GENDER & ADOLESCENCE: GLOBAL EVIDENCE

ENDLINE REPORT SERIES

Young people's sexual and reproductive health in Jordan

Evidence from the GAGE endline

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Introduction

Jordan has a young and rapidly growing population. Nearly one-third of residents are young people aged 10–24 years, and the population has nearly doubled since 2010, albeit in part due to the influx of Syrians fleeing that country's civil war (United Nations Population Fund (UNFPA), 2025). Although Jordan boasts an advanced health care system, has committed to the Sustainable Development Goals (SDGs), which include prioritising sexual and reproductive health (SRH), and has a government agency (the Higher Population Council, HPC) whose mandate is to improve reproductive health, its 2020–2030 National Strategy on Reproductive and Sexual Health acknowledges that young people have extremely limited access to SRH information and services, because the topic is seen as taboo (HPC, n.d.). Indeed, Sachs et al. (2024) report that the country is not on target to achieve its SRH targets under the SDGs.

This report, like the companion report on young people's broader physical health (Presler-Marshall et al., 2025a), draws on mixed-methods data collected in 2024 and 2025 by the Gender and Adolescence: Global Evidence (GAGE) research programme. It aims to contribute to the evidence base that the Government of Jordan and its development partners need to meet national and international goals regarding young people's sexual and reproductive health. Designed to build on baseline (2018–2019) and midline (2022–2023) research, surveys were undertaken with nearly 3,000 Syrian, Jordanian and Palestinian adolescents and young adults living in Jordan. Surveys were also completed by caregivers. In addition, qualitative interviews were conducted with over 750 young people (206 of whom have been followed since baseline), nearly 200 caregivers (77 of whom have been followed since baseline) and 63 key informants.

We begin with an overview of the Jordanian context, focusing on the contours of the population and what is known about young people's sexual and reproductive health. We then describe the GAGE conceptual framework and methodology. We present our findings, including access to timely puberty education, environments supportive of good menstrual health management, awareness of and support for family planning, marriage and access to contraception and maternity care, and access to programmes and services that prevent and redress marital violence-- focusing on differences by gender, age, nationality, location, and marital and disability status. We then conclude with a discussion of the key actions that are needed to accelerate progress and ensure that all young people living in Jordan have access to the SRH information and services they need to grow up healthy.

A charity worker shopping for menstrual products, Jordan © Marcel Saleh/GAGE 2025

Jordan context

Population

Jordan's population, estimated at 11.7 million (up from only 6.9 million in 2010), is very young (Department of Statistics, 2024). One-fifth (20%) of residents are adolescents aged 10–19, and nearly a third (29%) are young people aged 10–24 (UNFPA, 2025).

Approximately one-tenth of Jordan's residents (1.3 million people) are Syrian (Department of Statistics, 2016). Of those, 611,000 were registered as refugees with the United Nations High Commissioner for Refugees (UNHCR) as of December 2024 (UNHCR, 2025a). Nearly 80% of Syrians live in Jordanian host communities; most of the remainder live in formal refugee camps run by UNHCR (Zaatari and Azraq), although 15,000 Syrians are estimated to live in informal tented settlements scattered throughout the countryside (ibid.). Since the fall of the Assad regime in Syria, in December 2024, some Syrian refugees have begun returning home. As of August 2025, over 133,000 have left Jordan for Syria (UNHCR, 2025c). However, many more are reportedly planning to return after the end of the academic year and/or after they have put their economic affairs in order (Alheiwidi et al., forthcoming)

There are also nearly 2.4 million Palestinian refugees registered with the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) living in Jordan as of 2024 (UNRWA, 2025). Of these, approximately three-quarters have Jordanian citizenship, have full access to government services and employment, and live in Jordanian communities (Amnesty International, 2019). The remainder (some 630,000 people) – who either entered the country in the 1960s or later, or are descended from those who did – lack citizenship and its attendant rights. They are concentrated in one of 10 official camps run by UNRWA, one of which is Jerash camp (Amnesty International, 2019; UNRWA, 2025).

Jordan is classed as an upper middle-income country. However, low economic growth, coupled with high population growth – alongside external shocks such as the Covid-19 pandemic and conflict in Ukraine and Gaza, and accompanying volatility of international aid – have resulted in an increase in poverty over the past decade (World Bank, 2023; Hunaiti, 2024). In 2023, it was estimated[1] that the poverty rate had reached 27% (Economic and Social Commission for Western Asia (ESCWA), 2023). Refugees, who face legal restrictions on the type of employment they can do, are far more likely to be poor than Jordanians. UNHCR (2024) reports that in 2024, 67% of all refugee households under its remit were poor; American Near East Refugee Aid (ANERA, 2024) adds that the poverty rate that same year among Syrian households was 80%. Of Palestinians living in camps, it is estimated that 31% are poor (UNICEF, 2021). The highest poverty rate is in Jerash camp, where 53% of households live below the poverty line (ibid.)

Young people's sexual and reproductive health

Young people in Jordan receive extremely limited education about puberty and broader sexual and reproductive health, due to adults' concerns that providing such information at an early age might encourage sexual activity (Gausman et al., 2020; UNFPA, 2021; Presler-Marshall et al., 2023b, 2023c, 2023d; Alkhalili et al., 2024; Othman et al., 2025). GAGE midline research found that although most young people (83%) received some information about their developing bodies, information was often not timely (for example, with girls learning about menstruation after menarche). Information for boys was often restricted to religious requirements regarding hygiene, and what they could learn from peers (and pornography), such that few young people understood how reproduction works (Presler-Marshall et al., 2023d; see also Presler-Marshall et al., 2023a, 2023b, 2023c). The 2023 Jordan Population and Family Health Survey (JPFHS) also found evidence of this. Of ever-married girls aged 15–19, only 31% correctly understood the menstrual cycle and knew the days they were likely to be fertile; rates for married young women aged 20–24 were barely higher, at 38% (Department of Statistics and ICF, 2024). Knowledge is limited even among the most educated young people; Alkhalili et al. (2024) found that only a quarter of female university students had adequate knowledge of sexual and reproductive health.[2]

Because Jordan's laws include a 'loophole' that allows girls to marry at age 16 with the permission of a Sharia

1 The most recent Household Expenditure and Income Survey (HEIS) was conducted in 2017–2018; an update is expected in 2026.

2 The tool used for this study included questions about premarital tests, vaccination, menstruation, pregnancy and its symptoms, contraception, vitamins, and sexually transmitted illnesses (STIs); and total scores over the 75th percentile were judged adequate.

A clinic in Jordan © Nathalie Bertrams/GAGE 2025

court, and because early marriage is seen as protective of girls' and family honour, rates of child marriage – a form of violence against girls – are relatively high, especially for non-Jordanian girls (CARE, 2015; Presler-Marshall et al., 2020; Higher Population Council (HPC) et al., 2022). The 2023 JPFHS found that of young women aged 20–24, 20% of Syrians and 8% of Jordanians had married prior to age 18 (Department of Statistics and ICF, 2024).

Although the 2023 JPFHS found that nearly all (99%) married girls and young women aged 15–24 had heard of a modern method of contraception (Department of Statistics and ICF, 2024), a quarter of the young wives in GAGE midline research were not able to name a single form of contraception (Presler-Marshall et al., 2023d). Indeed, of those who were able to, it was not uncommon for them to admit that they had only learned about contraception after giving birth to their first child (Presler-Marshall et al., 2023d). Unmarried adolescent girls and young adult women (50%), young adult men (39%) and adolescent boys (16%) were much less likely than young brides to be able to name a form of contraception (ibid.).

It is unusual for young couples in Jordan to use contraception, because producing children is seen as a key reason for marriage (Kridli and Newton, 2005; Mrayan and Cornish, 2015; Presler-Marshall et al., 2023a, 2023d). The JPFHS found that of currently married girls aged 15–19, only 19% were using a modern contraceptive method (Department of Statistics and ICF, 2024). For currently married young women aged 20–24, the rate was 30% (ibid.). GAGE midline research found contraceptive uptake rates to be slightly lower. Of all young brides, most of whom were young adults rather than adolescents, 19% were using a modern method (Presler-Marshall et al., 2023d). Although the JPFHS found that 89% of married girls aged 15–19, and 96% of married women aged 20–24, participated in contraceptive decision-making, GAGE midline research found that 41% of young wives were not able to make decisions about using contraception (Presler-Marshall et al., 2023d; Department of Statistics and ICF, 2024).

Unsurprisingly, given high rates of marriage under 18 years and limited uptake of contraception, adolescent motherhood is common in Jordan. The JPFHS found that of girls aged 15–19, 2.3% of Jordanians and 8.9% of Syrians had been pregnant (Department of Statistics and ICF, 2024). Of the young wives in the GAGE sample at midline, 81% had ever been pregnant (Presler-Marshall et al., 2023d). Both the JPFHS and GAGE found that nearly all young mothers receive antenatal care and give birth in medical facilities (Presler-Marshall et al., 2023d; Department of Statistics and ICF, 2024).

Marital violence is a common experience for young brides. The 2023 JPFHS found that 17% of married young women aged 20–24 had experienced violence from their husband in the 12 months preceding the survey. Young brides who married prior to age 18 are especially likely to experience all forms of domestic violence. A study by the National Council for Family Affairs (NCFA) et al. (2022) reports that of married young women aged 20–24, 23% of those who married in childhood experienced physical violence at the hands of their husband, compared to 8% of those who married when over the age of 18. Young women who married as children were also more likely than their peers who married as adults to experience violence from their mother-in-law (21% versus 8%), their sister-in-law (15% versus 5%) and their father- or brother-in-law (5% versus 2%) (ibid.). GAGE midline research found that most young people (75%) – and especially most adolescent boys and young adult men (88%) – believe that a wife owes her husband total obedience (Presler-Marshall et al., 2025b). In addition, the JPFHS found that marital violence is widely perceived as justifiable. Of adolescents aged 15–19, two-thirds of boys (66%) and almost half of ever-married girls (46%) reported that wife-beating is justified for at least one reason (e.g. if a wife goes out without permission, burns food, or neglects the children) (Department of Statistics and ICF, 2024; see also HPC, 2020).

Sexual and reproductive health care is broadly available in Jordan. Jordanians and Syrians living in host communities primarily rely on services provided by the Jordanian government, Syrians living in camps rely on services provided by UNHCR, and Palestinians rely on services provided by UNRWA (Elnakib et al., 2024). That said, Syrian refugees are billed for services at the non-insured Jordanian rate (and then only if they can present a valid UNHCR certificate, without which there is no discount for services), and UNHCR and UNRWA have had their budgets slashed in recent years – which, given poverty levels, means that health care is unaffordable for many (El Arab and Sagbakken, 2018; UNRWA, 2023; Elnakib et al., 2024; UNHCR, 2025b). In addition, while the Higher Population Council has a digital platform (Darby[3] aimed at improving young people's SRH knowledge, the government's 2020–2030 National Strategy on Reproductive and Sexual Health acknowledges that young people have extremely limited access to SRH information and services (HPC, n.d.).

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 adolescents' capabilities.

The first building block of our conceptual framework is capability outcomes. Championed originally by Amartya Sen (1985, 2004) and nuanced by Martha Nussbaum (2011) and Naila Kabeer (2003) to better capture complex gender dynamics at intra-household and societal levels, 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 children and young people with diverse trajectories, including the most marginalised and 'hardest to reach' such as those with disabilities or those who were married as children. Although the GAGE framework covers six core capabilities, this report focuses on sexual and reproductive health. It includes: access to timely puberty education; environments supportive of good menstrual health management; awareness of and support for family planning; marriage and access to contraception and maternity care; and access to programmes and services that prevent and redress marital violence.

The second building block of our conceptual framework is context dependency. Our '3 Cs' framework situates young people socio-ecologically. It recognises that not only do girls and boys at different stages of the life course have different needs and constraints, but these are highly dependent on their context at the family/ household, community, state and global levels.

3 See: https://www.drhpy.org.jo/

Figure 1: GAGE conceptual framework

The third and final building block of our conceptual framework – change strategies – acknowledges that young people's 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 socio-ecological approach emphasises that to nurture transformative change in girls' and boys' 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. As noted earlier, this report concludes with our reflections on what type of package of interventions could better support young people's sexual and reproductive health.

Sample and methods

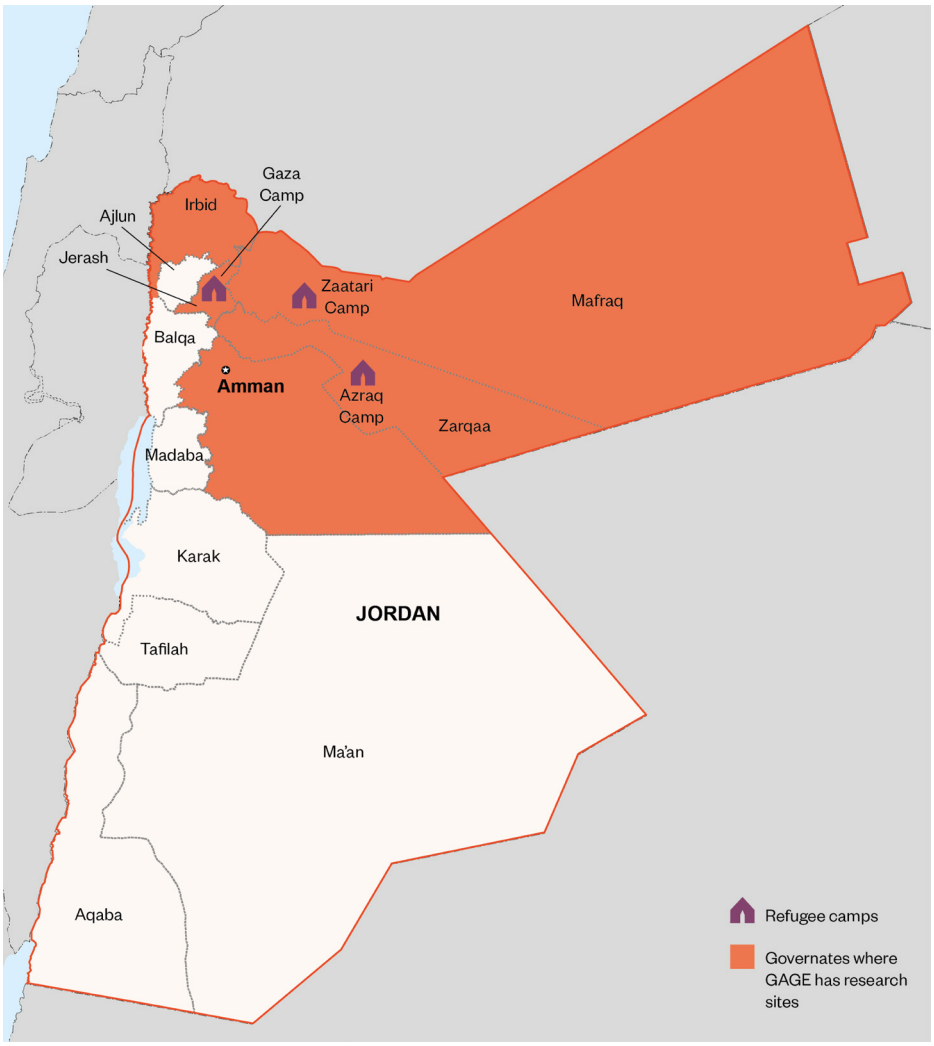
This report draws on mixed-methods data collected in Jordan in 2024 and 2025, following up on two earlier rounds of research – at baseline (2018–2019) and midline (2022–2023) (see Figure 2). At baseline, the quantitative sample included adolescents from marginalised households across two cohorts (aged 10–12 years and 15–17 years, averaging 11.3 and 16.1 years respectively), with purposeful oversampling of adolescents with disabilities and those who were married prior to age 18 – recognised as particularly vulnerable groups. The baseline sample consisted of 4,095 adolescents in five governorates: Amman, Irbid, Jerash, Mafraq and Zarqa (see Figure 2). At midline, the GAGE sample included 2,940 young people (a 71% follow-up rate), with the two cohorts then averaging 15.0 years old and 20.0 years old.

