


# Sexual and Reproductive Health Information and Experiences Among Syrian Refugee Adolescent Girls in Lebanon

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## Abstract

Providing adolescent girls with sexual and reproductive health (SRH) information protects them from risks and improves their well-being. This qualitative study, conducted in Lebanon, examined Syrian refugee adolescent girls' access to SRH information about and experiences with puberty and menarche, sex, marriage, contraception, and pregnancy. We gathered data through three focus group discussions (FGDs) with unmarried adolescent girls, 11 in-depth interviews with early-married adolescents, and two FGDs with mothers. Our findings highlighted that adolescent participants received inadequate SRH information shortly before or at the time of menarche and sexual initiation, resulting in experiences characterized by anxiety and fear. They also revealed discordance between girls' views of mothers as a preferred source of information and mothers' reluctance to communicate with their daughters about SRH. We advance that mothers are important entry points for future interventions in this refugee population and offer recommendations aimed to improve adolescent girls' SRH and rights.

## Keywords

sexual and reproductive health; adolescent girls; Syrian refugees; Lebanon

## Introduction

Adolescence is a critical phase of physical and psychological development that accompanies puberty and signals a transition into culturally prescribed and gendered social roles. It is a period of considerable curiosity and anxiety for young people who are undergoing numerous changes that they do not always understand. A life course approach emphasizes that restricting adolescents' access to accurate information about puberty and sexual and reproductive health (SRH) can compromise their transition to adulthood and lead to negative consequences that affect their well-being in early adulthood and beyond (Morris & Rushwan, 2015; Sawyer et al., 2012). The provision of comprehensive and accurate SRH information, as well as positive communication around puberty with adolescents, can positively influence adolescents' transitions to adulthood.

In low- and middle-income countries (LMICs) and among migrant communities in high-income countries, cultural prohibitions against discussing SRH are particularly damaging for unmarried adolescent girls, of whom a large proportion receive little if any information before

menarche (Chandra-Mouli & Patel, 2017; Hawkey et al., 2017; Salam et al., 2016). Adolescent girls living in situations of conflict and forced displacement in LMICs are particularly disadvantaged given their lack of access to school-based SRH programs and the disruption of family and friend networks through which girls access information around puberty and menstruation. At the same time, girls affected by conflict and displacement often face increased risk of early sexual initiation, marriage, and childbearing (Hutchinson et al., 2017; Neal et al., 2016), and therefore stand to lose the most from not receiving adequate information about sex, reproductive health, and contraception.

The aim of the present study was threefold: (a) to understand what information Syrian refugee adolescent girls in Lebanon receive about puberty and SRH; (b) to

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discern how this information shapes their experiences as they transition to adulthood; and (c) to identify the sources of the information received. The study addressed these aims through triangulating data from focus group discussions (FGDs) and in-depth interviews (IDIs) with unmarried and married adolescents as well as mothers of adolescent girls. Moreover, the study examined differences between adolescents' and mothers' perspectives of what information should be relayed about puberty and SRH, and by who, as well as discrepancies between adolescents' expectations and the reality of their experiences.

## Background

### *Adolescent Knowledge of Puberty and SRH*

Although adolescents in the Global South have increasingly been gaining access to formal education and exposure to new ideas through the internet and social media, evidence suggests that their knowledge about SRH remains low (Hindin & Fatusi, 2009). A systematic review of studies in Muslim-majority countries revealed that adolescents' knowledge is insufficient on most SRH topics, including puberty and menarche, reproductive anatomy and physiology, sexually transmitted infections (STIs), and contraception (Forsyth, 2018). Moreover, in sub-Saharan Africa, a substantial number of 12-year-old adolescent girls (65%) did not have any knowledge about menstruation, and more than half between 10 and 19 years of age had not heard of any STI other than HIV (Finlay et al., 2020).

Little is known about the SRH knowledge and behaviors of young people in the Arab region, where openness about sexuality is stigmatized and adolescents have limited access to SRH information and services (Obermeyer et al., 2015). Marriage remains a powerful institution in Arab culture and, while age at marriage is rising in most Arab countries, there are strong cultural and religious taboos against premarital sex, which has impeded research on the sexuality of unmarried youth (El Feki, 2015). The nascent literature on SRH knowledge among unmarried Arab adolescents comes from a few quantitative studies with school students from Egypt and several Gulf countries. These studies show that Arab adolescents do not have a good understanding of pubertal changes (Alqaiz et al., 2013; Jaffer et al., 2006) and that a considerable number of adolescent girls do not know about menstruation prior to menarche or the relationship between menstruation, sex, and pregnancy (Alqaiz et al., 2012; Hawkey et al., 2017; Roushdy & Sieverding, 2015). These studies further revealed that whereas a high proportion of adolescents identified HIV as an STI, much smaller proportions identified other STIs or could provide accurate answers about modes of transmission.

