GENDER & ADOLESCENCE: GLOBAL EVIDENCE

MIDLINE REPORT SERIES

‘I didn’t know anything!’

GAGE midline findings on the sexual and reproductive health of vulnerable young people in Jordan

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December 2023

Acknowledgements

We wish to acknowledge the close engagement with UNICEF Jordan staff and in particular we are grateful to Kenan Madi, Diana Moulla and Ghena Haikal for their support in facilitating data collection, and their thoughtful reflections and feedback to the research design and findings.

The authors wish to thank the GAGE Jordan quantitative research team based at Mindset, in particular Rana Samara, Majd Massanat, Majd Haddad, Mohammad Qardan, and Bana Makahleh, as well as all enumerators working hard to provide quality data. We would also like to thank the GAGE Jordan qualitative research team based at Mindset for their involvement in the qualitative data collection that underpinned the report findings including: Taghreed Al Abbadi, Wafa Al Amaireh, Sarah Al Heiwidi, Faisal Alshammari and Qasem Ashareef.

In addition, we would like to thank Kathryn O'Neill for copyediting, Jojoh Faal Sy for layout, and Ottavia Pasta for infographic design. We also wish to thank Megan Devonald, Faisal Alshammari, Anna Tobor, Joost Vintges and Sally Youssef for their support with coding transcripts.

We would also like to thank the HPC for their feedback, especially Dr Issa Masarweh, Ms Rania Al-Abadi and Mr Ali Al-Metleq for their valuable comments and suggestions.

Finally, we wish to thank all the adolescents, young adults, caregivers, service providers and experts who participated in the research and who shared their valuable insights into the experiences of adolescents girls and boys in Jordan.

Suggested citation:

Presler-Marshall, E., Oakley, E., Jones, N. Luckenbill, S., Alheiwidi, S., Baird, S., ... and Alshammari, F. (2023) *'I didn't know anything!': GAGE midline findings on the sexual and reproductive health of vulnerable young people in Jordan*. Report. London: Gender and Adolescence: Global Evidence

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Introduction

Jordan has a large and growing population of adolescents and young adults who lack access to sexual and reproductive health information and services. Cognizant of the relationship between sexual and reproductive health and broader development outcomes, the Jordanian government is committed to taking urgent action to meet these needs and achieve Sustainable Development Goal 3: Ensure Good Health and Promote Well-being. However, despite its policy efforts, the government remains highly constrained by cultural norms that render sexual topics 'taboo'. In Jordan, the Demographic and Health Survey (DHS) – a tool used by many countries to track health-related knowledge, behaviours and outcomes – does not ask unmarried young people about topics related to sexuality.

This report draws on mixed-methods data collected in 2022 and 2023 by the Gender and Adolescence: Global Evidence (GAGE) research programme. Surveys were undertaken with nearly 3,000 Syrian, Jordanian and Palestinian adolescents and young adults living in five governorates of Jordan. Individual and group interviews were conducted with a sub-sample of nearly 190 of these young people. Data was also collected from caregivers and key informants. The report begins with a brief section describing the context of the sexual and reproductive health of young people in Jordan. We then present the GAGE conceptual framework and methodology. Our findings are followed by a discussion of key actions needed to accelerate progress and ensure that all young people in Jordan have access to quality sexual and reproductive health information and services.

The Jordan context

Jordan's population, which was estimated to be 11.5 million in 2023, has increased quickly in recent years (Department of Statistics (DOS), 2023). Critically, because almost a third (29%) of its residents are aged 10–24 and are already in (or will soon enter) their reproductive years, it is set to continue along this growth trajectory (Higher Population Council (HPC), 2022a; UNFPA, 2023). While Jordan has an advanced health care system (in terms of doctors and health facilities per capita), and much better adolescent and youth health outcomes than most other countries in the Middle East and North Africa (MENA) region, young people's sexual and reproductive health needs are barely understood, owing to data limitations resulting from the topic being considered taboo (UNICEF, 2023; Presler-Marshall et al., 2023; Jones et al., 2019a). The Higher Population Council (the branch of the Jordanian government tasked with matters relating to reproductive health issues) is aware of limitations in terms of both evidence and servicing. Its 2022 Annual Report, which builds on previous research into child marriage in Jordan, acknowledges numerous challenges: that young people have limited access to sexual and reproductive health information; that child marriage rates are unacceptably high (especially among Syrians); that newly married girls and women are encouraged to become pregnant straight away; that modern contraceptive use is low; that son preference drives high fertility rates; and that intimate partner violence is widespread (see also HPC, 2017a, 2017b, 2022a, 2022b). Jordan's National Sexual and Reproductive Health Strategy and National Population Strategy aim to tackle these problems and improve not

A young Turkmen mother and her children and her sister © Marcel Saleh/GAGE

just sexual and reproductive health but also broader development outcomes, in part by reducing population growth (HPC, 2021a, 2021b).

There are several data limitations regarding sexual and reproductive health in Jordan. The DHS, known as the Jordan Population and Family Health Survey (JPFHS), asks questions about sexual and reproductive health only to ever-married girls and women over the age of 15. Girls aged under 15, those who are not married, and (with rare exceptions) males are not asked questions on sexual and reproductive health. In addition, while the JPFHS regularly disaggregates findings for Jordanian and Syrian women according to nationality, it does not report on Palestinians, owing to the fact that most Palestinians are Jordanian citizens.

With those limitations in mind, many JPFHS findings help situate our research. For example, consanguinity is common; 27% of Jordanian and 33% of Syrian women (aged 15–49) report that they are related to their husband (Department of Statistics and ICF, 2019). Consanguinity is most common among married adolescent girls (ibid.). Child and early marriage is quite common, especially among Syrians. The JPFHS reports that among girls aged 15–19, 0.2% of Jordanians and 7% of Syrians were married by age 15. Of young women aged 20–24, 8% of Jordanians and 37% of Syrians were married by age 18. For this same group of young women aged 20–24, 17% of Jordanians and 58% of Syrians were married by age 20. Few girls who had married as children reported using contraception, in part because the average desired number of children is 3.9. Of married girls aged 15–19, only 17% were using any method of contraception, and only 10% were using a modern method. Contraceptive decision-making among girls was primarily shared with husbands (85%). Only just over half of married girls aged 15–19 (54%) reported that they can say no to sex. Unsurprisingly, rates of adolescent motherhood are high, especially among Syrians. Over a quarter of Syrian girls (28%) aged 15–19 had already begun childbearing (compared to 3% among Jordanian girls). Nearly all young mothers (99%) receive antenatal care and deliver in health facilities. Nearly two-thirds of ever-married adolescent girls (63%) and boys (64%, with no marriage delineation) (aged 15–19) agreed that wife beating can be justified; 15% of ever-married adolescent girls reported experiencing sexual or physical intimate partner violence in the past year.

A 16-year-old Jordanian boy, working out at the gym © Marcel Saleh/GAGE

Conceptual framework

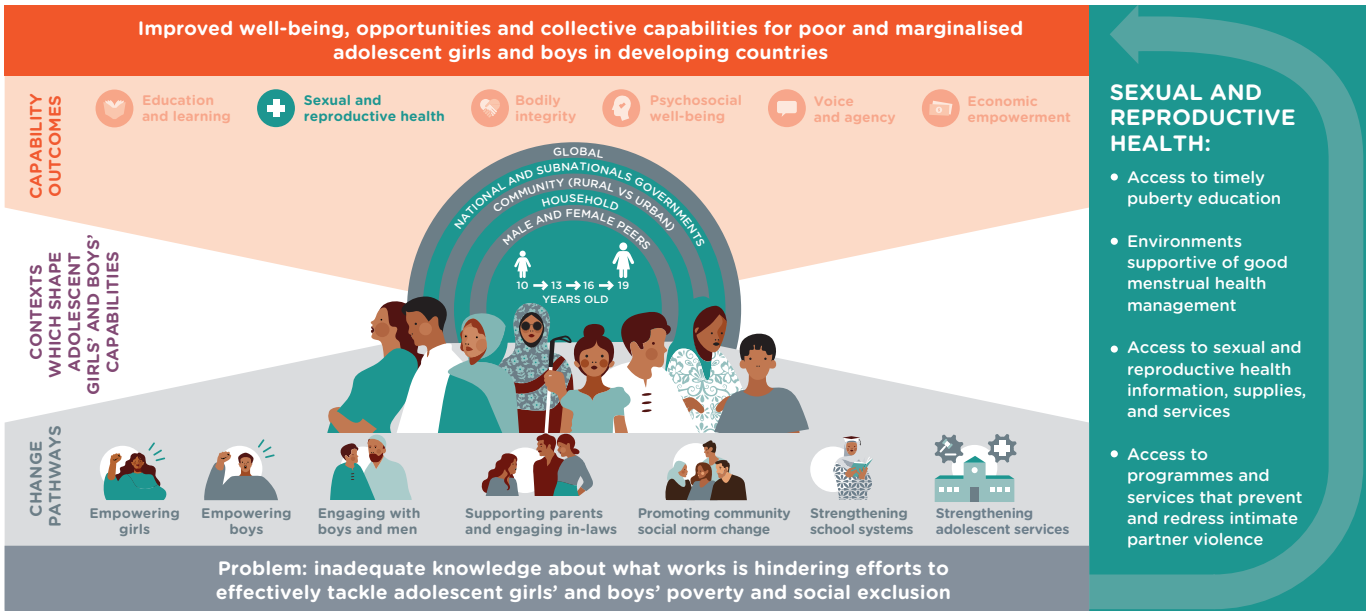
Informed by the emerging evidence base on adolescent well-being and development, GAGE's conceptual framework takes a holistic approach that pays careful attention to the interconnectedness of what we call the '3 Cs' – capabilities, change strategies and contexts – in order to understand what works to support adolescents' development and empowerment, both now and in the future (see Figure 1). This framing draws on the three components of Pawson and Tilley's (1997) approach to evaluation, which highlights the importance of outcomes, causal mechanisms and contexts, though we tailor it to the specific challenges of understanding what works in improving young people's capabilities.

The first building block of our conceptual framework is capability outcomes. Championed originally by Amartya Sen (1985, 2004) and nuanced to better capture complex gender dynamics at intra-household and societal levels by Martha Nussbaum (2011) and Naila Kabeer (2003), the capabilities approach has evolved as a broad normative framework exploring the kinds of assets (economic, human, political, emotional and social) that expand the capacity of individuals to achieve valued ways of '*doing and being*'. At its core is a sense of competence and purposive agency: it goes beyond a focus on a fixed bundle of external assets, instead emphasising investment in an individual's skills, knowledge and voice. Importantly, the approach can encompass relevant investments in adolescents with diverse trajectories, including the most marginalised and '*hardest to reach*' such as those who are disabled or are already mothers. In the case of sexual and reproductive health, the focus is on access to information, services and support that enable young people to maximise their health and well-being at a pivotal time in the life course, with immediate and longer term as well as intergenerational implications.

The second building block of our conceptual framework is context dependency. Our '3 Cs' framework situates adolescents socio-ecologically; it recognises that not only do adolescents have different needs and constraints at different times in the life course, but that these are also highly dependent on their contexts at the family/ household, community, state and global levels. In the case of sexual and productive health, cultural contexts and deeply entrenched gender norms are a key factor, as are the contours of the health care system.

The third building block of our conceptual framework – change strategies – acknowledges that adolescents' contextual realities will not only shape the pathways through which they develop their capabilities but also determine the change strategies open to them to improve their outcomes. Our ecological approach emphasises that in order to nurture transformative change in adolescents' capabilities and broader well-being, potential change strategies must simultaneously invest in integrated intervention approaches at different levels, weaving together policies and programming that support young people, their families and their communities while also working to effect change at the systems level. In this brief, we conclude by reflecting on what type of package of interventions could better support young people's sexual and reproductive health and well-being.

Figure 1: GAGE conceptual framework



Sample and methods

This report draws on mixed-methods data collected in 2022 and 2023. At baseline (2018-2019), the quantitative sample included adolescents from marginalised households across two cohorts (aged 10-12 and aged 15-17), with purposeful oversampling of adolescents with disabilities and those who were married as children. The baseline sample consisted of 4,095 adolescents recruited in five governorates in Jordan: Amman, Mafraq, Irbid, Zarqa and Jerash.

At follow-up in 2022-2023, the GAGE Jordan Midline sample included 2,923 young people – a 71% follow-up rate compared to baseline (see Table 1). Of these, just over two-thirds are Syrian refugees (2,145); most Syrian refugee respondents (56%) have lived in host communities consistently since baseline (1,195). Approximately 27% of Syrian respondents lived in refugee camps run by the United Nations High Commissioner for Refugees (UNHCR) since baseline (595), and 12% in informal tented settlements (257) at any point since baseline.[1] A small share of Syrian refugees (5%) have moved between host communities and camps in the time between the baseline and midline surveys (98).

