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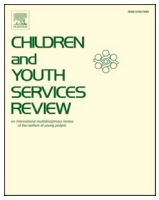

Stakeholders' views on addressing adverse childhood experiences in the Maghreb: A participatory approach

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ABSTRACT

Background: Adverse Childhood Experiences (ACEs) are traumatic events with lasting impacts on health and wellbeing into adulthood. Countries in the Maghreb have some of the highest rates of ACEs in the world, though there is minimal local research from the region.
Objective: To gather perspectives from local stakeholders to inform the development of effective and sustainable local programmes that address the high rates of ACEs across the Maghreb.
Participants and setting: We conducted nine Participatory Learning and Action (PLA) workshops with 86 stakeholders in Nouakchott (Mauritania), Taroudant (Morocco) and Mahdia (Tunisia). We conducted three PLA workshops in each country with: 1) Parents of children at risk of ACEs (n = 29); 2) Non-governmental organisations staff (n = 31); and 3) Senior professionals (n = 26).
Methods: PLA workshops consisted of Participatory Rank Methodology (PRM) activities to understand the factors influencing children's exposure to ACEs and a case vignette activity to understand stakeholders' perceptions of the available resources to protect children from ACEs. We coded and analysed data using thematic and narrative analysis.
Results: Factors influencing children's exposure to ACEs highlighted by stakeholders through the PRM exercises included parenting skills, access to services, and marginalisation of single mothers and their children. Responses to case vignettes varied by country, with stakeholders in Mauritania and Tunisia expecting response from government and community networks, while in Morocco the emphasis was on community networks only.
Conclusion: Local stakeholders proposed strengethening community networks to mitigate ACEs in the Maghreb. Findings demonstrate the importance of family stability, accessible government services, and community support for reducing children's exposure to ACEs. Further research is required to develop tailored programmes addressing regional challenges.

1. Introduction

1.1. Background

Adverse Childhood Experiences (ACEs) are traumatic events occurring during childhood, which have negative impacts on health and wellbeing into adulthood (Madigan et al., 2023). ACEs include childhood physical, emotional, and sexual abuse; neglect; and household dysfunction, such as domestic violence, substance abuse, mental illness, divorce, and incarceration of a family member. Individuals with at least

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four ACEs are at higher risk for sexual risk-taking, mental ill-health, substance abuse, and self-directed violence (Petruccelli et al., 2019). ACEs are also reported to reduce longevity and increase disease burden (Egle et al., 2016) and have been identified as a global public health concern, with a 10 % decrease in ACEs in Europe and North America reported to equate to annual savings of $105 billion (Bellis et al., 2019).

Despite the prioritisation of addressing ACEs in the United Nations' Sustainable Development Goals (Goal 16.2) (United Nations, 2024), high rates of ACEs have been reported in the countries of Maghreb (Algeria, Libya, Mauritania, Morocco, Tunisia, and Western Sahara) (Baghdadi et al., 2024; Elghossain et al., 2019). High rates of ACEs in this region have been influenced by an increase in rural-to-urban migration (Bouoiyour et al, 2017) due to climate change and the limited access to government services for growing rural populations (Waha et al., 2017), high unemployment and poverty (Yassin et al., 2016) and the stigmatisation of individuals living outside traditional family structures (Serrano-Ruano, 2018). Moreover, changes in the social contract between the public and the state in the twentieth century fragmented the traditional family and community structures in the Maghreb (El-Haddad, 2020).

In this study we focus on three countries of the Maghreb – Mauritania, Morocco, and Tunisia. Government strategies and policy objectives exist for strengthening the child protection systems to reduce ACEs in Mauritania (Davis et al., 2012), Morocco (Royaume Du Maroc, 2014), and Tunisia (Save the Children Sweeden, 2011a). However, challenges persist across these governments to implement the strategies. These include geopolitical and domestic instability (Hinnebusch, 2015) and a high proportion of children living in institutions in the region (4,180/100,000) compared to the global average (224/100,000) (Baghdadi et al., 2024; Desmond et al., 2020). Limited resources for government services also hinder progress (Bilo & Machado, 2018), as do cultural norms and legislative structures discriminating against those living outside prescribed family structures, usually single mothers and their children (Serrano-Ruano, 2018). Additionally, integrating alternative forms of care, such as *foster care,* with culturally compatible approaches like *kafala* presents further obstacles (Yassari, 2015). Lastly, all countries in the Maghreb face a shortage of accessible data and research to inform interventions and policy (Machado et al., 2018). While these countries share these challenges, each is shaped by unique socio-political and economic environments (Henry, 2018), leading to distinct obstacles in addressing the high rate of ACEs in the region.

Mauritania faces challenges in preventing ACEs due to high rates of poverty (32 % of the population) (World Bank, 2024a), limited resources dedicated to government services (Ouldzeidoune et al., 2013), and the legacy of chattel slavery (Snyder, 2012). These socio-economic and historical factors mediate an environment where harmful practices are more likely to persist. Poverty limits access to education and health services, which can perpetuate cultural practices such as female genital mutilation (41 % of girls aged 0–14 and 62 % of women aged 15–49) (Cetorelli et al., 2020) and child marriage (13–18 % of women aged 15 to 29 are married before age 15) (National Agency for Statistics, 2023), as families may see them as economic necessities or cultural imperatives. Similarly, the lack of governmental resources hampers the enforcement of laws and the provision of protective services, leading to high rates of child labour (37 % of children aged 5–17) (United Nations Children's Fund, 2023) and the physical abuse of children (80 % of children reported having been subject to violent discipline by a parent or guardian) (End Corporal Punishment, 2021). The country also serves as a destination for separated children from Western, Central and Eastern Africa, with many unaccompanied children forced into begging (UNHCR, 2019).