### *Sources of Information on Puberty and SRH*

Adolescents obtain information on SRH from a variety of sources, including school, parents, friends, and the internet.

*School-based SRH education.* School-based SRH programs are effective in delivering SRH knowledge and have been shown to reduce unintended pregnancies, abortions, and STIs among adolescents (Kivela et al., 2014). School years are also the ideal time to intervene to change attitudes and behaviors effectively for multiple reasons: SRH-related messages that are disseminated in school are tailored to the developmental age of adolescents; schools are valued by communities and considered a reliable source of information; and teachers are equipped with the skills and materials to facilitate learning, are trusted by students, and serve as role models for adolescents (Wahba & Roudi-Fahimi, 2012). Global evidence on the positive impact of curriculum-based sexuality education programs is strong, with a review of both school- and community-based sexuality education programs worldwide (29 from LMICs, 47 from the United States, and 11 from other developed countries) concluding that they were able to increase young people's knowledge and positively impact their sexual risk behaviors (United Nations Educational, Scientific and Cultural Organization, 2009). A systematic review of school-based sex education and HIV prevention programs from developing countries similarly found that these programs were effective in addressing multiple factors that affect sexual behavior, including knowledge, attitudes, norms, perceived risk, and self-efficacy (Kirby et al., 2006).

In the Arab region, coverage of SRH issues in school curricula is generally insufficient and progress on this matter remains uneven between countries (Roudi-Fahimi & El Feki, 2011). In Lebanon, SRH education was introduced into the national curriculum in 1997, in the form of lessons given at the middle and high school grade levels (Center for Educational Research and Development, 2020). However, curriculum coverage depends on students' academic track. In Grade 8, all students learn about HIV and its modes of transmission. In Grade 11, a full unit on reproduction, which includes the anatomy of the reproductive system, the menstrual cycle, pregnancy, contraceptive and abortion methods, and STIs is given to students majoring in humanities as part of their biology curriculum. The same unit is available as a booklet for students in the sciences track, but some biology teachers may decide against delivering it due to cultural taboos, presenting an obstacle to adequate school-based SRH education.

*Parents.* Another important source of information about SRH for adolescents is their parents. Studies indicate that

adolescents perceive their parents as a key source of SRH information (Nobelius et al., 2010). Adolescent girls specifically expect the mother to provide information on puberty and prepare them for menstruation (Teitelman, 2004). This is the case for adolescent girls in LMICs, including Syrian refugee adolescents in Jordan (Gausman et al., 2020; Sooki et al., 2016). Effective parent–child communication may help increase adolescents’ SRH knowledge, as well as their self-efficacy and interpersonal communication skills (including their sexual negotiation skills; DiClemente et al., 2001), and has been proven to protect from early sexual initiation among girls (Markham et al., 2010). Yet, even in cases when parents are willing to communicate with their adolescent children about sex, they identify barriers such as embarrassment and lack of information (Guilamo-Ramos et al., 2012).

Although parent–child communication around SRH matters can be highly beneficial, in the Arab region, adolescents predominantly live in communities where prevailing cultural norms create barriers to effective discussions around these topics (DeJong et al., 2007). Studies from Egypt, for instance, confirm that the role of mothers in preparing their daughters for puberty or as a source of SRH information is minimal, mostly for reasons related to a lack of mother–daughter communication (Ayed et al., 2016; Mohammed et al., 2017). Adolescents are often reluctant to ask their parents about SRH out of fear that parents may assume that they are sexually active (Ayed et al., 2016; DeJong et al., 2007). On the contrary, parents may lack sufficient knowledge about SRH or are too embarrassed to discuss these matters with their children (Ayed et al., 2016; DeJong et al., 2007; Roudi-Fahimi & El Feki, 2011). A recent qualitative study conducted with Jordanian and Syrian refugee parents in Jordan found that while parents acknowledged the need for parent–child communication around SRH matters, most did not feel confident or comfortable engaging in such discussions with their adolescent children (Othman et al., 2020).