The remainder are Jordanians (457), Palestinians (272), and a small group of individuals that identified as another (denoted "Other") nationality (49). Almost all Palestinians in the GAGE sample live in Jerash camp; most are ex-Gazans who lack Jordanian citizenship and its attendant benefits. Due to the sample size, the "Other" nationality group is not included in comparisons by nationality, but is included in all other demographic group disaggregation, such as gender and age cohort.

Just over half the sample was female. Although the sample was approximately equally split between the two age cohorts (younger and older), older adolescents were more likely than younger adolescents to be lost to follow-up between baseline and midline (67% follow-up for the older cohort versus 75% follow-up for the younger cohort). Because of this, the younger cohort is slightly overrepresented in the midline sample. At midline, on average, younger cohort adolescents were aged 15 years. They are referred to in this paper as adolescent girls and boys. The older cohort has transitioned to young adulthood (average age of 20) and are referred to as young women and young men.

GAGE's sample includes the most marginalised adolescents and young people, including those with a disability or who were married as children. Just over three hundred (306) young people report having a functional disability[2] even if they have an assistive device available (such as glasses, hearing aids, or a mobility device). Of the 336 females who have ever married, 229 married prior to age 18.

Most of the qualitative sample of 188 young people were selected from the larger quantitative sample, deliberately oversampling the most disadvantaged individuals in order to capture the voices of those at risk of being '*left behind*' (see Table 2). The qualitative sample also included 29 young people from Jordan's Turkmen and Bani Murra communities (highly marginalised ethnic minorities)(see Annex 1), as well as 84 caregivers and 24 key informants (government officials, community and religious leaders, and service providers). This report also draws on GAGE's ongoing qualitative participatory research with 42 young people who are living in Jordan (see Table 3).

Table 1: GAGE midline quantitative sample

	Nationality				Sub-sample of those with disability	Sub-sample of girls married <18	Total
	Syrian	Jordanian	Palestinian	Other			
Females	1057	291	156	24	160	228	1528
Males	1088	166	116	25	146	n/a	1395
Younger cohort	1163	277	183	23	179	25	1646
Older cohort	982	180	89	26	127	204	1277
Total	2145	457	272	49	306	229	2923

1 Between baseline and midline, a small minority of young people moved location. This was most common among Syrians, 10% of whom moved in the four years between baseline and midline. The bulk of movement was between UNHCR-run camps and Jordanian host communities. Because of this movement, young people are classified as camp-dwellers if they were living in a UNHCR-run camp at ***both*** baseline and midline; they are classified as 'ITS' if they were living in an informal tented settlement at *either* baseline or midline. Due to small samples sizes when stratifying young people by age cohort, young people who moved between camp and host were grouped in with the young people who lived in camp at both baseline and midline to form an ever camp group.

2 Determined by using the Washington Group Questionnaire: https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/

Table 2: GAGE midline qualitative sample

	Syrian	Jordanian	Palestinian	Bani Murra/ Turkmen	Totals
Females	37	12	13	16	78
Adolescent girls	23	6	6	6	41
Young women	14	6	7	10	37
Males	38	7	10	13	68
Adolescent boys	20	3	8	7	38
Young men	18	4	2	6	30
Married young people	34	3	3	8	48
Females	30	3	3	8	44
Females married <18	23	1	1	8	33
Males	4	0	0	0	4
Males married < 18	1	0	0	0	1
Young people with disabilities	26	12	7		55
Location					
Host	37	19	23	29	108
Camp	54				54
ITS	26				26
Total young people	117	19	23	29	188
Group interviews with parents	12 (incl. 42 individuals)	4 (incl. 15 individuals)	2 (incl. 13 individuals)	4 (incl. 14 individuals)	22 (incl. 84 individuals)
Key informants					24
Totals	159	34	36	43	296

Three sisters' hands covered in henna © Nathalie Bertrams/GAGE

Table 3: GAGE participatory research sample

	Syrian	Jordanian	Palestinian	Totals
Females	11	3	15	29
Adolescent girls	0	1	1	2
Young women	11	2	14	27
Males	7	6	0	13
Adolescent boys	1	0	0	1
Young men	6	6	0	12
Married young people	11	0	1	12
Young people with disabilities	1	9	15	25
Totals	18	9	15	42

Quantitative survey data was collected in face-to-face interviews by enumerators who were trained to communicate with marginalised populations. Surveys were broad and included modules reflecting the GAGE conceptual framework (see Baird et al., 2023).

Analysis of the quantitative survey data focused on a set of indicators related to sexual and reproductive health (data tables are available on request). Statistical analysis was conducted using Stata 17.0.

Qualitative tools, also employed by researchers carefully trained to communicate sensitively, consisted of interactive activities such as timelines, body mappings and vignettes, which were used in individual and group interviews (see Jones et al., 2019b). Preliminary data analysis took place during daily and site-wide debriefings. Interviews were transcribed and translated by native speakers and then coded thematically using the qualitative software analysis package MAXQDA.

The GAGE research design and tools were approved by ethics committees at the Overseas Development Institute and George Washington University. For research participants in refugee camps, permission was granted from the UNHCR National Protection Working Group. For research participants in host communities, approval was granted by Jordan's Ministry of Interior, the Department of Statistics and the Ministry of Education. Consent (written or verbal as appropriate) was obtained from caregivers and married adolescents; written or verbal assent was obtained for all unmarried adolescents under the age of 18. There was also a robust protocol for referral to services, tailored to the different realities of the diverse research sites.

A Jordanian father who married at age 17- and two of his six children © Marcel Saleh/GAGE

Findings

Puberty education

The survey results indicate that a significant minority of young people (17%) did not have a source of information about puberty (see Figure 2). Girls and young women are more likely to have a source of information than boys and young men (93% vs 72%), and Jordanians (87%) and Palestinians (89%) are more likely to have a source of information than Syrians (81%). Among Syrians, those living in host communities were more likely to have a source of information on puberty than those living in camps and informal tented settlements.

There are also important differences in terms of what sources of puberty information young people have. In aggregate – across cohorts, genders and nationalities – over half (52%) of young people reported that their parents were their source of information about puberty (see Figure 3). Adolescent girls and young women were more likely than their male counterparts to report receiving puberty education from parents (72% vs 31%), and Palestinians (60%) and Jordanians (57%) were more likely to report parental puberty education than Syrians (50%). A small minority (11%) of young people reported that a school teacher was their source of information; the same proportion reported learning about puberty from peers or siblings. Boys and young men are more likely than girls and young women to rely on teachers (13% vs 9%) or other young people (16% vs 6%) for information on puberty, because they are so much less likely to receive instruction from a parent. Syrians living in informal tented settlements are least likely to learn about puberty at school (5%), likely because of their lower enrolment rates; however, they were most likely (16%) to learn about puberty from another young person. Perhaps because the Higher Population Council's Darby[3] platform is relatively new, the midline survey found that it is rare (6%) for young people to seek puberty information online. This again is more common among males than females (9% vs 2%). It is rarer still (1%) for young people to report learning about puberty from an adolescent focused programme (such as girls' or boys' clubs, a UNICEF Jordan Makani ('My Space') multi-service centre for children and adolescents, or programmes implemented by non-governmental organisations (NGOs).

Critically, puberty education most often falls to mothers rather than fathers – which also explains why girls are better informed than boys (see Figure 4). Just over two-fifths of young people (43%) report that their mother

Figure 2: Did not have a source of information about puberty

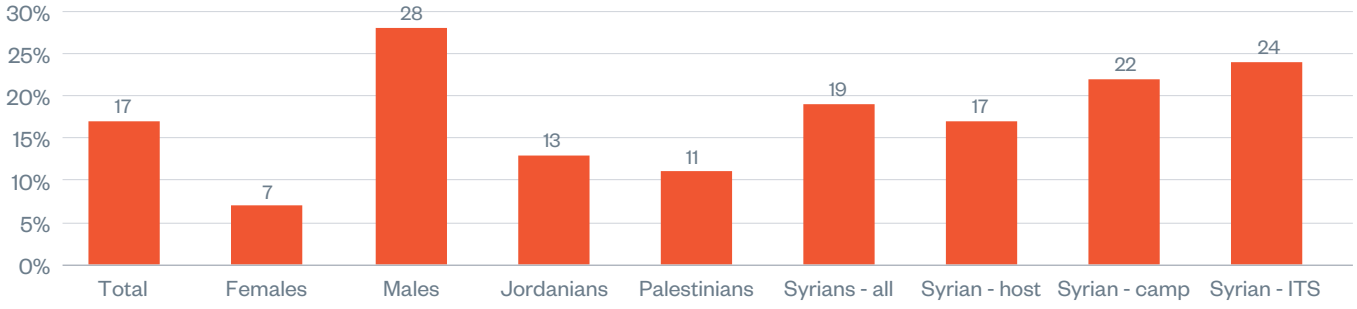
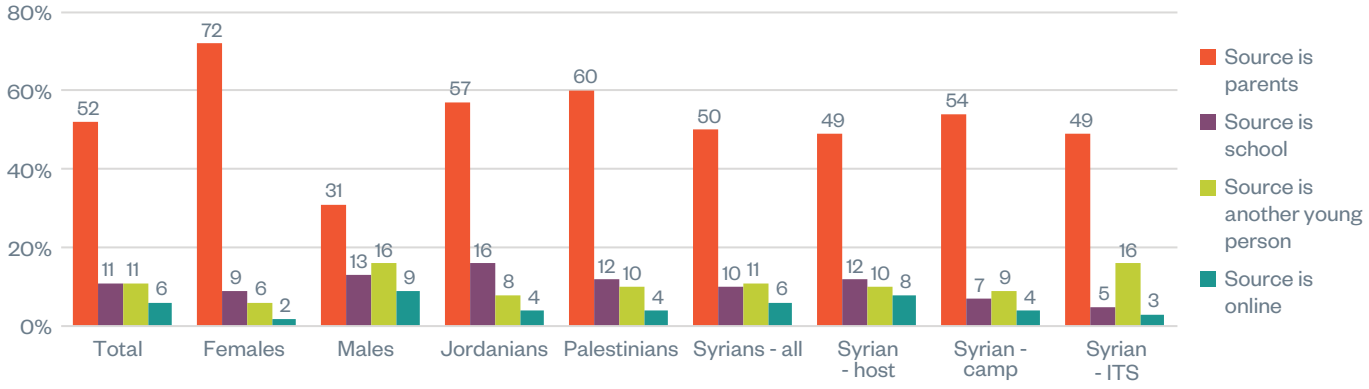
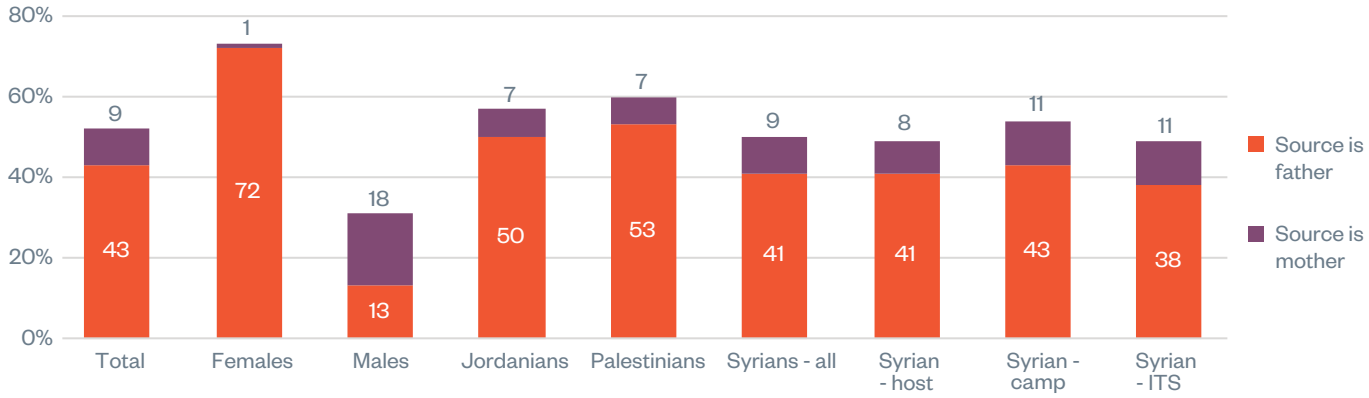