In Morocco, the absence of specific child protection legislation and under-resourced social services leads to a fractured child protection system (Save the Children Sweden, 2011b; UNICEF, 2023). Challenges include high levels of violence towards children (UNICEF, 2019a), child street connection, and child labour (UNICEF, 2019b). There are also high rates of child abandonment, with Moroccan courts identifying an average of six children abandoned at birth each day in 2021, approximately 1 in 300 births (Royaume Du Maroc, 2021; United Nations, 2021).

Tunisia experiences resource gaps in its public health and child protection systems (Save the children Sweeden, 2011a), contributing to high rates of ACEs including neglect and physical abuse (Braham et al., 2018). ACEs in Tunisia have been shown to contribute to addictive (El Mhamdi et al., 2017) and suicidal behaviours (Mlouki et al., 2023), obesity (El Mhamdi et al., 2019), and adverse pregnancy outcomes (Salah et al., 2019).

In the countries of the Maghreb, as in other regions of the Middle East and North Africa, the collectivist culture is characterised by a patriarchal endogamous kinship system (Harb, 2015). The culture perpetuates a sense of collective responsibility and close-knit social bonds, with people expected to conform to societal norms and expectations (Al-Hassan, 2024). This culture may not always fully align with the interventions, strategies, and systems developed and implemented through an individualist Western lens and may therefore impede the development of effective and sustainable local interventions, strategies, and systems to reduce ACEs (Krueger et al., 2015; Finkelhor & Lannen, 2015). Child protection strategies in the Middle East and North Africa region must be tailored to specific countries and contexts, considering local cultural values and child protection system typologies (El-Hoss, 2023).

The Maghreb region is underrepresented in the global ACEs literature. For example, a report on the effectiveness of parenting interventions to prevent child maltreatment, including two primary systematic reviews, two systematic sub-reviews, and one narrative review, with a total of 435 randomised controlled trials from 65 countries, did not include studies from the Maghreb (Backhaus, et al., 2023). Similarly, the recent Oxford Handbook of Child Protection Systems (Berrick & Skivenes, 2023), providing an overview of child protection typologies in 50 countries spanning seven continents, does not provide information on child protection systems in any country of the Maghreb. This gap in research underscores the importance of incorporating local perspectives to inform effective and sustainable local programmes in response to the high rates of ACEs across the region.

This study aims to gather perspectives from local stakeholders to inform the development of effective and sustainable local programmes that address the high rates of ACEs across the Maghreb. We used participatory learning and action techniques to identify the views of key stakeholders in three countries of the Maghreb to explore two areas: 1) factors influencing children's exposure to ACEs; and (2) available resources to protect children from ACEs.

2. Methods

2.1. Study design

This paper presents findings which form one part of a larger project, StrengtEning Child safegUarding Research through knowledge Exchange and collaboration between Wales and the Maghreb (SECURE) (Swansea University, 2023). SECURE aimed to strengthen relationships between researchers and Non-Governmental Organisations (NGOs) in the United Kingdom and the Maghreb to support the inclusion of local perspectives into future ACEs research in the region. We used a qualitative design, conducting Participatory Learning and Action (PLA) workshops with local stakeholders. We utilised a phenomenological approach within a constructivist paradigm to ensure that the research is rooted in the participants' experiences, allowing for a more thorough and culturally sensitive analysis (Liamputtong & Rice, 2021).

2.2. Study aim

This study aimed to gather perspectives from local stakeholders to inform the development of effective and sustainable local programmes

that address the high rates of ACEs across the Maghreb. We sought to understand the views of local community members, practitioners, and stakeholders on factors increasing or reducing children's exposure to ACEs and to identify protective and mediating factors that could guide the development of locally adapted interventions. As part of the wider SECURE study, we aimed to support the inclusion of these local perspectives in future ACEs research and intervention development, fostering collaboration between researchers and NGOs in the Maghreb.

2.3. Study setting

We conducted the study at three urban sites across the Maghreb region: Nouakchott, the national capital of Mauritania; Taroudant, a provincial capital in the Souss-Massa region of Morocco; and Mahdia, the capital of the Mahdia Governorate in Tunisia. Researchers from the University of Nouakchott Al Aasriya (Mauritania), Ibn Zhor University Agadir (Morocco), University of Monastir (Tunisia), and Swansea University (United Kingdom) collaborated with local NGOs to facilitate the workshops, including Association Mauritanienne pour la Sante de la Mere et de l'Enfant (AMSME) in Nouakchott, Mauritania, Fondation Amane pour la Protection de l'Enfance (FAPE) in Taroudant, Morocco, and Voix de l'Enfant (VdE) in Mahdia, Tunisia. We partnered with local NGOs as they possess unique local knowledge, trusted relationships with the local populations, and a long-standing commitment to addressing ACEs in their communities.

