



Tackling the ‘culture of silence’ to improve adolescent sexual and reproductive health in Jordan

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Introduction

For an upper middle-income country, Jordan has a very young population. UNICEF Jordan (2022) reports that 63% of the country’s estimated 11 million people (Department of Statistics, 2022) are under the age of 30. Adolescents aged 10–19 years, who comprise one-fifth of the population (Department of Statistics, 2015), are poised to become an even larger share of Jordan’s population over the next few years (Higher Population Council, 2021). This is partly because Jordan’s refugee population² is especially young and partly because fertility rates remain high across all population groups (Higher Population Council, 2021; Department of Statistics and ICF, 2019).

¹ The authors are grateful to the Higher Population Council researchers for their detailed and insightful comments on a draft version of this policy brief. All errors are those of the authors alone.

² Jordan is hosting nearly 3 million registered refugees. The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) (2018) reports that Jordan is home to 2.2 million refugees from Palestine. The United Nations High Commissioner for Refugees (UNHCR) (2023) reports that Jordan is hosting 650,000 refugees from Syria and 72,000 from other countries.

Aware of the many risks and opportunities inherent in this ‘youth bulge’, the Government of Jordan is working to reduce child marriage and adolescent parenthood while supporting young people to develop the healthy lifestyles and skillsets they need for productive adulthood (Higher Population Council, 2021; Jordan Ministry of Youth, n.d.). The Higher Population Council, tasked with addressing the demographic challenges facing the country, has taken the lead on these efforts. It has undertaken several studies on child marriage and adolescent sexual and reproductive health, and carefully reviewed findings from the 2018 Jordan Population and Family Health Survey (JPFHS) to develop priority actions for addressing the sexual and reproductive health issues facing young people in Jordan (Higher Population Council, 2017; UNICEF and Higher Population Council, 2019; Higher Population Council, 2019, 2020, 2021). The Council has also developed a National Action Plan on Child Marriage, a National Strategy for Population, a National Strategy for Reproductive and Sexual Health, and national standards for youth-friendly reproductive health services (Higher Population Council, 2018, 2021; Higher Population Council and United Nations Population Fund (UNFPA) Jordan, 2021). A common thread across studies and policy documents – and in line with international consensus that adolescence is a critical life stage for encouraging safe sexual practices and healthy reproductive choices (Morris and Rushwan, 2015) – is the need for Jordan to better address adolescents’ access to sexual and reproductive health information and services. Indeed, recent national strategies identify adolescents’ lack of information and services as a major challenge facing the country, and call for action to improve adolescents’ sexual and reproductive health as a priority (Higher Population Council and UNFPA Jordan, 2021; Higher Population Council, 2021).

This brief draws on mixed-methods research conducted by the Gender and Adolescence: Global Evidence (GAGE) programme and aims to contribute to the Higher Population Council’s efforts to improve the sexual and reproductive health of adolescents living in Jordan. Using data collected between 2018 and 2022, it focuses on young people’s timely access to information about puberty and reproductive biology, child marriage practices, barriers to contraceptive use, girls’ experiences with maternity care, and intimate partner violence. It concludes with implications for policy and programming.

Sample and methodology

GAGE’s Jordan sample of 4,101 adolescents reflects the complexity of the country’s population (see Table 1). Drawn to capture those most at risk of being left behind, it comprises Syrian, Jordanian and Palestinian girls and boys who live in host communities, refugee camps, or informal tented settlements in the governorates of Amman, Mafrqa, Irbid, Zarqa and Jerash. Adolescents are in two age cohorts – younger, aged 10–12 years; and older, aged 15–17 years at baseline (2018). The qualitative sample of 250 adolescents is drawn from the larger quantitative sample, as is the participatory research sample of 56.

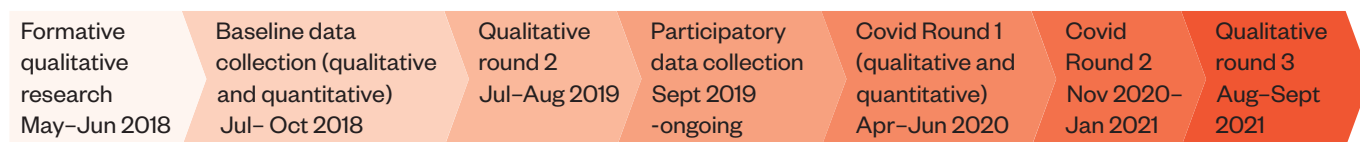
GAGE uses mixed research methods to explore the risks and opportunities facing adolescents. Methods include: surveys with adolescents and with their primary caregivers (baseline conducted in 2018³); individual and group interviews with adolescents, caregivers (and spouses), community members, service providers, and formal and traditional leaders (conducted each year between 2018 and 2022); and participatory research groups with older adolescents, including those who are married (ongoing since 2019) (see Figure 1 for details).

Table 1: A breakdown of GAGE Jordan’s adolescent baseline sample

	Quantitative survey	Qualitative research	Participatory research
Nationality	3,090 Syrians 642 Jordanians 304 Palestinians 65 other	158 Syrians 52 Jordanians 40 Palestinians	28 Syrians 8 Jordanians 20 Palestinians
Location	2,445 host communities 1,348 camps 308 informal tented settlements	80 host communities 125 camps 45 informal tented settlements	36 host communities 20 camps
Gender and age	1,108 younger girls 1,065 younger boys 1,006 older girls 922 older boys Including 186 married girls	65 younger girls 54 younger boys 85 older girls 46 older boys Including 30 married girls	38 older girls 18 older boys Including 15 married girls
Total	4,101	250	56

3 Our midline survey was delayed due to the Covid-19 pandemic. It is currently in progress. We fielded two phone surveys during the pandemic instead.

Figure 1: Overview of GAGE data collection rounds in Jordan to date



Given the sensitive nature of our research focus, we took great care when developing the research protocol. The study obtained ethics approvals from Jordan, and from research institutes in the United States (George Washington University) and the United Kingdom (Overseas Development Institute). For participants in refugee camps, we sought permission from UNHCR’s National Protection Working Group; and for respondents in host communities, approval was granted by Jordan’s Ministry of Interior and the Department of Statistics. We also secured and regularly updated an Institutional Review Board approval from George Washington University and from the Overseas Development Institute’s ethics review. The GAGE programme also established a Child Protection Policy and referral protocols in case any adolescents disclosed to researchers any experiences of gender- or age-based violence. Researchers were trained in the use of these protocols. Research instruments were piloted with adolescents and caregivers, and adapted where necessary to make sure that questions were culturally appropriate.⁴

During data collection, care was exercised to ensure that the principles of research ethics were respected and strictly adhered to. Interviews were carried out by researchers of the same gender as the respondent, and recurring visits were carried out by the same researchers to build trust and rapport with adolescents. Assent was obtained from young people aged 17 years and under through either oral or written forms that articulated the project goals, timeframe of the research, and contact information for researchers. Consent was obtained for adolescents aged over 18 years, and from parents of all minors.