Figure 3: Source of puberty information



3 DARBY (Reproductive Health Knowledge Platform for Youth) is an online platform developed by HPC to provide youth with safe and accurate information on sexual and reproductive health topics. See: https://share-netinternational.org/newsblogs/darby-arabic-youth-platform-for-sexual-and-reproductive-health-launched-in-jordan/

Figure 4: Which parent is the source of puberty information



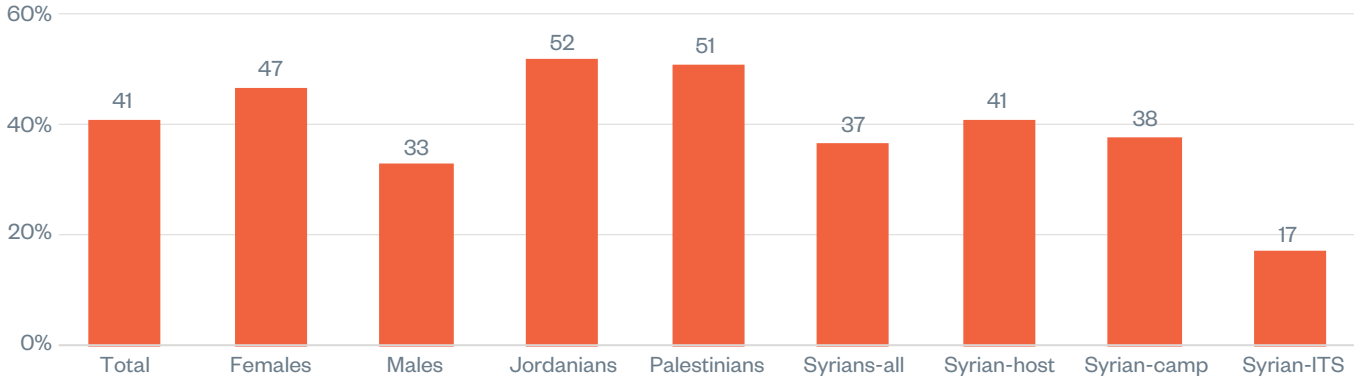
is their source of information on puberty, whereas less than a tenth (9%) report that their father is their source. Girls and young women are more likely to receive maternal puberty education than boys and young men (72% vs 13%), and Jordanians (50%) and Palestinians (53%) report receiving more instruction from mothers than do Syrians in any location.

When asked directly whether they had ever had a class on puberty, 41% of young people answered yes (see Figure 5). Adolescent girls and young women were more likely to have had a class than boys and young men (47% vs 33%), and Jordanians (52%) and Palestinians (51%) were more likely to have had a class than Syrians (37%). Differences by nationality may be due to Syrians' more limited access to formal education (particularly those living in informal tented settlements), as nearly all puberty education courses were delivered at school. Only 17% of Syrians living in an informal tented settlement reported having taken a class on puberty.

Our qualitative findings extend and nuance the survey findings. In individual and group interviews, most girls reported being able to discuss pubertal changes with their mothers, albeit (as we discuss in more detail below) often after they have already begun menstruating. A 13-year-old Palestinian girl explained, '*I feel very comfortable with my mother, I tell her everything.*' Girls who felt they could not rely on their mother generally noted receiving information from older sisters and cousins, as well as aunts. A 17-year-old Syrian girl recalled, '*My mother feels shy about such things… She used to tell my sister to teach me.*' Boys, on the other hand, rarely reported receiving any practical information about their changing bodies from their parents. A Makani facilitator noted that this is because mothers cannot discuss sexual maturation with their sons and because fathers tend to rely on '*the teacher of Islamic education*' due to their own feelings of embarrassment. Fathers agreed. A Syrian father, when asked if he had taught his adolescent son about his changing body, replied: '*By God, by God, I do not know how to tell him*!'

Young people reported taking puberty education classes at school starting, for girls, in the fifth grade. Information was included first in religious education and then in science class. An 18-year-old Palestinian young woman recalled, '*I got a lot of information at school… It was in the fifth grade at first.*' Several girls, all Syrians, acknowledged that they found these classes very difficult to sit through, because the topic was shameful. A 14-year-old Syrian girl explained, '*The teacher tells us that these are very important things for you, you should attend… Girls*

Figure 5: Has taken a class on puberty



cover their faces with shame... I tell the teacher that I do not want to hear the lecture, I do not want to know these things.' Instruction for boys appears to start several years later. A 20-year-old Syrian young man reported that, '*I learned at school, from seventh grade and older*.' However, an 18-year-old Syrian young man, who left school during seventh grade, noted that he had not only never had the opportunity to take a human biology class at school, but that when he asked his teacher, he was told that he was too young to know about such topics: '*When a student asks the teacher about this, he tells him that he will teach him that in the ninth grade*.' At midline, none of the young people reported learning about puberty at a UNICEF-supported Makani centre. Key informants noted that while such information could in theory be included in life-skills programming (as is typically the case in life-skills classes in other low- and middle-income country contexts), facilitators would be uncomfortable delivering that content, and parents would most likely pull their children out of such classes.

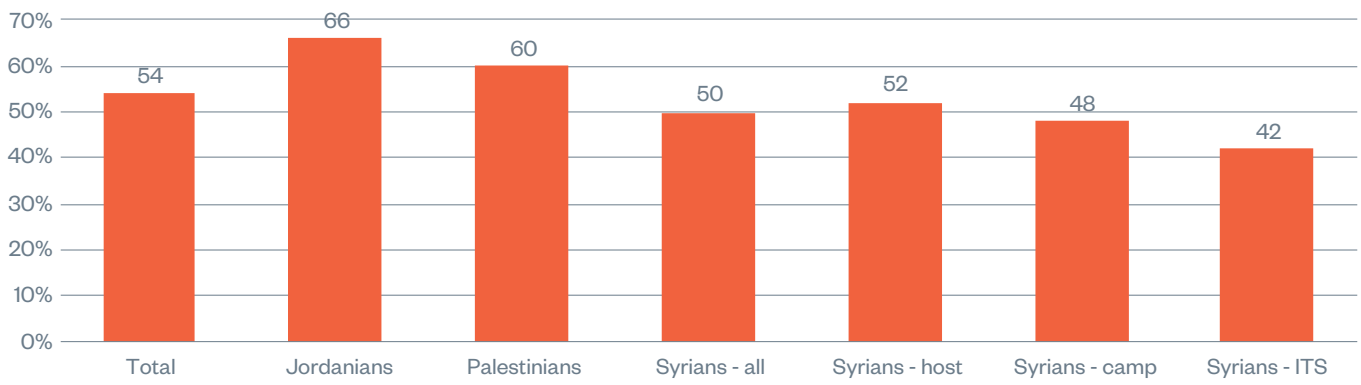
In line with the survey findings, qualitative research found that boys are more likely than girls to rely on peers for puberty information. A 17-year-old Jordanian boy, when asked how he learned about puberty, replied, '*I learned from the peers, who use random and taboo words*.' A Syrian father acknowledged that this is common: '*There is no young man who does not have a young friend who knows about things and understands him*.' Girls noted that they rarely talk about their bodies with their friends; when they do, it is only to exchange information on pregnancy and childbirth, and only with other married girls. A Makani facilitator noted that this is because sharing information is not safe for girls: '*We tell them not to trust just anyone, if they face something, because even among colleagues there are some private details [due to risk of gossip and stigma]*.'

While the survey found that it is uncommon for young people to use the internet to find puberty information, qualitative research suggests that this is becoming more common as young people become more connected. A 14-year-old Syrian girl reported that, '*When a person is curious to get information, I search in Google, there are many lectures*.' A 20-year-old Syrian young man added that although he now looks up information, this is a new habit: '*I didn't use the internet that much when I was younger, this is the first time I got a phone, so I didn't know much online*.'

Although girls are more likely than boys to have a source of information about puberty, survey results underscore that girls' information is often not timely. Only just over half (54%) reported having known about menstruation prior to menarche (see Figure 6). There was a significant difference in having had advanced knowledge between nationality groups, with Jordanian girls (66%) more likely than Palestinian girls (60%) and Syrian girls (50%) to report having advanced knowledge and Syrians living in informal tented settlements (42%) the least likely to report having advanced knowledge. A 19-year-old Syrian woman recalled being scared when she first got her period: '*I had no information about my period, so when I saw the blood, I felt scared... I went and told my mother and she told me that this is the menstrual cycle and she explained to me about it*.' An 18-year-old Syrian young woman added that while she had some information about menstruation, it was not enough; she plans to teach her own daughters starting from the age of six, so that they will grow up knowing that menstruation is part of every woman's life and can be discussed freely. She explained, '*I knew, as my brother's wife had told me some things about it. But I didn't know it is like this, when I saw it at first, I felt unwell and sat quietly and cried. I didn't tell my mother*.'

Qualitative research underscores that even adolescents who have a source of information about puberty often have only the most basic information. Girls are taught how to manage their periods; boys are

Figure 6: Knew about menstruation before menarche



taught to keep their bodies clean and to refrain from engaging in *haram* (forbidden) acts. A Bani Murra father reported, '*I talked to my son and made him understand. I asked him, "What are these pimples on your face? Why do you have them?" He said he doesn't know. I told him… You are a grown-up young guy now. You are suitable for marriage now. Be careful about yourself or it could lead to something wrong*.' A Syrian father added that his instruction to his sons was focused on masturbation. He stated, '*I always warn my sons about it… Masturbation alone exhausts the body, weakens mental powers, weakens physical strength*.'

A Makani facilitator observed that adolescents' lack of information is primarily related to parents' reluctance to talk to their children about sex. He stated, '*Families have weaknesses in dealing with boys and girls with regard to the issue of sex.*' A Syrian mother agreed that girls in particular should be shielded from knowledge about reproductive biology, as it might lead them to be sexually curious – or to refuse a marriage proposal: '*Why should we let the girls know when they are young?… The girl might commit a mistake. It might affect the girl's married life*.' A 21-year-old Syrian mother added that adolescents' lack of information is also related to parents' lack of information. When she failed to conceive in the months after marriage, she consulted a doctor who explained to her how fertility works. Her mother-in-law admitted that despite having been married for decades, she had also been ignorant. '*In Syria, we knew nothing*,' she explained. In our sample, no caregiver mentioned having been exposed to the film and booklet produced by HPC and aimed at improving parents' and adolescents' communication around SRH.

Even school-based human biology classes appear to rarely deliver the information that young people need in order to understand the changes that puberty brings to their bodies. A 19-year-old Syrian young woman reported that in her ninth-grade biology class, students were not allowed to '*open the book*' to see the graphics that accompanied the '*lesson about the female physiology*'. For girls and boys who learned about '*fertilisation between the ovum and the sperm*' (17-year-old Jordanian boy), information was confined to the cellular level – with no education about how egg and sperm come to be in the same place at the same time. A Makani facilitator noted that schools refrain from sex education, even as they teach puberty education, because '*this issue falls under the name of shame*'.

Menstrual management

Although all girls and young women (100%) reported using sanitary pads (either purchased or home-made) to manage their periods, over half (56%) reported that their daily activities are affected by menstruation (see Figure 7). Older cohort girls were more likely to report impacts than younger girls. In both cohorts, Syrian girls living in host communities were the most likely to report that menstruation impacts their normal activities. Qualitive research suggests that the effects of menstruation on girls' and young women's lives are primarily the result of the cost of period products, which are felt more keenly in host communities where girls are most likely to be using purchased supplies. A Syrian mother reported that, '*Some families complain about the cost of pads increasing because they have more than one girl*.' An 18-year-old Syrian young woman added, '*I buy pads after giving birth only… Normally, we actually can't use pads, we use old clothes… I cut it and make it like a pad*.' Another Syrian young woman of the same age noted that disposing of period products also complicates girls' and women's lives: '*Women's stuff is Haram!… We women can't throw [the pads out with the garbage] because there are dogs and they scatter the trash and so on, so we burn them immediately*.'