2.4. Participant recruitment

We conducted PLA workshops in each country with: (1) Parents of children at-risk of ACEs who were service users of our partner local partner NGOs (AMSME, FAPE, VdE), (2) Frontline staff at our local partner NGO, and (3) Senior professionals who held respected and influential positions at each study site (e.g. elected officials, civil servants, and the directors of local schools, residential centres, and NGOs). We used purposive sampling (Palinkas et al., 2015) to recruit participants for the PLA workshops from our target groups. Our partner NGOs in each country sent invitations through their community, staff and stakeholder networks by flyers through mobile text messaging and email as well as through face-to-face contacts.

2.5. Data collection

We collected data from April 2022 to April 2023. We conducted three PLA workshops at each study site: Nouakchott, Mauritania (November 2022), Taroudant, Morocco (March 2023), and Mahdia, Tunisia (March 2022). We designed our PLA workshops based on the Child Protection System Mapping Research Manual developed by Child Frontiers (Child Frontiers, 2010) which features recognised PLA activities tailored for engaging with local stakeholders. The manual has been used in five countries in West Africa to provide national stakeholders with a descriptive profile of their existing child protection system (Krueger et al., 2014). We followed international guidelines on ACEs research and selected PLA activities to ensure local stakeholders from the Maghreb were able to contribute to our future research and programme development (World Health Organisation, 2016). FB and VC created PLA workshop guides based on the Child Frontiers PLA activities in English and AS translated PLA workshops guides into Arabic, with guides cross-checked for accuracy by ESB, FB, and SEM.

Following the Child Frontiers manual, the guides provided information to a facilitator and notetaker on how to conduct and report on (1) a Participatory Rank Methodology (PRM) activity (Ager et al., 2011) which asked participants' views on what increases or reduces children's exposure to ACEs in their community and (2) a case vignette reflection activity which described a potential incident of child maltreatment for discussion about what would and should happen and the barriers preventing what should happen.

PRM activity: We asked participants to identify factors that *make children feel bad, unsafe, and insecure*. The facilitator then wrote factors on index cards. The facilitator then asked participants to think about whether there were other factors that should be considered and to provide a definition of each factor and the reasons they chose them. We then asked participants to rank all the factors in order of importance by placing the index cards along a line – numbered one (most important) to ten (least important) – that had been pasted with tape on the wall. Participants were encouraged by the facilitator to discuss, explain and debate among themselves about the factors, their meaning, and ranking. Once the ranking was finalised, participants were asked to discuss the ranking and to highlight areas of doubt or where disagreement could not be resolved. We then asked participants to identify factors that, "make children feel good, safe, and secure?" and repeated the ranking process.

Case vignette activity. This activity began with the facilitator reading aloud a vignette about a potential incident of child maltreatment relevant to the community. The vignette was also displayed on a projector to be easily visible to all participants. The case vignette was developed with our partner NGOs to ensure that it was culturally relevant and reflected a potential child maltreatment incident that would occur in each country. NGO partners agreed a shopkeeper at the local corner store – the Hanoot – would be the most likely person to encounter a child maltreatment incident and someone to whom all participants could relate. The case vignette was:

> Hanan Mouftale is 12 years old. She and her 4-year-old sister live with her uncle's family because her parents are working on a farm in another province. Last week, when Hanan went to the Hanoot, they saw bruises on her face. She told the Hanoot that she has been physically abused by her uncle. Sometimes the neighbours hear her and her sister crying.

Members of the research team [AS, EHBS, SEM] alternated between the roles of facilitator and notetaker for each workshop. We conducted PLA workshops in local Arabic dialects; Hassaniya (Mauritania), Darija (Morocco) and Tounsi (Tunisia). Notetakers took notes in Arabic which were later translated into English for analysis by AS, EHBS, FB, and SEM. We conducted all PLA workshops at local NGO partner offices, with staff members available to provide support if participants experienced distress. We invited all participants to a final dissemination event at each site to present preliminary results of the study and our future research plans.

2.6. Data analysis

FB coded data with the assistance of facilitators and notetakers (AS, EHBS, SEM,) directly following PLA workshops to ensure consistency and clarity with originally translated notes. Following initial coding, FB used inductive thematic analysis to identify patterns and themes across sites and participant groups (Naeem et al., 2023). When analysing the ranking data, we searched for similar themes within sites and for the participant groups across sites. When analysing the case vignette data, for the questions who would and who should support, we used thematic narrative analysis (Esin, 2011). We organised the information chronologically to develop a narrative detailing the processes of care from the perspective of each participant group at each site (i.e. parents, frontline staff, senior professionals). For the question regarding the barriers to support, we identified key themes in the responses provided by participants to develop codes across participant groups for each country. We then shared a copy of the draft manuscript in Arabic and English with the wider team for feedback and validation. We present the results for each activity and question by country, and then highlight commonalities and differences within the discussion section of this paper.

2.7. Ethics

We gained a favourable ethical opinion from the Swansea University

Medical School Research Ethics Committee (SUMS RESC 200-0041). Participant information sheets and consent forms were translated into Arabic. However, some participants were illiterate and therefore the workshop facilitators began each activity by reading aloud the participant information sheet in the local Arabic dialect to ensure all participants were able to provide informed consent. Staff from local NGOs were not present within the focus groups but were available in an adjacent room to support should participants feel distressed.