Figure 2: Timeline of GAGE research in Jordan, with the distribution of the original baseline sample

Baseline
2018-2019
4,095 adolescents

Midline
2022 - 2023
2,940 adolescents and young adults

Endline
2024 - 2025
2,784 adolescents and young adults



The GAGE Jordan endline sample involved 2,914 total participants. This included 2,784 young people from the original baseline sample (a 68% follow-up rate since baseline and 80% follow-up since midline, see Box 1), and 130 new participants who were not included in the baseline sample. These are: (1) 96 new young people who belong to either the Bani Murra or Turkmen ethnic minority groups[4] and (2) 34 new young people previously included only in qualitative research.[5]

This report focuses on the 2,838 participants who were living in Jordan at the time of the endline survey and surveyed after the pilot (see Table 1). This omits the 43 young people surveyed as part of the pilot and the 33 young people who had moved internationally at endline but completed an abbreviated survey over the phone. Of these 2,838 participants, nearly three-quarters (72%) are Syrian refugees (2,021), just over half of whom (51%) have lived in host communities consistently since baseline (1,031). Approximately 26% of Syrian respondents (522) have lived in refugee camps (Zaatari or Azraq) run by UNHCR since baseline, and 14% (293) have lived in informal tented settlements (ITS) at any point since baseline[6]. A minority of Syrian refugees (170, or 8%) have moved between host communities and camps in the time between the baseline and endline surveys. The remainder of the endline sample are Jordanians (425), Palestinians (273), and a small group of individuals (23) who identified as another nationality (denoted 'other', these include Iraqi and Egyptian respondents). Almost all Palestinians in the GAGE sample live in Jerash camp, which is located in Jerash governorate and is informally known as Gaza camp because most of its residents are ex-Gazans who were displaced during the 1967 Arab–Israeli war and 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.

Box 1: Attrition over time

Minimising attrition, or loss-to-follow up, is a key challenge for longitudinal studies where the goal is to understand changes over time. This challenge is acutely felt with the GAGE Jordan sample because many participants are migratory, including refugees leaving Jordan to return to their country of origin (especially Syrians returning to Syria after the fall of the Assad regime in December 2024), those living in Informal Tented Settlements (ITS) moving for seasonal agricultural work, young adult males leaving their communities to seek out paid work, and newly married females leaving their natal household to move into their husband's household. Further, the mandatory secondary school exam and Ramadan fell within the endline survey timeframe, creating logistical challenges with scheduling interviews. Difficulties extending the permits needed to enter the UNHCR refugee camps created additional logistical challenges at endline.

Several mitigation strategies were implemented at endline to minimise attrition:

- Offered in-person participants incentives for their time (monetary for those in host communities, ITS, or Jerash camp and snacks for Syrians in refugee camps due to UNHCR gift restrictions).
- Offered virtual phone interviews, including outside of the typical working hours, to reach young males engaged in paid work, as well as Syrians in camps
- Created an intensive tracking protocol that utilised the qualitative team for intensive tracking to capitalise on their rapport with participants

With these mitigation strategies in place, 68% of the original baseline sample from 2018-2019 and 80% of those surveyed at midline in 2022-2023 were re-surveyed at endline. This attrition is in-line with another longitudinal research study on Syrian refugees conducted in a similar timeframe (2019-2024), where they retained 63% of their sample, highlighting the challenges with tracking migratory samples (Alrababah et al., 2025).

4 Turkmen and Bani Murra young people typically have Jordanian citizenship. Because the new Bani Murra and Turkmen participants were identified through a different sampling strategy and have fundamentally different lived experiences, they are presented separately and not included where overall averages are presented. There were 23 individuals in the original baseline sample who self-identifying as ethnic minorities at endline, the majority of whom were classified as Jordanian at baseline.

5 These 34 individuals were included in the quantitative baseline sampling frame but were unable to be surveyed at baseline due to a variety of reasons, namely difficulties locating and scheduling interviews with the household within the baseline study period. They were intended to be surveyed at midline but due to an error were not.

6 In the seven years between baseline and endline, a minority of young people moved location. This was most common among Syrians (18%). The bulk of movement was between UNHCR-run camps and Jordanian host communities. Because of this movement, young people are classified as 'always camp' dwellers if they were living in a UNHCR-run camp at baseline, midline, and endline. They are classified as movers if they moved from a camp to a host community, or from a host community to a camp, in the years between baseline and endline. They are classified as 'ITS' if they were living in an informal tented settlement at either baseline, midline or endline.

Table 1: Quantitative sample

	Nationality				Sub-sample of Bani Murra and Turkmen	Sub-sample of those with disability	Sub-sample of those married <18	Total
	Syrian	Jordanian	Palestinian	Other				
Females	1043	263	150	9	46	149	307	1515
Males	978	162	123	14	50	135	3	1323
Younger cohort	1119	252	174	14	27	173	93	1626
Older cohort	902	170	99	9	69	111	217	1212
Total	2021	425	273	23	96	284	310	2838

Just over half (53%) of the endline sample are female. Although the baseline sample was approximately equally split between the two age cohorts (53% younger [10-12 at the time] and 47% older [15-17 at the time]), the older cohort were more likely than younger cohort to be lost to follow-up between baseline and endline (62% follow-up for the older cohort versus 73% follow-up for the younger cohort, $p<0.01$). Because of this, the younger cohort is over-represented in the endline sample. Older cohort males were especially likely to be lost to follow-up (57% follow-up), and as such are the most under-represented at endline. At endline, on average, younger cohort adolescents were aged 17.2 years, and are referred to in this paper as adolescent girls and adolescent boys; the older cohort had transitioned to young adulthood (average age of 22.1) and are referred to as young adult women and young adult men. Where both cohorts are discussed simultaneously, they are referred to as young people. Where adolescent boys and young men are discussed together, they are called young males; where adolescent girls and young women are discussed together, they are called young females.

Because GAGE's sample includes the most marginalised adolescents and young adults, about a sixth of young people in our quantitative sample have any functional disability (479).[7] Among those, 284 report having functional difficulties even if they have an assistive device (such as glasses, hearing aids, or a mobility device). Our sample also includes adolescent girls and young adult women who were married prior to age 18. Of the 527 ever-married females, 307 married prior to 18.

The qualitative sample is also large and complex. In total, it included 756 young people, 195 caregivers and 63 key informants (government officials, community and religious leaders, and service providers) (see Table 2). Of young people, 206 were selected from the larger quantitative sample, deliberately oversampling the most disadvantaged individuals in order to capture the voices of those most at risk of being 'left behind'. These young people have been followed since baseline and were interviewed individually. Of caregivers, 77 have taken part in iterative individual interviews. The remainder of young people and caregivers took part in focus group discussions and were not part of the longitudinal sample.

Quantitative survey data was collected in face-to-face interviews[8] by enumerators who were trained to communicate with marginalised populations. With the exception of never-married adolescent boys, enumerators were typically the same sex as the respondent: all female respondents were interviewed by female enumerators, and the majority of young men/ever-married males were interviewed by male enumerators. Surveys were broad (see Luckenbill et al., 2025) and included modules reflecting the GAGE conceptual framework. Analysis of the quantitative data focused on a set of outcomes related to psychosocial well-being and voice and agency (data tables are available on request). Statistical analysis was conducted using Stata 18.0. Importantly, where we present endline survey findings, we include the 2,838 young people (2,708 from the original baseline sample who were not part of the pilot or moved internationally and 130 new participants, detailed above) who completed the endline survey. Where we present change over time, however, we restrict our sample and include only the 2,289 young people who completed baseline, midline and endline surveys[9] These are referred to as the panel sample. For change over time for any

7 Determined by using the Washington Group on Disability Statistics Questionnaire, which was filled out by caregivers at baseline: www.washingtongroup-disability.
8 A small number of surveys (81) were completed over the phone, because respondents were unable to be interviewed in person.
9 There are exceptions to this rule, because some questions were not asked at baseline or were asked of only adolescents over the age of 15. These exceptions are carefully noted in the text.

Table 2: Qualitative sample

		Syrian	Jordanian	Palestinian	Bani Murra/ Turkmen	Mixed nationality	Sub-sample of those with disability	Sub-sample married < age 18	Total
Individual interviews with young people	Girls	8	8	46	5		26	41	67
	Young women	6	8	36	1				51
	Boys	4	2	29	7		27	3	42
	Young men	7	8	26	5				46
Total		25	26	137	18		53	44	206
Group interviews with young people	Females	9	5	21	4	4			43 groups (306 people
	Males	6	5	18	2	5			36 groups (244 people)
Total		65	62	313	42	9			
									756 young people
Individual interviews with caregivers	Mothers	6	5	36	0				47
	Fathers	5	6	19	0				30
Total		11	11	55	0				77
Group interviews with caregivers	Mothers	3	1	3	1				8 groups (59 people)
	Fathers	2	1	5	1				9 groups (59 people)
Total		5	2	8	2				17 groups (118 people)
									195 care-givers
Key informants		25	6	24	8				**63 key informants**

given outcome, we also restrict to the sample who have answered that question at all rounds to ensure a consistent sample across all survey rounds.

Qualitative tools, also employed by researchers carefully trained to communicate sensitively with marginalised populations, consisted of interactive activities such as timelines, body mappings and vignettes, which were used in individual and group interviews (see Jones et al., 2025). 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 ODI Global 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.

Findings

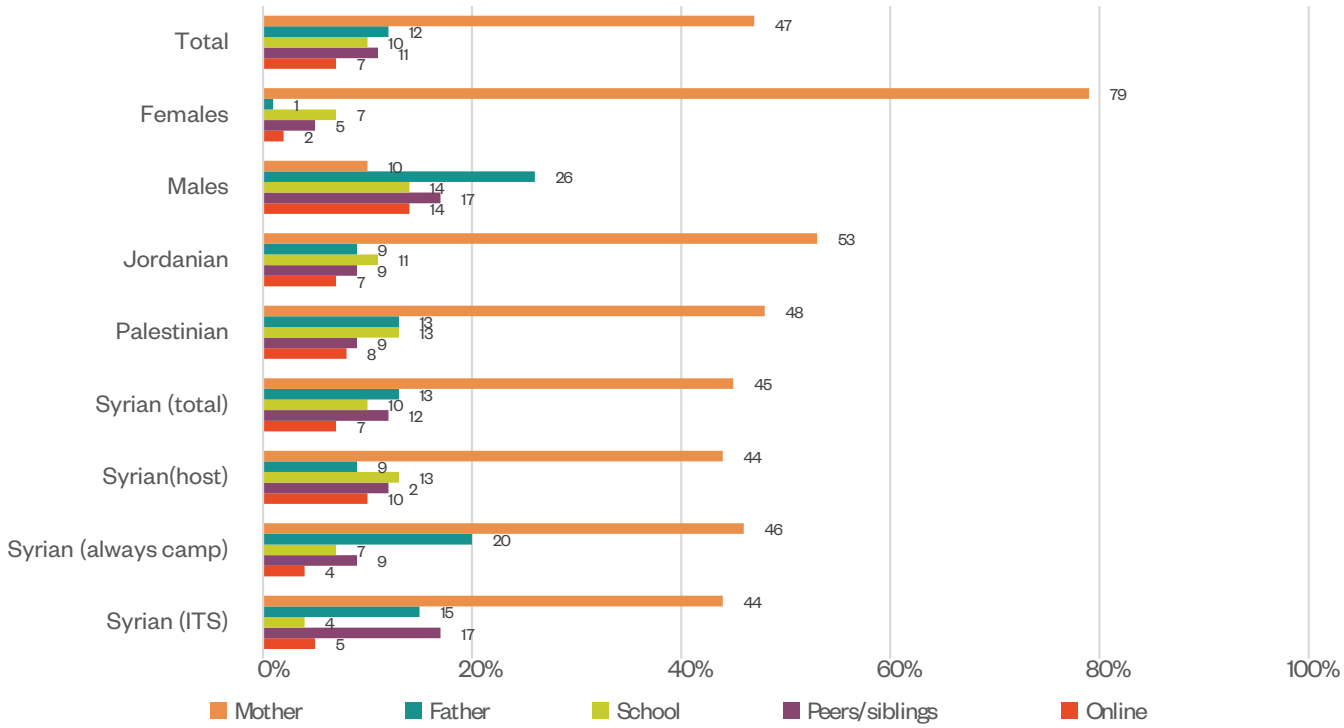
Our findings are organised in line with the GAGE conceptual framework (see page 5). We begin with young people's access to timely puberty education and environments supportive of good menstrual health management. We then turn to young people's knowledge about and support for family planning, marriage and experiences with sexual activity, and access to contraception and maternity services. Differences are significant at the 5% significance level unless otherwise indicated with an asterisk (*) to signify a significant difference at the 10% significance level, and when we use the word significant we are referring to statistical significance. We conclude with a section on marital violence. In each section, we present qualitative findings after the survey findings.

Puberty education

A large majority (91%) of young people reported on the endline survey that they had had a source of information about puberty (not shown). Gender differences were significant, with young females (96%) more likely to have had a source of information than young males (85%).

Young people's most important source of puberty information varied significantly – primarily by gender, but also by nationality and (for Syrians) location. Young females (79%) were overwhelmingly likely to report that their mother had provided them with information about puberty (see Figure 3). For young males, fathers (26%) were the most likely source of puberty information. Because they were less likely to receive puberty information from a parent, young males also reported learning from peers and siblings (17%), teachers at school (14%) and from online sources (14%). Jordanian young people were the most likely to report learning about puberty from their mother (53% in aggregate and 83% of young females). Syrian young people living in formal camps were the most likely to report learning from their father (20% in aggregate and 39% of males), perhaps reflecting those fathers' greater emphasis on religious ablutions. Young people's reliance on teachers (10%), peers and siblings (11%) and online sources (7%) is heavily shaped by several factors, including whether they could rely on their parents for puberty education and also whether they had been enrolled in formal education at the appropriate age or had access to the internet. Syrians living in informal tented settlements, most of whom are surrounded by extended family (including cousins), stand out for being the most likely to have had to rely on peers or siblings for puberty education (17% in aggregate and 24% of males).

Figure 3: Source of young people's information about puberty, of those with a source (by gender and nationality/location)



Underscoring how limited young people's puberty education tends to be, at endline, only 38% were aware that menarche means that pregnancy can occur (see Figure 4). Cohort and gender differences were significant, with young adults more aware than adolescents (44% versus 33%) and young females more aware than young males (46% versus 28%) (not shown). With the caveat that they were more likely to have already been married (61%) than they were to be aware that menarche means that pregnancy can happen (53%), young adult women were the most aware of the link between menstruation and pregnancy; adolescent boys (25%) were least aware. Although nationality differences were not significant, location differences were significant for Syrians. Those living in formal camps (32%) were significantly less likely to be aware of the link between menarche and pregnancy than their peers in host communities (41%). Syrian adolescent boys living in formal camps were the least aware of the link between menarche and pregnancy (19%).