The impact of menstruation on girls' and women's activities is partly shaped by their reluctance to discuss their need for period products with family members. Nearly two-fifths of females surveyed (39%) reported that they were embarrassed to ask family members for support with menstrual hygiene (see Figure 8). A further 14% reported being fearful to ask. Adolescent girls were more reluctant and afraid to ask for support than young women. A 17-year-old Syrian girl participating in qualitative research explained that this is because, '*The girl is especially*

Figure 7: Daily activities are affected by menstruation

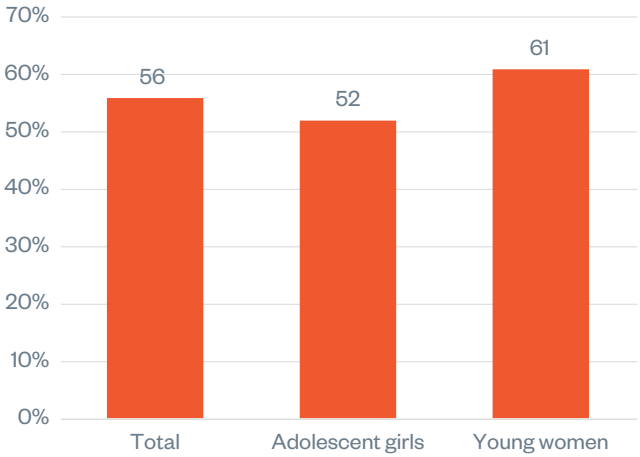
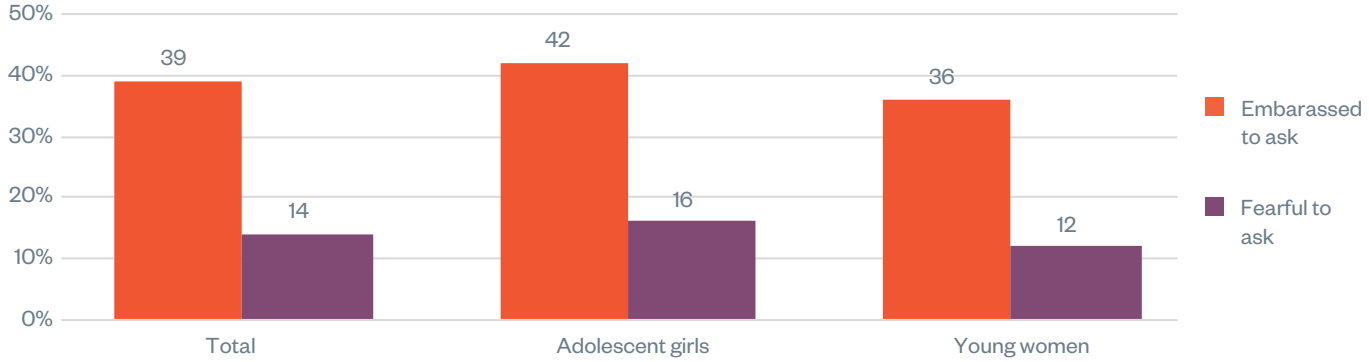


Figure 8: Constraints on asking for family support for menstrual hygiene management



ashamed of her period, and her family finding out, the first time.' In interviews, respondents noted that marriage can make it more difficult for girls and young women to approach family members for support with menstrual hygiene management. Whereas unmarried girls can talk to their mother, married girls must approach their husband. A 15-year-old Syrian girl reported that she never runs out of supplies: '*We do not feel a shortage of sanitary pads... My father is the one who buys me sanitary pads, I ask my mom and she asks my dad to buy sanitary pads.*' An 18-year-old Syrian young woman, on the other hand, noted that she often uses rags because she does not know how to ask for what she needs: '*I feel shy to tell my husband... I said to him I want 2 JD [Jordanian dinars] to buy my private things. He said to me: "What do you want? Tell me to bring"*.'

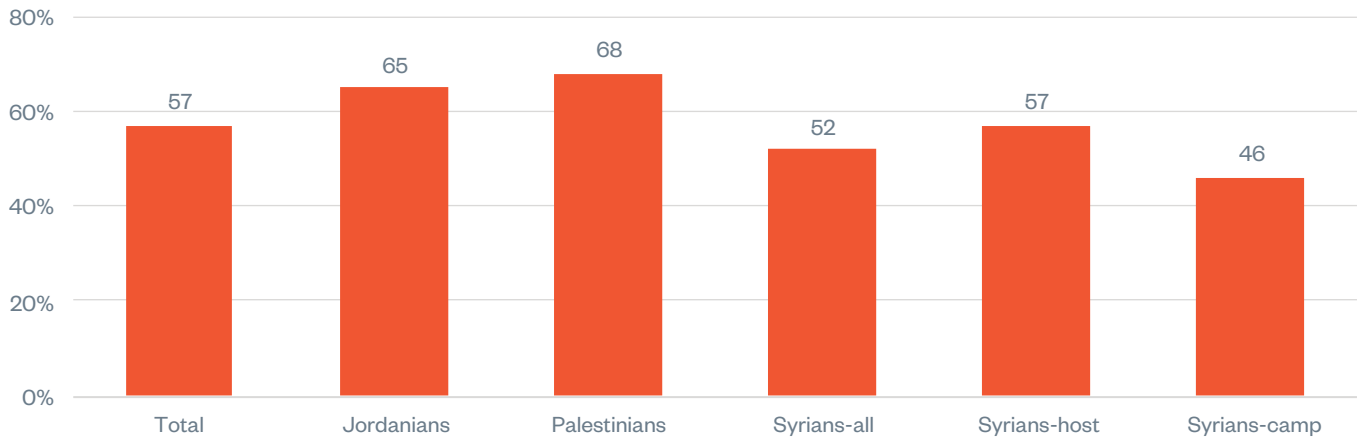
Box 1: Disability and menstrual health management at school

The midline survey found that girls and young women with disabilities are less likely to have access to menstrual hygiene management facilities at school than their peers without disabilities. Among those currently enrolled in school, 63% of those with no disability and only 44% of those with disabilities report that their school has facilities for menstrual hygiene management. Schools typically lack accessible bathrooms (both in terms of the location of the bathroom as well as the design of the bathroom stall and type of toilet), and teaching assistants who can facilitate access.

The impact of menstruation on girls' daily activities is partly due to the reality that not all schools have accessible menstrual hygiene management (MHM) facilities (see Box 1). Among adolescent girls who are enrolled in school, just over half (57%) reported that their school has such facilities (see Figure 9). Syrian girls (52%), especially those living in camps (46%), were least likely to report that their schools are well equipped; Palestinian girls (who attend schools run by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) rather than by the Jordanian government through the end of grade 10) were most likely to report this (68%). A Makani facilitator explained that school toilets are often completely unusable:

> *At school, there is no water at all. The number of bathrooms in the schools is very few, and not enough to meet the needs of the students. If a committee comes to conduct an examination of these bathrooms, I am sure that they will close them.*

Figure 9: Menstrual hygiene management facilities in school (enrolled adolescent girls only)



Syrian respondents, who attend school in the afternoon, noted that toilets are especially unsanitary, as they are rarely cleaned or restocked after Jordanians' morning shift.

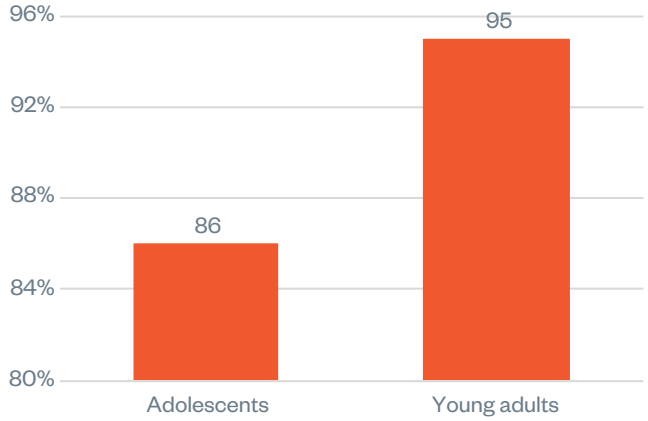
Aspirations for parenthood

Nearly all of the young people in the GAGE sample, regardless of gender or nationality, would like to have children in the future. Unsurprisingly, young adults (95%) were more likely to want children than adolescents (86%) (see Figure 10).

Most young people also wish to have relatively large families. Across groups, the average number of desired future children is 3.6 (see Figure 11). However, this average hides marked differences between groups. First, across cohorts, nationalities and locations, boys and young men want significantly more children than girls and young women (3.9 vs 3.3). Second, there were significant differences between nationality and, for Syrians, by location. Syrians living in informal tented settlements (4.3), Palestinians (3.9), and Syrians living in UNHCR camps (3.8) were more likely to report wanting larger families than those living in host communities (3.2 for Jordanians and 3.4 for Syrians).

While none of the young respondents to the survey reported wanting '*as many children as possible*', qualitative research suggests that many young people, and especially young men, want large families. A 19-year-old Syrian father of two, for example, reported that he wants 10 children because, '*I grew up in a small family. My father, mother, brother, two sisters and I, so I'd like to make our family bigger.*' A 24-year-old Syrian mother of four reported that for her, the limit is six or seven, because she does not think her body can stand more: '*Maybe we can have six children. I gave birth to my children by caesarean section so I cannot give birth to more than seven children.*' Interestingly, several older boys used rights-based framing to discuss limiting the size of their future families. For example, an 18-year-old Syrian young man stated that, '*I mean the limit should be four kids for a person… The fifth baby will come and won't enjoy his rights.*' A 21-year-old Syrian young man added, '*To us, having more than five children is unfair.*'

Figure 10: Would like to have children in future



Sexual activity

The GAGE Jordan study includes a significant number of adolescents and young adults who are married, with many having experienced marriage before the age of 18. Nearly half (46%) of young women in the older cohort had been married by midline, with 30% married prior to age 18. Marriage was less common among young men (10%) and adolescent girls in the younger cohort (3%) (see Figure 12). Syrian young women were more likely to be married – and to have been married as children – than their Jordanian and Palestinian peers.

Qualitative findings highlight that parents' and teachers' reluctance to discuss sexuality leaves girls

Figure 11: Ideal number of children

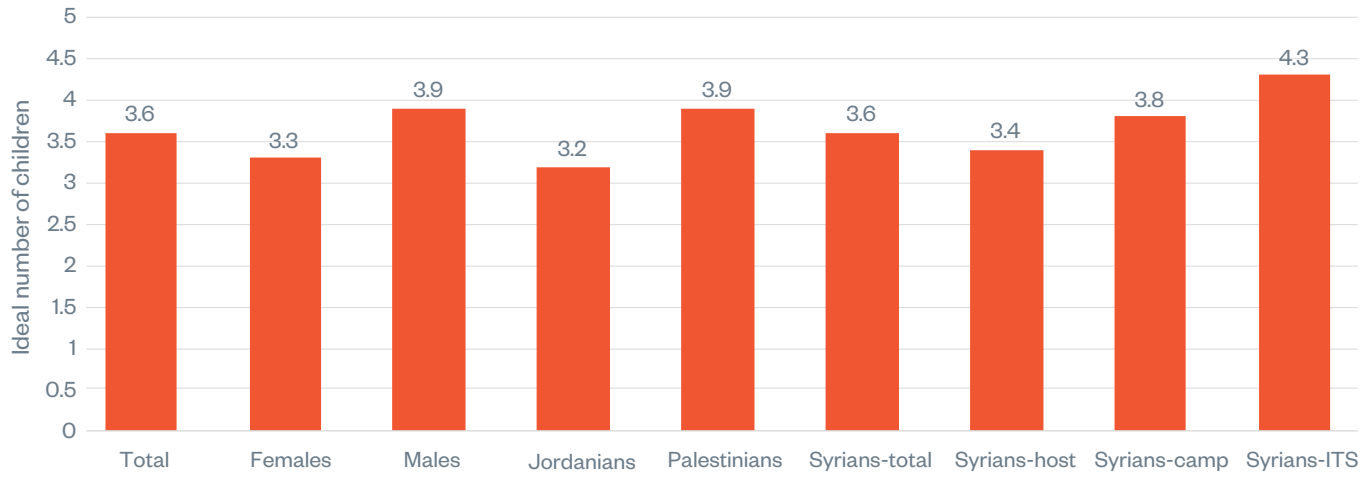
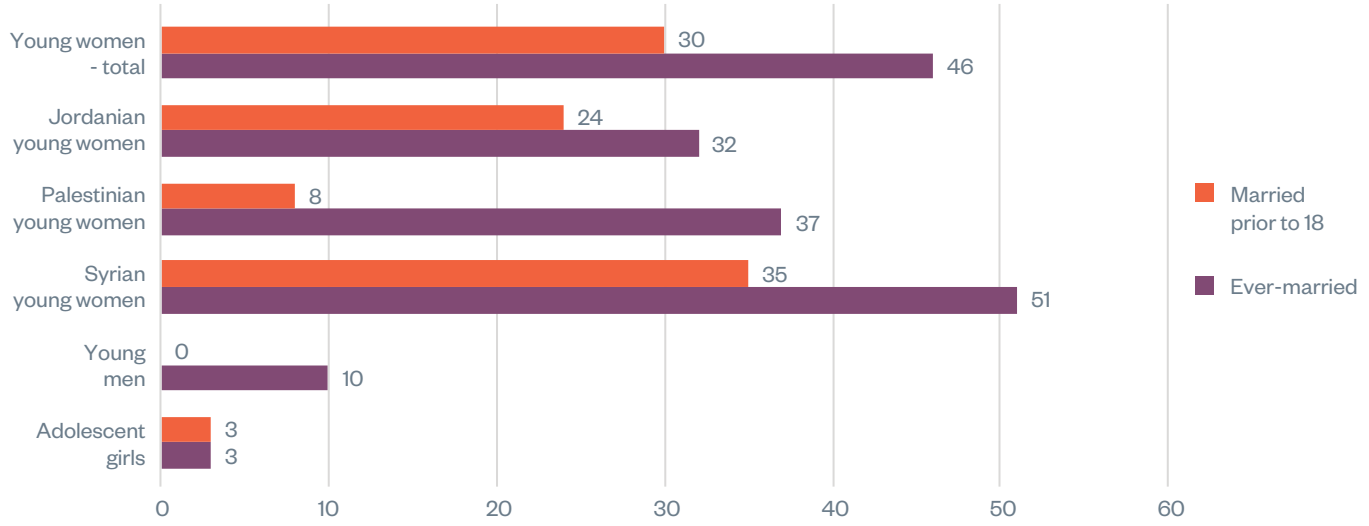