3. Results

We conducted nine PLA workshops with 86 participants in Mauritania (n = 30), Morocco (n = 26) and Tunisia (n = 30). The participants included 29 parents of children at risk of ACEs, 31 frontline staff from local NGOs, and 26 senior professionals. The mean age of all participants was 34 years, ranging from 19 to 55 years. Further participant characteristics are presented in Table 1.

3.1. Participant ranking

What makes children feel bad, unsafe, and insecure? During the PRM activities with stakeholders in Mauritania, parents and senior professionals both ranked poverty as the highest concern, followed by a lack of parenting skills. Family breakdown and limited access to social services was identified by all participant groups. While physical and sexual abuse was recognised by parents and frontline staff, it was not identified by senior professionals. Both frontline staff and senior professionals however expressed concerns about weak legislation, child marriage, and limited coordination between actors increasing children's exposure to ACEs. Senior professionals identified rural–urban migration as a concern and frontline staff identified corporal punishment, *talibs* (Islamic boarding schools, with reported high rates of corporal punishment (Ballet et al, 2012)) and marriage without official papers increasing children's exposure to ACEs (Table 2).

In Morocco, all participant groups expressed concerns about limited access to social, educational, and health services, with senior professionals highlighting the lack of services for care leavers as a particular concern. School non-attendance was recognised by parents and senior professionals as a concern but not by frontline staff. Single mothers and their children experiencing discrimination, family breakdown, poverty, and physical and sexual abuse were only identified as increasing children's exposure to ACEs by frontline staff and senior professionals. Street connection and the lack of parenting skills were acknowledged as concerns by parents and frontline staff. Frontline staff identified issues related to social media, sex work, substance use, and malnutrition. Parents were the sole group to identify the lack of child protection legislation increasing children's exposure to ACEs, while senior professionals were concerned with the implementation of the current law and the prevalence of child labour (Table 2).

In Tunisia, all participant groups identified poverty, a lack of parenting skills, family breakdown, and physical and sexual abuse of children as key factors increasing children's exposure to ACEs. Additionally, all groups highlighted weak social, psychological, and educational services as factors increasing children's exposure to ACEs. Both parents and frontline staff expressed concerns about discrimination against single mothers and their children. Frontline staff and senior professionals identified abandonment as a specific concern. Parents and senior professionals expressed concerns about social media. Parents were the sole group identifying violence towards women and substance use by children as concerns, while frontline staff was the only group to identify neglect and senior professionals the only group to identify school non-attendance as a concern (Table 2).

What makes children feel good, safe, and secure? In Mauritania, all groups identified the significance of free education and healthcare, the culture of community safeguarding, child protection legislation, and government social services in reducing children's exposure to ACEs. Frontline staff and senior professionals specifically highlighted the importance of local NGO services. Parents particularly emphasised the benefits derived from government employment services, which facilitated their access to employment opportunities, enabling them to secure a steady income to support their children. Senior professionals emphasised the role of residential centres and having a national strategy for a child protection system, while parents expressed the benefits of extended family support (Table 3).

In Morocco, all groups identified free education and healthcare as key factors reducing children's exposure to ACEs. Additionally, the availability of existing extra-curricular activities was recognised by all groups as also reducing children's exposure to ACEs. Parents and frontline staff highlighted the importance of everyday policing, while senior professionals emphasised the benefits of having a legal framework and political stability. Frontline staff and senior professionals underlined the crucial role of NGO services, while parents stressed the significance of good parenting skills. Frontline staff emphasised the importance of adequate housing, and senior professionals identified financial stability, government social services, and the culture of community safeguarding as integral factors reducing children's exposure to ACEs (Table 3).

In Tunisia, all groups emphasised the significance of child protection legislation, access to free healthcare and education, and government social services. Good parenting skills were considered crucial by all groups in reducing children's exposure to ACEs. Parents and frontline staff acknowledged the pivotal role of the government employed child protection delegate and NGO services. Additionally, frontline staff and senior professionals highlighted the positive impact of extra-curricular activities on reducing children's exposure to ACEs. Parents and senior professionals stressed the importance of access to basic needs and the

Table 1
Overview of workshop participants by country, participant group, and role. AMSME (Association Mauritanienne pour la Sante de la Mere et de l'Enfant); FAPE (Fondation Amane pour la Protection de l'Enfance); NGO (Non-Governmental Organisation); VdE (Voix de l'Enfant.

Country	Participant group	Number of participants	Gender		Mean age	Details
			Female	Male		
Mauritania	Parents	10	6	4	36	Service users of AMSME
	Frontline staff	11	6	5	35	Street outreach officers, social workers
	Senior professionals	9	2	7	42	NGO directors, school director, director of child protection in government social services, director of residential centre
Morocco	Parents	9	9	0	34	Service users of FAPE
	Frontline staff	10	7	3	33	Street outreach officers, social workers
	Senior professionals	7	2	5	40	School directors, local council representative, managers of community centre, NGO director
Tunisia	Parents	10	10	0	26	Service users of VdE
	Frontline staff	10	6	4	30	Nursery staff, social workers, foster care workers
	Senior professionals	10	4	6	39	Emergency centre directors, social work managers, school directors, child protection delegate
	Total	**86**	**52**	**34**	**34**	

Table 2
What makes children feel bad, unsafe, and insecure?