Each of GAGE’s three research methods (quantitative, qualitative and participatory research, see Table 1) have been used to explore adolescents’ sexual and reproductive health. However, due to cultural sensitivities among the communities taking part in GAGE research in Jordan, questions about puberty and physiological maturity were asked only of older adolescents, and questions that directly addressed experiences with sex were asked only of adolescents who had been married. Where quotes from younger adolescents are included, this is because the

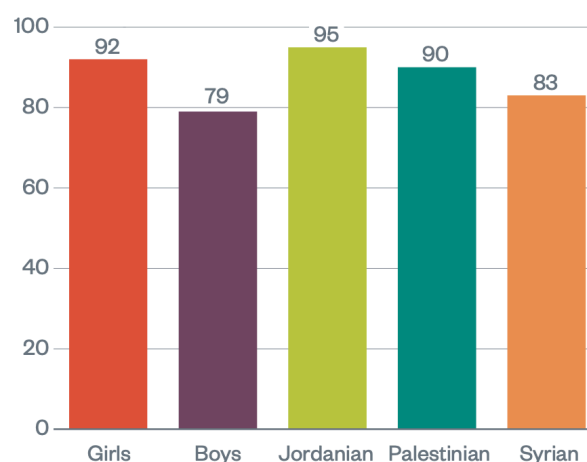
information was freely volunteered without questioning. We note for the reader that some adolescents were quite explicit in the language they used.

Findings

Adolescents receive limited information about puberty – and usually too late

More than three-quarters of older adolescents (aged 15–17 at the time of the baseline survey) reported that they had a source of information about puberty (see Figure 2). However, girls (92%) were more likely to have a source of information than boys (79%), and Jordanians (95%) were more likely to have a source of information than Palestinians (90%) and Syrians (83%). Most adolescents cited their parents, aunts (girls only), older siblings and friends as sources of information, although some reported learning about some ‘*simple topics*’ at school, and a few mentioned classes they had taken at UNICEF Jordan’s Makani (My Space) centres. A 14-year-old Jordanian girl said, ‘*We learned it at school... I just talk about it with my friends.*’ And a 15-year-old Jordanian boy explained, ‘*We see these differences and we received it [information about puberty] at school.*’

Figure 2: Older adolescents have a source of information about puberty, by gender and nationality (%)



⁴ For GAGE research instruments, see: GAGE baseline qualitative research tools: www.gage.odi.org/publication/gage-baseline-qualitative-research-tools/
 Qualitative toolkit to explore child marriage dynamics and how to fast-track prevention: <https://www.gage.odi.org/publication/qualitative-research-toolkit-to-explore-child-marriage-dynamics-and-how-to-fast-track-prevention/>
 Jordan baseline survey <https://www.gage.odi.org/publication/jordan-baseline-survey-2017-18/>

Qualitative evidence suggests that girls' relatively better access to information about puberty is mainly due to fathers' limited involvement in childrearing – and that boys' lesser access is mainly due to mothers' hesitancy to discuss puberty with sons. A Jordanian father explained that 'you do not discuss these issues with your sons'. A Palestinian mother said:

I feel embarrassed to talk with my sons about the changes in adolescence. My husband told me that they learned about it at school. He depends on me to explain things to them and have conversations with them. He says, 'You have time and you can talk with them.'

Several boys admitted that while they could ask their fathers for information, this would never happen because they are too embarrassed to do so. A 15-year-old Syrian boy explained, 'My father answers me, he has no problem, but I am the one who does not ask him... I feel embarrassed.' A 17-year-old Jordanian boy agreed: 'These are personal things that I do not ask about.'

Our qualitative research also uncovered strong evidence of a culture of silence that surrounds sexuality. It suggests that Syrian adolescents have even less access to information on puberty than their Jordanian peers, partly due to their lower school enrolment rates. Although Jordanian parents were more likely than Syrian parents to answer their children's questions, several Jordanian mothers admitted that they refuse to discuss any sexual topics, even menstruation as they are considered taboo. One stated, 'She [her daughter] knows that topic [menstruation] is shameful and it is not allowed to talk about it.' Other Syrian mothers said they relied on their own younger siblings (their daughters' aunts) – or their children's older cousins – to discuss puberty with their daughters. As one said: 'I depend mostly on her cousins, they are at the same age and very close to her. I asked them to teach her the true and wrong things.' Syrian mothers were also often forthright about the information they are not giving their children. One mother living in an informal tented settlement, when asked whether she had discussed menstruation with her daughter, said: 'I did not tell her about periods, this generation is taught by themselves, they teach each other... They know more than me.' Another mother, when asked how her daughter might learn about menstruation as she was already out of school, replied simply: 'No clue'.

Older adolescents looked back on their younger selves and recalled how surprised – and scared – they had been about some of the things that happened to them during puberty, because their parents had delivered 'only a little information' (Palestinian adolescent mother) and, even then, 'only after her menses came' (Jordanian adolescent mother). A 16-year-old Jordanian girl said that she was

completely unprepared for menarche (the first occurrence of menstruation):

I went to the bathroom, I had abdominal pain, then I saw red stuff. I shouted and cried to mom. She came and she told me not to be scared and this is normal. She told me that I became older and I reached the puberty age.

A Syrian boy in a participatory research group admitted, with some embarrassment, that he was alarmed when he experienced his first 'wet dream' (an erotic dream accompanied by emission of semen). He recalled: 'I did not know anything about these things... One wakes up wet!... The shock!... I thought I had peed on myself!'

Although some older adolescents (when asked what sorts of puberty education they would have wanted when they were younger) reported wishing that their parents had been more proactive, most would have preferred a class or course taught by strangers to whom they could ask questions. A Syrian girl explained, in a group discussion: 'I feel that it's better to know from people whom I don't know.' Boys suggested that courses should cover both 'physical and psychological changes' and be taught for two hours at a time, several times a week, for at least a month. This would give sufficient time for adolescents to absorb new information, and formulate and ask questions. Key informants agreed with this suggestion, with several noting that many parents have only limited and incorrect information themselves. Others noted that parents' discomfort in discussing puberty often prevents adolescents from asking questions. As a national-level health key informant said, 'There is not sufficient awareness among the families and they are not qualified to educate their children about sexual education and to guide them.'