Figure 12: Ever married and married prior to age 18



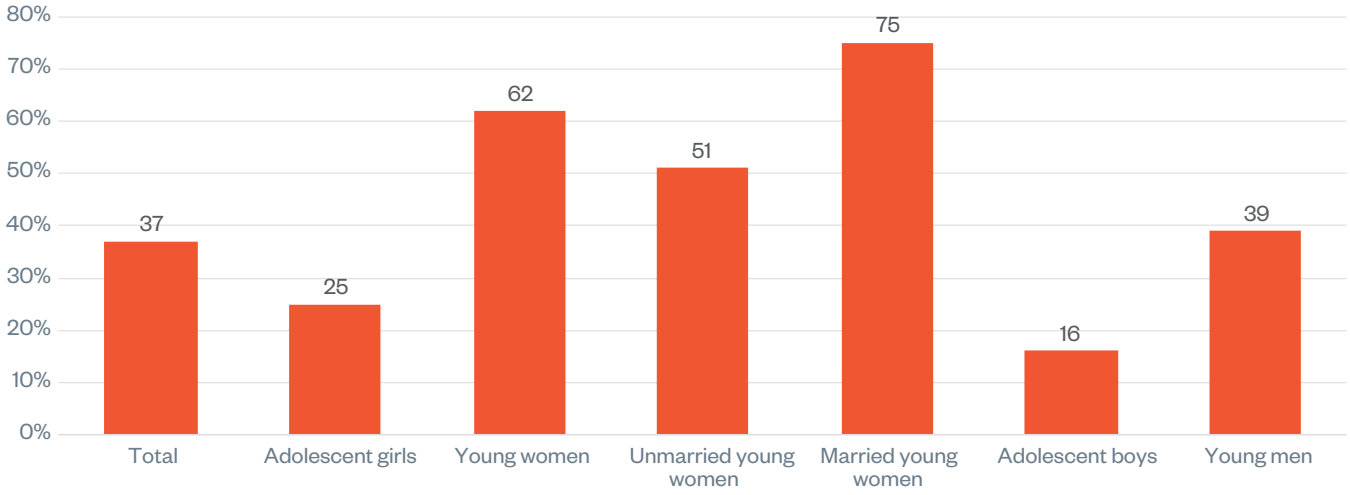
and young women unprepared for marriage. During interviews, many young wives – and most child brides – reported being unaware before marriage that it entails a sexual relationship; indeed, it was not uncommon for girls to report that they were told about sex only on the day of the wedding ceremony. Even these girls were often not told that pregnancy results from sex. A 19-year-old Palestinian mother recalled of her wedding night: '*I didn't know anything [about sex]… and they did not say anything to me, because it is shameful for them to say such things to a girl… I was afraid and ashamed.*' A 16-year-old Turkmen girl added, '*I knew that there will be a marriage and God will bless me with a child… Even my mother told me nothing.*' Young people reported that husbands tend to know much more about what marriage entails than wives. In part, this is because unmarried boys and young men are allowed to listen in to their married relatives' and peers' conversations in ways that girls are not. A 20-year-old married Syrian young man explained that he had learned a lot by paying attention, including that the scenes depicted in pornography are not real: '*There are older men who I socialize with… they tell me what's wrong and what's right… They used to talk and I heard them – for example, they talked about married life… what to do, what not to do, and what you cannot do, and things in guys' imaginations that aren't true.*'

Despite prevailing social norms that frown on premarital sexual activity, qualitative research suggests that it is not uncommon for boys to become sexually active prior to marriage. A 21-year-old Syrian young man admitted that while he would never ask his fiancé to have sex, he does visit sex workers. He stated, '*I won't marry a girl I get dirty with… I couldn't do it with her as I was really in love with her.*' A 20-year-old Syrian young woman reported that she was warned, by a female relative of her husband, to avoid sex with him because of his sexual history: '*She told me not to have a normal sexual relationship with my husband because he might be infected with the disease.*' Adult respondents attributed young men's haram sexual activities to the internet – and to parents' inattentiveness. One mother stated, '*They experienced more openness, as compared to the previous generations… It resulted from the introduction of the internet… Sexual awareness, there is too much openness towards this.*' A Makani facilitator described how, '*The father will be outside his home for the whole day, working… The mother will have four or five kids and she has to catch up with her house chores and so, thus there is no time for their sons and daughters.*' Respondents agreed that girls are far less likely to engage in premarital sex than boys. Indeed, they reported that if a girl '*had an illegal sexual relationship with a boy… they will not accept that… They will beat her… they might kill her*' (19-year-old Syrian young woman).

Knowledge of contraception

At midline, just over a third (37%) of young people age 15 and older were able to name a form of contraception (see Figure 13). There were large differences between those in the younger and older cohorts and between females and males. Among girls and young women, only 25% of those age 15 and older in the younger cohort could name a method of contraception, compared to 62% of those in the older cohort. Among boys and young men, the respective figures were 16% and 39%. Although young women who had been married (75%) were better able to name a form of contraception than those who had not (51%), only three-

Figure 13: Can name a form of contraception (among those over age 15)



quarters of married young women were able to name a form of contraception.

Qualitative research again highlights that parents and teachers are failing to provide young people –and especially girls, given their higher likelihood of marriage – with the information they need to improve their sexual and reproductive health outcomes. Most married girls and young women reported that when they married, they had been unaware that there are ways to prevent pregnancy. This is unsurprising given the large number of girls who did not know that marriage entails a sexual relationship at all, or that unprotected sex can result in pregnancy. A 16-year-old Turkmen mother, when asked about her first son, born 9 months after she was married, replied that she had known nothing about how pregnancy happens and how to delay it: '*I conceived instantly… I was too young and didn't understand anything*.' A 21-year-old Syrian mother of three added that she had not known about contraceptives until after she had delivered her second child; even the medical staff who delivered her first child did not tell her how she might delay the second. She recalled, '*Regarding birth control pills and family planning and these things, I didn't know anything about them, and nobody told me about them… I became pregnant for the second time, and I also did not know what the contraceptive was*.'

Family planning

Among girls and young women who were currently married, less than a third (29%) reported on the survey that they were currently using any method of family planning (see Figure 14). Syrians in host communities (39%) and Jordanians (38%) were far more likely to report using a family planning method than Syrians in formal camps (15%) and informal tented settlements (16%). (There were too few married Palestinians in the sample to disaggregate.)

Use of a modern method of family planning is even rarer – only 19% of currently married females reported currently using a modern method (see Figure 15). Jordanians (33%) were far more likely to report doing so than Syrians (18%) in any location, even those living in host communities (23%).

As might be expected given broader trends, currently married females' preferences for contraceptive methods vary by nationality and location (see Figure 16). Jordanians were most likely to report using an intrauterine device

Figure 14: Currently using any method of family planning (among currently married females)

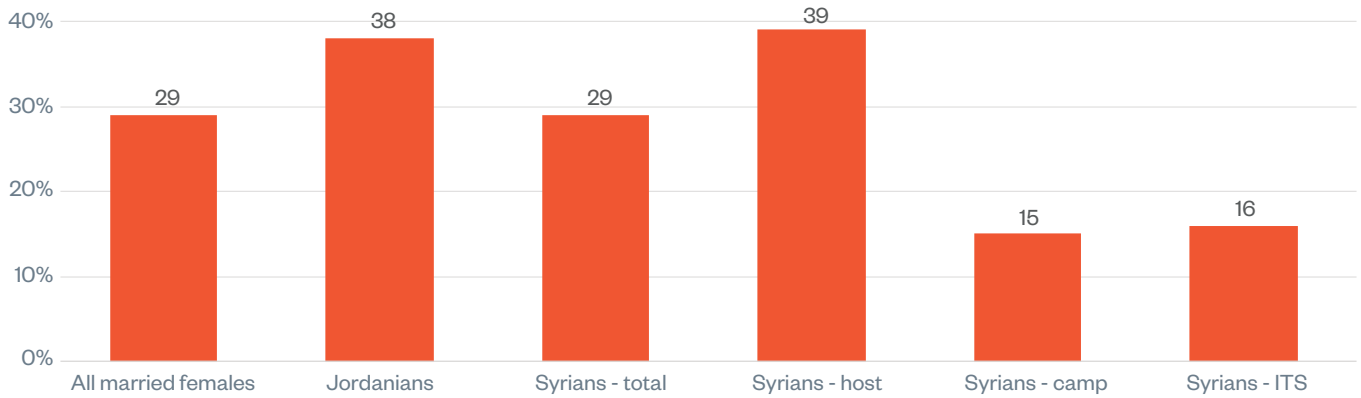


Figure 15: Currently using a modern method of family planning (among currently married females)

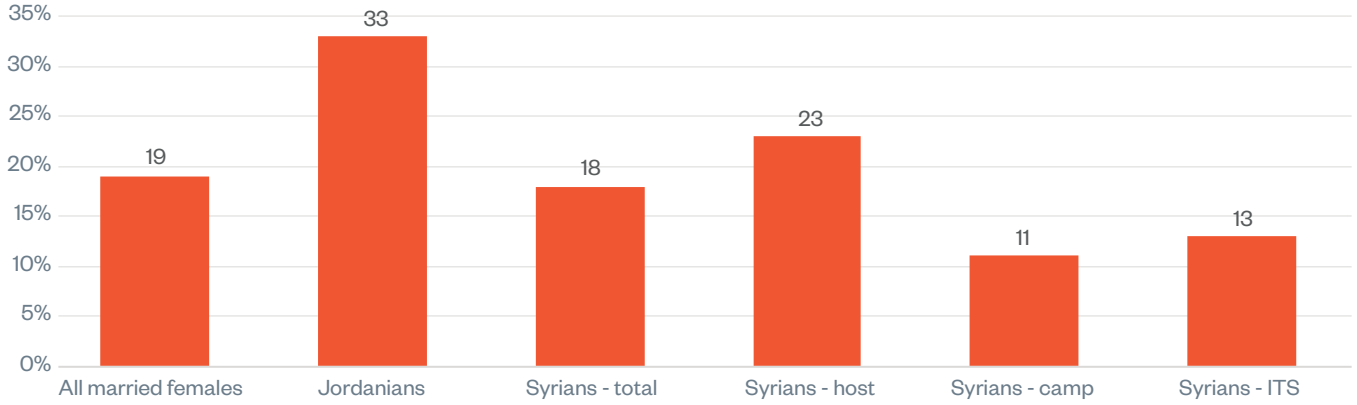
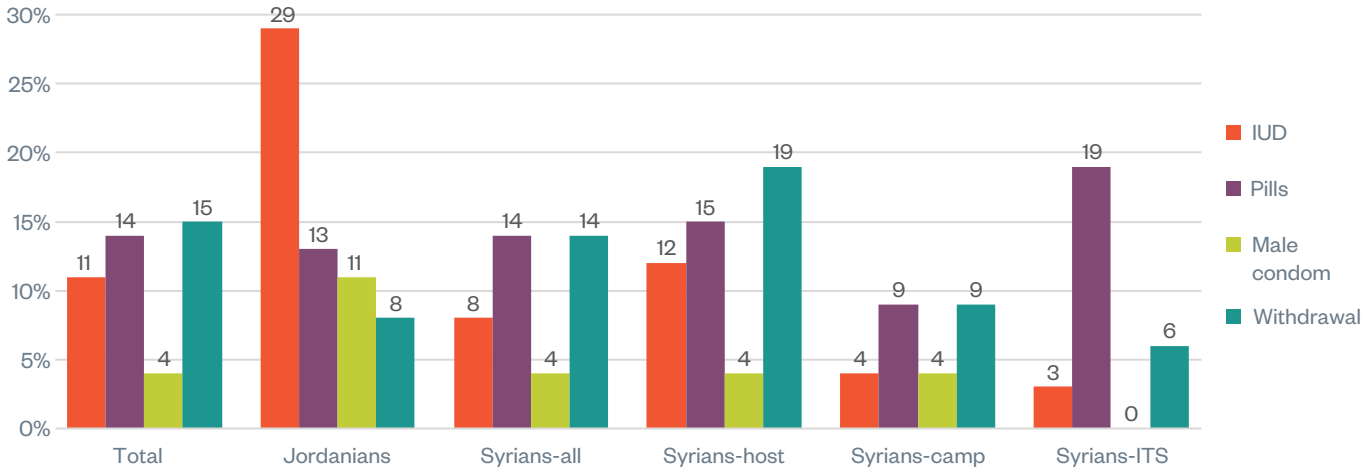


Figure 16: Most recently used method of family planning (among currently married females)



(IUD) (29%), the pill (13%) and condoms (11%). Syrians were mostly likely to report using withdrawal (14% overall, and especially common among those living in host communities, at 19%), and the pill (14% overall, and especially common among those living in informal tented settlements, at 19%), followed by the IUD (8%). Other methods were reported to be rarely used (<5%).