Rank	Mauritania			Morocco			Tunisia		
	Parents	Frontline staff	Senior professionals	Parents	Frontline staff	Senior professionals	Parents	Frontline staff	Senior professionals
1	Poverty	Limited access to social services	Poverty	Children not attending school	Family breakdown	Physical and sexual abuse	Violence towards women	Abandonment	Family breakdown
2	Lack of parenting skills	Children not attending school	Lack of parenting skills	Street connection	Discrimination against single mothers and their children	Discrimination against single mothers and their children	Poverty	Physical and sexual abuse	Physical and sexual abuse
3	Family breakdown	Weak legislation	Family breakdown	Lack of child protection legislation	Street connection	Family breakdown	Lack of parenting skills	Family breakdown	Lack of parenting skills
4	Weak education services	Limited coordination between actors	Children not attending school	Limited access to social services	Physical and sexual abuse	Children not attending school	Family breakdown	Neglect	Children not attending school
5	Street connection	Physical and sexual abuse	Child labour	Lack of parenting skills	Weak education services	Child labour	Limited access to social services	Limited psychological services	Poverty
6	Physical and sexual abuse	Family breakdown	Weak legislation		Lack of parenting skills	Limited health services	Discrimination against single mothers and their children	Lack of parenting skills	Limited childcare services
7	Limited access to social services	Talibs	Limited access to birth registration		Social media	Poverty	Substance use	Weak education services	Abandonment
8		Marriage without official papers	Child marriage		Sex work and substance use	Weak implementation of the law	Weak education services	Poverty	Weak education services
9		Corporal punishment in schools	Rural-urban migration		Malnutrition	Limited access to social services	Sexual abuse of children	Discrimination against single mothers and their children	Social media
10		Child marriage	Limited coordination between actors		Poverty	No support for children in care after 16 years	Social media		

culture of community safeguarding for reducing children's exposure to ACEs. Frontline staff specifically identified the positive influence of family stability (Table 3).

3.2. Case vignette

What would happen? All participant groups in Mauritania highlighted the role of the shopkeeper in referring the case to relevant authorities and guardians in Hanan's life. Frontline staff and senior professionals, but not parents, expressed that the Green Line – a telephone hotline for reporting child maltreatment established by AMSME with the Mauritanian Ministry of Social Action, Children and Families (UNICEF, 2020) – would be called to make a referral. All participants mentioned that the police would investigate. Frontline staff and parents added that the police would also place the child with family members or an institution, and senior professionals explained that the police would provide a medical certificate. While parents suggested that Hanan would be removed from her uncle's household by her family for her safety, frontline staff and senior professionals described a mixture of government and NGO services would be involved to provide support to Hanan and her family (Table 4).

In Morocco, none of the participant groups indicated a formal referral process. Frontline staff mentioned that neighbours or the shopkeeper might inform NGOs or the police, and the hanoot could confront the uncle. In contrast, parents stated that Hanan would seek support from neighbours, her parents, or the shopkeeper. However, parents also expressed concerns about Hanan's fear of the uncle and her reluctance to discuss abuse, a worry shared by senior professionals. The societal acceptance of "physical discipline" was specifically identified as a concern by senior professionals. Frontline staff and senior professionals highlighted potential police involvement, with the latter conducting investigations and providing medical certificates (Table 4).

All participant groups in Tunisia recognised the significant role of the shopkeeper, neighbours, and NGOs in referring cases to the child protection delegate. All participants highlighted the role of the child protection delegate, with parents stating that the child protection delegate would initiate legal actions, and the tribunal would implement them. Frontline staff described the role of the child protection delegate in conducting investigations would be to determine the suitability of the children to remain with their birth families or to be placed in alternative care. Senior professionals providing details on the involvement of the child protection delegate at each stage of the process of care. All participant groups expressed the role of the NGOs in the case. Parents viewed the NGOs role primarily as making referrals. Frontline staff also noted that the NGO would refer the case to the child protection delegate and where the children would be placed for their protection, a sentiment echoed by the senior professionals. Government involvement was only mentioned by frontline staff and senior professionals. Frontline staff expressed government psychologists and social workers would support Hanan, while senior professionals expressed that the prosecutor and police would play a role in arresting the uncle (Table 4).

What should happen? In Mauritania, parents expressed the need for community witnesses to make referrals, psychologists to provide support, and social services to support parents. Frontline staff highlighted leveraging the collectivist culture in Mauritania to strengthen community safeguarding networks, public awareness campaigns, and to

Table 3
What makes children feel good, safe, and secure? CPD (Child Protection Delegate), NGO (Non-Governmental Organisation).