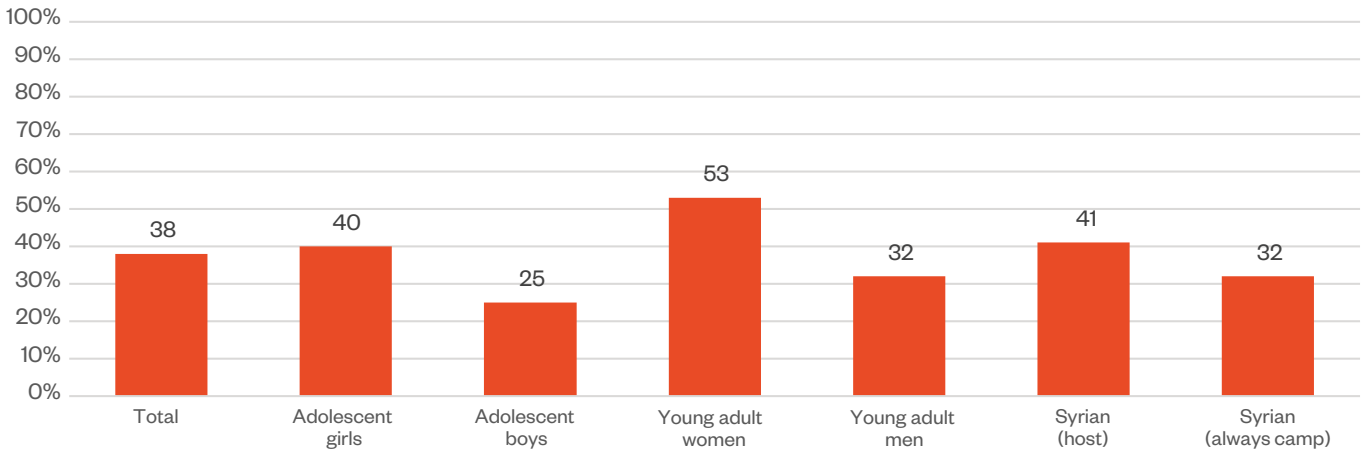
During qualitative interviews, most young people reported that their puberty education had been too little and too late. With exceptions, young females reported that it was only after menarche that they were taught that menstruation is normal. Young males, when they received any formal instruction about their maturing bodies, largely reported that they had been taught only to keep clean and avoid impure thoughts. A 19-year-old Bani Murra young adult woman recalled of getting her period:

> *My mother couldn't tell me, she was embarrassed... At first I didn't know. I was surprised, what's this blood? I hid it for two days and my mother found out through my clothes. I was in the bathroom and she saw my clothes... She understood that I was on the period.*

A 21-year-old Jordanian young adult woman similarly stated, '*When I first got my period, I was really scared... I started screaming, and my mom told me not to worry, to trust in God and not be afraid. She said that as you grow up, these things happen.*' Although a Syrian father from a host community acknowledged that '*One should educate their children about these topics* [sexual development]*, with the father talking to his son and the mother talking to her daughter*', most young males echoed the words of a 22-year-old Jordanian young adult man, who stated that he was self-taught, outside of religious lessons about cleanliness: '*I taught myself... and my father taught me cleanliness when I was young.*' A Palestinian father explained what he has taught his son about growing up: *'I just tell him to stay away from wrongdoings in Islamic culture.*'

Young females and males' differential access to information about puberty is heavily shaped by both biology and social norms. Regarding biology, young females' pubertal changes are more disruptive than young males'. Young females must be taught how to practically manage menstruation; while mothers are often late on this task, most do provide their daughters with needed education and support once a girl has reached menarche. A 16-year-old Syrian adolescent girl from a host community explained, '*My mother didn't tell me everything before I got my period, but when I got my period, she educated me about everything.*' Young female pubertal changes are also more easily divorced from sexuality than young males', allowing mothers to focus on the hygiene aspects of menstruation rather than addressing more overtly sexual changes such as wet dreams. Regarding social norms, in nearly all cases mothers and not fathers are the primary

Figure 4: Proportion of young people aware that menarche means that pregnancy can occur (by cohort, gender and nationality/location)



caregiver (see Presler-Marshall et al., 2025c). This means that as young males arrive at puberty, there is only a limited history of father-son communication on which to build, especially given the embarrassment that surrounds sexual development. A Palestinian mother, when asked if her husband has discussed puberty with their son, replied, '*There is no talk between them*.' A 25-year-old Syrian young adult man from an informal tented settlement noted that not only did his father provide him with no relevant education, but that he had been too embarrassed to ask: *'I don't ask. Not shame, but shy*.'

A minority of young people reported having had any sort of puberty education at school. This was most common among Syrians living in formal camps and among Palestinians. For young females, instruction was most often a part of science class and was usually given in 8th or 9th grade. A 16-year-old Syrian adolescent girl from Zaatari camp was among the few girls who reported learning about menstruation prior to menarche, saying that:

> *In schools, the counsellor used to come and give us lectures about this… We were still young. We hadn't reached this stage yet. But they used to give us talks about them. They told us that there were girls who came to their period early.*

A 23-year-old Palestinian young adult woman noted that girls would be better served if more schools provided these '*courses in grade 7 or 6*.' Although a few young males also reported learning about puberty in science class, it was more common for young males to report that puberty education had been provided by religious teachers, usually in 9th or 10th grade. A 16-year-old Bani Murra adolescent boy recalled, '*I learned in 9th grade. Religion teacher. He used to teach us that when you grow up, you will go through a phase and things like that*.'

Cognisant of the fact that most parents are deeply uncomfortable discussing sexual topics (including puberty) with their children, the Jordanian government has invested in an online platform, Darby (mentioned earlier), to provide young people with SRH information. When asked directly, none of the young people taking part in GAGE qualitative research reported having used the platform. Indeed, only one, a 17-year-old Syrian adolescent girl from Zaatari camp, had even heard of it: *'I've heard of it. But I haven't tried it yet.'*

Although the Darby platform is underutilised by the young people taking part in GAGE research, the internet is a growing source of SRH information, especially for young males, who are less likely than their female peers to have their search histories closely monitored (see Presler-Marshall et al., 2025c). Young males, when asked how they learned about their developing bodies given their lack of adult-led education, regularly reported that they relied on Google and YouTube to reassure themselves they had not 'missed' puberty. A 16-year-old Syrian adolescent boy from a host community, when asked how he learned about puberty, replied, '*We have the internet, man*!' Respondents added that young males' use of the internet for SRH education is not limited to factual queries. It was common for adolescent boys and young adult men to admit to having watched pornographic videos, often alongside their brothers, cousins and friends. A 16-year-old Jordanian adolescent boy stated, '*Adolescents know that pornographic sites are forbidden, but they browse them as it is normal for them*.'

Young males' use of pornography for sex education underscores a critical gap in the puberty education provided to young people in Jordan – namely, even when young females and males are taught about how their bodies are maturing (and will produce eggs and sperm alongside pubic hair and body odour), they are not provided with the comprehensive sexuality education that would help them understand why their bodies are changing (to enable reproduction) and how to manage the complex emotions that adolescence brings. A Syrian mother from Zaatari camp explained that this is because parents are afraid that talking to their children about sex and relationships will encourage them to experiment: '*We don't talk like that… I'm afraid that if I tell them, they'll think of other things*.' A 21-year-old Jordanian young adult man similarly said, '*This topic is taboo*.'

Menstrual health management

At endline, 100% of adolescent girls and young women reported that they had begun menstruating, with a mean starting age of 13.3 years. Of young females, 83% reported using pads to manage their periods (see Figure 5). Better-resourced Palestinian (96%) and Jordanian (90%) females were more likely to report using pads than their Syrian (79%) peers (see Presler-Marshall et al., 2025d). Interestingly, Syrian females living in formal camps were the least likely to report using pads (71%) for menstrual hygiene management (MHM).

In aggregate, 8% of young females reported that they face challenges managing their periods (see Figure 6). Syrian females (10%), especially those in informal tented settlements (14%), were significantly more likely to report

Figure 5: Proportion of females who use pads to manage their periods (by nationality/location)

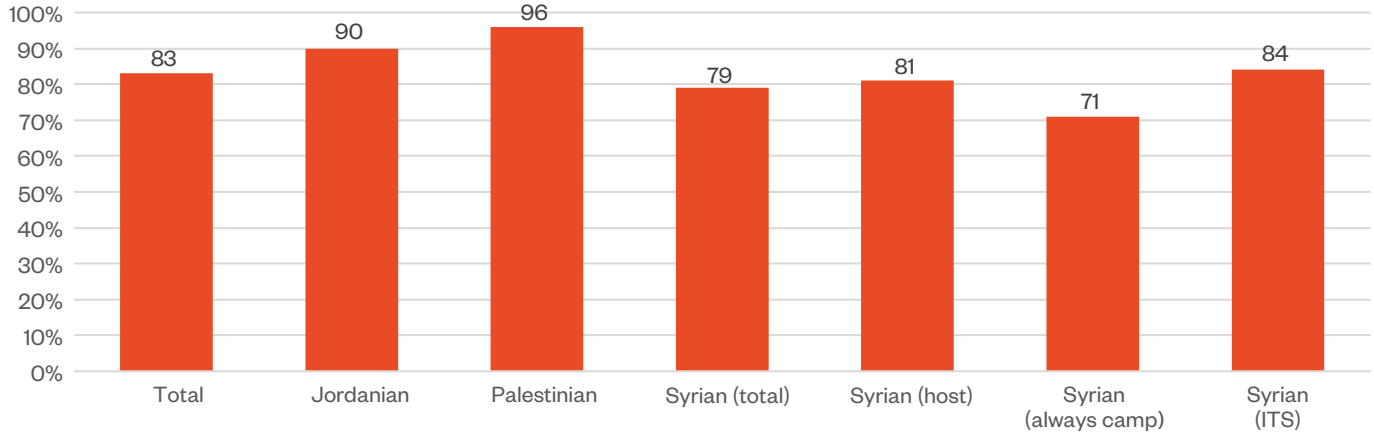
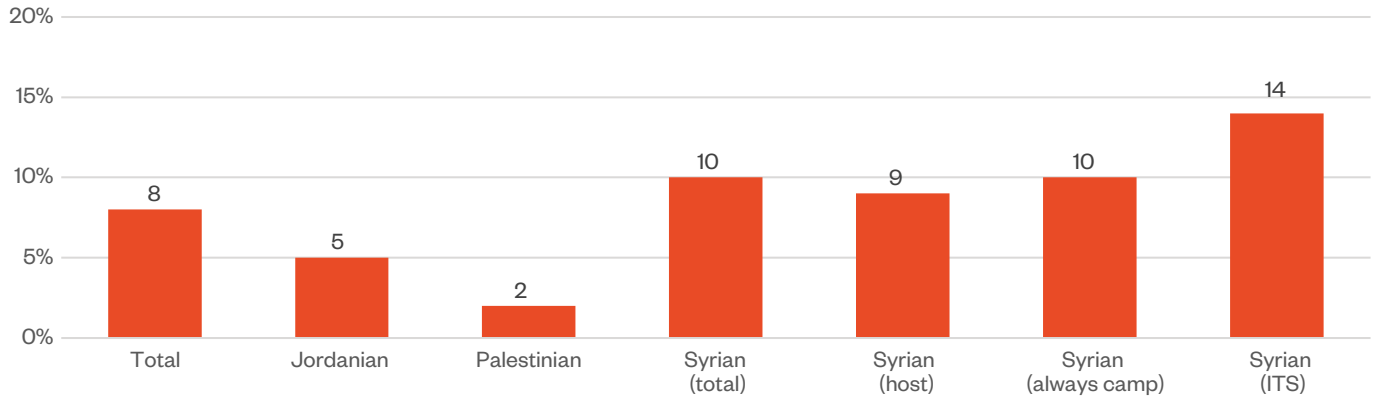


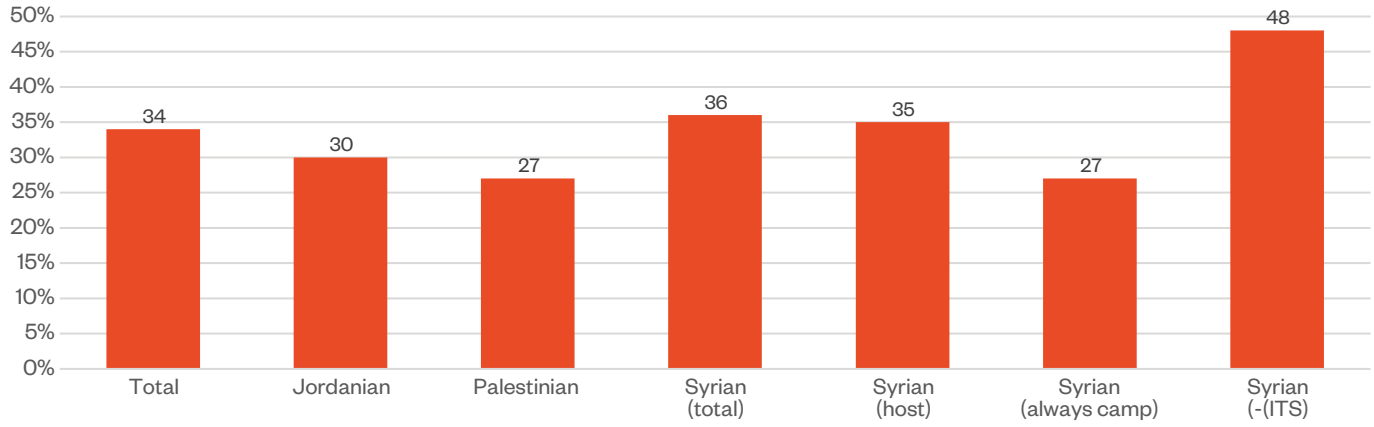
Figure 6: Proportion of females who report challenges with MHM (by nationality/location)



MHM challenges than their Jordanian (5%) and Palestinian (2%) peers. Of young females who reported challenges with MHM, 49% reported the cost of period products, 44% reported the unavailability of period products, 36% reported a lack of privacy, and 33% reported inadequate supplies of soap and water.[10] Nearly three-fifths (57%) of adolescent girls and young adult women reported on the endline survey that their normal daily activities are impacted by menstruation (not shown). Of those, 47% reported that they cannot work, 21% that they do not prepare food, and 20% that they do not fast.

One-third (34%) of young females reported on the endline survey that they are afraid or embarrassed to ask for family support with managing their periods (see Figure 7). Nationality and location differences were significant. Young Palestinian females (27%), whom qualitative

Figure 7: Proportion of females who report being embarrassed or afraid to ask for family support with MHM (by cohort and nationality/location)



10 Respondents were allowed to choose multiple options, meaning the sum is greater than 100%.

research suggests are more likely than their peers to have open discussion about menstruation with their mothers, were the least likely to report fear or embarrassment. Young Syrian females in informal tented settlements (48%) were the most likely to report fear or embarrassment.

The endline survey asked adolescent boys and young adult men whether they supported their sisters and/or female peers during menstruation. It also asked adolescent girls and young adult women whether they were supported by their brothers and/or male peers during menstruation. In aggregate, 23% of young males reported that they supported their sisters or female peers, while only 14% of young females reported that they were supported by their brothers or male peers (see Figure 8). The perspective gap was the largest among Syrians living in informal tented settlements, where young males were nearly three times as likely to report supporting sisters or female peers as young females were to report being supported (32% versus 12%). Only among Palestinians did young males and females agree on males' support for menstrual management: 13%.

Of adolescent girls and young adult women who were enrolled in school (or had been during the most recent semester), most (82%) reported that schools have facilities that students can use to manage their periods (see Figure 9). Only 40%, however, reported that those facilities were generally clean enough to use without discomfort. Among all young females, only 31% reported that public spaces have facilities that can be used to manage menstruation with only 15% reporting that facilities were generally clean enough to be used without discomfort.

In part due to careful coaching by their mother, most young females agreed that while menstruation might be a central facet of womanhood, it should also be hidden. An 18-year-old Syrian young adult woman from an informal tented settlement reported that she was deeply bothered by a TikTok influencer's attempts to make periods a topic of open discussion:

> *There's a famous Syrian girl on TikTok who talks about how menstruation is normal, like having a cold… But I disagree… Menstruation is private. A girl should have modesty and shyness. No one should know* [she has her period].