**Other sources.** To fill gaps in SRH knowledge, many Arab adolescents rely on their friends, the media, or the internet for information. A study among adolescent school girls in Saudi Arabia found that 42% of participants discussed SRH matters with their friends but only 15.8% discussed them with their mothers (Alquaiz et al., 2012). In Oman, while mothers were the main source of information on puberty for adolescent girls, adolescent boys relied on sources outside the family, including friends (Jaffer et al., 2006). Similarly, a national survey in Egypt found that the most common source of information on puberty for youth (aged 13–35) was “friends, neighbors, and/or relatives” (41.1%), whereas family was cited by 26.5% of participants (Roushdy & Sieverding, 2015).

### *SRH Needs of Adolescent Syrian Refugee Girls in Lebanon*

While access to SRH information remains low among Arab youth, adolescent Syrian refugees are even further disadvantaged given the neglect of their needs in local responses to the Syrian humanitarian crisis (DeJong et al., 2017). In Lebanon, only 22% of 15- to 17-year-old Syrian adolescents are enrolled in secondary level (VASyr, 2019), which means that only very few are exposed to SRH information in school. Nongovernmental organization (NGO)–funded schools and programs—which proliferated following the displacement of Syrians into Lebanon (El-Ghali et al., 2016)—do not follow the Lebanese curriculum and hence it is impossible to know how many of them include sessions on SRH, the kind of information that they provide, and the reach of these sessions. Findings from a 2014 multiagency situation analysis indicated that less than 2% of a sample of 1,121 Syrian refugees aged 15 to 24 had received SRH information from teachers, health workers, or at an awareness session, and only 30% of boys and 41% of girls aged 15 to 24 had ever had somebody talk to them about SRH issues (Chahine et al., 2014). Qualitative findings from a study by DeJong and colleagues (2017) indicated that some adolescent Syrian refugees in Lebanon lacked basic knowledge about puberty.

Syrian refugee girls experience barriers to education differently from boys their age. After a period of educational disruption due to forced migration, out-of-school boys may engage in child labor (in economic sectors such as agriculture or construction), whereas adolescent girls and their families may resort to early marriage as a way out of poverty and insecurity (United Nations Children’s Fund, 2015). A recent systematic review on early marriage among Syrian refugees in Lebanon and Jordan found that physical protection, financial stresses, traditions and family expectations, and girls’ recognition of their lack of education and employment opportunities were important drivers of early marriage in this population (El Arab & Sagbakken, 2019). An early marriage prevalence study among Syrian refugees who live in Bekaa (Lebanon) found that 23.7% of 15- to 17-year-old girls were married (Abdulrahim et al., 2017); 61% of those married had at least one pregnancy and the majority of married 18- to 24-year-old Syrian refugee women (77%) were not using any form of contraception.

The high rates of early marriage among Syrian refugees are particularly worrisome given that very few adolescents have access to SRH information. Prevailing cultural norms in Syrian refugee communities dictate that it is inappropriate to give SRH information to girls who are not yet married (DeJong et al., 2017). On the contrary, early-married adolescents are expected to get pregnant

immediately following marriage irrespective of whether they are prepared to make informed decisions about their SRH (Cherri et al., 2017). In light of these realities, understanding what SRH information Syrian refugee adolescent girls receive and who they receive it from is an important first step in designing appropriate programs to delay marriage and protect the health of those who marry early.

## Method

### Study Design

The present qualitative descriptive study was carried out as part of an ongoing early-marriage community-based intervention among adolescent Syrian refugee girls in a town in Lebanon's Bekaa governorate. A pilot intervention was implemented in 2018 with 210 eleven- to fourteen-year-old unmarried school girls and was designed around interactive sessions on decision-making, empowerment, health and puberty, and early marriage. The pilot also invited the girls' mothers/female caregivers to discussion sessions that addressed girls' schooling, health, and puberty. In 2019, an expanded intervention was designed to include both married and unmarried adolescent girls irrespective of school attendance and to encompass a stronger focus on SRH. The study presented in this manuscript was carried out in 2019 to inform the content and mode of delivery of the SRH content of the expanded intervention. It was approved by the American University of Beirut's Institutional Review Board (IRB).