Rank	Mauritania			Morocco			Tunisia		
	Parents	**Frontline staff**	**Senior professionals**	**Parents**	**Frontline staff**	**Senior professionals**	**Parents**	**Frontline staff**	**Senior professionals**
1	Free education	Free healthcare	Child protection legislation	Policing	Family stability	Family stability	Child protection legislation	Child protection legislation	Parenting skills
2	Culture of community safeguarding	Free education	Culture of community safeguarding	Free healthcare	Free education	Free education	CPD	CPD	Child protection legislation
3	Government employment services	Child protection legislation	Free education	Free education	Free healthcare	Financial stability	Parenting skills	Family stability	Government social services
4	Extended family support	Government social services	Residential centres	Parenting skills	Adequate housing	Legal framework	Free healthcare	Free healthcare	Free education
5	Child protection legislation	NGO services	Free healthcare	Extra-curricular activities	Policing	Culture of community safeguarding	Access to basic needs	Free education	Free healthcare
6	Government social services	Culture of community safeguarding	NGO services		NGO services	Free healthcare	Free education	Parenting skills	Access to basic needs
7	Free healthcare		The national strategy for child protection		Extra-curricular activities	Government social services	Government social services	Government social services	Extra-curricular activities
8			Government social services			Political stability	NGO services	NGO services	Culture of community safeguarding
9						Extra-curricular activities	Culture of community safeguarding	Extra-curricular activities	
10						NGO services			

simplify legal processes. Senior professionals emphasised making referrals to appropriate authorities, continuous follow-up by government agencies, and proactive police responses (Table 5).

In Morocco, parents advocated for improved reporting of incidents of child maltreatment, leading to investigations by local authorities, schools, and the police. Health services, the shopkeeper, and NGOs were suggested for providing care and guidance by parents. Frontline staff focused on community referrals, government support for the biological family, and psychological support through social workers and psychologists. Senior professionals underscored the importance of community support, increased social workers for case support, health and legal support provision, removal of children from harmful situations, and the involvement of state-affiliated child protection centres (Table 5).

In Tunisia, parents called for increased government social services and support from NGOs. Frontline staff sought more support from the government's health ministry, while senior professionals emphasised reporting by all stakeholders to the CPD and investigations for all cases (Table 5).

What are the barriers? In Mauritania, all participant groups highlight issues with both the official and community referral processes. Parents stated that it was difficult to navigate the referral system. Meanwhile, frontline staff indicated that there were long and complex processes to obtain justice, which also included costs many would not be able to afford. Senior professionals expressed that referral pathways are not confidential, so people are afraid to speak up (Table 6). Similarly, frontline staff suggested that shame would deter people from whistleblowing about members of their tribe. Both frontline staff and senior professionals, however, explained that the community did not believe that sexual abuse occurs, so they would not act. Parents explained that while there was a lack of social and psychological services, even those available, such as the Green Line, were unknown to most families (Table 6).

In Morocco participants highlighted significant barriers to reporting and responding to incidents of child maltreatment, citing the lack of essential services such as health, social, education, and psychological support, particularly challenging for those without birth registration. The limited authority of social workers, attributed to the absence of a legal social work stature, was a common concern expressed by both frontline staff and senior professionals. Additionally, all participants identified a lack of community referral culture, difficulties in navigating referral procedures, and a non-confidential process of care. The acceptance of violence in the community, insufficient knowledge of ways to reduce children's exposure to ACEs, parenting skills, and inadequate coordination within the child protection system were also emphasised by all participants. The absence of services dedicated to responding to child maltreatment and foster care emerged as critical barriers reported by senior professionals (Table 6).

In Tunisia participants identified key barriers to responding to incidents of child maltreatment, emphasising the absence of a referral culture and the inhibiting influence of close-knit communities, discouraging reporting due to fear of retribution. Both parents and senior professionals highlighted this challenge. Frontline staff and senior professionals also highlighted the limited availability of psychologists and dedicated. Similar resource constraints were emphasised by frontline staff and senior professionals, who cited a shortage of social workers and inadequate resources for child protection delegates. Additionally, parents expressed concerns with the inconsistent implementation of laws by government workers and a lack of awareness regarding children's needs within the community (Table 6).

4. Discussion

This study aimed to gather perspectives from local stakeholders to inform the development of effective and sustainable local programmes that address the high rates of ACEs across the Maghreb. With limited published data on ACEs in this region, understanding local insights is critical. Previous research has suggested that the imposition of external (usually Western) perspectives in understanding and attempting to influence child protection ecologies in the global South may be unhelpful (El-Hoss, 2023; Krueger et al., 2015). Therefore, by gathering and analysing local insights, this study contributes to the development of effective and sustainable local programmes that reflect the region's

Table 4
What would happen? CPD (Child Protection Delegate), NGO (Non-Governmental Organisation).

	Mauritania	Morocco	Tunisia
Parents	1) Hanan shares her situation with parents, teachers, NGOs, social services, and the police 2) Police investigate, and Hanan's parents would confront her uncle 3) Hanan taken with her parents back to the farm where they work or placed in a residential institution by the police	1) Hanan seeks support from neighbours, parents, or the Hanoot 2) Fear of the uncle and a lack of awareness of her rights may deter her from speaking about her abuse	1) Hanoot, neighbours and NGOs refer the case to the CPD 2) Legal action against the uncle and parents for neglect initiated by CPD at tribunal
Frontline staff	1) Hanan would disclose her situation to her family, the police, and the 'Green Line' 2) The prosecutor, police, and commune (local council) would initiate an investigation 3) Police place child with family members 4) If no resolution is found, the police or judge place the child in an institution 5) Government services provide healthcare and psychological support to Hanan, with NGOs aiding in post-care	1) Neighbours or Hanoot inform NGOs or police 2) The Hanoot might attempt mediation with the uncle 3) The police investigate, provide medical certificates, and potentially place the child in a residential centre	1) Hanoot, neighbours and NGOs report the case to the CPD, who may relocate the child and sister 2) Foster families or NGOs were expressed as potentially where the children would be placed 3) Psychologists and social workers employed by the government provide support, and the CPD would formally assess the parents' ability to care for the children
Senior professionals	1) The Hanoot and community members would confront the uncle or make a referral to local NGOs and the 'Green Line' for support 2) Police provide medical certificate, enabling family to receive health and legal support and initiate judicial procedures 3) NGOs offer psychological support and assign social workers to follow the case and explore kinship placements for both children	1) Hanan might turn to a trusted individual, like the Hanoot, but due to societal acceptance of "physical discipline", she might not receive support 2) Hanan may also be afraid to report the abuse	1) Hanoot makes a referral to the CPD 2) CPD investigates and informs prosecutor 3) Prosecutor informs the special department in police for child maltreatment 4) Police go with the CPD to arrest the uncle 5) CPD with psychologists conduct an interview recorded with children and shared with authorities 6) Family, extended family, or an NGO will take in the child if needed