Knowledge about reproductive biology is highly gendered

Adolescents' knowledge about reproductive biology is highly gendered. Boys – whether married or unmarried, and regardless of nationality – usually admitted that they had learnt the 'facts of life' quite young, often through watching pornography (porn) online. Married girls, on the other hand – nearly all of whom in our sample were Syrian – said they were often completely unaware of sex until they became engaged to be married. Indeed, in line with the Higher Population Council's earlier research (UNICEF and Higher Population Council, 2021), several girls admitted that they did not learn about the nature of marital relationships until their wedding night.

Although parents unanimously expressed the view that 'I cannot talk to my son about those [sexual] topics until he gets engaged' (Jordanian father) – due to concerns that boys who know about sex may be 'inclined to sexual desires' (key informant) – most older boys in our study



A 17-year-old Jordanian boy who wants to become a pilot © Nathalie Bertrams / GAGE 2022

reported getting explicit information about sex during early adolescence, and mainly through downloading pornographic videos. A Syrian boy in a participatory research group explained that, *'Porn is available for all... The first time I saw something like this, I was 10 years old... I loved it so much!*' A younger Jordanian boy, in a group interview, when asked what he does with friends, replied: *'We watch porn movies together.'* Boys reported that after the videos they watched had piqued their interest in sex, they used Google, Facebook and TikTok to help them understand what they were seeing. *'Google has lots of information,'* noted one Jordanian boy, who then went on to explain how to do private searches and clear one's browser history. Several boys added that they also rely on their older friends for information, even though they know that *'two-thirds of the information is wrong'*, and that they refuse to consult Wikipedia, because *'anyone can edit it.'*

Girls, in stark contrast, are usually deliberately shielded from any information about sex *'so that they don't mature early'* (Syrian girl) and preserve their family's honour by eschewing premarital sexual relationships. Most participants agreed that if girls were to gain knowledge about sex, it would be considered dishonourable for their families. As a Syrian girl in a participatory research group said, *'They will say that the girl hasn't been raised well.'* Indeed, another Syrian girl recalled being beaten as a child for repeating words she had heard but did not understand:

When I was a kid my mother and my maternal aunt were talking... I repeated the same just like them, without knowing what it meant, and they started beating me just because I knew.

Families appear to step up their efforts to protect girls from knowledge about sex as the girls approach marriageable age, due to fears that if girls do know about sex, they will refuse a marriage offer. An 18-year-old Palestinian young woman explained: *'It is a norm here that we don't tell anything to the girl before the night of the wedding party.'* A 16-year-old Syrian girl similarly noted: *'This is because if the girl knows about what happens beforehand, she would be afraid of getting married.'* Such efforts by families include breaking up girls' friendships, partly to make sure that married girls do not talk about sex to their unmarried peers. As an unmarried 16-year-old Palestinian girl confirmed: *'It is not allowed to visit a girl that's married.'*

Parents are aware that boys' use of pornography is widespread, and leads to beliefs and practices that are contrary to custom. As a Jordanian father noted, *'What they watch on the internet is not the reality.'* Even religious leaders admit that it is unfortunate that society is not meeting young people's need for accurate information about sex and sexual relationships. Yet none of the adolescents in our research reported having taken a class on sex or sexuality, and none of the parents reported having discussed pornography with their sons. Indeed, several girls noted that when they were

taught about eggs and sperm in 10th grade biology class – and asked questions about how eggs and sperm meet – they were told only that ‘We will get to know about them after marriage’. Key informants confirmed that this is the case. A teacher reported that ‘sex education is forbidden’, outside of basic biological information about male and female bodies. A doctor explained that most adolescents and young adults have no formal access to information about sexual and reproductive health prior to marriage.

Awareness of sexually transmitted infections are rare – but sexual experience may not be

Adolescent girls and boys agreed that it is absolutely forbidden for girls to have sex before marriage. As one girl in a participatory research group said, ‘It’s not only shameful, it’s prohibited.’ A boy in a different group asked, ‘Do we live in Europe!? Do we live in Las Vegas?!’ Adolescents agreed that boys have different rules, with ‘nearly all’ boys having had at least some sexual experience prior to marriage. A Syrian boy explained, ‘As my father says... men are like horses. They destroy and then they leave.’ That said, our findings suggest that a minority of girls do engage in sexual activities before marriage – usually with their fiancé, who applies considerable pressure, and in ways that enable them to ‘protect the hymen’ so that the girl ‘stays like a sealed box’ (according to a boy in a participatory research group).

In line with the 2018 JPFHS, which found that fewer than 2% of girls and 8% of boys aged 15–19 had comprehensive knowledge about HIV, our findings suggest that very little attention is being paid to the risks of young people acquiring sexually transmitted infections. When asked what they knew about infections of the reproductive tract, most girls in participatory research groups spoke only of urinary tract and yeast infections. One girl said, ‘I think there are many types, we just don’t know about them.’ Boys reported that they learned about HIV and AIDS through watching movies, with one boy describing a movie ‘... about AIDS and the lives of people living with AIDS’. Adolescents reported that although couples are required to take a blood test prior to marriage to screen for genetic diseases, including Beta Thalassemia, there is no requirement for HIV testing, which, according to an adolescent girl in a participatory research group, is perceived to be ‘socially notorious because it’s connected to prostitution’. This is especially problematic, given that most boys are loath to use condoms, believing them to ‘reduce pleasure’ and to be only for homosexuals and prostitutes. Key informants acknowledged that far too little is being done to educate young people about the risks of sexually transmitted infections. As a national-level key informant said, ‘If there are sexually transmitted diseases, people will not say, because our society is a conservative society.’ A healthcare provider working in a UNHCR camp confirmed that, ‘With

regard to sexual diseases, because here in the camp there is a culture of shame and there is a religious conscience, so there are no sexually transmitted diseases...’