The design of the study is qualitative descriptive whereby data were gathered from participants through semi-structured FGDs and IDIs. Qualitative research is valuable in humanitarian settings as it can capture sensitive gender and SRH concerns that cannot be captured through quantitative research (Mahmood et al., 2010). Specifically, the qualitative descriptive methodological approach allows researchers to examine a phenomenon—SRH among Syrian refugee adolescent girls in this case—in its natural context while utilizing purposive sampling techniques and maintaining theoretical flexibility (Kim et al., 2016; Sandelowski, 2000).

### Recruitment and Study Participants

We recruited participants who fell into one of three separate groups: (a) 14- to 17-year-old unmarried Syrian adolescent girls; (b) 15- to 20-year-old married Syrian adolescents who married before age 18; and (c) mothers of 11- to 14-year-old Syrian adolescent girls who had participated in the pilot intervention. The mothers were not related to the adolescent participants. Unmarried and married adolescent participants were recruited through convenience sampling with the help of Syrian community

workers (CWs). The CWs initiated contact with the parents of potential participants below age 18, described the study, and obtained their tentative agreement to be contacted by the research team. Then, a research team member scheduled a family visit, during which she explained the study in detail and obtained the consent of one of the parents; Lebanese law requires parental consent for research with minors even if the minor is married. The research team member approached potential participants above age 18 directly to describe the study in detail and to obtain their consent. The consent of married adolescents and assent of unmarried participants were obtained shortly before data collection.

Mothers were recruited through a purposive sampling strategy. We intended to organize two FGDs, one with participants who attended more than half of the mothers' discussion sessions during the pilot intervention and one with participants who attended only a few sessions. A community research assistant contacted mothers and invited them to participate in an FGD to evaluate the pilot intervention and to discuss their views on providing information to adolescents about puberty and SRH. The first FGD proceeded as planned with eight participants. The second FGD, planned with mothers who attended only a few of the pilot sessions, was canceled due to low attendance. An alternative FGD was scheduled at a later date. The mothers' consents to participate in FGDs had been obtained at the time of their recruitment to the pilot intervention.

Unmarried and married participants belonged to the same community in which the pilot intervention was implemented but were older in age and had not participated in the pilot. Unmarried FGD participants all resided in informal tented settlements (ITSs); the majority was not enrolled in school with the exception of three. All but three married participants lived in an ITS. Their level of education ranged between no formal education and middle school; with the exception of one participant who was studying early childhood education in a technical school, all married participants were out of school. All FGDs were held in one of the ITSs. Most IDIs were held in the girl's home (six inside and two outside an ITS) and three were held in a community center. The first FGD with mothers was held in the home of one of the participants while the second was held in a community center. A symbolic stipend was offered to mothers as a gesture of appreciation for participating; no financial compensation was given to unmarried or married participants.

### Data Collection

Data were gathered through three FGDs with unmarried adolescents (five to seven participants per FGD), 11 IDIs with married adolescents, and two FGDs with mothers of

11- to 14-year-old girls (four to eight participants per FGD). We initially planned to conduct two FGDs and up to six IDIs with unmarried adolescents. However, after evaluating the quality of the data from the first two IDIs, where it was clear that unmarried adolescents were too embarrassed to talk to an adult in a one-on-one interview format, we decided to halt IDIs and gather data through FGDs only. A total of three FGDs were carried out. The FGD setting provided a less intimidating atmosphere that facilitated open discussion and the sharing of experiences around puberty and menstruation. As for married adolescent participants, data were gathered through IDIs, which are better suited to research requiring the elicitation of personal and sensitive information that cannot be shared in a group setting (Creswell, 2009). FGDs with mothers were planned as part of the evaluation of the pilot intervention. As the FGDs were delayed for logistical reasons and corresponded with the design phase of the expanded intervention, we amended the mothers' FGD interview guide to include additional questions on adolescent girls' SRH. FGDs were the preferred mode of data collection in this case because the intent was to capture an exchange of general views, rather than individual knowledge and experiences. All FGDs and IDIs were carried out by the manuscript's first author, who is a female in her late twenties with experience teaching biology to adolescent students in Lebanese public schools.

Data were gathered through three data collection instruments: (a) FGD guide for unmarried adolescents, (b) IDI guide for married adolescents, and (c) FGD guide for mothers. The adolescents' FGD and IDI guides integrated questions adapted from core instruments developed by the World Health Organization on young people's SRH (Cleland et al., 2001) and from other studies conducted in the Arab world (Alquaiz et al., 2012; Jaffer et al., 2006). We also added specific questions to gather structured data that clarify and build on informal notes compiled during the pilot.