Among the minority of girls and young women who reported using family planning, most reported that they were using it to space their pregnancies. A 23-year-old Jordanian mother, for example, reported that she and her husband are using the pill to delay a second pregnancy until their financial situation is more stable. She stated, '*My daughter is still young, and it worked out because our financial situation isn't good now... We're still young, we didn't live our lives, and we saw what happened with people who got married before us, regarding the expenses, and we want to provide a good life for our children.*' A 20-year-old Syrian mother of two explained that she and her husband are delaying a third pregnancy, using natural methods, because it would be difficult for her to care for their children while pregnant:

> *He knows that the situation is difficult and that I cant raise more than our two children. Currently, my son is little and if I get pregnant, Ill suffer from pregnancy and nausea. I get extremely nauseous.*

Young mothers added that they often learned about contraception, and the advantages of spacing pregnancies, from the NGOs and health care providers that deliver antenatal services. A 21-year-old Syrian mother recalled learning about family planning at the same time as she learned about childbirth: '*The midwife told us about contraceptive pills as well as IUD [intrauterine device] implantation.*'

A small minority of girls and young women – mostly those who married in early adulthood rather than childhood, and primarily those with relatively more formal education – reported using family planning to delay their first pregnancy. A 19-year-old Syrian young woman, now pregnant with her first child, worked with her husband to delay parenthood – over the objections of his mother – until she had completed secondary school. She explained,

> *We were doing natural contraception... We didnt want to have a child who would distract me from my studies.*


An 18-year-old Syrian mother and her infant © Marcel Saleh/GAGE

He wanted me to finish my education… They waited for me… My aunt used to say "I want to see your children".

A 20-year-old Bani Murra young woman, who was very unusual in that she was using an injectable contraceptive, added that she did not want children until she had been married for several years, and that she had taken matters into her own hands at a local pharmacy: '*I did not want to be pregnant… I went to the pharmacy and took the injection and paid 5 liras… Women told me about it.*'

Among the majority of young couples not using any form of family planning, qualitative research highlights that lack of demand was the single largest reason. During interviews, girls and young women reported that the point of marriage is to produce children and that they are under considerable pressure – from their family and the broader community – to conceive immediately after marriage. A 20-year-old Syrian mother explained that, '*In our country, the girl should be pregnant immediately after she gets married… The problem is not just the mother-in-law… the problem is everybody. They all ask me, "Why you did not get pregnant, did you go to the doctor, did you conduct a medical test?" And [they ask] if I took medicine.*' Indeed, young people were more likely to report seeking fertility treatments than modern contraceptives. A 19-year-old Syrian father, whose wife was only 15 years old and not yet menstruating regularly when they married, recalled: '*She had… a disease… Her period wasn't regular… I took her to the doctor because of the pregnancy issue.*' Although medical staff do appear to explain to young couples that young girls are healthy, and that time will solve any fertility concerns, they are also dispensing medication to speed up conception. A 17-year-old Syrian mother reported that she had gone to the doctor after six months of not falling pregnant: '*I went to the doctor in the next month and she told me that I am still young… Each day I took two pills to stimulate ovulation.*' A 19-year-old Syrian mother added that she had been delighted when fertility treatments resulted in pregnancy. She recalled:

I went to a gynaecologist and obstetrician and he told me that I don't have any problems that prevent me from getting pregnant… but he gave me a treatment. I took the treatment and then I got pregnant… I felt great joy. My neighbours went and brought sweets and food. They were happy because I am happy.'

Qualitative findings indicate that low uptake of modern contraceptives as opposed to natural methods is primarily related to widespread beliefs that they are unhealthy. This causes many girls and young women to eschew them entirely and others to use them unreliably. Most concerns centre around impacts on fertility. Hormonal methods that disrupt the menstrual cycle are widely believed to have long-term consequences for young women's future ability to produce children. A 20-year-old Syrian mother explained:

My sister-in-law told me if you dont want to get pregnant, there are pills and injections… But pills are better than injections… Because the pills keep the menstrual cycle going every month, but the injection stops the menstrual cycle. A 17-year-old Syrian mother of two added, *I heard that IUDs cause bleeding for some women, and the chip is dangerous.*

Girls and young women are also worried about other side effects, including weight gain and mood disorders.

An 18-year-old Syrian mother of one explained that she refused to take the pill because of impacts on emotional regulation: '*All the people who I know took contraceptive pills, they feel angry.*'

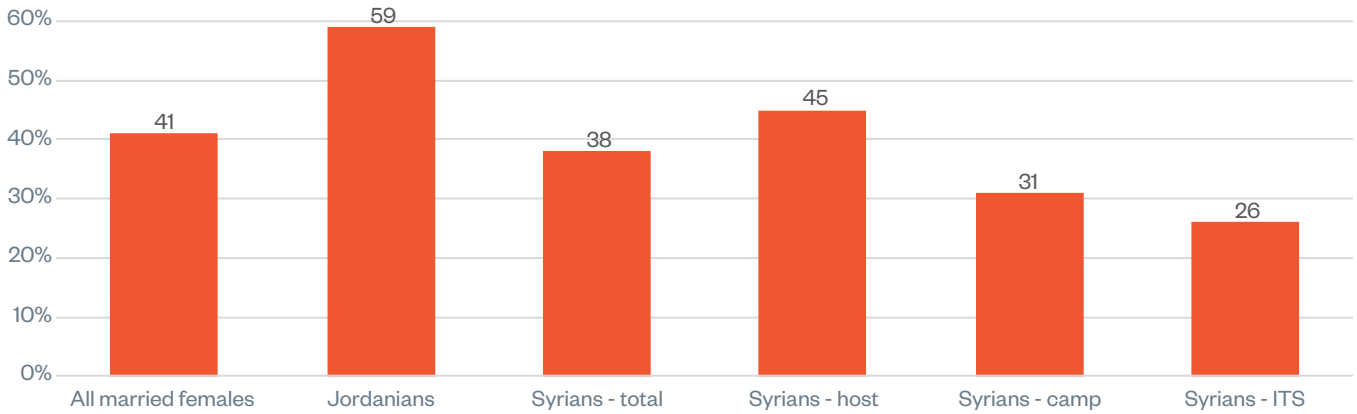
Our findings suggest that many health care providers are not working with girls and young women to help them find a method that works for them. It was common for young mothers to report having tried the pill – and occasionally even an IUD – but they reported having given up on contraception when they experienced side effects, rather than finding a different method. A 19-year-old Syrian mother of two explained that, '*After I gave birth to my daughter, I took the pills, I didn't even plan to give birth to my son at all... I bought contraceptive pills and they caused bleeding and they didn't suit me... So I stopped taking them.*' A 22-year-old Jordanian mother added, '*IUDs are free and 100% effective – but the breakthrough bleeding makes many females remove it.*' A 19-year-old Syrian mother recalled that a doctor at a private clinic had incorrectly told her that side effects were inevitable, because her body simply was not compatible with modern hormonal methods: '*I went to see a doctor who told me that my body can't bear contraceptives... She told me that my body isn't compatible... There's an injection, but it's difficult for me to take... Because I'm the one taking care of my children, she told me that if I took any of that, it will affect me.*'

Survey findings underscore that even if girls and young women prefer to use contraception, the choice is usually not theirs to make. Fewer than half (41%) of the ever married females in our survey reported that they were able to make their own contraceptive decisions (see Figure 17). Jordanians (59%) were far more likely to do so than Syrians (38%); Syrians living in informal tented settlements (26%) and formal camps (31%) were least able to make their own decisions.

Although a 23-year-old Jordanian young woman exclaimed that '*If my husband didn't support contraception, I would have made him support it forcibly!*', most married girls and young women reported that their husband is the primary decision-maker when it comes to contraception. This has significant implications given young men's desire for large families. A 21-year-old Syrian mother, who was pregnant with her third child, stated that she would be allowed to use contraception after this child had been safely delivered. She stated, '*He told me that we should have three children before we start taking contraceptive pills, and then we can stop having children for a time.*' A 24-year-old Syrian mother of five, whose body has been so damaged by repeated and closely spaced pregnancies that she has begged him to take a second wife, added that her husband refuses to allow her body a chance to heal: '*He pressures me a lot and asks me to have more children. I told him that the doctors prevented me from getting pregnant again, but he insists, he wants more children.*'

Many young mothers added that they are pressured not only to produce children – but male children. A 20-year-old Turkmen mother, whose second baby was premature and died at birth, in part (she believes) because the baby was conceived only a month after she had given birth to a daughter, recalled being pressured by her entire family into the second pregnancy. She explained, '*My sister-in-law and my mother, sister. Everyone told me... My husband wanted it... he wanted a son.*' It was not uncommon for young wives who were working with their husband to plan their family to say that they were doing so in secret. A 19-year-old Syrian young woman reported that she and her husband are hiding her use of pills from his mother: '*If she finds out, for sure there will be a disaster... The first thing she will do is to be very angry with her son, as he didn't tell her.*'

Figure 17: Able to make own decisions about family planning (among ever married females)



Motherhood

Unsurprisingly, given reported levels of contraceptive uptake, among the ever married females in the sample, over four-fifths (81%) had been pregnant at least once (see Figure 18). Girls and young women who married prior to age 18 were significantly more likely to have ever been pregnant (89%). On average, young mothers first became pregnant at 17.6 years of age. Most young mothers had been pregnant only once or twice (mean= 1.6).