Child marriage is common – and the drivers are complex

Despite efforts by the Jordanian government and its development partners, child marriage remains a significant risk in Jordan – especially among Syrians and Palestinians without citizenship. The 2018 JPFHS found that of young women aged 20–24, nearly 10% had married before the age of 18. Although Syrian girls (36.6%) were far more likely to marry as children than their Jordanians peers (7.5%) (Department of Statistics and ICF, 2018), UNICEF and the Higher Population Council (2019) observe that the rate of child marriage is climbing among the Jordanian population. Of girls aged 15–17 in the GAGE sample, 18% were already married at baseline (see Figure 3). Echoing the Higher Population Council’s (2017) own work, a Syrian mother living in Azraq camp explained that among Syrian refugees, child marriage is seen as normal: ‘Almost 95% – the majority of girls here get married early.’ A 17-year-old divorced Palestinian girl added that the same is true of Palestinians who live in Gaza camp. She said: ‘All the girls got married while they were under 15 years old. These are our traditions.’ Most married Palestinian girls were married at age 15 or 16, but a few girls had married at age 11 or 12.

Although the youngest child brides were almost always forced to marry – usually by their father, who felt compelled to provide an inexpensive bride for a nephew – nearly all married girls in the GAGE sample (94%) perceived their own marriages to have been voluntary, and most (63%)

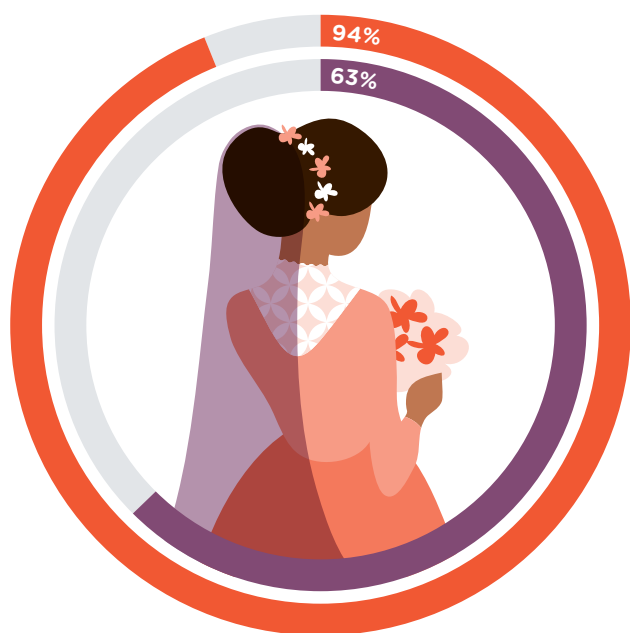
Figure 3: Percentage of girls aged 15–17 who had been married by baseline



reported that they felt ready to marry when they did (Figure 4). As in UNICEF and the Higher Population Council's (2019) earlier research, girls in the GAGE sample gave a variety of reasons for having 'chosen' child marriage. Some of these reasons highlight their immaturity, whereas others are deeply rational. A 16-year-old Syrian girl, married at age 13, admitted that she had married because she wanted a wedding party: 'I did not know anything. All I was happy about was the dress and the gold back then, ha ha!' A 17-year-old Syrian girl, married at age 12, added that she had married in order to escape gruelling work in a factory: 'I was working as long as 12 hours a day... I felt tired and broken.' With the caveat that marriage often provides the only socially acceptable setting in which young couples may interact, other girls reported marrying for love. A 17-year-old Syrian girl, who was born in Jordan but is now living in Zaatari camp with her husband and his family, explained how: 'I told my mother that we both love each other and that I constantly think about him and that I really wanted to get married to him.'

However, to fully understand girls' narratives about their 'choice' to marry, we must situate those narratives alongside adults' (particularly parents') efforts to encourage girls to marry as children. Most married girls reported persuasive efforts on the part of their parents. As a 16-year-old Syrian girl who married at age 15 said: 'He [her father] said that it is better to marry because he won't stay with me... After that, I

Figure 4: Percentage of girls who perceive their own marriage as voluntary and reported feeling ready to marry when they did



94% perceived their own marriages to have been voluntary

63% felt ready to marry when they did.

agreed to marry.' An 18-year-old Syrian young woman who married at age 14 noted, 'My mother said that we will not find anyone like him [the girl's husband] because he is a good man... Also, his family is good.'

It was not uncommon for parents to admit manipulating their daughters into marriage. A Syrian mother recalled of her daughter: 'She said that she didn't want to marry since the beginning... I played in her mind.' A Syrian father added, 'She will say as you want.' The mothers of bridegrooms – who often want their sons married in order to settle them down and sometimes have strong preferences for younger brides because they are more malleable – can also play a critical role in encouraging girls to 'choose' marriage, usually trying to influence the girl's parents. A 14-year-old Syrian girl who had married at age 13 first reported that her marriage was a love match – 'I loved him at first sight' – before adding, 'Both our mothers agreed together. His mother saw me one day earlier and came to marry me the next day.'

The wedding night

In line with the study by UNICEF and the Higher Population Council (2019) on child marriage, married girls in the GAGE sample commonly reported that their wedding night was highly traumatic. Some girls, usually those married at the youngest ages, reported having experienced marital rape. An 18-year-old Syrian mother of four, who was married to a cousin at the age of 12, recalled how:

He put the bed sheet over my face to prevent me from crying and he had sexual relationship with me. Then, he went out and I started crying. I had bleeding.

Even girls who were 'prepared' for sexual debut (with information provided by either their mother or mother-in-law) reported being very afraid and embarrassed – particularly when bloodied sheets were shown around to verify their virginity; or when their virginity was questioned because they were not seen to bleed 'enough'. 'I was terrified,' admitted an 18-year-old Palestinian young woman talking about her wedding night. A 15-year-old Syrian girl commented that, 'If any woman asks me about my wedding night, I feel ashamed to answer her.'