The FGD guide for unmarried adolescents included a set of open-ended questions about what information they received about puberty and menstruation, their preferred versus actual source of information, and whether they felt the information received was sufficient to prepare them for menarche. We integrated into the FGD guide two vignettes about girls who are similar to participants in age and cultural background. Vignettes are qualitative data collection methods used in health and social research to explore potentially sensitive, controversial, or painful issues that participants might otherwise have difficulty discussing (de Rios et al., 2005). The first vignette was adapted from an Arabic toolkit on adolescent SRH by Save the Children that aimed to promote young people's appreciation of the importance of their right to receive SRH information from trusted sources (Ataya & Dakkash,

2012). The second vignette was developed by the research team based on the information gathered during the session on puberty delivered during the pilot intervention. The aim of this vignette was to understand why girls may not talk to their parents about some worrisome issues in relation to menstruation. The FGD guide did not include any direct questions about sex as it is taboo to discuss this subject with unmarried adolescents in the cultural context of Syrian refugees.

The IDI guide used with married adolescents included open-ended questions about sources of information about marriage, sex, pregnancy, and contraception. The guide also included questions about participants' personal experiences and their feelings and expectations when they were getting married and/or got pregnant the first time. Finally, the FGD guide for mothers included questions on what mothers liked about the pilot intervention, including the session on puberty, what information they would have liked to be addressed differently, and how they and their daughters may have been affected by the pilot project. The guide also included questions about what information mothers thought should be provided to adolescent girls about puberty, menstruation, and marriage, as well as who should provide this information and when.

### *Data Analysis*

All FGDs and IDIs were audio-recorded and transcribed verbatim in Arabic. Transcription and preliminary analysis were conducted in tandem, which allowed for continuous appraisal of patterns in the data. Following the completion and open-coding of data from three FGDs with unmarried adolescents and 11 IDIs with married adolescents, it was decided to halt further data collection as patterns and relationships began to emerge indicating theoretical saturation.

As recommended by Braun and Clarke (2006), we read the transcripts several times to immerse ourselves in the data. First, the transcripts were divided among the authors to code them individually and to prepare a summary of the findings. Coding was carried out using Dedoose (2018). Following the generation of a comprehensive list of open codes from all FGD and IDI data, the authors discussed the codes thoroughly and agreed on a list of themes that captured the most important findings. The themes were also examined in terms of how they fit together and jointly contribute to answering our research questions. For example, a theme from the girls' FGD data was linked to a theme from the mothers' FGD data to illustrate the divergent perspectives of the two groups of participants. As recommended by Morse (2015), we sought to enhance the rigor of the analysis and validity of our findings through multiple readings of the data,

engaged discussions among the authors during analysis, and constant verification and examination of biases during data interpretation. In the presentation of results, we include a parsimonious set of quotes that best illustrate the main themes and capture the essence of the findings overall, giving equal weight to all the FGDs/IDIs. The quotes were translated from Arabic to English by the authors.

## Results

We present the results of the study thematically, combining findings from the data gathered with unmarried and married adolescents, and mothers. We begin with a presentation and discussion of the information adolescents received on the topics of puberty and menstruation, sex and the “wedding night,” marriage, pregnancy and contraception, and how this information related to their experiences with their transition to adulthood. We then turn to participants’ views of sources of information on these different topics, including school- or NGO-based education, mothers, peers, and the media.

### SRH Experiences and Information

**Menarche.** Adolescent girls’ experiences with menarche varied and were shaped by whether they had received information on puberty and menstruation to prepare them. Girls who did not have previous knowledge of and did not anticipate menarche expressed negative emotions in relation with this event. They used terms like *shocked* and *scared* to describe their reaction upon the sight of the blood of their first period. Correspondingly, fear emerged as the most important theme regarding the experiences of unprepared girls:

P: I was outside the house [the first time I got my period]. I came back to tell my mom. My mom said: “why are you scared?” I was scared. She told me that what happened is normal.

I: You did not know about the period at all?

P: No.

I: How did you feel when you got your period [the first time]?

P: I was scared and flustered. I was afraid I was sick or something. (Unmarried adolescent)

My cousin was at school [the first time she got her period]. She came home but her mother was not there. My mother [her aunt] was and saw how her clothes were stained. She [cousin] was in Grade 4 and did not know anything [about

the period]. She came home crying and shaking and scared. (Unmarried adolescent)

Girls who had not heard about the period perceived menstrual blood as illness or injury. This contributed to their fear and worry and positioned menarche in a negative light. As revealed in the quotes, it was common for the mother to be the first person that participants went to for advice and comfort. However, a girl may get her first period outside the house—at school for example—and the mother may not be present when the girl needs her, which can potentially amplify feelings of distress.