A large majority (87%) of young mothers had sought antenatal care during their first pregnancy. Young mothers experiencing their first pregnancy attended a clinic an average of 6.2 times prior to giving birth. Young mothers reported that they were prescribed antenatal vitamins, received ultrasounds, and given information on healthy pregnancy and infant care, though some admitted that they did not take the vitamins they had been prescribed. During interviews, young mothers credited NGOs for making quality antenatal care possible. A 21-year-old Syrian mother explained that all her care was free:

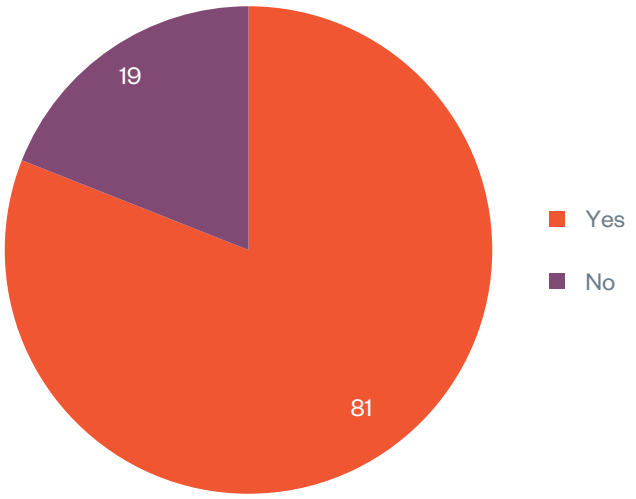
> *I had to go 6 times during my pregnancy, to get a check-up, I didnt have to pay a single penny... She showed us the growth of the baby from the first moment of pregnancy until the last moment in the last month... In one of the sessions... they brought a midwife... She explained about the giving birth procedure.*

Nearly all firstborn babies (98%) born to girls and women in the GAGE sample were born in hospitals or clinics (with similar rates for subsequent babies). Young mothers noted that services are not free; they range from 180 JD for natural childbirth to 380 JD for a caesarean section birth. Several respondents, all of them Syrian, also noted that services (especially in government hospitals) are not good quality. A 21-year-old Syrian mother of one recalled that her needs for pain relief were ignored: '*When I gave birth, there was no care at all, during and after the childbirth. Imagine, one is in the middle of childbirth and it is too painful and you are asking for help from the doctor or the nurse and no one is helping.*' Although many of the youngest mothers reported that their medical needs were well met, which they attributed to providers being '*more scared when the patient is younger*' (20-year-old Syrian mother of two), others reported being blamed, shamed and even abused for having fallen pregnant too early, or for their own high fecundity. A 25-year-old Syrian mother of six, who had her first child at age 14, stated, '*There was a doctor who beat me... She hit me, she put her hand on my mouth and she didn't want me to scream... I was scared, and I was screaming and crying! I didn't know how to give birth!... When I go to the doctor, she makes a big deal and screams at me! I don't dare to tell her that I have six children! When I go, I tell her I just have a child and this is the second one... I don't dare to tell her that I have six.*' A few young Syrian mothers, all living in informal tented settlements, reported using a midwife for delivery, which was reported to be half the price of a hospital delivery but also involved a health care worker who was kinder and more supportive of young mothers. A 21-year-old Syrian mother explained,

> *She is better than the hospital, she helps you, and doesnt scream or bite or make you suffer! Shes good, and after you deliver, she dresses you and cleans you, and she dresses the baby and showers him, and you go out of her house clean and ready.*

Pregnancy loss among the girls and young women in the GAGE sample appears to be very common. Respondents' narratives feature many stories about repeated miscarriage, stillbirth, and extremely premature delivery resulting in infant death. In part, this appears to be related to consanguinity. The young people taking part in participatory research all acknowledged that young couples who are closely related are more likely to experience pregnancy loss (and also to have children with disabilities). One young man, whose sister has had eight miscarriages and stillbirths, acknowledged that even this has not changed his parents' opinions about cousin marriage: '*For the parents it is better to get married to the relatives, rather than a stranger.*' Pregnancy loss also appears to be linked to closely spaced and repeated pregnancies. During individual interviews, respondents evidenced misconceptions about how long it takes

Figure 18: Has ever been pregnant (%) (among ever married females)



a woman's body to recover from childbirth. It was not uncommon for respondents to report 40 days, which is the time after giving birth when sex is haram. Even those who understand that 40 days is aimed at women's immediate recovery, not at optimising subsequent pregnancy outcomes, often fail to understand the benefits of two-year (or longer) pregnancy spacing. A young Syrian father, who ultimately wants five children, explained that,

> *Even those five children that I want to have, they must have distance and the distance should not be only one year. I know that women need four or five months to recover from birth.*

More troublingly, respondents often reported that they were working to reduce the risk of miscarriage using medication protocols (injected heparin) that are not intended for use by young, healthy women whose only risk factor is too closely spaced pregnancies. A 21-year-old Syrian mother stated that she had had injections for the first four months of her pregnancy to '*stabilise*' it: '*These injections are taken in the abdomen… during the first four months of pregnancy… They give these injections to prevent clots from occurring*.'

Unsurprisingly, given that abortion is considered *haram*, few respondents spoke of accessing – or even considering accessing – abortion services. When the word is used, it is almost entirely used to describe completing a naturally occurring miscarriage. Several young women reported having had an early abortion to end an ectopic pregnancy, to save their life. A 21-year-old Syrian mother of two reported considering an abortion for her current pregnancy, because her abusive husband told her that if she aborted the pregnancy then he would allow a divorce:

> *There was a problem between me and him… He said to me: "It is enough, you must abort the child in your womb, and I will release you…" I am thinking to abort the foetus, I am thinking to abort this foetus and getting divorced.*

Another 21-year-old Syrian young woman reported that she found out, in the fifth month of pregnancy, that her baby had severe abnormalities related to consanguinity. Although her doctor urged her to have an abortion, because the child would '*come to this world tormented*', she refused. The baby lived only a few weeks; the mother was pregnant again before he died.

Intimate partner violence

In order to capture information about general attitudes toward marital relationships and spousal violence, the quantitative survey asked whether respondents agreed with the statement that wives owed their husband obedience in all things. At the aggregate level, a large majority (75%) of young people agreed. Although there were minimal differences between cohorts, males – across all nationalities and locations – were significantly more likely to agree than females (86% vs 66%) (see Figure 19). Among young women, those who had ever been married were more likely to agree than those who had not (70% vs 59%). Syrians (78%), especially those living in informal tented settlements (88%) and formal refugee camps (81%), were more likely to agree that wives owed their husband total obedience than Palestinians (74%) and Jordanians (64%).

The survey also asked young people aged 15 and older whether they agreed with the statement that it is acceptable for a man to beat his wife to mould her behaviour. This statement was less supported than the previous statement. At the aggregate level, 14% agreed (see Figure 20). Age, gender, nationality, and location differences were significant. Adolescents were more likely to agree than young adults, males were more likely to agree than females, and Syrians were more likely to agree than Jordanians, with Syrians living in UNHCR run camps and informal tented settlements more likely to agree than those living in host communities. Syrian males living in informal tented settlements (34%) were the most likely to agree that wife beating is justifiable. There were no differences between married and unmarried young women.

Finally, the survey asked young people aged 15 and over whether they agreed with the statement that a man's use of violence against his wife is private and should not be discussed outside the home. At the aggregate level, 43% of young people agreed (see Figure 21). Adolescents were more likely to agree than young adults, males were more likely to agree than females, married young women were more likely to agree than unmarried young women (36% versus 26%), and Palestinians (48%) and Syrians (44%) (especially those living in informal tented settlements) were more likely to agree than Jordanians (35%). Palestinian males (60%) were the most likely to agree that spousal violence should be kept private.

During individual interviews, married girls and young women reported that intimate partner violence is common, can be severe, and is almost always kept private due to the stigma that surrounds divorce and the lack of alternatives for young wives experiencing such violence. A 21-year-old Syrian mother recalled having tolerated abuse for some years before she finally returned to her parents' house and asked for a divorce:

Figure 19: Agrees with 'A woman should obey her husband in all things'

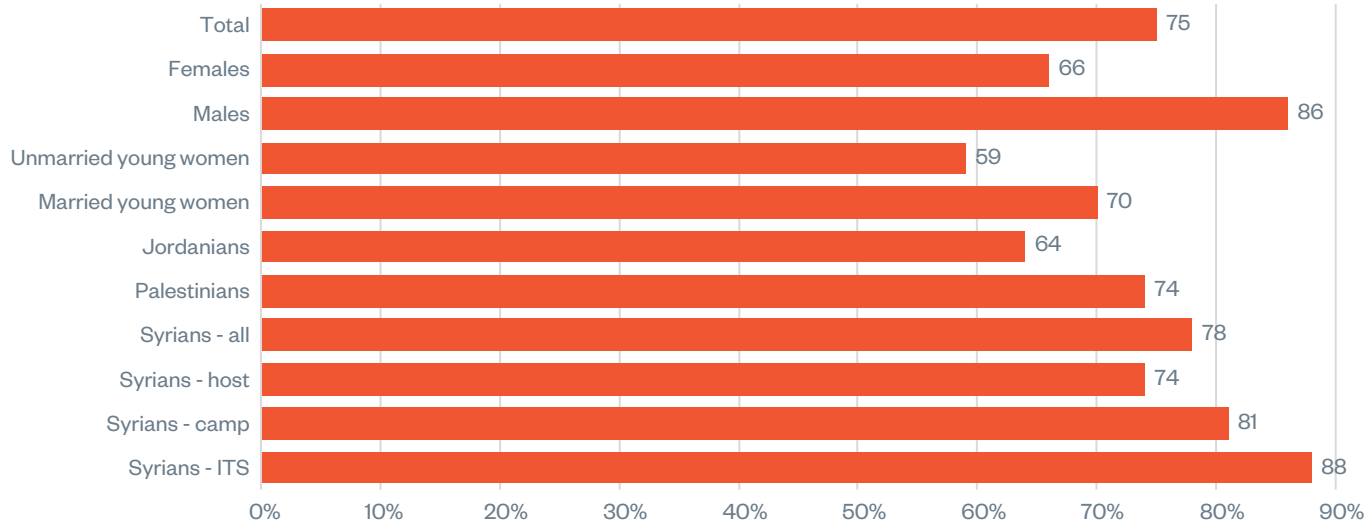
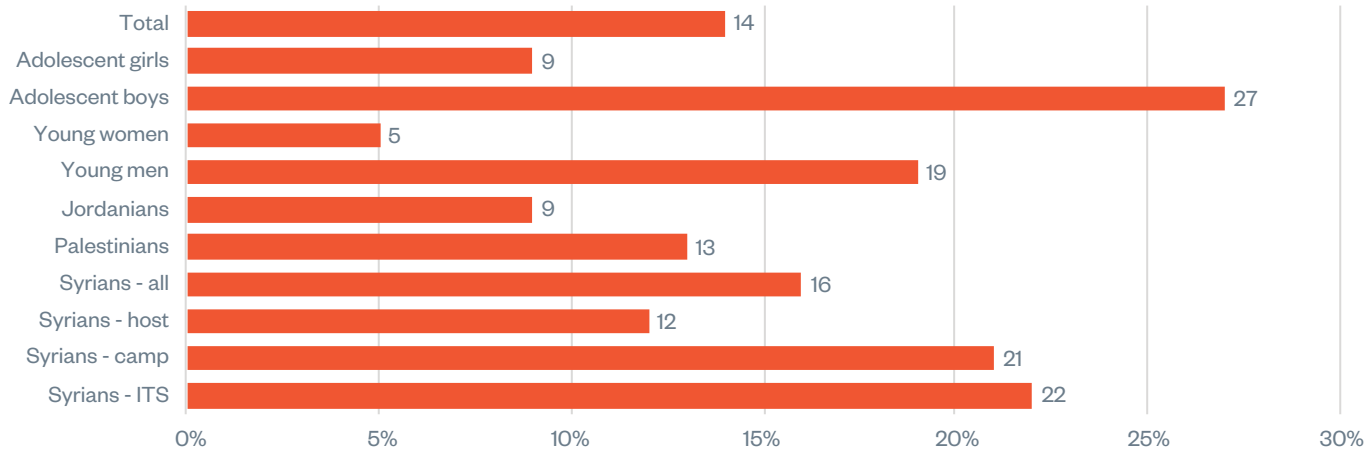


Figure 20: Agrees with 'It is acceptable for a man to beat his wife to mould her behaviour' (15+)



> *I was living like an animal... He would leave me and the children alone and I was forced to put up with everything like lack of money, insults, beatings... No one knew about it, and if I told anyone about our problems, he would refuse anyones interference.*

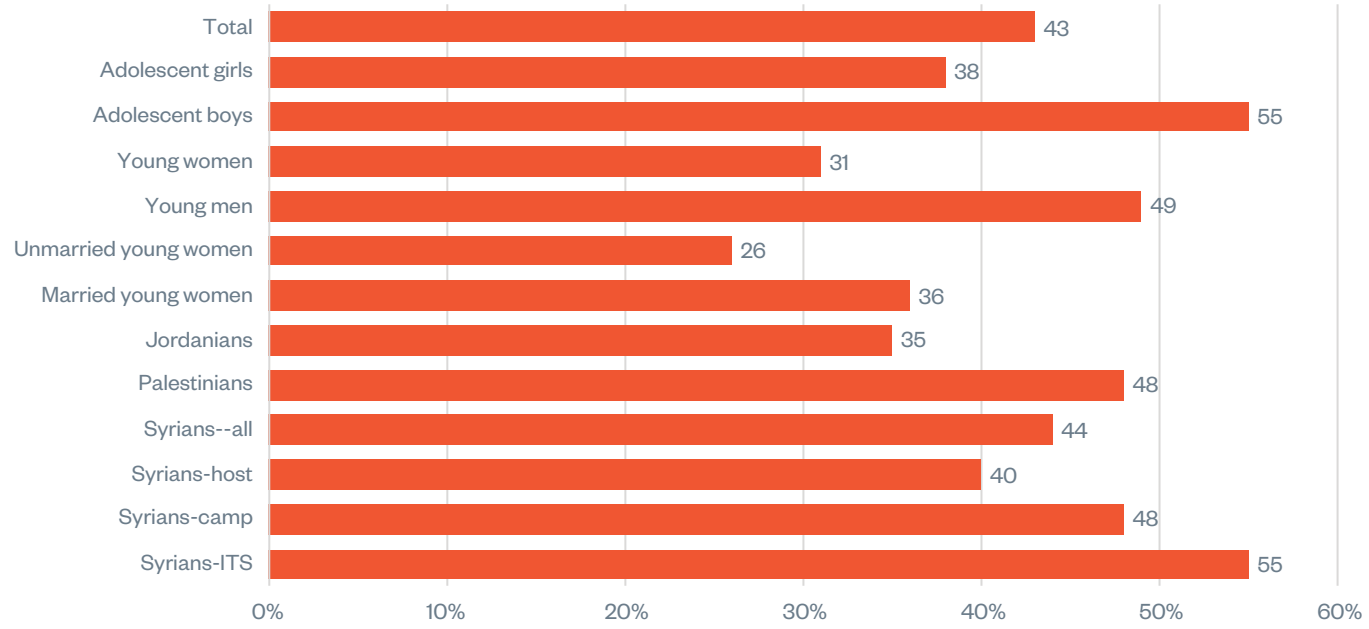
A 20-year-old Bani Murra mother, asked why she tolerated violence for some years, replied, '*I had a daughter who needed money, I needed money and my parents cannot bear our expenses*.'