Married girls had different views on how to better prepare girls for what happens on their wedding night. Some were still angry – often years later – that their mother did not tell them about what marriage entails. A young Jordanian mother was indignant when she recalled her own ignorance: 'My mother didn't tell me anything! I got married and my mother didn't tell me anything!' Those girls and women believe that girls should be given accurate information well in advance. Other girls felt that it was better to keep girls ignorant for as long as possible. A young Syrian mother, when asked what she would teach adolescent girls about their developing bodies,

replied that while she agrees that girls should learn about their periods, *'I won't teach them about marriage... Still she is too young.'* A 17-year-old Syrian girl, married at age 15, agreed, arguing that if girls were aware of sex they would *'neglect everything and think of these issues only.'*

However, married girls were agreed that boys need to be educated about the wedding night – not necessarily about what happens sexually, but about how to treat their usually younger and quite scared wife. As a Syrian girl said, *'It is necessary for him to have some awareness about how to behave on their first wedding night.'* A married Syrian young woman in a participatory research group explained, *'I feel that it is necessary for him to learn about how to behave/interact with his wife and that it is necessary for him to be very loving.'* Another girl in a different research group said that before marriage, boys should spend time watching romance films, rather than pornography: *'He should watch movies and try to act the same as shown in the movies... He should be gentle towards her when he penetrates her.'*

Boys' responses in the participatory research groups underscore this need for them to be educated about respectful wedding night behaviour. Although they admit that *'the first night is about fear'*, they also believe that *'it is her duty'*. When asked whether it is ever acceptable for a man to force sex upon his new wife if she is too scared to continue, a Syrian boy disdainfully replied that marital rape is not recognised under Jordanian law. He said: *'Raping is for the foreign countries.'*

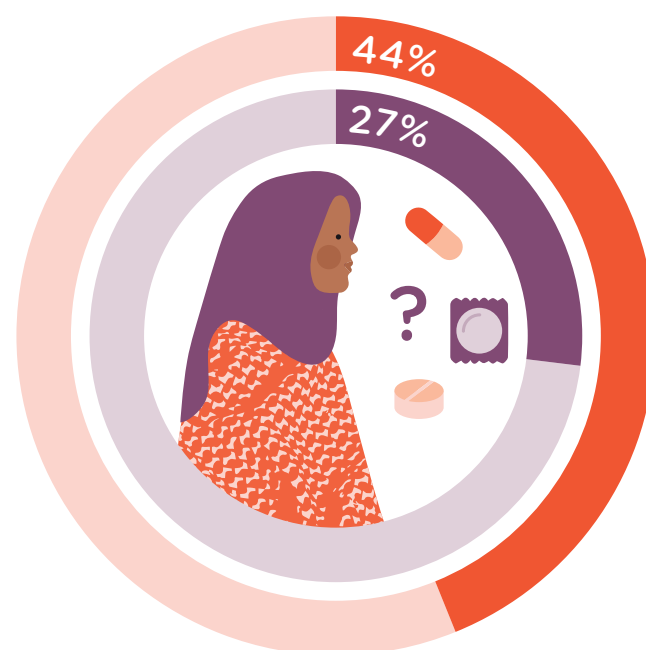
Demand for contraception is limited

Unsurprisingly, given girls' lack of sex education, many girls start married life not understanding how they get pregnant – or how they might prevent it. Indeed, of the married girls in our sample, at baseline only 44% reported having heard of a method of contraception (compared to 27% of unmarried girls) (Figure 5). As a young Syrian mother said, when asked why she had not tried to delay her first pregnancy, *'We didn't even know that it [contraception] exists.'* A young Syrian mother of three, whose husband ironically delivers sexual and reproductive health education for men, explained that, *'I got pregnant during the second month of marriage... I didn't know anything when I got pregnant the first time... even though my husband is very aware and he gives sessions about these things.'*

Interestingly – but explicable in that Syrian girls are more likely to already be mothers and to have been counselled about contraception after delivery – Syrian girls (46%) were more likely than their Jordanian peers (30%) to report having heard of a method of contraception.

Although key informants, parents and adolescents reported that contraception is easily obtainable locally,

Figure 5: Percentage of married/unmarried girls who recognised a method of contraception



Only **44%** of married girls recognise a form of contraception...

compared to **27%** of unmarried girls.

including at clinics, hospitals and pharmacies – and with the caveat that we were constrained in terms of what questions we were allowed to ask unmarried adolescents – contraceptive use is relatively rare, even among those married young people who are aware of the risks of early pregnancy and how to prevent it. This is in line with the 2018 JPFHS, which reported that fewer than 10% of married girls aged 15–19 were using a modern method of contraception. In part, non-use is due to cultural preferences for pregnancy immediately after marriage. As a Jordanian key informant said (who has a six-month-old daughter but is already feeling pressure to produce a son), preferences start with the broader community: *'There is a lot of pressure from society... When people see me, they pray that I have a baby boy.'* Married girls report that their in-laws push hard for early pregnancy – and often prohibit them from using contraception. A 19-year-old Jordanian young woman said that her in-laws ask her every month, *'Why aren't you pregnant?'* In many households, son preference is strong and a driver of the pressures to reproduce as soon as possible after marriage. A Syrian girl in a participatory research group explained that this is because

'Our girls, when they get married, they do not only marry the husband, but they also marry the whole family... The mother-in-law is the most interfering one... She wants to see her grandson.'



A pharmacist in Jordan. His pharmacy offers contraception (condoms and also hormonal) over the counter © Nathalie Bertrams / GAGE 2022

Most young wives, influenced by the 'culture of shame' (key informant) that surrounds those who do not fall pregnant immediately after marrying, soon sign up to this preference for early pregnancy. A 19-year-old Jordanian young woman, who had reported that she and her husband had wanted to delay their first child because 'life is long and we are young', noted that she now thinks of nothing other than pregnancy. She explained: 'I've been married 5 months and I'm going to the doctor next month... I do not think of anything else.' Indeed, a few girls – who observed that their husband 'did not want to have children' and were using condoms to avoid pregnancy – reported that they were so desperate to conform to expectations that they had been willing to argue with their husband to try for a baby. As a 17-year-old Syrian girl from a host community, who married at age 14, said: 'I told him that what he was doing was haram... We have been married for 7 or 8 months, and his parents have started to talk about that.' She added that when her husband refused to reconsider, she reported him to his own parents, who told him that he must stop using contraception: 'I said to him [the husband's father] that his son did not want to have children from me... His father answered that it [avoiding pregnancy by using contraception] is not permissible.'

Widespread misunderstanding about how contraception works – and the erroneous belief that it might somehow permanently damage girls' fertility – also limits young couples' uptake of contraception. Boys in participatory

research groups reported that 'pills destroy the sperm before it can reach the egg', condoms are covered in an 'oily, petroleum product' that is 'bad', that 'injections are also dangerous', that contraception is a way of 'killing a child', and that 'IUDs [intrauterine devices] are truly disgusting because they work like a door, forever, sending out pee but not receiving anything'. Several boys said that only natural methods of family planning are acceptable. A young Syrian husband explained that: 'You need to control yourself... That is all.' Girls are less convinced that contraception is dangerous – at least compared to pregnancy and childbirth – but, as noted by the Higher Population Council (2022), girls are given little chance to make their views known, much less act on them. A young Syrian mother, who was trying to explain during an interview what she had been told about the risks of contraceptives, was silenced by her mother-in-law, who interjected: 'She can't have the contraceptives at the first and second pregnancy... She can have the contraceptives to delay the third pregnancy.' Another young mother in a participatory research group told a similar story, about when she was offered contraception by someone who worked for a non-governmental organisation (NGO) who had come to help her learn to breastfeed. She said:

They told me about contraception, in case I would like contraception... I didn't ask [any questions] due to my mother-in-law... She won't allow me to say anything at all, and she would reply on my behalf.