By contrast, girls who were informed about the period were more psychologically prepared for menarche and viewed it as a normal event. They described their experiences in less negative terms. Those who had older sisters indicated that they learned about the period vicariously before they themselves experienced menarche. This helped reduce the sense of shock and fear that other girls in the study described:

. . . I did not know about the period. When my sister got her period, I came to know about it. And when I got my period, I felt it was normal. I was not scared or anything . . . My sister is only one year older than me. When my mother explained to her about the period, I was present. So I was not scared. (Unmarried adolescent)

Whereas the predominant reported narrative was that girls would seek their mothers’ advice upon getting their first period, participants’ accounts indicated that familial responses to menarche in the Syrian refugee community were quite diverse. Some girls worried about their family’s reaction and preferred to keep their periods a secret. Not understanding that menstruation is a normal physiological process, some girls were reported to feel anxious, embarrassed, or ashamed when they had their first period, and thus to go to great lengths to conceal this news from others. In extreme cases, a girl may even hide the news from her own mother, as revealed in the following short conversation between two unmarried participants in one of the FGDs:

P1: Some girls hide it. I mean, they get their period . . .

P2: . . . but they do not tell anyone.

P1: They are too afraid to tell their parents. Or maybe it is not fear, but still, they do not tell anyone about it.

P2: They do not like to talk about it . . . they are too embarrassed. (Exchange between unmarried adolescents)

As opposed to the narrative of fear and secrecy surrounding menarche, one study participant described how her

female family members celebrated when she had her first period, an uncommon reaction in Arab culture:

I've been getting my period for about seven years, I mean it is normal, I've been getting it since I was in Syria. I've always felt that the period is normal . . . [When I got my period the first time,] they [female family members] started ululating. I am the eldest girl in the family and I have an aunt who does not menstruate at all . . . so they started ululating because I reached puberty. (Unmarried adolescent)

The family's celebration promoted a positive and welcoming message around menarche, creating a different experience for the girl. The support that the girl received from her immediate circle led her to view menstruation as normal.

*Sex and the wedding night.* Across the interviews with married adolescents, it was evident that communication around the issue of sex constituted a very important part of their experiences with and their expectations of the wedding night. Regardless of whether the marriage happened following a romantic relationship with the husband or was arranged by family, girls who had the most unpleasant experiences were those who were not aware of the details of intimate sexual relations before getting married. When describing their wedding night and first experience with sexual intercourse, married participants who had not learned about sex evoked the fear, worry, and loneliness that they felt on that night. The fear and anxiety reported were attributed to lack of knowledge of the intimate details of marital sexual relations, and the misconceptions and mixed messages they had received oftentimes only a few days before their wedding. One participant, who was 14 when she married a young man with whom she had a romantic relationship, recollected how she had no idea what would happen on the wedding night:

I did not know what happens on the first night. I thought it would be hugs and kisses and that's it. When we went into the bedroom, he [husband] explained everything to me. I was shocked. We stayed up until the morning and he explained everything to me in detail. (Married adolescent)

The participant's account highlights the stark contrast between intimacy expectations and the details of sexual intercourse. She experienced shock but also fear that she would get hurt. In this case, the husband advised her to remain calm in order not to end up in a hospital, as she explained later during the interview:

[My husband] told me that girls who are not calm and who move [during sex] end up going to the hospital, so I should not get tense and remain calm in order not to go to the

hospital. . . He told me that [sex] will hurt and that I will bleed, but that it is normal . . . and that I shouldn't be afraid. (Married adolescent)

Other participants who had some knowledge about sex prior to getting married nevertheless still experienced fear around the event, in part due to mixed messages about sex that they had received in preparation for the wedding night. One girl who married her cousin at the age of 14 recalled her feelings of fear and anxiety about sex and being alone with the groom for the first time:

One woman would tell me that [sex] is not painful, another would tell me that it is, and another would tell me that I will enjoy it later. I remained silent. I just wanted to know what they were getting at. On the wedding day, the groom arrived [to the in-law's dwelling] and took a bath and prayed. I thought that my mother would spend the night with us, but she left. When she left, I got really scared. Everyone left and I was alone with [the groom] . . . I got really scared, being young and with a man for the first time. It was the first time a man touched me. (Married adolescent)