Indeed, most young females explained that they are so embarrassed by their periods that they go out of their way to make sure that their mother (and sometimes older sisters) are the only ones in the household who are aware of when they are menstruating. Despite survey findings that brothers sometimes support sisters with menstruation, during qualitative interviews, respondents reported that brothers are kept completely unaware that their sister is menstruating. A 17-year-old Syrian adolescent girl from a host community stated: '*I change when no one is around… I feel shy from my grown-up brothers.*' A Palestinian mother similarly reported of her daughter: '*She put it* [pads] *in bags so that it would not appear in front of her brothers.*'

It was also common for respondents to report that poverty complicates the ability to manage menstruation. For example, a 17-year-old Syrian adolescent girl from Azraq camp reported that she changes pads less frequently than she should due to lack of money: '*I started using pads for longer to save money. I don't change them frequently, to make them last.*' A 24-year-old Syrian young adult woman from an informal tented settlement explained that she is forced to rely on old cloth, because she cannot afford ready-made pads: '*I do not buy… I use cloth from clothes.*' A key informant from Zaatari camp noted that families with many daughters are especially sensitive to the cost of period products, saying:

Figure 8: Males' support for sisters' and female peers' MHM (by nationality/location)

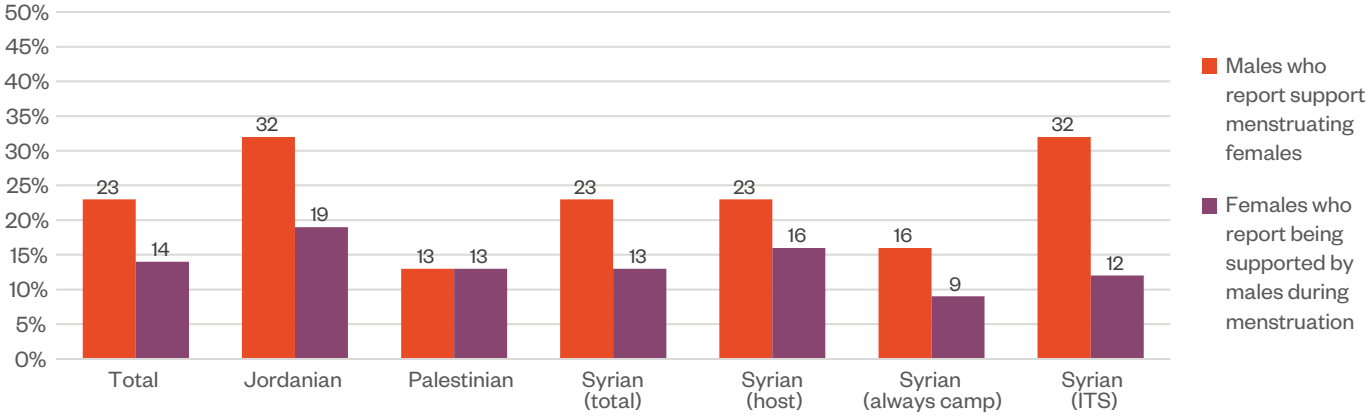
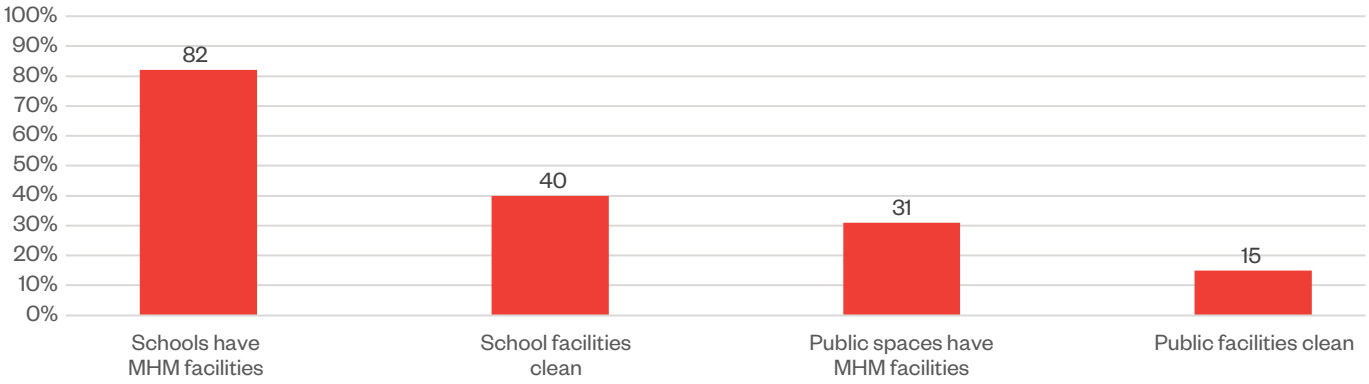


Figure 9: Availability and cleanliness of MHM facilities



Some families have four girls and some families have six girls at the age of puberty and need many items during her menstrual cycle... Her father cannot provide her with enough of her needs during her menstrual cycle.

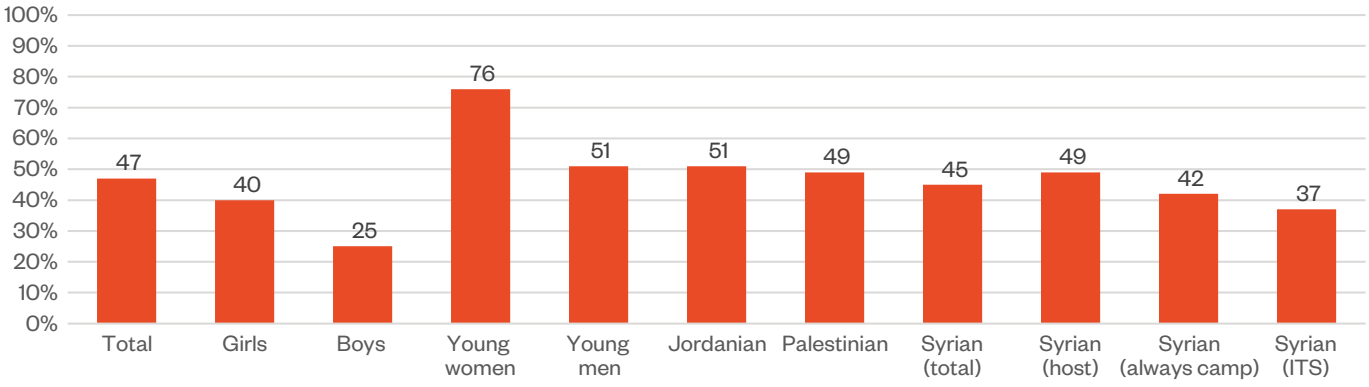
Although adolescent girls and young adult women reported that teachers are generally supportive of students whose periods start while they are in school (sometimes providing them with pads from their own personal supply and other times offering them hot drinks to calm cramps), most young females agreed that managing their periods at school is difficult and unpleasant. Toilet stalls, they reported, regularly lack doors (and have no locks), and trash bins with a strong odour. A 16-year-old Palestinian adolescent girl stated, '*The bathrooms here are a bit clean and a bit not... Water is available 24 hours. But there is a bad smell in the bathrooms*.' A 22-year-old young adult woman from Azraq camp recalled that toilets were frequently backed up, because with no bins available, '*Girls threw their pads in the toilets*.' Young females also noted that because they find it embarrassing to ask a teacher for a pad, it would be better if supplies were simply available in all bathrooms.

Knowledge and attitudes about family planning and fertility preferences

In aggregate, and despite improvement over time driven by young people's climbing odds of marriage, fewer than half of young people (47%) could name a form of contraception at endline (see Figure 10). Cohort and gender differences were significant and primarily reflect young people's chances of marriage (see Box 2). Adolescent boys (25%) and adolescent girls (40%) were less often able to name a form of contraception than young adult women (76%) and young adult men (51%) (Box 2). Nationality and location differences were also significant when considered jointly, with Palestinians (49%), Syrians in host communities (49%) and Jordanians (51%) better able to name a form of contraception than Syrians living in formal camps (42%) and those in informal tented settlements (37%). Of those able to name a form of contraception, the most common method named was oral contraceptive pills (79%), followed by intrauterine devices (IUDs) (39%).[11]

Of the young people who were able to name a form of contraception, the largest group (39%) reported that

Figure 10: Proportion of young people who could name a form of contraception (by cohort, gender and nationality/location)

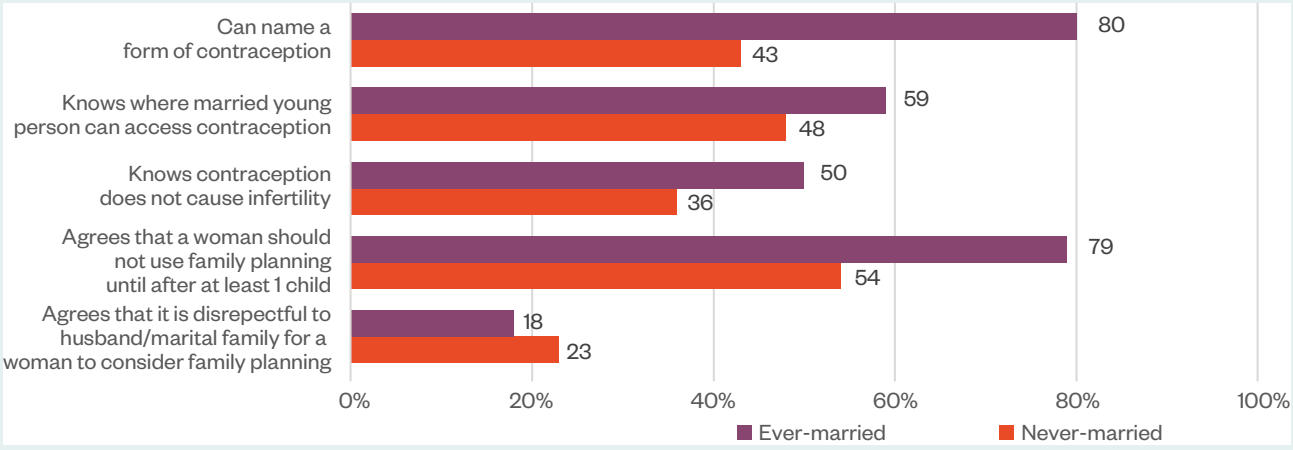


11 The total is greater than 100% because respondents were allowed to provide more than one answer.

Box 2: Marriage shapes young people's knowledge and beliefs about family planning

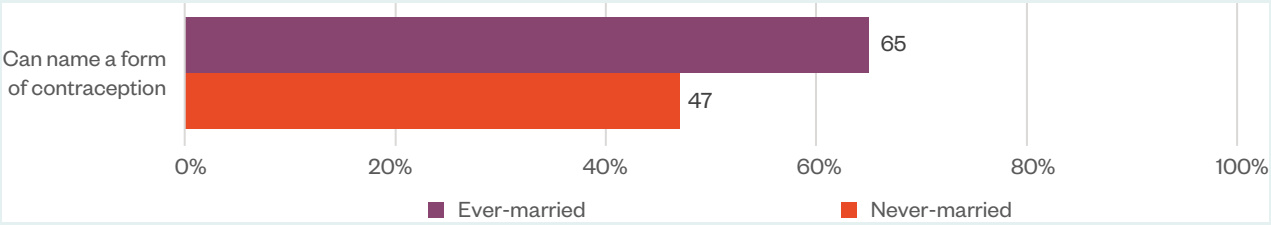
The endline survey found that young females who had been married were significantly more likely than their never-married peers to be able to name a form of contraception (80% versus 43%), to know where to access contraception (59% versus 48%), and to know that contraception does not cause infertility (50% versus 36%) (see Figure 11). Ever-married females who tend to come from the most conservative families, generally have less education, and who have personally experienced pressures to produce grandchildren (see Presler-Marshall et al., 2025d, 2025e) were also more likely than their never-married peers to believe that a woman should not use family planning until after she has given birth to at least one child (79% versus 54%). Interestingly, and perhaps because most young brides are already young mothers who have experienced the intensive work involved in caring for young children, ever-married girls and young women are significantly less likely than their never-married peers to report that it is disrespectful for a young mother to consider using family planning (18% versus 23%).

Figure 11: Young females' knowledge and beliefs about family planning (by marital status)



Marriage also shapes young adult men's knowledge about family planning. Compared to their never married peers, ever-married young adult men were significantly more likely to be able to name a form of contraception (65% versus 47%) (see Figure 12).

Figure 12: Young men's knowledge about family planning (by marital status)



their mother had provided them with information about contraceptives (see Figure 13). Another 12% reported sourcing information online, 10% receiving information from their father, and 10% reported getting information from a health care worker. Gender differences were significant; young females were far more likely than males to have been educated by their mother (52% versus 16%) or health care workers (13% versus 3%), whereas young males were accordingly more likely than females to have been given information by their father (24% versus 2%) and to have used online sources (21% versus 7%). There were also some significant nationality and location differences. For example, Palestinians (17%) and Syrians living in formal camps (15%) were disproportionately likely to have received information from a health care worker. Similarly, Syrians living in host communities (15%) were much more likely to have consulted online sources than their peers in informal tented settlements (8%) and formal camps (8%).

Approximately two-thirds (65%) of young people reported on the endline survey that they were aware that early pregnancy can be dangerous for young mothers (see Figure 14). Cohort and gender differences were

Figure 13: Source of young people's contraceptive information, of those able to name a form (by gender and nationality/location)

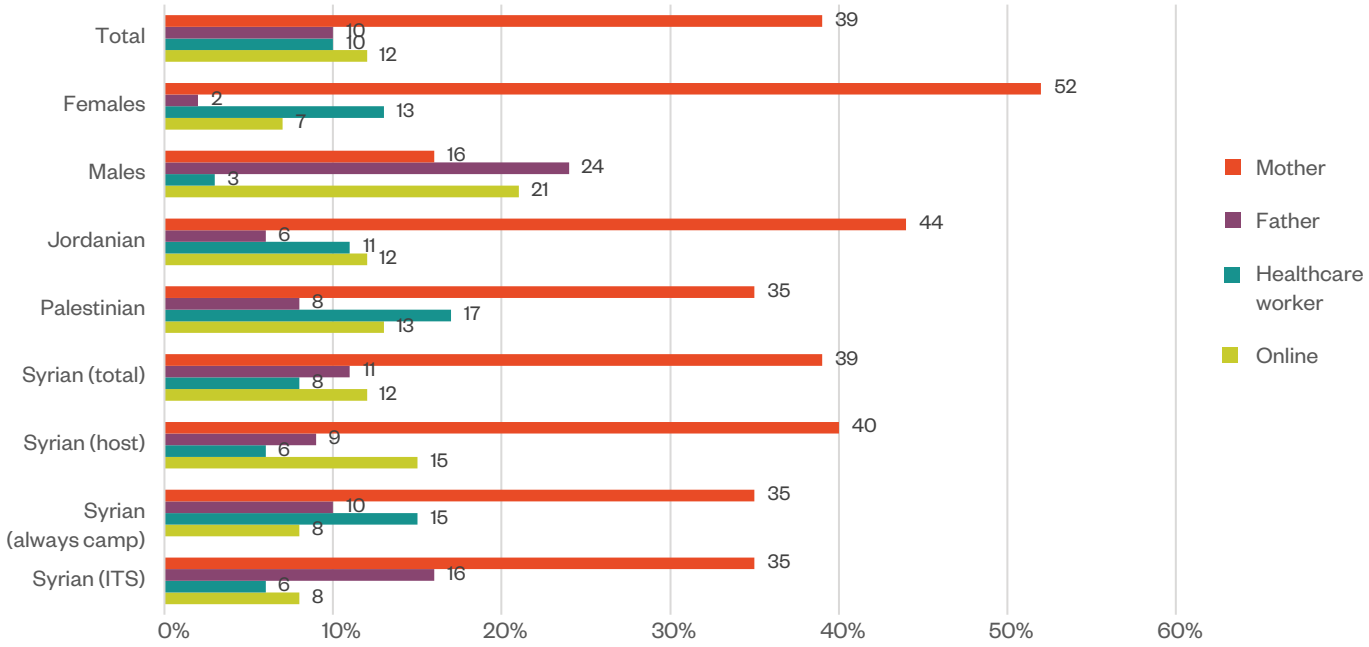
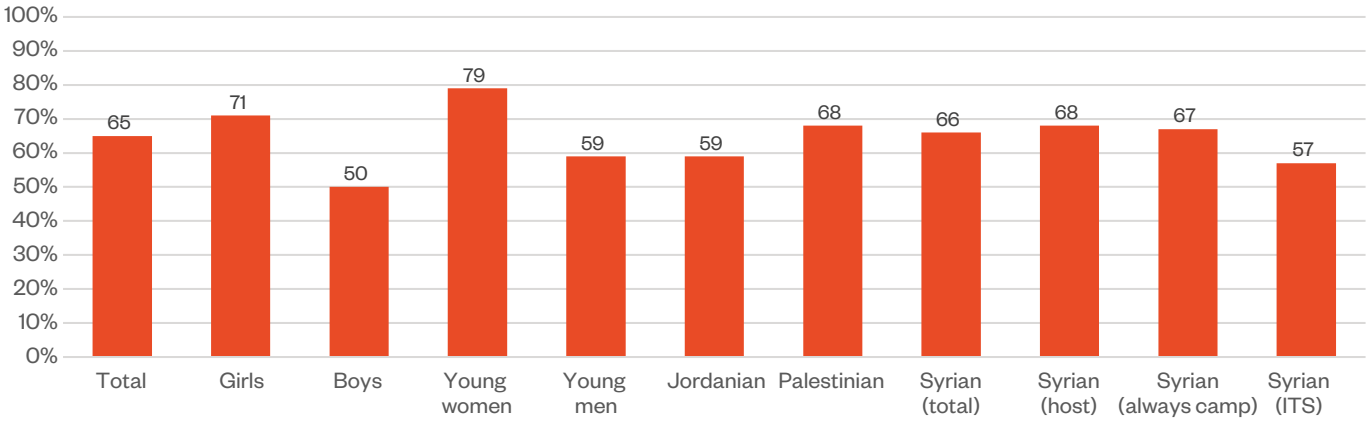


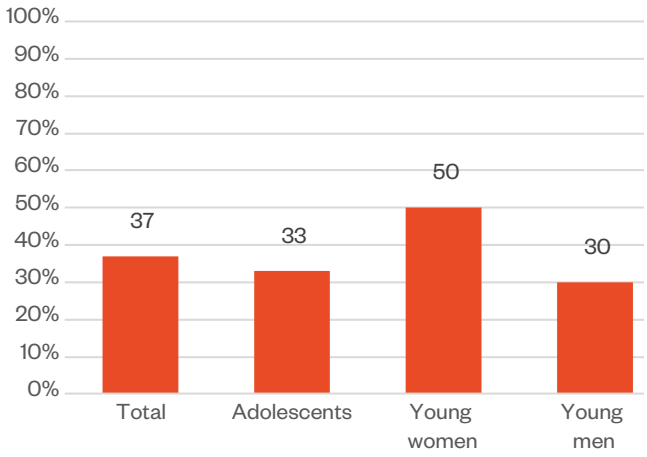
Figure 14: Proportion of young people aware that early pregnancy has health risks (by cohort, gender and nationality/location)



significant: young adult women (79%) and adolescent girls (71%) were significantly more likely to be aware than young adult men (59%) and adolescent boys (50%). Nationality differences were also significant. Likely reflecting their more limited exposure to non-governmental organisation (NGO) programming, Jordanians (59%) were significantly less likely to be aware than Palestinians (68%) and Syrians (66%). For Syrians, location differences were significant: those living in informal tented settlements (57%) were less aware that early pregnancy can be dangerous for young mothers than those living in formal camps (67%) and host communities (68%).