In many families, the pressure on young couples to produce a child (preferably a boy) as soon as possible after marriage is such that some married adolescents admit to using 'fertility enhancers' rather than contraceptives. Alongside Viagra (a drug taken to improve erectile function), which appears to be widely used, boys in our participatory research groups reported using 'sexual tonics to increase desire', 'masculinity hormones' to 'raise the sperm', and creams to make themselves 'more virile'. One young Syrian husband had even had his sperm count verified. Girls reported similar machinations; quite a few mentioned using special tea, honey and massages to help their uterus 'go back to its place' to improve their odds of conception. Other girls detailed approaches that are 'painful beyond expectation', such as having a heated box placed on their stomach. Several girls – who are now mothers – reported that they had been forced by their husband and mother-in-law to use fertility drugs to stimulate their too-young bodies into ovulating. For example, a Syrian girl married at age 15 explained that she conceived her first child after her husband obtained fertility drugs from a friend who was a pharmacist, despite knowing that the drugs might kill her. She said:

The doctor said if you took the needle your womb might blow and you could die. He said, 'It's fine, I want her to take it'. The doctor kicked him out. He told him you just give me the prescription, and I'll inject her with it. It won't be your responsibility. And he did get the prescription.

A young man who works at a pharmacy acknowledged, during a participatory research group, that these injections are readily available and in 'high demand', for just 168 Jordanian dinars.

Despite mothers' and mothers-in-law's protestations that girls are allowed to use contraception to space their pregnancies to protect their health – at least for their third and subsequent pregnancies – our research finds that it is not uncommon for girls to be pushed into one high-risk pregnancy after another despite risks to the girls' health. For example, an 18-year-old Syrian young woman, who was married at age 14 to a cousin, reported that after two caesarean sections, she had been told 'that I should stay for 2–3 years before I get pregnant again', to let her body heal. 'I couldn't,' she added. 'He wanted children... The third was a pregnancy outside the uterus... I get happy when I get my period. I'm afraid of getting pregnant.'

For the minority of young couples who are trying to delay or space pregnancies, sometimes because they are waiting until they are more financially secure and usually because their parents are more forbearing than most in terms of pressure, decision-making and methods vary. Some married girls reported having jointly decided to put off parenthood, with a Syrian girl explaining, 'I told my

husband that I want contraception and we went and bought it [pills] together.' In a few cases, girls reported that the decision had been theirs and theirs alone. Another Syrian girl noted, 'I'm responsible about the topic, I decided to use an IUD and I went to get it fitted.' Although a boy in a participatory research group argued that if a wife were to use contraception without permission, the consequences would be 'disastrous' and could include both violence and divorce, several girls admitted doing just that. An 18-year-old Syrian young woman said, 'I don't care if he agreed or not, I take pills secretly.'

Maternity care

Of the married girls aged 15–17 in the GAGE sample, 42% were already mothers. In line with the 2018 JPFHS, Syrian girls (45%) were more likely to already have a child than their Jordanian peers (26%). Young mothers' experiences of pregnancy and delivery were sometimes quite disparate. For example, some reported feeling terrified and having no control over their own impending motherhood, while others reported actively seeking out information and carefully monitoring their own pregnancies. In other ways, however, young mothers' experiences were quite similar. For example, healthcare was reported to be of good quality, although highly medicalised and possibly at risk of harming the most vulnerable girls due to mechanisms designed to discourage child marriage (such as lack of health insurance coverage for deliveries by mothers aged under 16 years – see discussion below).

The youngest and least educated mothers – typically those from the most conservative Syrian and Palestinian households and who are married to cousins – often reported having little information and no control over their own experiences of becoming a mother. It was not uncommon for girls to have not known they were pregnant until the fifth or sixth month of pregnancy, and some girls even reportedly began labour not knowing what to expect. As the mother of a Syrian girl who is now a mother herself said, 'I did not teach her anything... She did not know that she was pregnant.' One young Syrian mother in a participatory research group reported that she had arrived at the hospital 'very scared', because she had 'no information'. Another added that her lack of knowledge had significantly slowed delivery, putting both herself and her child at risk of the complications identified in a report by the Higher Population Council (2022) as being more common among girls who married as children. She recalled:

The nurse told me that I have to help myself, I told her that I don't know how to, so she taught me... 'Push as if you're using the toilet'... I used to push my belly instead of pushing down there, because I didn't know... If I had known, I wouldn't have spent six hours in labour.

Girls in our research were adamant that no girl should have to endure pregnancy and childbirth without understanding what is happening to their body. As a Syrian girl in a participatory research group said: *'The girl must know because she'll go through this experience.'*

More educated and older adolescent mothers, especially those living in marital households where they are allowed unfettered access to the internet, tended to report much better access to information. Some girls were educated about pregnancy and childbirth by NGOs. A young Syrian mother recalled, *'They gave us a book explaining things about marriage and pregnancy until delivery... It had photos explaining the way the [epidural] injection is given and what it does and how it's given.'* Other girls reported carefully researching what to expect. A Syrian girl in a participatory research group said, *'Everything is available on TikTok, on Instagram, on Google.'* Another girl noted, *'I have joined a doctor's channel on TikTok regarding things which are beneficial for the pregnancy and the compulsory things you need to learn and do, and regarding difficulties which you face during pregnancy.'*

With some exceptions, the girls in our qualitative and participatory research streams reported having received relatively high-quality maternity care. This included: regular laboratory tests to check for conditions ranging from anaemia to gestational diabetes; ultrasound scans to monitor foetal development; planned caesarean sections for the youngest and smallest girls at greatest risk of delivery problems; and postnatal follow-up aimed at keeping mothers and babies healthy. As an 18-year-old Syrian young woman said, *'I went for an ultrasound and they told me that I have twins.'* A 16-year-old Syrian mother living in Azraq explained how, *'Here in the camp, after giving birth, she should visit the clinic... It is a must. Because if a woman did not go there, then they will keep checking with her.'*

