focuses on adolescents living in middle- and low-income countries where they are most vulnerable. Yet, in many of these countries, adolescents are not seriously considered in the planning process and their issues are not prioritized in national agendas. Staff working at the program are culturally remote and socially distant and often fail to recognize the needs of the young girls and women that they should be supporting. Frequently, planning staff still adhere to cultural misconceptions about the ability of adolescents to understand their needs and take decisions for themselves or whether they are entitled to discuss fears, issues, and anxieties associated with their sexual sphere. In some social contexts, the senior staff feel that younger women, in particular, must adhere to social norms, and thus they have no say or choice in how they behave. This last factor in planning and decision-making for adolescent girls and young women is especially prevalent in the Middle East, where strong social norms and customs dictate every layer of sexual or reproductive behavior.

There are many contributing factors that limit girls' and women's ability to make choices in the Middle East. Taboos and norms about sexuality pose strong barriers for humanitarian agencies to provide information, reproductive health services and other forms of support that adolescents need to be healthy. Parents reserve the right to marry off their daughters against their will, and the husband decides when to have children on behalf of his wife, who is too often under the age of 18 years old when she marries. A husband and wife are bound under strong and enduring social and cultural expectations to these roles. Even when the marriage is a source of great suffering for young women, they find it impossible to adopt solutions more appropriate to their physical and emotional well-being. In this context, the global community must question what a 15-year strategy[i] can do in a socially and politically unstable region, where so many factors including economic disparity, insecurity, social norms, and low education make reproductive rights and health equity among adolescents hard to achieve.

The Syrian crisis, after five years, is considered the biggest emergency in human terms since the World War II. It has left almost five million women of reproductive age, without adequate proper sexual and reproductive health education, vulnerable and in need of assistance. In Jordan alone, over 650,000 Syrians have sought refuge. Here, there are 156,000 registered women of reproductive age of which 42,000 girls are between 12 and 17 years.[ii] The situation of these adolescent girls is alarming; they are forgotten and their voices are not heard, and their status as refugees increases their vulnerability. Today, thousands of adolescent girls who are physically and mentally transitioning from childhood into adulthood are exposed increasingly to emotional stress, social instability, and exploitation, including sexual and gender-based violence (S-GBV). While this humanitarian crisis unfolds a dramatic increase in early marriage and early pregnancy amongst adolescents putting them at high risk of maternal mortality and morbidity.

For example, the percentage of underage Syrian refugee girls who registered their marriages in Jordan increased three times from 2011 rates, to reach 32% of all marriages by 2014.[iii] Child marriage was already an acceptable practice inside Syria before the crisis, now the strains felt upon families has led to a dramatic increase in this phenomenon.[1] Syrian refugees resort to child marriage as a common and appropriate response to 'compelling circumstances,' such as to gain economic security.

In Zaatari camp, which is one of the biggest refugee camps in the world, hosting around 80,000 refugees including 2000 pregnant women at any given time, evidence shows deliveries among girls under 18 years of age has increased from 5% in the first quarter of 2013 to 8.5% in 2014.[iv] Despite efforts to prevent early pregnancy through multi-sectoral effort and, in particular, through S-GBV and family planning programing and awareness campaigns, few girls are able to attend reproductive rights sessions and access services, and even when they do, their choices and ability to make decisions remain limited. Many refugee girls already face steep challenges to continue their

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education due to economic and social barriers, and early marriage and motherhood virtually ensures the end of educational opportunity. Additionally, on top of imposed pressures to marry, some girls see marriage as a means to lift restrictions on their movement and social life, which are limited as families perceive greater risk for girls in camps or communities where traditional social systems are broken down and see confinement as the best means of protection.

Aid planning in Syrian refugee camps must take into account that discussing sexual and reproductive health is a prohibited practice, particularly for girls. Adolescents in the Zaatari camp are under pressure to marry and become mothers, they live in small, conservative communities, they are left with no options to continue their higher education and with no hope to become economically independent. We assist these girls, but this systematic abuse of vulnerable women will not desist without advocating aid and humanitarian agencies to implement courageous policies (no compliance-no aid) aimed at disseminating knowledge of reproductive biology and awareness of health and rights in young girls living in refugee camps. We need to challenge taboos and traditions, and ensure that, in a not too distant future, deprived young vulnerable girls have a say in their reproductive and social life.

These girls and young women have the right to decide freely and responsibly on matters related to sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. They have the right to have more opportunities, to be empowered and supported. They must have a voice in the decisions and policies that impact their lives, and they should not stay forgotten.

We need to ask what we, as a global community, can do to ensure that the lives of these girls are protected and saved. We must re-examine our collective efforts to create and enact policies, provide services, implement programs and interventions on reproductive health to reduce the percentage of girls who marry as children and experience early pregnancy. We also need to better engage men and boys in the planning and implementation process while we increase the participation of girls in social and educational activities. Simply, we should be more serious in addressing the root causes of the problem and its contributing factors rather than staying within the comfort zones of our own beliefs, tradition, culture or authority.

If these young girls had a choice; they would keep studying and playing as our own children do.

Notes

i The global strategy for women's, children's, and adolescents' health (2016–2030).
ii http://data.unhcr.org/syrianrefugees/country.php?id=107#.
iii A study on Early Marriage in Jordan, October 2014, UNICEF.
iv Health Sector Humanitarian Response Strategy: Jordan 2014–2015.

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Reference

1 Almerie Y, Almerie MQ, Matar HE, Shahrour Y, Al Chamat AA, Abdulsalam A. Obstetric near-miss and maternal mortality in maternity university hospital, Damascus, Syria: a retrospective study. BMC Pregnancy Childbirth. 2010;10:65. doi: 10.1186/1471-2393-10-65.

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