At endline, a minority of young people (37%) understood that contraception does not cause infertility (see Figure 15). Reflecting their greater likelihood of having been married –

Figure 15: Knows that contraception does not cause infertility (by cohort and gender)



and therefore of having contact with SRH services – young adult women (50%) were more likely to be aware of this than adolescents (33%) and young adult men (30%).

In aggregate, nearly half (47%) of young people reported that they knew where a married young person might obtain contraceptives (see Figure 16). Cohort and gender differences were significant and primarily reflect young people's chances of being married. Young adult women (62%) were the most likely to know where a married young person might obtain contraceptives, whereas adolescent boys were least likely to know (33%). Nationality differences were also significant: Palestinians (55%) were more likely to know where a young person might obtain contraceptives than Jordanians (52%) or Syrians (45%). For Syrians, location differences were also significant; knowledge was better among those in host communities (47%) and formal camps (45%) compared with those in informal tented settlements (39%).

Only just over a quarter of young people (27%) reported on the endline survey that they knew where an unmarried young person might obtain contraceptives (see Figure 17). Gender differences were not significant, but cohort differences were: young adults were more likely to know where an unmarried young person could access contraceptives than adolescents (32% versus 23%). Nationality differences were also significant, with Jordanians (33%) more aware than Syrians (26%) and Palestinians (24%). For Syrians, location differences were also significant, with those in host communities (30%) having similar levels of knowledge to their Jordanian peers, and far better knowledge than their peers in formal camps and informal tented settlements (21%).

Nearly two-thirds (64%) of young people agreed, at least in part, that '*A young woman should not use methods of family planning until she has had at least one child*' (Figure 18). Cohort differences were significant, with young adults (70%) more likely to agree than adolescents (59%). Gener differences were also significant, with adolescent boys (61%) more likely to agree than adolescent girls (56%) and young adult women (72%) more likely to agree

Figure 16: Proportion of young people who know where a married young person might obtain contraceptives (by cohort, gender and nationality/location)

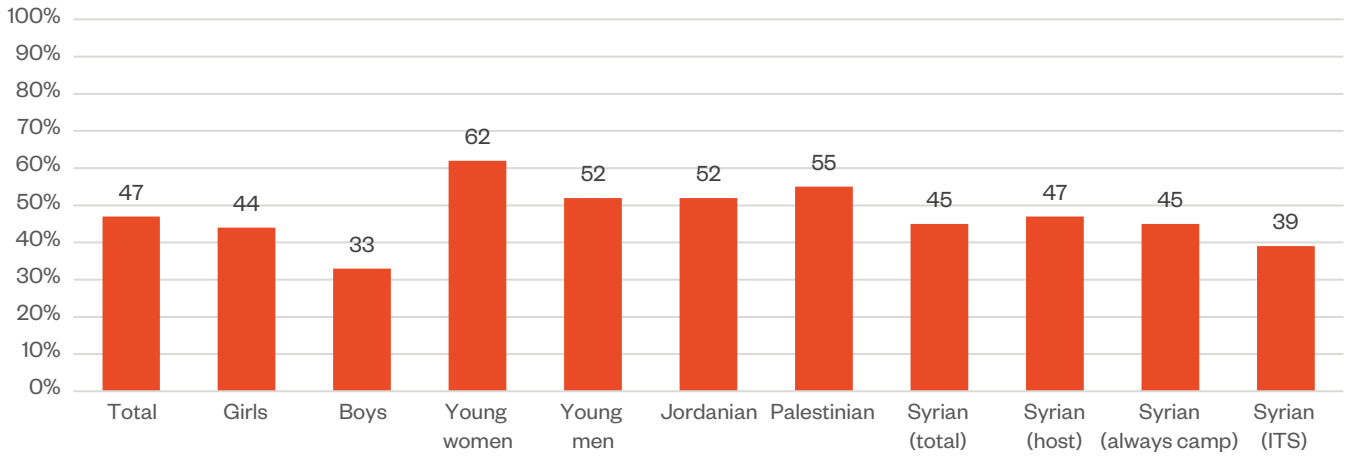


Figure 17: Proportion of young people who know where an unmarried young person might obtain contraceptives (by cohort and nationality/location)

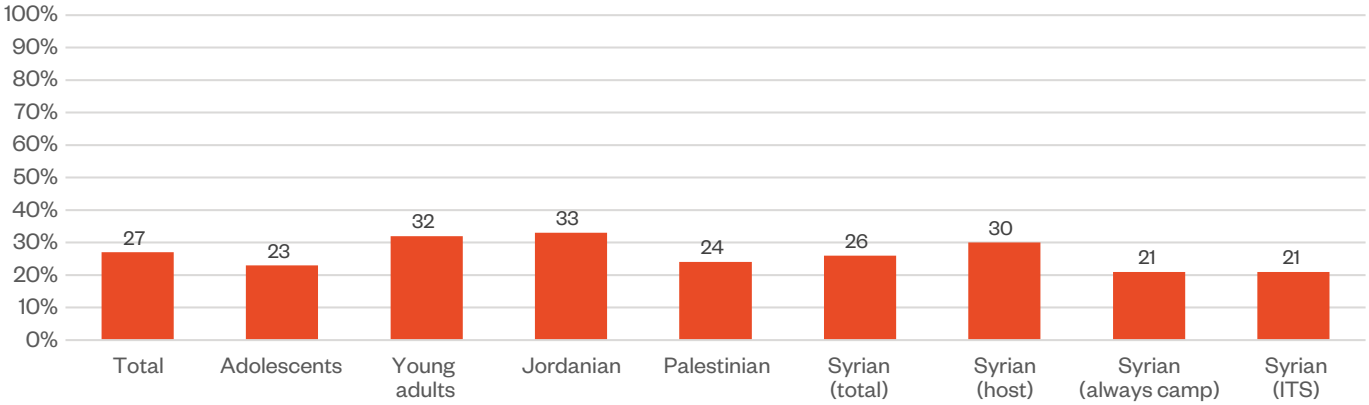
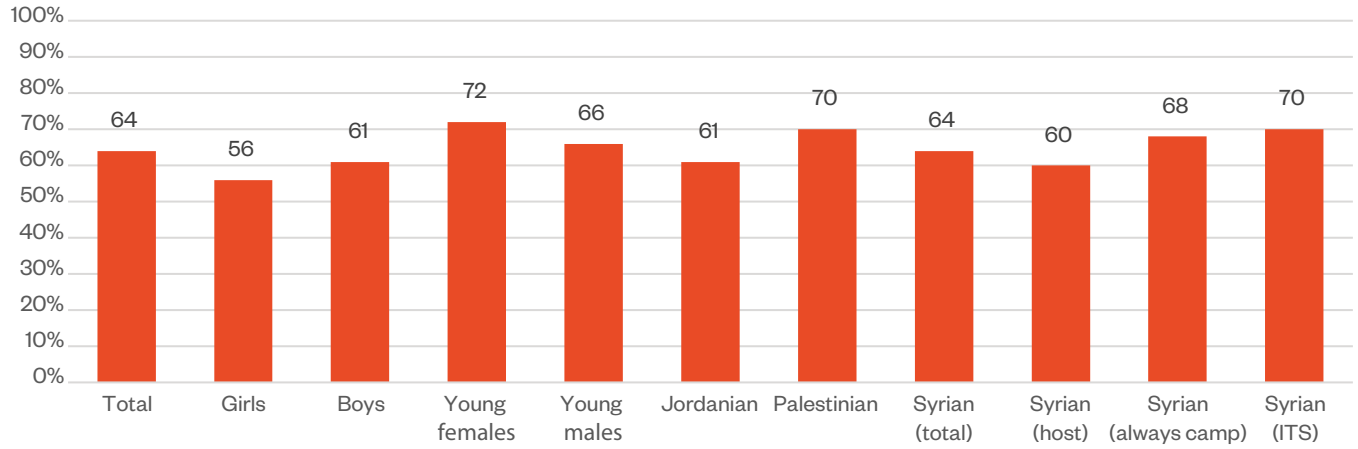


Figure 18: Agrees, at least in part, that a woman should not use family planning until she has had at least one child (by cohort, gender and nationality/location)



than young adult men (66%). Palestinians (70%) were significantly more likely to agree than Syrians (64%) or Jordanians (61%). For Syrians, location differences were also significant: young people living in informal tented settlements (70%) and formal camps (68%) were more likely to agree than their peers in host communities (60%).

One-third (33%) of young people agreed, at least in part, that a married young mother's consideration of family planning is disrespectful to her husband and/or family (see Figure 19). Gender differences were significant, with young males not only more likely to hold conservative views than young females, but also become more so with age. Among adolescents, boys were 17 percentage points more likely to agree than girls (42% versus 24%). Among young adults, the gender gap was starker: young adult men were 35 percentage points more likely to agree than young adult women (53% versus 18%).

Of never-married young people, a large majority (92%) would like to have children in the future (see Figure 19). Cohort and gender differences were significant, when taken together. Adolescent girls (88%) were less likely to want children than adolescent boys (93%) and young adults (95%). Nationality differences were also significant, with Jordanians (89%) and Palestinians (92%) slightly less likely to want children than Syrians (93%). For Syrians, location differences were significant: those living in formal camps (96%) and host communities (93%) were more likely to want children than those living in informal tented settlements (87%), where daily life is most difficult.

In aggregate, and including both those who have and have not been married, young people would like to have a total of 3.6 children (see Figure 20). Gender differences were significant, with young males (3.9 children) wishing to have larger families than young females (3.3 children). Palestinians and Syrians living in informal tented

Figure 19: Proportion of never-married young people who would like to have children in the future (by cohort, gender and nationality/location)

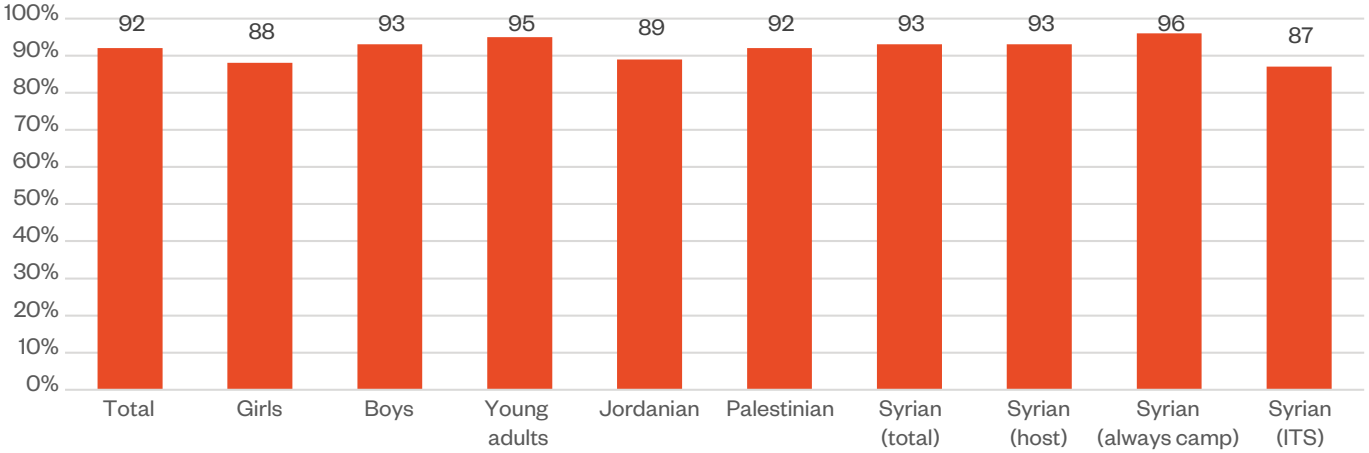
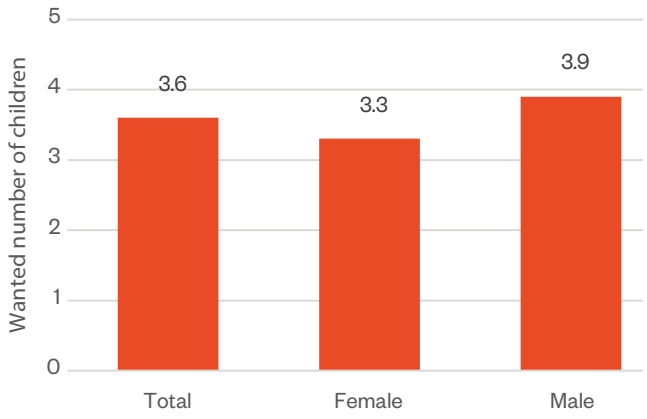


Figure 20: Wanted number of children (by gender)



settlements wanted the largest families (4.1 children) (not shown). Of married young females, nearly a quarter (22%) reported that their husband wants more children than they do. Of married young males, the same is true of only 1%.

Young people taking part in qualitative research had only limited – and quite inaccurate – information about contraception. For unmarried young females, this is generally because they are carefully shielded from all knowledge about sexual topics prior to marriage. A 19-year-old Palestinian young adult woman who was engaged, when asked what she knew about contraception, replied, '*It's rude for girls to ask before marriage… totally unallowed… I have never heard of it.*' Unmarried adolescent boys and young adult men, on the other hand, are not so much carefully shielded as simply uneducated, outside of what they hear from '*people's stories and conversations*' (18-year-old Syrian young adult man, Zaatari camp) and what they look up on Google. Indeed, several unmarried young males, when asked how males might prevent pregnancy and disease, were unable to name condoms or explain how they work. A 17-year-old Syrian adolescent boy from an informal tented settlement stated, '*I don't know its name, I swear!*' An 18-year-old Bani Murra young man said, '*There is something. It is like a bag.*' Adults admitted that there is no attempt to teach unmarried young people about contraception. Indeed, a Palestinian key informant was aghast at the very idea:

> *How can I give such topics to teenagers? We always give workshops before marriage, but some people believe we made a mistake by educating children about these topics. Let's be honest, stuff like condoms, injection… Imagine a child using a condom?! Those under 18, it's forbidden to educate them!*

With the caveat that quite a few young mothers reported that they had not been informed about their contraceptive options after giving birth, married young females were overall more aware of contraception than their unmarried peers. This was because most had been informed of their options after giving birth. A 19-year-old Syrian mother of two from a host community recalled of her first antenatal visit, '*The doctor was telling me.*' Married young males were generally less aware of contraception than their wife. This is because, explained an 18-year-old Turkmen young adult man, contraception is seen as women's purview: '*It's related to women.*' Indeed, a 24-year-old Syrian young adult man from Azraq camp added that NGOs' efforts to educate young wives about contraception frequently exclude their husbands, saying, '*All the activities are aimed at females.*'

In line with survey findings, even young females who reported having discussed contraception with a medical professional often reported that they relied first and foremost on their mother for contraceptive advice, both because they trust their mother to recognise and prioritise their broader and longer-term interests, and because many mothers either are using (or have used) contraception themselves. A 21-year-old Jordanian young adult woman recalled that her mother had been reassuring: '*He used condoms and things, and I was scared. Then I asked my mom… She helped me understand.*' A 20-year-old Syrian young adult woman similarly stated, '*I asked my mom what the pill was for, and she said, "So I don't get pregnant"*.'