However, two aspects of maternity care stand out as potentially problematic. First, as is noted in Jordan's National Strategy for Reproductive and Sexual Health (Higher Population Council and UNFPA Jordan, 2021), childbirth is increasingly medicalised in a way that puts girls at risk. While the youngest mothers may need a caesarean section because their body is not yet sufficiently developed to allow for safe vaginal delivery, many young mothers reported that surgical deliveries have become the norm, because *'a natural birth is so difficult'* (18-year-old Jordanian young woman). One Syrian girl said she did not even understand how birth is meant to happen. She stated: *'I came to know about natural delivery when I heard about someone who gave birth at home. I wondered how it happened, how did they open her belly at home?'* Other girls appeared to not understand the risks of anaesthesia,



A 15-year-old Syrian girl married at 14 to a friend of her mother's. Now divorced with a 6-month-old baby © Nathalie Bertrams / GAGE 2022

believing that *'general anaesthesia is better because... it doesn't have future effects'*.

The second problematic area concerns the mechanisms designed to discourage child marriage, which are having unintended consequences that sometimes put the most vulnerable young mothers at greater risk. The youngest girls – for example, those who are not yet old enough to be legally married even with the consent of a religious court [which sets the minimum at age 16] – do not receive free maternity care at government hospitals. This means they must pay out of pocket for private care, which can cost hundreds of dinars – money that families do not have. A 19-year-old Syrian young man living in an informal tented settlement, who married at age 16 to his 13-year-old cousin, explained:

I did know that it is necessary to go to the court. After I got married, they told me I was not allowed to finish legal marriage procedures in court because she was under 15. But I was already married and she was pregnant with the first child. We needed to borrow the money. We could not afford to pay it on our own.

Intimate partner violence is common

Our baseline survey did not ask married girls about their own experiences with marital violence, due to concerns that asking such questions might further jeopardise girls' safety. The survey did, however, enquire about community practices and beliefs. In line with research undertaken by the Higher Population Council (2022), which found that child marriage exacerbates the risk of marital violence, nearly all married girls in the GAGE sample (86%), regardless of nationality, admitted that husbands have a right to control their wives and agreed with the statement that 'A wife should obey her husband at all times'. More than half of all married girls in the sample (57%) also agreed with the statement that 'Husbands' violence towards wives is private and should not be discussed outside the household'.

Our qualitative research adds to the survey results and finds that intimate partner violence – which, for many girls, begins on their wedding night – is a regular facet of girls' lives once married. The violence that girls and young women report experiencing is emotional, physical and sexual, and the youngest girls – who typically have the largest age gap between themselves and their spouse – are most at risk. Married girls reported that they are abused for any number of reasons, but mainly for failing to uphold prevailing gender norms. Common reasons given by girls included: not responding to their husband's demands fast enough; not cooking the right kinds of food; not performing housework well enough; dressing inappropriately; and speaking without permission. A now-divorced 18-year-old Syrian young woman said of her ex-husband, 'He started beating me from

the second day... He beat me out of nowhere.' Girls observed that their husband's expectations were often so exacting that it was challenging for them to know how to avoid incurring violence. For example, a 17-year-old now-divorced Palestinian girl was beaten for changing her underwear, as her husband thought this meant she was having an affair:

Once he left the home for two days and it was summer and the weather was hot. You know, we as women have discharges, and I needed to change my underwear during the day. Once he came back, he started looking through the washing basket and looked to my underwear and asked me why did you change your underwear?! He did not listen to me and he was beating me!

Although the study by the Higher Population Council (2022) found that child marriage exacerbates girls' risk of sexual violence, married girls in the GAGE sample rarely reported sexual violence other than on their wedding night. This is because, girls noted, they do not refuse sex. As a Syrian girl in a participatory research group said, 'You might embarrass him like that... The angels will curse you the whole night.' Another girl commented that refusing sex would not be wise, because 'He can be scary when he is mad.'

Echoing another finding of that same study (Higher Population Council, 2022) – that child marriage increases the risk of violence during pregnancy – some girls in the GAGE sample reported that violence does not stop, and can even escalate, when they are pregnant and unable to move as quickly or work as hard. 'Even when I was pregnant, he hit me,' reported an 18-year-old Palestinian young woman, who



Adolescent Palestinian girl doing handiworks, Gaza Camp, Jordan © Marcel Saleh/GAGE 2023

left and then returned to her husband, despite his temper and his taking a second wife. An 18-year-old Syrian mother of four living in an informal tented settlement said of her husband, *'He beat me during my first months of pregnancy with my youngest son. I had bleeding and went to hospital.'* For girls who are pregnant with a child that their husband does not want – often a result of his having been forced into a marriage he did not want – husbands were reported to use violence in an attempt to end the pregnancy. An 18-year-old divorced Syrian young woman explained that her ex-husband – initially excited about becoming a father because of the higher status afforded to men with children – changed his mind when he considered the costs of bringing up a child:

He was happy for two or three days, then he changed his mind and asked me why I got pregnant and that I shouldn't have gotten pregnant now. He wanted me to have an abortion and would beat me on my stomach.

Conclusions, and implications for policy and programming

GAGE findings provide independent verification of the Higher Population Council's own research, and strengthens the evidence base on the sexual and reproductive health of adolescents living in Jordan. The culture of silence surrounding sexuality leave adolescents – whether from host or refugee communities – unprepared for the physical and psychological changes that puberty brings. Such taboos are also leaving adolescents to rely on online and peer-sourced information that is often inaccurate. Girls are at an even greater disadvantage; many are so carefully shielded from information about reproductive biology that they are often ignorant about what will happen to them when they agree to a marriage they are encouraged by families and peers to believe they want. Strong family and cultural preferences for immediate and repeated parenthood – and widespread misunderstandings about the safety of contraception – are not only leading to high rates of adolescent pregnancy, but also encouraging dangerous health behaviours. Girls again bear the greatest risk, as they generally have little say in the decisions that shape their lives, and are at risk of violence if they try to speak for themselves.