Caregivers and key informants did not gainsay young wives' narratives. A Palestinian mother reported that nearly '*all wives are beaten and insulted*'. A Syrian mother noted that this is because men do not have enough access to work and instead focus on what their wives are doing (or not doing) – and how this reflects on men. She explained, '*The husband is sitting at home for 24 hours. Why this and that? Why is that thing here and so. And all this reflects on whom?*' A Makani facilitator clarified that the beatings that young mothers endure often arise from them carrying out their duty to care for their children. He reported that a young mother had been beaten badly for asking to take her very ill daughter to the doctor: '*Her husband had beaten her when she came to me, she told me that her husband had beaten her and that her head was swollen because he did not want her to take the girl to the doctor.*'

Young wives experiencing intimate partner/ spousal violence reported limited support available were they to disclose what was happening. It was not uncommon for young wives to note that their natal families ignored bruises and lumps until they were actively shamed by neighbours for allowing violence to continue. A 21-year-old Syrian young woman recalled that,

> *I was always beaten up, they [the neighbours] would interfere to break the fight, they then started telling my family: where have you brought your daughter from to let her live such a life?*

Figure 21: Agrees with 'A man's use of violence against his wife is private and should not be discussed outside the home' (15+)



A 22-year-old Jordanian young woman added that even when families witness violence, they are hesitant to get involved. She reported that her brothers were there when her husband shoved her into a wall and hit her, but declined to intervene because '*they thought that it was a private issue between us and they think my husband has the right to do what he wants*'. A 14-year-old Palestinian boy noted that his father had finally agreed to protect his oldest sister, but had then backed down – and forced her to return to her marital home – when the sister's husband visited her natal family with elders '*My father told him that you keep hitting her and we will help her divorce you... but then they brought notables to my father and he returned her.*'


A medical clinic in Mafraq © Nathalie Bertrams/GAGE

Conclusions and implications

In line with existent evidence, GAGE's midline research underscores the very limited education that adolescents and young people receive about sexual and reproductive health. Although most adolescents and young adults reported having a source of information about puberty, a large minority of boys receive no information at all and only half of the girls in the sample learned about menstruation before menarche. The discomfort felt by parents (especially fathers) around preparing their children for the changes puberty brings and how it affects their roles in life is not offset by comprehensive sexuality education (CSE) courses provided by schools and NGOs. School-based instruction is not provided until later grades, by which time many young people have already left school; even courses on reproductive biology fail to include information on how sperm and eggs meet; and NGOs are wary of offending parents by providing young people with necessary information. The end result is that many girls including those who received belated information on menstrual hygiene management, marry without knowing about sex and how pregnancy happens, and many young couples fall pregnant without knowing that contraception exists. Young people's ignorance about their own bodies is coupled with social pressure to produce children, especially sons, immediately after marriage. For this reason, as well as broad concerns about the safety of modern contraceptives, few young couples practice family planning, even fewer use a modern method, and most girls and young women are pregnant within a year of marriage. Indeed, girls and young women who do not become pregnant '*on schedule*', or who are prone to pregnancy loss related to consanguinity or too closely spaced pregnancies, are regularly subjected by their husbands and in-laws to medical interventions that violate best-practice protocols. Young wives feel voiceless in many of these decisions, partly because most believe they owe their husband obedience in all things and partly because husbands enforce obedience and silence with violence. Because divorce is highly stigmatised, because girls' own families are often unable or unwilling to take them in, and because the legal system awards custody of children to fathers, most girls who experience intimate partner violence – especially those with children – feel they have no choice but to tolerate it.

A 17-year-old Jordanian boy sitting on train tracks © Marcel Saleh/GAGE

If Jordan is to deliver on the Sustainable Development Goals, and achieve the policy objectives laid out in its national strategies on Population and Sexual and Reproductive Health, our research suggests the following priorities for policy and programming:

- **Adolescents need to be provided with comprehensive sexuality education at school**, starting ideally no later than grade 7, by teachers carefully trained for the task. Courses should follow an approved international curriculum, be timely and accurate, and be inclusive of young people with disabilties. They should address, in an iterative age-appropriate way, puberty and how male and female bodies work, alongside issues such as sexual reproduction, consent, and family planning. We suggest that the Higher Population Council, the Ministry of Education, and the National Centre for Curriculum Development partner to plan and scale these classes, drawing on existent work by UNFPA and the World Health Organization (WHO).
- **There is a critical need for complementary community-based life-skills programming to shift gender norms and address adolescents' needs for sexual and reproductive health information.** Programming offered by NGOs and/or at mosques should directly tackle beliefs that boys are more valuable or better than girls, that girls should be silent and subservient, and that violence is an acceptable way to demonstrate masculinity. It should also provide young people, including those with disabilities, with accurate information on their developing bodies and a safe place to ask questions. In conservative communities, provision of awareness-raising sessions by Qur'an education centres could be especially valuable as it could be framed as religious awareness rather than being considered and rejected as '*unwanted knowledge*'.
- **Parents need courses on parenting adolescents,** provided by NGOs or at mosques. These should address gender norms and preferences for early and consanguineous marriage, early and repeated pregnancy, and male children. Courses should also provide accurate information on human reproduction and contraception, build parents' acceptance for the provision of more formal comprehensive sexuality education courses, and – in line with HPC's existent multi-media efforts – support parents to talk to their children about 'taboo' topics that can no longer be ignored given young people's exposure to mass media and social media. Given the psycho-emotional challenges that many parents face in a context affected by forced displacement, including a component on psychological first aid could be beneficial so that parents can better manage their own emotions and thus more effectively exercise improved parenting skills and advice.
- **Young couples need premarital counselling sessions,** both individually and as a couple. Existing premarital counselling sessions could be strengthened and expanded to include: processes of human reproduction; contraception; the value of delayed, spaced and limited pregnancies for maternal and child health and financial stability; open communication; the importance of consent even within marriage; and gender norms.
- **All girls' schools need accessible and clean menstrual hygiene management facilities,** with lockable doors and disposal bins. Where possible, schools should anonymously provide period products for free.
- **There is a need for mass media and social media campaigns to de-stigmatise sexual and reproductive health issues.** The Higher Population Council and its partners could invest in campaigns to: build awareness of information sources, including Darby; shift preferences for consanguineous marriage, early and high fertility, and male children; encourage family and community members to intervene in and report intimate partner violence; and facilitate girls and women who are experiencing violence to get medical, legal and psychosocial support.
- **Medical professionals need more and tailored training** that helps them tackle young wives' need for accurate SRH information and services as well as broader concerns about fertility and contraception. Training should include sensitivity to gender norms, and how they shape and limit young wives' knowledge and behaviour; and also awareness of intimate partner violence. There is also a need for iterative refresher training on best practices surrounding fertility treatments, miscarriage prevention, and supportive maternity care.

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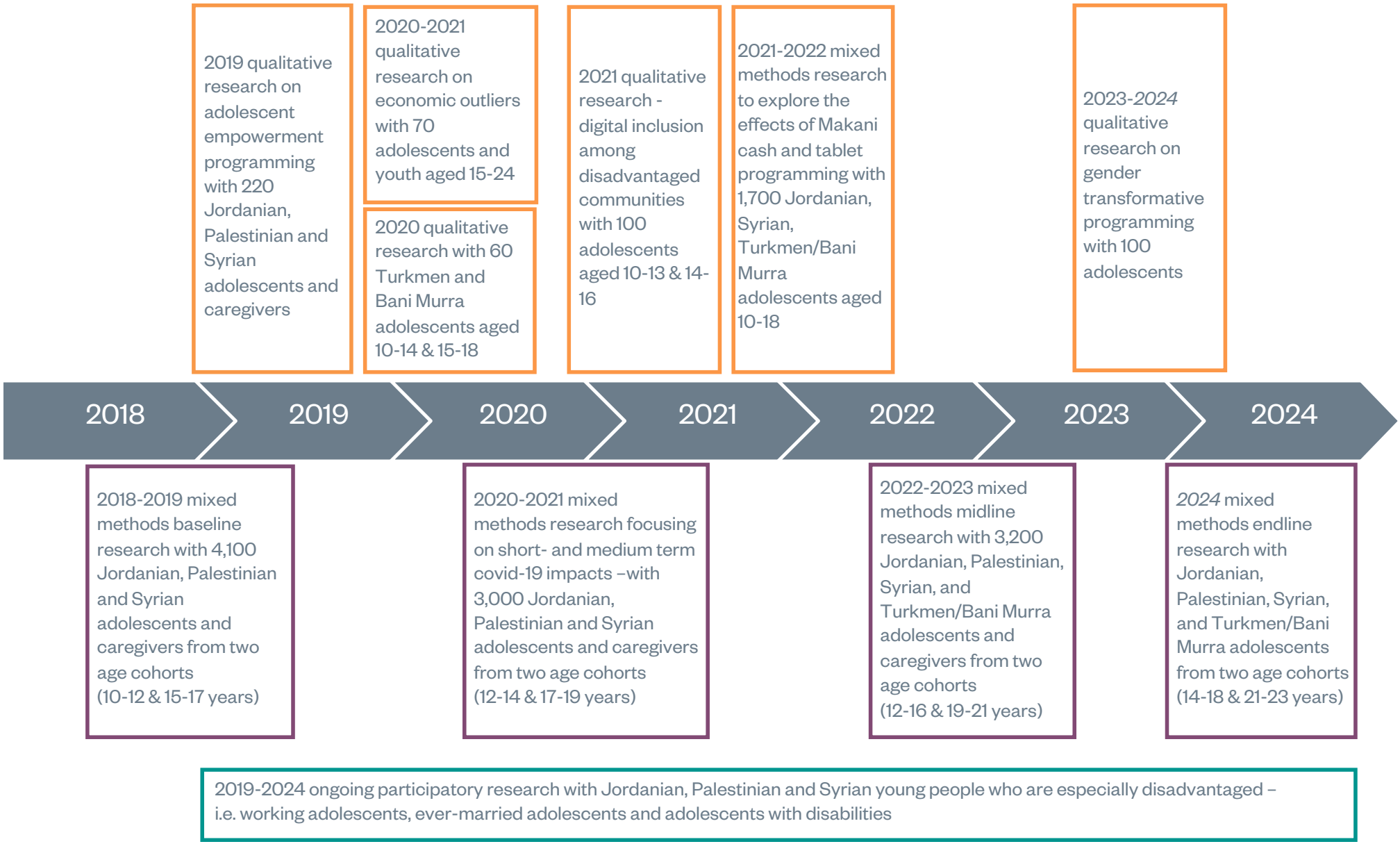
Annex 1: GAGE Research timeline



About GAGE

Gender and Adolescence: Global Evidence (GAGE) is a nine-year longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit www.gage.odi.org.uk for more information.

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Front cover: An 18-year-old Syrian mother and her two-year-old son © Nathalie Bertrams/GAGE

GENDER & ADOLESCENCE: GLOBAL EVIDENCE

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ISBN: 978-1-915783-22-6

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