With exceptions, young people – and their mothers and mothers-in-law – had very inaccurate information about contraception. Hormonal contraceptives were widely believed to cause sterility if used prior to the first (or even second or third) pregnancy. A 19-year-old Syrian young mother from a host community stated, '*You can't take contraceptives… They say it will cause sterilisation.*' Contraceptives were also blamed for a host of other health complications, including weight gain and mental health issues. A 19-year-old Bani Murra young mother, who had tried the pill, explained, '*I do not recommend contraception… It changes the human psyche.*' Contraceptive implants were believed to be even more dangerous, since they not only alter hormones and can result in irregular menstrual cycles, but were believed to get 'stuck' in the body. A 21-year-old Syrian young mother from Zaatari camp reported, '*And the chip… may God not show it to you… they said it goes inside the body… between the veins and the bone, and they had to*

An 18-year-old pregnant Syrian refugee woman in an ITS camp, Jordan © Nathalie Bertrams/GAGE 2025

do surgery to remove it.' IUDs were also believed to be quite dangerous, both to women and to their husband. A Palestinian mother explained why she refuses to allow her daughter-in-law to get an IUD: '*We once had a situation… Her husband got stuck in the IUD and they were both taken to the emergency. That was so embarrassing*.' Young respondents' information about natural methods of family planning were also broadly inaccurate. For example, most believed that it is not possible to become pregnant while breastfeeding, and one young adult woman, a 27-year-old Syrian from a host community, reported that she had been told by a medical professional in Saudi Arabia that withdrawal '*causes dryness in the uterus… and sterilisation after a while*'.

Qualitative research participants were broadly aware of where married young people might access contraceptives. They reported that pills, injections and condoms are available at pharmacies, and that implants and IUDs are readily available at health clinics (and free in formal refugee camps). A 23-year-old married Syrian young adult man from Azraq stated, of IUDs, '*They take it from clinics and give it for free*.' Unmarried young people, however, were reported to have no access to contraceptives at all. A key informant stated, '*It's* [contraception] *just for married women*.' Indeed, even over-the-counter methods such as condoms were considered inaccessible. A 22-year-old Jordanian young adult man explained that this is because adolescent boys and young adult men are afraid that their parents might find out: '*The pharmacist can ask him [the purchaser]; who is your father? They scare him in this way!*'

Respondents' attitudes about contraception are shaped not only by their concerns that products are dangerous, but also by widespread beliefs that the very essence of marriage is to produce children, and that attempts to prevent this contravene Islamic principles. A 21-year-old Jordanian young adult woman reported that only natural methods of family planning are acceptable: '*After I got engaged, I searched what were the right things allowed in Islamic culture… I would never use birth control*.' A 17-year-old Syrian adolescent girl from an informal tented settlement shared that view. When asked how many children she would like to have, she replied, '*In the end, it's God's will*.'

Marriage, family planning and pregnancy

In Jordan, GAGE did not ask young people whether they had had sex, as it would be highly sensitive due to strong cultural norms. Instead, rates of sexual activity must be estimated from rates of marriage. By endline, a majority (62%) of the young adult women in the GAGE sample had been married, as had a large minority (23%) of the young adult men (see Figure 21). Marriage was uncommon among adolescent girls (14%) and very rare among adolescent boys (<1%). Syrian young adult women (67%) were significantly more likely to have been married than their Jordanian (49%) and Palestinian (49%) peers.

The endline survey found that 39% of currently married adolescent girls and young adult women are using any method of family planning (see Figure 22). Cohort

differences were significant: young adult women were more than twice as likely to be using a method than adolescent girls (44% versus 21%). Nationality differences were also significant, with Palestinians (21%) less likely to be using a method than Jordanians (42%) and Syrians (40%). For Syrians, location was also significant: those in informal tented settlements (22%) were less likely to be using any method than their peers in host communities (46%) or formal camps (36%). Underscoring the close relationship between marriage and motherhood, although 50% of young mothers were using a method of family planning, only 3% of married adolescent girls and young women who did not have a child were using a method.

Of the young females using a method of contraception, the pill (32%) was the most common method, followed by IUDs (25%) and condoms (16%) (see Figure 23).

Figure 21: Proportion of young people who have ever been married (by cohort and gender, and for young women, by nationality/location)

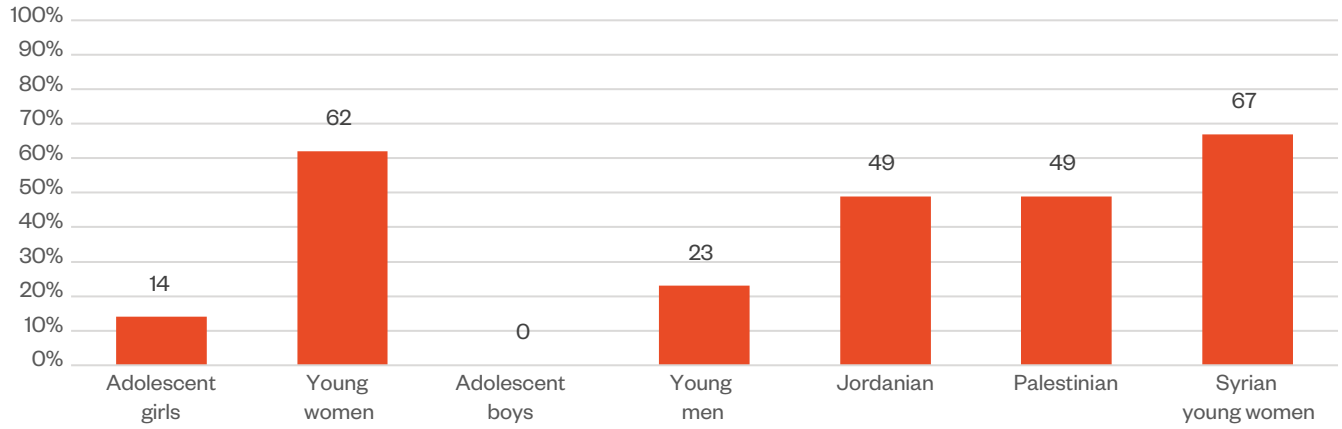


Figure 22: Proportion of young married females currently using any method of family planning (by cohort, nationality/location, and motherhood status)

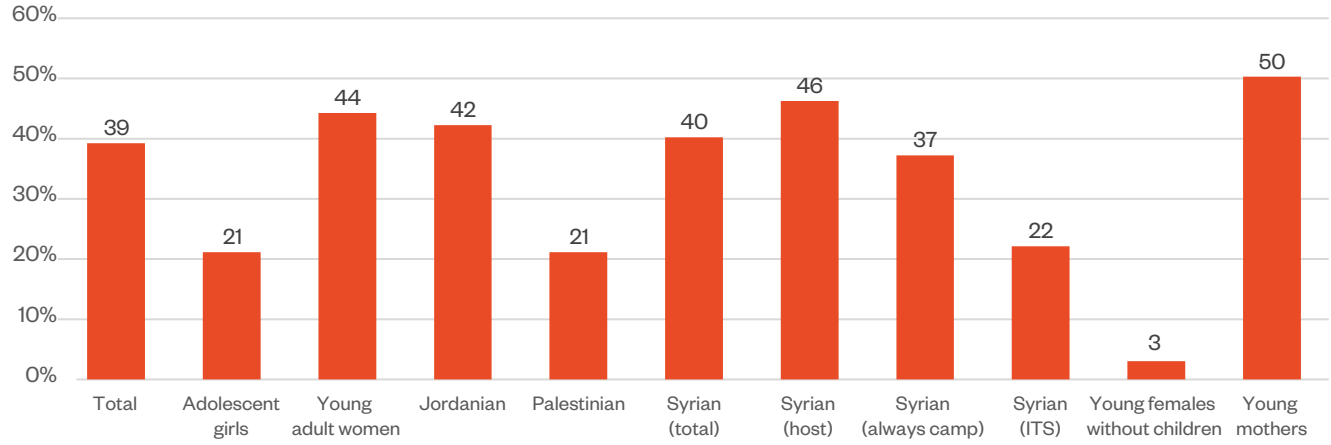
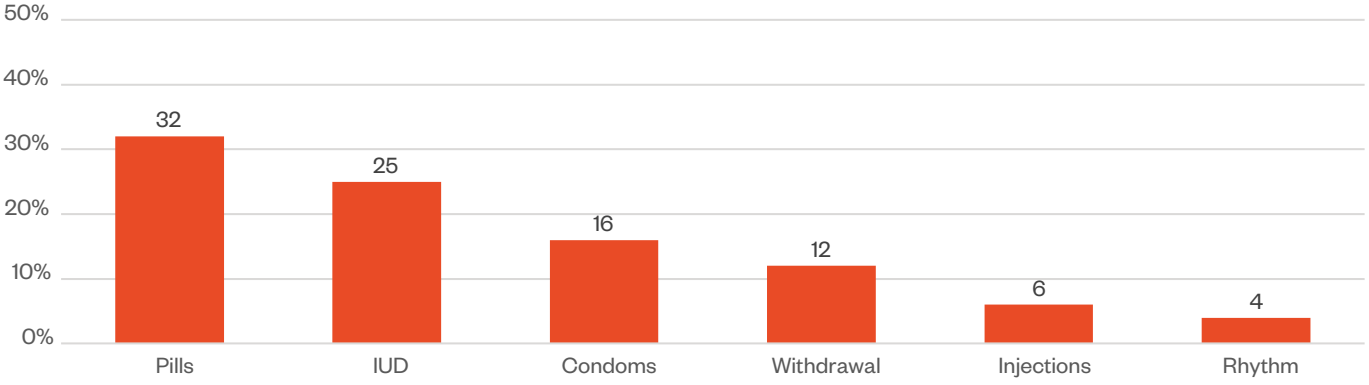


Figure 23: Family planning method (of young females who report current use)



Of currently married adolescent girls and young adult women, just under one-third (32%) reported on the endline survey that they were using a modern method of contraception (see Figure 24). Cohort differences were significant: young adult women (37%), who had a mean of 1.7 children, were significantly more likely to be using a modern method than adolescent girls (17%), who had a mean of 1 child. Although 42% of young mothers were using a modern method of contraception, only 2% of married adolescent girls and young adult women who did not have a child were using a modern method.

In aggregate, 42% of young wives reported that decision-making about family planning was shared between themselves and their husband (see Figure 25). Another 25% reported that they had the final say, and another 24% reported that their husband had the final say. Among married females, young adult women were significantly more likely than adolescent girls to report that they had the final say about family planning (28% versus 13%, not shown). There were significant nationality differences in decision-making. Jordanian young females (49%) were far more likely to report that they made their own decisions about family planning than their Palestinian (15%) and Syrian (22%) peers. Palestinians (64%) and Syrians (43%) were more likely to report shared decision-making than Jordanians (23%). For Syrians, location differences were also significant. Young females living in host communities (27%) were more likely to report that they had the final say than their peers in formal camps (16%) and informal tented settlements (16%)*. Those living in formal camps (50%) and host communities (43%) were more likely to report shared decision-making than those living in informal tented settlements (28%). In aggregate, 70% of young wives reported that they were satisfied with their input into family planning decisions.

Of the ever-married girls and young adult women who completed the endline survey, 84% had ever been pregnant (see Figure 26). Young adult women, who had on average been married for longer than adolescent girls, were significantly more likely to have been pregnant (88% versus 71%).

Of ever-married young females, 65% reported on the endline survey that they knew where the nearest maternity hospital is located. Of those who had ever been pregnant, 82% had sought out antenatal care for their first pregnancy, and attended an average of 6.6 visits over the course of that pregnancy. Most young mothers received antenatal care from private hospitals (34%) and government health

Figure 24: Proportion of married females currently using a modern method of contraception (by cohort and motherhood status)

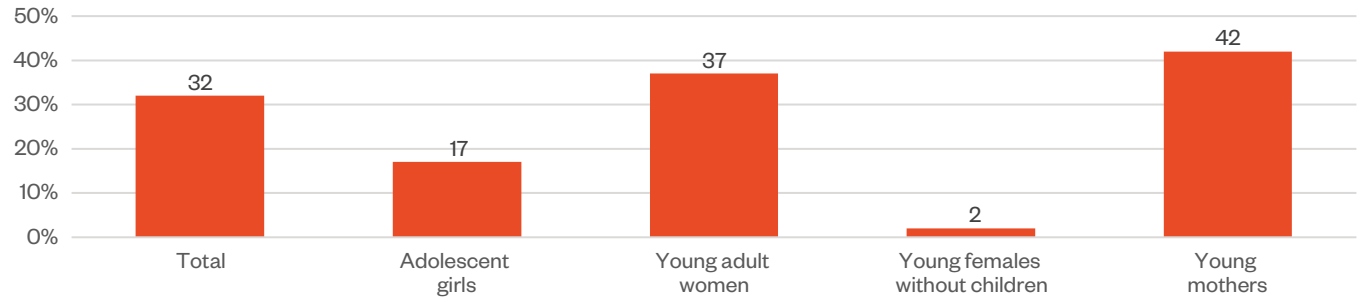


Figure 25: Family planning decision-making (by nationality)

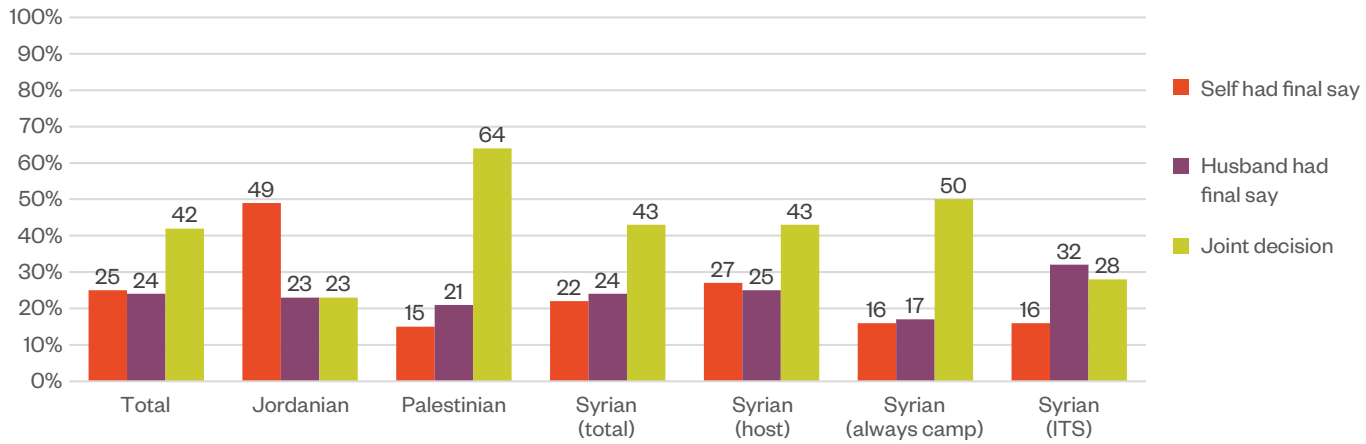
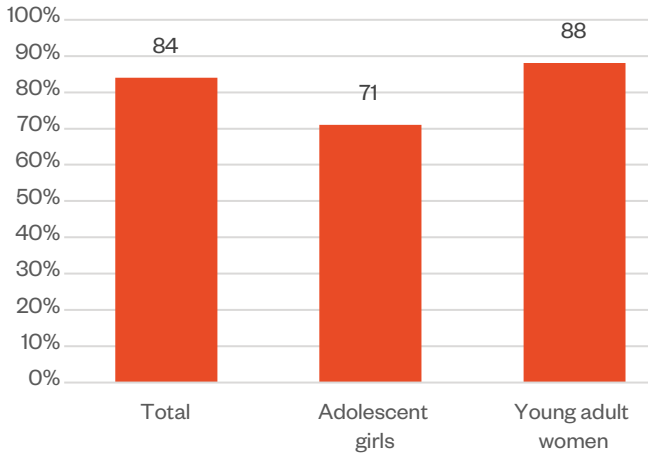


Figure 26: Has been pregnant, of ever-married females (by cohort)



facilities (32%) (see Figure 27). It was very rare (1%) for young mothers to receive antenatal care from a traditional birth attendant (TBA). Nearly all young mothers (98%) delivered their first child in a hospital.