The implications of GAGE research for policy and programming are overwhelmingly in line with the aims of Jordan's National Strategy for Reproductive and Sexual Health and the National Action Plan on Child Marriage. They underscore the need for adolescents and youth to receive comprehensive sexuality education, to have improved access to youth-friendly sexual and reproductive health services, and to be protected from child marriage. Specifically, we recommend that the Government of Jordan and its development partners take the following priority actions:

- **Provide all adolescents with age-appropriate, comprehensive and iterative sexuality education, starting no later than 5th grade.** Girls and boys, regardless of their nationality and disability status, need timely information about pubertal changes, taught by trained educators who are comfortable answering questions using factual and accurate information. Courses should be delivered at school, so that all young people have access, and allow for anonymous questions. However, school-based courses should be accompanied by community-based programming, perhaps through UNICEF Makani centres, to reach those who are out of school or who want more information. Annual refresher courses, integrated into the health curriculum, should provide adolescents with additional and tailored information, in line with their developing needs and capacities. For girls, this must include detailed information about reproductive biology and how sex and conception work. For boys, it should include directly addressing misunderstandings linked to pornography. It should also explain the importance of using condoms, and why it is important to develop respectful and caring relationships with their partner. Such courses should also address (with girls and boys, either in mixed or single sex groups) prevailing gendered norms and how these impact adolescents' sexual and reproductive health. Topics must include consent and intimate partner violence, as well as where and how to get help if experiencing sexual violence.
- **Offer courses for parents on how to communicate more effectively with their adolescent children – including how to discuss topics about sexual and reproductive health.** Classes should be based on facts, to make sure that the information parents receive is accurate; and they should include mothers and fathers, attending to fathers' responsibility to educate sons, including about the unreal picture of sexual relationships that pornography presents. Classes should also include enough role play and other participatory activities that parents are *'pushed through'* their discomfort in discussing these taboo topics. As with adolescent programming, it is vital to address gender norms and how these impact adolescents' sexual and reproductive health – including girls' risk of child marriage and intimate partner violence. And given that adults are both parents and (future) parents-in-law, classes should directly focus on the risks associated with preferences for immediate childbearing, and instead encourage families to wait for grandchildren. Partnering with the Ministry of Awqaf Islamic Affairs and Holy Places and using courses aimed at strengthening families may improve parental buy-in.



Adolescent Syrian girl living in Al Mafraq, Jordan © Marcel Saleh/GAGE 2023

- **Design and publicise adolescent-friendly resources to give adolescents and youth a way to access accurate information privately.** This should be done in partnership with young people, to ascertain what information and platforms they prefer, and might include booklets, educational text messages, or websites (such as the Higher Population Council's new Darby platform⁵). Information should be detailed enough to answer adolescents' questions, without them needing to go to sources that are not adolescent-friendly; it might also be paired with more public sources such as interactive theatre or peer education to build young people's demand for information.
- **Redouble efforts to implement the National Action Plan on Child Marriage and ensure that no girl marries before the age of 18.** There should be greater efforts to keep girls in school until the end of secondary stage, using labelled cash transfers for education or transportation vouchers as needed. This should go alongside: efforts to raise awareness with girls, boys (and young men), and parents (of girls and boys) of the risks of child marriage and the advantages of delaying marriage until adulthood; greater efforts to enforce the marriage law, including anonymous ways for planned child marriages to be reported, and penalising religious leaders who officiate child marriages. There should also be greater efforts to prevent consanguineous marriage, given that the youngest brides are those most likely to marry a cousin. Consideration should also be given to eliminating any exceptions to the legal age of 18 years for marriage. In the short term, this will leave some girls even more vulnerable, because they will be pushed into unions without legal status; however, in the medium term, it will likely result in significantly fewer child marriages.
- **Develop 'marriage courses' for engaged couples and newlyweds.** These courses should be designed through working closely with young people to tailor content to their needs, and should be delivered in both single-sex (females only and males only) and mixed-sex (groups of couples together) settings. Courses should make sure that young wives and their husbands have accurate information on sexual and reproductive health, including: how pregnancy happens; the advantages of delayed and spaced pregnancy; the advantages and potential side effects of different forms of contraception; how to recognise pregnancy; and how to optimise pregnancy outcomes (including through pre-conception nutrition and health practices). Courses should also address gender norms, marital communication (including about sex and consenting to sex) and conflict resolution, and intimate partner violence (including where to get help). Again, partnering with the Ministry of Awqaf might improve buy-in.
- **Expand efforts to ensure that all pregnant mothers have access to good-quality information about what to expect during pregnancy and childbirth.** Information

⁵ Higher Population Council, Darby – Knowledge Platform for Youth Reproductive Health (<https://drhpy.org.jo>)

should be available in print, audio and video formats, and should cover foetal development as well as adolescent girls' own health, and any warning signs of pregnancy health concerns they should look out for. For expectant mothers who are nearing full term, information should be paired with birthing classes that are open to the mother and her partner (this could help strengthen the father's bond with the infant).

- **Expand training for healthcare providers.** Because cultural sensitivities also affect doctors, nurses and other healthcare providers, they should have access to courses that help them become more comfortable providing information and services to adolescents. This must include recognition of the pressure that married girls are under to conceive, creative ways to afford girls opportunities to communicate their personal preferences (given that girls are silenced by the presence of marital families), and hands-on practices to address (with adolescents and their families) the gendered social norms that drive preferences for early and repeated pregnancy and prevent contraceptive uptake. Courses should also address healthcare workers' discomfort with providing information and services to unmarried adolescents – preferably through intensive role play – so that providers are able to non-judgmentally respond to young people's inquiries and also to initiate conversations with adolescents to find out if they have questions or needs.

- **Expand the capacity of educators and school staff to support adolescents' sexual and reproductive health.** As with healthcare providers, it is important to address the culture of silence that prevents teachers and counsellors from being able to provide adolescents and youth with accurate information about their developing bodies and what healthy relationships should look like. As most adolescents are in school for some hours each day, it is vital that educators be supported to address facts as well as feelings.
- **Strengthen the role of the Ministry of Awqaf in improving reproductive health outcomes and preventing and responding to intimate partner violence.** Imams should be supported to understand how these mandates align with Qur'anic teaching and be provided with information (e.g. on how delayed and spaced pregnancies improve child outcomes and how eschewing violence strengthens families) that they could use to inform their weekly sermons and Qur'anic education sessions.
- **Improve regulation of medication aimed at improving fertility.** Some medications – especially those that induce ovulation – should only be available by prescription and only at hospitals and clinics. Other medications such as Viagra and testosterone should be made far more difficult to access. Stronger regulation should be accompanied by a public information campaign to tell people why these actions are being taken.



Adolescent Jordanian girl from living in Al Mafraq, Jordan © Marcel Saleh/GAGE 2023

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