

# Adolescents in Jordan: health, nutrition and WASH

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**Authors:** Elizabeth Presler-Marshall, Nicola Jones, Sarah Baird with Agnieszka Malachowska

During adolescence – a time of rapid physical growth and change – young people need access to relevant health, nutrition, hygiene and sanitation related information, services and supplies. GAGE research found that much more could be done to improve adolescents’ physical health and help them develop the habits and patterns that will support good health over the life course.



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## GAGE research findings

Although our survey found that most adolescents (82%) reported good health, we also found reasons for concern. For example, sanitation-related illnesses are common, due to overcrowding in the camps. As a site manager at Azraq camp reported, *‘We had many cases of children (in the camp) going outdoors instead of using the toilets’*. Other concerns are gendered. For boys, substance use is a growing problem. Of older boys, 34% admitted to smoking cigarettes and 45% admitted to smoking shisha (a water pipe). Rates were highest for Jordanians (45% and 56% respectively). For girls, strict limitations on their mobility typically precludes physical exercise. Syrian adolescents also complained that health workers do not always listen to their complaints and were quick to dismiss concerns as psychological rather than physical. Our survey also found that adolescent nutrition is compromised. The average adolescent, regardless of nationality, lives in a moderately food-insecure household.



Nearly **one-fifth of** GAGE adolescents reported going **hungry at least once in the last month**.

Young people living in camps for displaced people, which have school feeding and free distribution of bread, fare markedly better than those in host communities and informal tented settlements. Our qualitative work highlighted concerns about diet quality. A Syrian mother in an informal tented settlement explained:

*My children eat only boiled potatoes ...*

*We only taste the fruit from the coupon [WFP food vouchers for refugees] and also the meat.*

Adolescents are not getting the information they need about sexual and reproductive health (SRH). Our qualitative research revealed that most mothers do not discuss puberty with their daughters until after they have begun menstruating. A Syrian mother living in an informal tented settlement explained: *‘I did not tell her about the period, this generation is taught by themselves, they teach each other, aren’t they working together? They know more than me.’* Boys also appear to receive very limited information. Their mothers reported being too embarrassed to discuss sexual topics with them and their fathers were dismissive. Finally, we found that adolescents have very limited knowledge about contraception and sex. Married girls often reported that they only learned about marital relations on their wedding day, and doctors noted that some pregnant girls did not know how they became pregnant. Less than half (44%) of married girls reported recognising a single form of contraception when presented with a list of methods.

## Makani programme effects

Although UNICEF Jordan’s integrated Makani programming is not explicitly aimed at improving adolescent health and nutrition, outside of making referrals, we found some evidence that it is doing so. For example, compared to non-participants, older boys who attend Makani are 19% less likely to smoke cigarettes and older girls are more than twice as likely to participate in a sport. We also found that while puberty education classes are rare, due to social norms that preclude open discussions of SRH topics, where classes are offered, adolescents and mothers are grateful. As a 14-year-old Syrian girl living in Azraq recounted, ‘I took a course at the Makani centre, called *The Woman and The Girl*, and they got us a female doctor so we could ask her anything’. Participation in Makani is also linked with higher adolescent health care uptake. Compared to non-participants, younger girls are 18% more likely to have sought care in the last year—although we note that this is a double-edged sword in a context in which the health care system is already stretched thin. Indeed, Makani staff noted that health care referrals for adolescents with serious health challenges were of limited value, due to backlogs. As a programme implementer from an informal tented settlement reported:

***‘There was a child aged 13 years. She was disabled and weak. We contacted some NGOs [non-governmental organisations] and told them about her story. Her situation is very hard. They said they will visit her. And they did visit her after a month. And they met her, and they did nothing so far. I am depressed for her.’***

## Programme recommendations

**Expand Makani health education classes for young people and ensure that they discuss nutrition, sanitation, basic self-care, substance use and puberty.**



**Develop and scale up, depending on context, female-only sports/physical recreation opportunities.**



**Continue and expand the *Nashatati* (‘My activity’) physical education programme in public schools and work to ensure that regular physical activity becomes a habit that young people take forward into adulthood.**

**Target parents—with a particular emphasis on outreach and engagement with fathers—for classes on substance use so that they can serve as good sources of knowledge and act as role models.**

**Work with the Ministries of Education, Health, and Youth to ensure that school canteens provide nutritious food and include free fruit.**