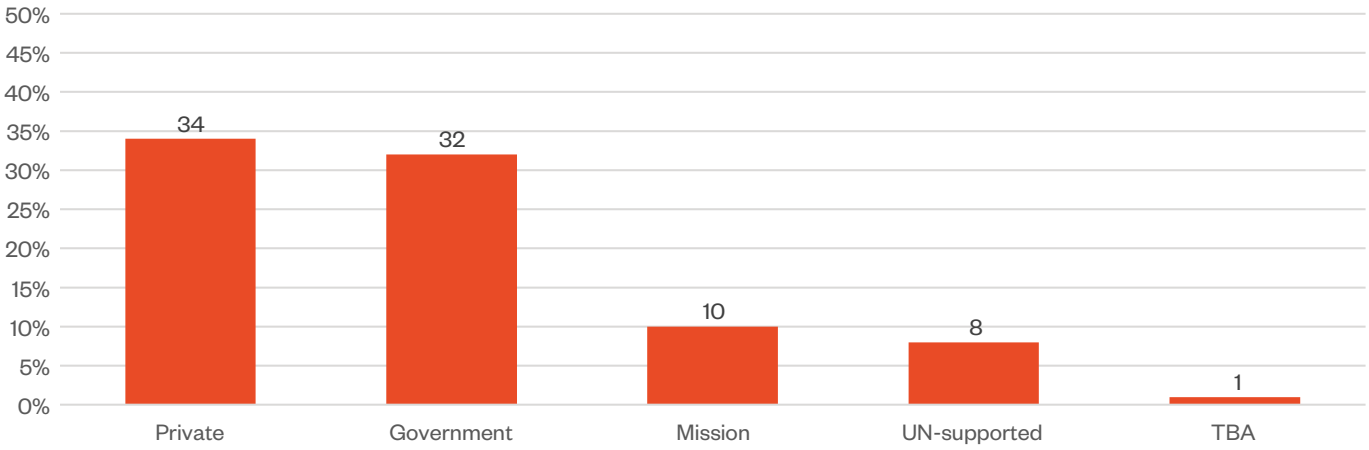
Most qualitative research participants reported that sex outside of marriage is rare in Jordan. This is because, they explained, such behaviour is '*prohibited in Islam*' (21-year-old Bani Murra young adult man). That said, while only two young males (one Palestinian and one Turkmen) reported that they personally had had sex prior to marriage, it was not uncommon for young males to report that some of their peers engage in premarital sexual activity. A 17-year-old Jordanian adolescent boy stated, *'I have so many friends doing this*.' A 23-year-old Syrian young adult man from Zaatari camp elaborated, '*It's more common among the guys who live outside the camp… They say things like "I used to mess around with so many girls*"'.

In part because females who have premarital relationships are at risk of honour killing (see Presler-Marshall et al., 2025f), young females did not report sexual activity prior to marriage. Indeed, as has been noted in previous GAGE publications (Presler-Marshall et al., 2023c, 2023d), young female's narratives about sexual debut overwhelmingly focused on the wedding night – and how unprepared many girls and young women were for sex. A 21-year-old Syrian young adult woman from a host community reported that she had no idea that marriage involves a sexual relationship until told so by her husband: '*My husband was the one who taught me. He told me that this was his right and my right too*.' A Jordanian young adult woman the same age recalled that although her mother had tried to prepare her, she had been too scared to listen, *'I got engaged and things got closer to marriage… My mom sat down and tried to talk to me, but I didn't want to hear it from her. I was either scared or embarrassed*.'

Young brides from the most conservative families noted that in addition to being surprised to learn about their 'marital duties' (which also include dressing well and smelling nice, according to respondents), they were embarrassed at having to exhibit bloody towels to prove their virginity. A 20-year-old Jordanian young adult woman, married to her cousin, explained, *'I am embarrassed… My aunt said, "If you see the blood. It's your honour… If you don't show it to someone, they'll say you're not a girl* [virgin]*".'* Cognisant of the fact that the youngest brides are generally the least well informed, a recent government initiative aims to educate brides-to-be and to discourage child marriage. A key informant explained:

> *Premarital counselling* [under the oversight of the Shariah Court] *typically includes a comprehensive focus on health and sexual issues… For someone who is getting married at the age of 16 or 17, they need to be informed about what marriage entails. This includes understanding the sexual aspects.*

Figure 27: Provider of antenatal care, for first pregnancies



In line with survey findings, qualitative research found that it is rare for young couples who do not have children to be using any form of family planning. In some cases, this is because couples (more often the female partner) are unaware that pregnancy results from sex. A 21-year-old Syrian young adult mother from an informal tented settlement reported that she was unaware of how pregnancy happens until she got pregnant: '*I didn't know anything. I was a simpleton about life*!' More frequently, this is because young couples are expected to produce children as soon as feasible after marriage. A pregnant 18-year-old Syrian young adult woman from Azraq camp, when asked if she had wanted to become pregnant immediately after marriage, replied, '*No. But he wanted children*.' One respondent, an 18-year-old Bani Murra young woman, explained that there are consequences of delaying pregnancy, saying '*if a woman is late getting pregnant, they taunt her*'. This explains why it was more common for childless brides to report using fertility enhancers than to report using contraceptives. A 21-year-old Jordanian young adult mother recalled, '*I took a long time to get pregnant… They kept talking about it. They even brought me medicine for pregnancy*.'

Young parents who reported using family planning discussed both natural and modern methods. In terms of natural methods, they reported using the rhythm method, withdrawal, and exclusive breastfeeding. These were most often reported as used after their first baby, since according to a 19-year-old Syrian young mother from a host community, '*they* [women] s*ay that you should not use contraception between the first and second child*'. Unsurprisingly, many of these young parents soon found themselves with their second baby, at which time more couples adopted modern methods of contraception. Despite grave concerns about the potential health risks of the contraceptive pill, and in line with survey findings, most young mothers who used modern contraceptives reported that they were using the pill, because unlike IUDs and implants, pills are non-invasive and easily discontinued. A 21-year-old Jordanian young adult mother reported, '*It was forbidden to put an IUD or any other pregnancy preventers except for the pills*.' Young mothers with three or more children, if they were using contraceptives, generally preferred the IUD, which is broadly perceived as a healthier option than the pill and does not require remembering to do something every day at the same time-- which becomes more difficult with a house full of small children. A 19-year-old Syrian young adult mother explained, '*If you don't take a pill at the exact same time every day, it messes things up*.'

Most young mothers who were using family planning reported carefully negotiating this with their husband and mother-in-law, who (with exceptions) tended to want more, and more closely spaced, children than did young mothers themselves. A 21-year-old Jordanian young mother of two stated that although she had been unable to convince her husband to allow a space between her daughter and son, because he wanted a son, she had convinced him to wait for their third baby: '*At first, he wasn't ok with it… But I told him, "I want to rest, I want to live my life a little!"*' A 21-year-old Palestinian young mother of three, whose husband agrees that finances are stretched thin enough, reported an even more strident conversation with her

A pharmacy in Mafraq, Jordan © Nathalie Bertrams/GAGE 2025

mother-in-law, who has been pushing for their fourth baby: '*I told her, "Even if you die, I won't have more kids and leave them hungry!"*' At endline, young husbands' support for family planning appears higher than it was at baseline and midline, primarily because more are aware of how expensive children are. In addition to the young mothers who reported that their husband agrees that their families are large enough, a 21-year-old Syrian young mother from Zaatari camp reported that her husband is even more committed to contraception than she is: '*Actually, he's more determined than I am… He tells me no, we already decided. But I really want a daughter*.'

Some young mothers reported that they had no say about if and when to become pregnant. Younger mothers with fewer children were the most likely to report that they were excluded from decisions about family planning. A 19-year-old Palestinian young mother of two stated that her second pregnancy was years earlier than she had wanted, because of her husband and his mother: '*I decided to take the pills but they prohibited me*.' That said, even young mothers with many children occasionally reported that they are effectively trapped into producing child after child. A 25-year-old mother of five from Zaatari camp, who was told by medical staff that her life was at risk because of closely spaced, difficult pregnancies, reported '*I was always blamed*' if she did not fall pregnant immediately. Respondents noted that because young wives are effectively prohibited from leaving home unless they are accompanied by their husband or mother-in-law (see Presler-Marshall et al., 2025c), young females effectively do not have the option of using contraception secretly. Indeed, only one young mother – a 21-year-old Jordanian young mother of two who breastfed her older child until the age of 3 (and plans on doing the same with her baby) – reported that she had deliberately contravened the demands of her marital family to reduce the time between pregnancies. Notably, health care workers are not universally agreed that young females ought to be allowed to make unilateral decisions about family planning. When asked if he would provide a young woman with contraceptive pills, if he knew that her husband's family was against it, a pharmacist replied, '*I might give her the pills, she has the right to ask for them. I can't deny her that. But I would advise her that coordination with her husband is essential, especially with the husband*.'

The young mothers taking part in qualitative research reported receiving quality and (largely) free antenatal care. They were informed about the importance of good nutrition and exercise; were provided with prenatal vitamins; had access to monthly (and then weekly) medical check-ups that included bloodwork, ultrasounds, and treatment for hyperemesis gravidarum and Rh incompatibility; and were offered classes on breastfeeding and infant care. A 19-year-old Bani Murra young mother recalled, '*She would write to me* [prescribe] *vitamins and warn me about a lot of things, whether I should do them or not. She would even tell me how to sleep, how to eat, how to sit*.' A 24-year-old Palestinian mother similarly reported, '*They did all the tests, blood test, urine test, stool test and blood pressure measurement and took a lot of information from me… They were telling me what is the right nutrition for pregnant women… They talked to me about breastfeeding*.'

Delivery care was more often criticised than antenatal care. In large part, this is because it usually entails costs. Although those costs are considered small (for uncomplicated vaginal births), they can reach hundreds of dinars – for example, for caesarean sections (which are common, especially for the youngest mothers), for mothers who are under the age of 16 (due to government efforts to eliminate very early child marriage), and when newborns need nursery care. A key informant from Zaatari camp reported that:

> *As for childbirth cases, they are covered by the hospital, but if the child needs to go to the nursery, the nursery costs must be paid by the child's family from their own account, and also the special operations that women need, they pay for them from their own account.*

Government hospitals were also criticised for their treatment of labouring mothers. Criticisms were more common – and harsher – among Syrian and ethnic minority mothers, some of whom had such negative experiences that they paid out-of-pocket for midwives or private hospitals for second and subsequent births. A 21-year-old Syrian young mother recalled that:

> *In the government hospital… excuse my language, but they were awful – really bad treatment… They leave you in pain until you've had enough, until you completely break down… Before and after giving birth, they'd say, 'Why are you screaming?'*

A 19-year-old Bani Murra young mother shared a similar view, saying, '*Honestly, the government hospital was a mess… They don't care… And the doctor, he keeps yelling at you!*'

Marital violence

The endline survey found that beliefs about marital violence vary by gender and nationality/location, but not by age cohort. In aggregate, 74% of young people reported that they agreed (at least in part) that a wife owes her husband total obedience (see Figure 28). Young males (85%) were significantly more likely to agree than young females (63%). Syrians living in informal tented settlements (87%) and formal camps (81%) were more likely to agree than Palestinians (75%), Syrians living in host communities (71%), and Jordanians (62%). A large minority (37%) of young people also agreed (again, at least in part) that marital violence is private and should never be discussed outside the home. Young males (48%) were again significantly more likely to agree than females (28%). Syrians living in informal tented settlements (49%) and formal camps (45%) were more likely to agree than Syrians living in host communities (34%), Jordanians (30%), and Palestinians (29%). A minority of young people (12%) agreed (at least in part) that beating is an acceptable way for a man to mould his wife's behaviour. Young males (21%) were more than four times as likely to agree as young females (5%), and Syrians living in informal tented settlements (22%) were far more likely to agree than Jordanians (9%), Palestinians (12%), and Syrians living in host communities (10%) and formal camps (14%).

Beliefs about marital violence also vary by marital status, with young brides and young grooms more likely to espouse conservative views than their unmarried peers. Of young females, 57% of those who have never married but 74% of those who have married agreed (at least in part) that a wife owes her husband total obedience (see Figure 29). Of young adult men,[12] analogous figures were 86% and 93% respectively. Young wives (33%, versus 26% of unmarried young females) and young grooms (61%, versus 45% of unmarried young adult men) were also more likely to believe that marital violence is private and should never be discussed outside the home. For young females, marital

Figure 28: Beliefs about marital violence (by gender and nationality/location)

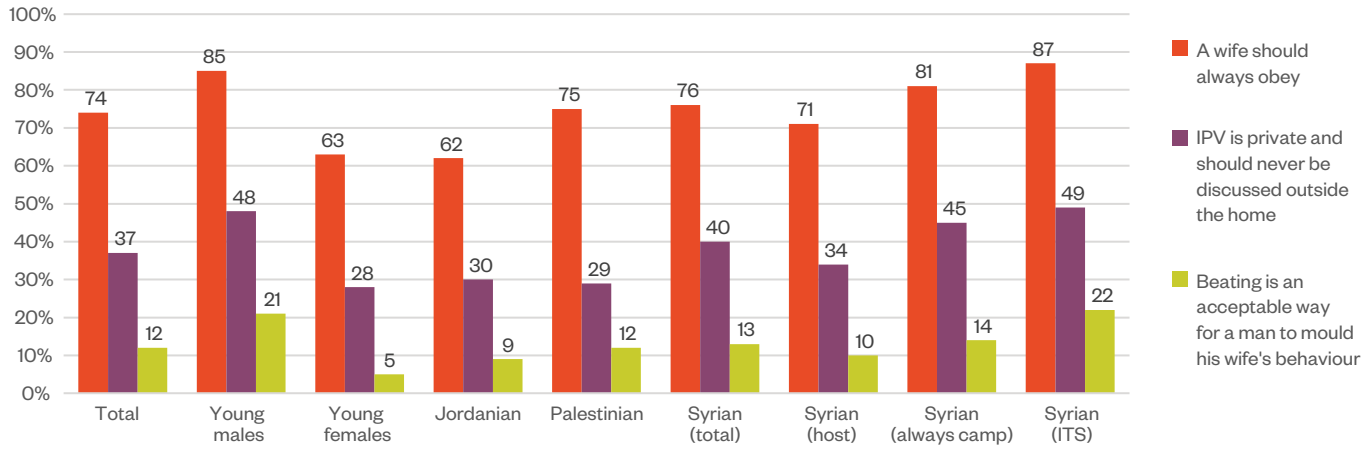
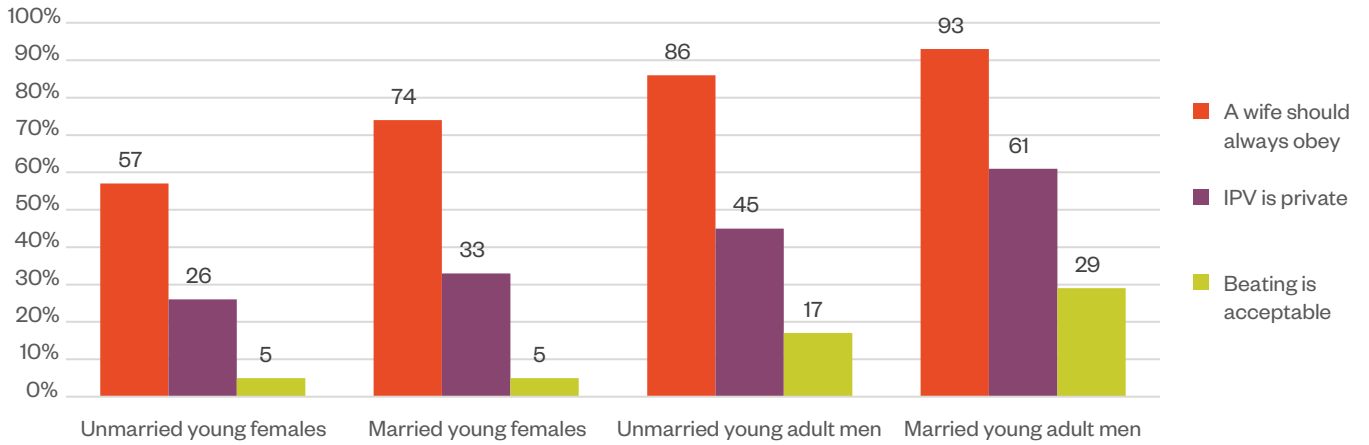


Figure 29: Beliefs about IPV (by gender and marital status)



12 Too few adolescent boys had ever married to include boys alongside young adult men.

status does not affect beliefs about the acceptability of physical violence. However, this is not the case for young adult men; 29% of those who were ever-married agreed (at least in part) that beating is an acceptable way for a man to control his wife's behaviour, compared with 17% of unmarried young adult men.

At baseline and midline, there were age limits on who was asked about marital violence, such that only the older cohort were asked. This means that change over time can be explored only for the older cohort (now young adults). Among young adults in the panel sample, there is some improvement over time, with young adults generally espousing less conservative views on the issue at endline than at baseline. These differences, however, are primarily due to changes in young adult women's beliefs – not young adult men's. For example, at baseline, 71% of young adult women agreed that a wife owes her husband total obedience; this fell to 64% at midline and then 63% at endline (see Figure 30). For young adult men, the percentages were 87%, 83% and 86% respectively. A similar, albeit less stark pattern emerges in terms of beliefs about marital violence being a private matter. Declines between baseline and endline for young adult women (25 percentage points, from 52% to 27%) were larger than those for young adult men (17 percentage points, from 64% to 47%). Beliefs about the acceptability of beating significantly decreased over time for young adult women (3 percentage points, or a 43% reduction compared to baseline), but not for young adult men.