protective factors and contextual complexities. We highlight shared themes across the countries, such as the significance of family stability and access to essential services, while also addressing country-specific challenges that resist broad categorisation. These findings offer pathways for locally adapted interventions and point to further research needed to tailor responses to the high rates of ACEs in the Maghreb.

The Participatory Ranking Methodology (PRM) activities provided an insight into participants' perceptions of what is needed to reduce children's exposure to ACEs, encompassing both primary and secondary prevention (Garrison et al., 2022). All participant groups across countries highlighted family stability and access to government services (especially free education and free healthcare) as key factors reducing children's exposure to ACEs. For example, ensuring stable family environments and accessible services can prevent the initial occurrence of ACEs (primary prevention) and also provide crucial support for families already experiencing adversity (secondary prevention) (Maguire-Jack & Negash, 2016). There is emerging though limited evidence describing methods to support effective parenting and family stability (Sampaio et al., 2022). The initial findings of this small study suggest that it may be constructive to explore how parenting skills and family support interventions might usefully be introduced in Maghrebi contexts (Bosqui et al., 2024). Specific barriers to accessing services for families and children in the countries of the Maghreb should also be separately investigated.

The PRM activities also highlighted perspectives distinctive to each country group. In Mauritania, which has a much lower gross domestic product than either Morocco or Tunisia (World Bank, 2024b), poverty was highly ranked as increasing children's exposure to ACEs. It is notable however that the Mauritanian groups identified free education and healthcare as important factors reducing children exposure to ACEs, as well as community-based responses. This suggests that, from their perspective, limited resources have not prevented effective institutional

Table 5
What should happen? CPD (Child Protection Delegate), NGO (Non-Governmental Organisation).

	Mauritania	Morocco	Tunisia
Parents	1) Community witnesses to make referrals 2) Psychologists provide support 3) Social services provide support to the parents	1) Parents report issue 2) Local authorities, schools, and the police investigate the case 3) Health services, shopkeeper, and NGOs provide care and guidance to the child and parents	1) Increase government social services 2) Increased support from NGOs
Frontline staff	1) Leverage collectivist culture of Mauritanian society to safeguard children 2) Public awareness campaigns to educate parents about child maltreatment and potential child safeguarding incidents 3) Simple legal processes to ensure easier access to justice for children	(1) Neighbours and shopkeeper make referrals (2) Government offer support to the biological family (3) Psychological support through government social workers and psychologists (4) Streamlined legal procedures	1. More support from the government's health ministry
Senior professionals	1) Referral of the case to the appropriate authorities such as the police or NGOs 2) Continuous follow-up and support for the child's needs by relevant government agencies 3) Proactive police response to child maltreatment cases	1) Greater community support in reporting 2) More social workers for case support 3) Provision of health and legal support by relevant professionals and organisations 4) Children should be removed from the current situation 5) State-affiliated child protection centres following cases	1) Reporting by all community and professional stakeholders to CPD 2) CPD investigates all cases

Table 6
What are the barriers? CPD (Child Protection Delegate), NGO (Non-Governmental Organisation).

	Mauritania	Morocco	Tunisia
Parents	• Referral system difficult to navigate • Families unaware of 'Green Line' and other support services • Lack of social services • Lack of psychologists	• No referral culture • Physical violence is accepted in community • Corruption • Lack of health services and difficulty to access government subsidised healthcare • Referral system difficult to navigate • NGOs don't have authority to act • Lack of civil registration makes it difficult to access health, education, and other services	• Community is close and if you report on neighbours there will be problem in the community • If someone is reported on and they go to prison, when they come out, they can target the victim again • The law is not always followed or implemented by the frontline (e.g. police) • People are unaware of children's needs
Frontline staff	• Community don't believe that sexual abuse occurs so they will not act • Tribalism means there will be shame if someone is charged with abuse • People lack the finances to follow the court processes • Long and complex process for justice	• Lack of knowledge on ways of reducing children's exposure to ACEs in the community • No referral culture • Lack of parenting skills • Lack of social services • Lack of evidence for large scale action • No social work statute limits social workers abilities • Not enough psychologists • Lack of coordination between actors	• Not enough psychologists • Social services are not provided with enough resources to support the number of cases they receive
Senior professionals	• Community don't believe that sexual abuse occurs so they will not act • Referral pathways are not confidential, so people are afraid to speak up	• No confidential reporting • Complex legal processes • Lack of services dedicated to responding to child maltreatment • Not enough psychologists • No foster care • Lack of health services • Lack of social services • Lack of training and human resources in government and NGOs • No social work statute	• Not all community members and professionals will do referrals because they may know the person and it is not their problem • No referral culture • Not enough CPDs – each CPD could have 200–600 cases • CPDs do not have enough resources – e.g. one car between four workers • NGO's fulfill role of state– e.g. Emergency centres are not available in Mahdia, so in emergency cases they place children in an NGO run women's shelter