The endline survey found that of currently married young females, 5% admitted to having been publicly humiliated by their husband, and 7% admitted to having been physically assaulted by him (see Figure 31). Nationality differences suggest under-reporting, with Jordanian brides (16%) over twice as likely to report physical violence as Syrian (6%) and Palestinian brides (3%).

In qualitative endline research, young wives reported being insulted, hit (including with objects) and kicked, even while pregnant, for reasons ranging from using a mobile phone or leaving home without permission, to failing to meet their husband's needs in a timely manner, to being unable to keep children calm and quiet. A 21-year-old now-divorced Palestinian young adult woman recalled that she was beaten for not making dinner:

Figure 30: Beliefs about IPV, over time (by gender)

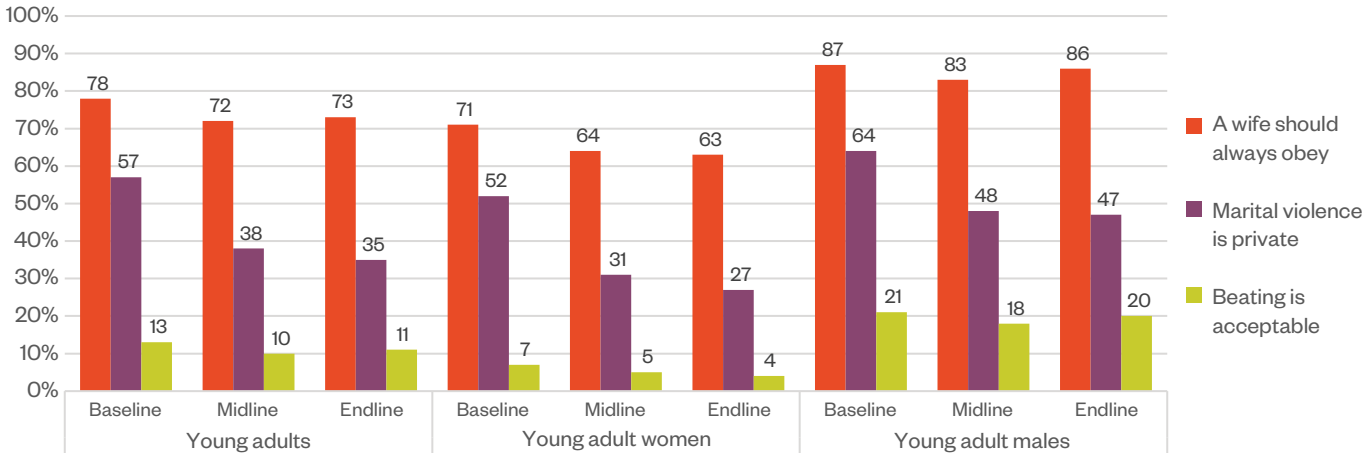
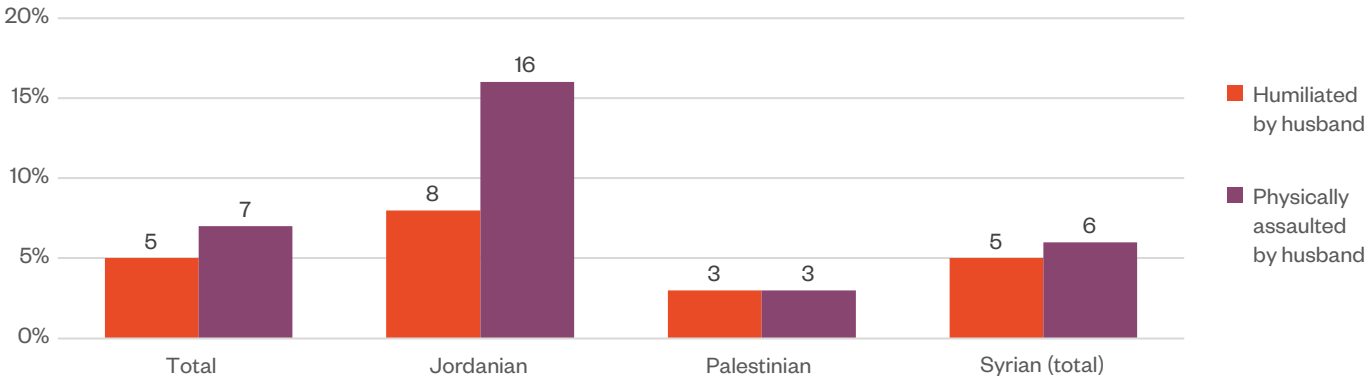


Figure 31: Have experienced IPV, of married females (by nationality)




A 16-year-old Jordanian girl © Marcel Saleh/GAGE 2025

He even used to beat me up for not cooking. How was I supposed to cook it? I didn't have money to buy food!

A 21-year-old Syrian young adult woman stated that she was beaten because she wanted to sleep, rather than have sex with her husband: '*I said no, I want to sleep… at that time he beat me up, he caused bruises on my arm*.' A 24-year-old Jordanian young adult woman explained that her children are her protectors: '*My children hold their father and tell him "Don't hit our mom"*.' Key informants, caregivers and unmarried young people agreed with the accounts of young wives that marital violence is rampant. A 22-year-old single Jordanian young adult man stated, '*It* [marital violence] *exists, and in large numbers too. Like our neighbour – God bless him – every day, his wife and daughter are screaming*.'

Respondents offered varied reasons for wives' silence about marital violence. A key informant from Azraq camp explained that they are afraid of making the violence worse:

The first time a woman is beaten by her husband, and she goes to the Family Protection, this will be a deterrent, but she is afraid that it will increase the second time, so she remains silent in the situation.

A 22-year-old Syrian mother from a host community stated that she had moved on from fearing her husband's violence, but was terrified of losing her children:

I didn't fear losing him and wanted to protect my children… I tried many times but he refused to divorce me. His condition was that I release custody of my children.

A 17-year-old Syrian adolescent girl from an informal tented settlement said that divorce can cost young wives not only their children, but their place in the community: '*People talk about her and blame her for everything… She says she will bear it for whole her life, rather than losing everything*.' Young wives' hesitancy to report marital violence to authorities is also shaped by the way that such violence is normalised and even seen as being the wife's fault. A key informant from Azraq camp noted that many adolescent girls and young adult women do not even tell their parents, because they know they will be blamed, saying that, '*Many times, her family does not support her. They tell her she is at fault and should stay with her husband*.' A Bani Murra mother agreed that this is true, '*If my daughter is not good… he has the right to hit her*.'

In line with survey findings, husbands were most likely to normalise marital violence. This is because, as explained by a key informant from a host community, *'It's a masculine society*.' A 19-year-old Bani Murra young adult man stated that marital violence is simply part of marriage: '*It happens, it's normal… There are reasons, I mean, in marriage, it's known that no house is without problems*.' A 23-year-old Syrian young adult man asserted that marital violence cannot even be considered a form of violence, stating that, '*These are family disputes, but there is no violence*.' Adult men (male caregivers and community key informants), although more likely to acknowledge marital violence as violence, were more likely to frame violence as being a wife's own fault. A Syrian man from Azraq camp, for example, stated that men beat their wives because women keep insisting that their husbands buy things that

they cannot afford: '*When wives require so many things from their husbands who can't afford everything… When wives keep insisting, the husband just violates them*.' A Syrian man from Azraq camp similarly reported that wives are beaten when '*the mom doesn't respect the dad*'.

Although marital violence remains under-reported, endline findings suggest that young wives are increasingly aware of their rights, and that more and more are choosing to speak up for themselves. A key informant reported that due to the efforts of NGOs and donors, 'Women have become aware that they have rights.' A 17-year-old Syrian adolescent girl from Zaatari camp, who was engaged, explained what she had learned: '*God says, "Obey your husband," but that doesn't mean you have to obey when it goes against your will*!' In some cases, young females' growing awareness has translated into reduced violence. A 21-year-old Syrian young adult woman from a host community stated that her husband hit her only once: '*He only hit me one slap – I told him "never use your hand on me"*.' In other cases, awareness enables young wives to seek help. A 21-year-old Palestinian young adult woman reported that when her ex-husband had stolen their son and called her trash for pursuing a divorce, she climbed through a window, stole the child back, and replied, '*If you want to take him, do it in court… Yes, I'm the kind that gets divorced, and I'll show you who the real trash is!*'

In qualitative interviews, respondents also reported that violence from in-laws is common. Although some young wives reported physical violence from their father-in-law (most common when young couples are cousins and the fathers-in-law are also uncles), most reported emotional abuse from their mother-in-law. A 24-year-old Jordanian mother reported that her mother-in-law insults her and her family, '*She shames me about things that are personal between me and my family*.' A 21-year-old divorced Palestinian young adult woman stated that her mother-in-law had encouraged her son to engage in marital violence, saying that, '*She was the one instigating him against me*.' A 17-year-old Syrian adolescent girl from a host community reported that mothers-in-law also regularly overwork young brides, and insult them for not being able to successfully manage women's work: '*They take the girl and treat her like an object… They then abuse her, telling her, "You don't know anything. Why aren't you doing this? You're not a woman!"*' Key informants and the mothers of young wives also spoke at length about mother-in-law violence. A key informant from Azraq camp estimated that half of young wives live completely under the thumb of their mother-in-law. Indeed, a Syrian mother from Zaatari camp acknowledged that she continues to turn down proposals for her younger daughter, who was 19 years old at endline, because she is afraid of what her daughter might then experience:

> *The house is usually managed by the mother-in-law and not the husband… The mother-in-law controls her son's wife, it is common in the camp. I have a 19-year-old daughter – many people come to propose marriage, but I do not agree. I am afraid for her from the mother-in-law and what she will do to her.*

A Syrian adolescent mother with her child at an informal tent settlement, Jordan © Marcel Saleh/GAGE 2025

Conclusions and implications

GAGE endline research found that because it remains deeply taboo to discuss sexual topics in Jordan, young people have too little access to sexual and reproductive health information and services. This puts young people – and especially young females, given biological realities – at risk of disease and injuries due to early pregnancy and too closely spaced pregnancies.

Endline research found that although most young people in Jordan report having received some form of puberty education, usually from their parents, instruction is too often delayed (until after menarche in the case of girls), and any information they are given is generally superficial and limited to instructions about hygiene and religious requirements. Due to parental worries that if they teach their children about sex, it will encourage them to experiment, young people rarely receive any information that helps them understand why their bodies are changing (to enable reproduction) and how to manage the complex emotions that adolescence brings. Overall, females are better educated about puberty than males, because puberty is more disruptive for females and because mothers are primary caregivers. Many males are left to rely on peers and the internet (including pornography sites) for information.

Menstrual health management is shaped by a mix of resource constraints and entrenched social norms. Although most young females use pads to manage their periods and feel they can talk to their mother about menstruation, period products are expensive, especially considering the depth of household poverty. Schools and other public spaces often have inadequate water, sanitation and hygiene (WASH) facilities to help girls manage menstruation. Moreover, menstruation is widely seen as something that must be kept hidden, especially from brothers. Young brides' access to period products is especially limited, because young couples tend to be poorer and because household resources are not allocated to their needs.

Young people's knowledge about contraception remains limited at endline. Females tend to be better informed than males, albeit only because young mothers are generally informed about their contraceptive options after giving birth to their first child. There are widespread misconceptions (passed on from mothers and mothers-in-law to daughters and daughters-in-law) about the safety and side effects of modern contraceptives. Hormonal methods are believed to cause infertility and to be inappropriate until after young brides have produced at least one and often two children. In addition, modern methods are regularly believed to contravene Islamic law. Unmarried young people, and especially unmarried young females, face extremely high barriers to accessing accurate information and services, because of beliefs that they should be shielded from all information about sex.

In Jordan, sexual activity is almost entirely confined to marriage. However, because child and early marriage are common, especially among Syrians and ethnic minorities, sexual debut for young females is generally early. It is unusual for young couples to use family planning, even natural methods (such as withdrawal). Newly married couples are expected to produce children as soon as feasible. Indeed, marital families sometimes seek medical assistance when young brides do not become pregnant fast enough. Uptake of family planning becomes more common after young couples have two or three children. Contraceptive pills and IUDs are the methods preferred by young females. The plurality of married girls and young women report that they share contraceptive decision-making with their husband. That said, a large minority – especially the youngest, and Syrians who live in informal tented settlements – report that final decisions regarding contraceptives are the purview of husbands.

Unsurprisingly, given high rates of child marriage and limited uptake of family planning, early motherhood is common. Most married girls and young women had been pregnant by endline. Maternity care is generally quite good in Jordan. Antenatal care is especially well regarded, with young mothers reporting regular and high-quality services from health-care providers and NGOs. Delivery care is more variable, with some young mothers – especially those who are Syrian or from ethnic minorities – reporting poor-quality care. Many young mothers also reported that fees payable are too high.

Marital violence is common in Jordan – albeit under-reported (especially by Palestinians) on the survey. Many young brides are hit by their husband, and humiliated by their husband and mother-in-law. They are also effectively abandoned by their own family to cope with this alone, due to widespread beliefs that a wife owes her husband total obedience, that a husband does not need consent from his wife to have sex, and that marital violence is private and should never be discussed outside the marital home.

An 18-year-old Syrian girl with two children in an informal tent settlement, Jordan © Marcel Saleh/GAGE 2025

Although young females are more aware of their right to bodily integrity at endline than in previous years, largely due to the efforts of NGOs, young males' beliefs about their own authority and 'right' to perpetrate violence remain effectively unchanged over time.

Based on our research, we suggest the following policy and programmatic actions to improve the sexual and reproductive health of young people in Jordan:

- **Ensure that all girls' schools are equipped with accessible and clean menstrual hygiene management facilities**, with lockable doors and disposal bins. Where possible, schools should anonymously provide period products for free.

- **Provide adolescents with comprehensive sexuality education (CSE) 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 disabilities. They should explain, 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 together to plan and scale these classes, drawing on existent work by UNESCO, UNFPA and the World Health Organization (WHO).

- **Invest in complementary, community-based, life-skills programming to shift gender norms and address young people's needs for sexual and reproductive health information.** Programming offered by NGOs and/or at religious institutions should directly tackle beliefs that males should be decision-makers, that females should be silent and subservient, and that violence against girls and women 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 socially 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 information unsuitable for young people.

- **Expand courses on parenting of adolescents targeting male and female caregivers, to be provided by NGOs or at religious institutions.** These should address gender norms and preferences for child (under 18 years) and consanguineous marriage, early and repeated pregnancy, and male children. Courses should also provide accurate information on human reproduction and contraception, build parents' acceptance of the provision of more formal CSE 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. In light of the psycho-emotional challenges that many parents face in a context affected by forced displacement, it may be beneficial to include a component on psychological first aid so that parents can better manage their own emotions and thus improve their parenting skills and advice. Particular efforts should also be made to reach out to fathers and to select times and formats for classes that mean men are more able to attend (e.g. sessions in the evening over coffee or integrated into sports sessions).

- **Scale up premarital counselling sessions for young couples, for both individuals separately and together.** Existing premarital counselling sessions could be strengthened and expanded to include all married couples (not just those who are aged 16–17 years), and should cover: 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.

- **Promote mass media and social media campaigns to de-stigmatise sexual and reproductive health issues.** HPC 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 marital violence; and facilitate girls and women who are experiencing violence to get medical, legal and psychosocial support.

- **Expand and tailor training for medical professionals to helps them respond to young wives' need for accurate SRH information and services,** as well as broader concerns about fertility and contraception. Training should highlight the importance of targeting first time mothers with SRH education (especially on the advantages of spaced pregnancies) and include sensitivity to gender norms, and how they shape and limit young wives' knowledge and behaviour; and also awareness of marital violence. There is also a need for iterative refresher training on best practices surrounding fertility treatments, miscarriage prevention, and supportive maternity care, including proactive outreach to young first-time mothers.

- **Provide fee waivers for institutional delivery for households below the poverty line, so as to ensure equitable access and promote maternal and infant health.** Link fee waivers to attendance at antenatal and post-natal classes, and provide information on contraception and support for and reporting of intimate partner violence in all sessions.

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A 17-year-old Jordanian boy in school © Nathalie Bertrams/GAGE 2025

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Gender and Adolescence: Global Evidence (GAGE) is a decade-long (2016-2026) longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit www.gage.odi.org for more information.

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