and community responses to address child maltreatment, a finding that aligns with international literature which suggests that poverty alone is not a strong independent risk factor for child maltreatment (Blair et al., 2019; Karatekin et al., 2022). While participants in Mauritania and Tunisia recognised the importance of child protection legislation, it was notably absent in the considerations of participants from Morocco, which is likely to reflect the country's absence of formal child protection legislation.

Discrimination against single mothers and their children was a distinctive factor identified by Moroccan gorups as increasing children's exposure to ACEs. Whilst the socio-cultural factors that underpin such discrimination are unlikely to be absent in Mauritania and Tunisia, this initial signal suggests that a fuller understanding of how this discrimination is structured in Morocco is likely to be important to reduce exposure of the children most at risk of ACEs in the wider Maghreb region. Literature highlights the difficulties experienced by women and their children at odds with conventional social structures (e.g. single mothers; children born outside of marriage) in Mauritania (Wiley, 2020), Morocco (Rodgers, 2021) and Tunisia (Amroussia et al., 2017). The marginalisation of single mothers (not necessarily or exclusively due to poverty) may lead to maltreatment or abandonment of their child (Schlumpf, 2016). While the groups in Tunisia were the only ones to identify child abandonment as an issue for children's increased exposure to ACEs, data suggests that child abandonment rates continue to be high in both Morocco and Mauritania (Baghdadi et al., 2024). Therefore, while social forces may push children towards harm, the findings of this study suggest that within the collectivist structure of Maghrebi communities, social forces may also mitigate and address exposure to ACEs for vulnerable children.

When asked to think about "what would happen" in an individual case vignette focused on secondary prevention, all groups described how Hanan and her family would gain support from their community, and in "what should happen", all groups (although less emphasised in the Tunisian responses) emphasise how that support should be reinforced. This suggests that building on existing mechanisms of community support may be a more widely supported and therefore a more effective approach to reducing children's exposure to ACEs. However, even in child protection systems where NGO's play a significant role – linking community groups to formal government services and in many instances providing services on behalf of the state – it has been argued that the overall system may not function well if that linkage is unclear or the two approaches are not consonant (Wessells, 2015; Wulczyn et al., 2010). Integrating the community-driven approaches highlighted by participants into formal child protection strategies could help programmes become more resilient and adaptive to local needs, ensuring their long-term viability and increase their likelihood of reducing the prevalence of ACEs (Ellermeijer et al., 2023; Krueger et al., 2015). Further research should explore which methods of family support are most likely to engender broad community acceptance in Maghrebi countries.

Whilst the results from workshops can only be interpreted as preliminary data, they provide a strong baseline for further investigation of themes identified. Family stability, strengthening parenting skills, and utilising community support networks emerged as key mediators in reducing children's risk of exposure to ACEs. Evidence from other contexts suggests that community mobilisation approaches can effectively strengthen these mediating factors and help reduce children's exposure to ACEs (Campbell, 2014; Lo, 2021). Further research could explore the development of community mobilisation interventions in the Maghreb to prevent ACEs.

4.1. Strengths and limitations

A notable strength of this study lies in the practicality of its methods adapted from the Child Frontier Child Protection System Mapping Manual (Child Frontiers, 2010). This approach involved training local, place-based researchers, ensuring the research incorporated local

experiences and knowledge (Neely, 2017). The absence of audio recordings eliminated the need for transcription and translation, enhancing its applicability in the field and fostering a more comfortable environment for participants who are not used to taking part in research, especially those uneasy with authority or recording devices. However, the absence of audio recordings also limited our ability to include direct quotations from participants, potentially missing nuanced expressions. Additionally, our sample size was small, only included parents who were already in-contact with services, was restricted to one site in each country, and did not include Algeria, Libya, or Western Sahara. Although this phase of our research concentrated on professionals and guardians to establish an initial understanding of ACEs, including young people's voices in future research is crucial for a more complete picture of ACEs in the Maghreb. Despite its limitations, the SECURE study exemplified a multi-year collaboration involving various universities, NGOs, and international partners across multiple countries in the Maghreb, showcasing a dedicated commitment to a culturally relevant and locally contextualised multi-disciplinary research approach.

5. Conclusions

The study aimed to gather perspectives from local stakeholders to inform the development of effective and sustainable local programmes that address the high rates of ACEs across the Maghreb. Protective factors such as family stability and accessible government services consistently emerged. In contrast, poverty and discrimination against single mothers and their children were noted to increase children's exposure to ACEs. This highlights the importance of exploring parenting skills and family support interventions in Maghrebi contexts. While preliminary, the findings suggest the need for further investigation into these themes and the development of locally tailored approaches to supporting families in the countries of the Maghreb.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2024.108096.

Data availability

Data will be made available on request.

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