As with the participant quoted above, fear of sex as a result of inadequate preparation played an important role in transforming the wedding night into an unpleasant experience. The provision of information about sex shortly before or on the wedding day gave the girls little time to process it and prepare emotionally for physical intimacy. In contrast to the experience of the participant quoted above, adolescents who received information outside the time pressure of the upcoming wedding, and by a trusted source like the mother or sister, tended to be more accepting of sex as a "fact of life," although a link between adequate preparation and positive sexual experience was not evident from our data:

I reacted well [when my mother told me about sex]. I mean, I accepted it. Because it is a fact of life. My mother and I sat together [and had a conversation about sex]. It was good so that I would not get married without knowing anything. (Married adolescent)

*Marriage.* Beyond its intimate aspects, married participants' descriptions of their marriage experiences converged toward the theme of disconnect between premarital expectations and the realities of married life. While their reasons for marriage were diverse, participants shared the expectation that their lives would get better after marriage. However, marriage realities rarely met their expectations, oftentimes due to financial constraint:

I hoped to travel abroad with my husband. I hoped to travel, to have my own home, to be happy and go out with my husband, to the amusement park, and to have children. But

none of this [happened]. Now, if I want to go to the doctor, I cannot because we do not have money. (Married adolescent)

This account is an example of how the aspirations that participants attached to marriage were dissociated from their actual living situations, which were heavily shaped by the deprivations of living in displacement. Married respondents also expressed a general sense of unpreparedness for the gendered responsibilities and obligations of married life. Upon getting married, girls are expected to fulfill their duties as wives, housewives, and mothers regardless of their age and prior knowledge of these tasks. One participant who used to live in an unsafe region of Syria accepted a marriage proposal from her cousin in Lebanon in the hope that she would improve her life. While she was physically safe in Lebanon, as a married woman she now had to abide by “customs and traditions,” or the set of social responsibilities and obligations of married women:

There are customs and traditions [that a girl has] to abide by [after marriage]. Before I got married, I was carefree. But now that I am married, I have many obligations. For example, I have a child now. A child raising a child, so I don't know how to take care of him. If he starts to cry, I go to my mother-in-law to know what he wants, I do not know how to deal with him . . . I did not consider these things [before marriage]. I thought that if I get married I would get out of [the life I had in Syria]. [I thought that] my life would be better. (Married adolescent)

Participants who were warned by their parents about the responsibilities of marriage still underestimated the burden of domestic and child care duties. A quote by an early-married adolescent who dismissed her parent's warnings about marriage responsibilities is illustrative of how adolescents themselves understood that they were not mature enough to grasp what marriage entails in terms of obligations for both husband and wife and to assess their own readiness to shoulder marriage responsibilities before accepting a proposal. A participant who married at age 14 stated,

My parents told me that I should not get married . . . [my husband] was 21 at the time. They told me that I should not get married, and that [marriage] is a responsibility. But I did not listen to them. [At that age,] girls are not mature. When they get older and start to have a home and responsibilities, then they appreciate that what their parents told them was for their own good. (Married adolescent)

**Pregnancy.** Participants' experiences with pregnancy contrasted between those who got pregnant quickly and unexpectedly shortly after marriage and those who had difficulty conceiving or carrying a first child to term. Among the first group, participants' lack of information

around the biology of the menstrual cycle extended to a limited understanding of reproduction and the relationship between sex and pregnancy, which contributed to unintended pregnancy. A major theme that emerged from discussions around pregnancy experiences was participants' shock upon learning that they were pregnant because they did not think that it could happen so soon after becoming sexually active, indicating a lack of understanding of the relationship between sex and pregnancy. Moreover, participants who felt disappointed to learn that they were pregnant explained that they had planned to enjoy marital life before becoming restricted by the responsibility of taking care of a baby. Despite the cultural and religious taboo around abortion, one participant stated that she tried to terminate her pregnancy upon learning of an unplanned pregnancy:

When I came back from the doctor's, I tried to induce miscarriage. I lifted anything I could lift—the closet, the fridge, the bed—anything. But I was not able to miscarry. (Married adolescent)

After the initial shock, participants experienced a mixture of feelings during their pregnancy. On the one hand, they were worried about shouldering the responsibility of raising a child at their age and being able to provide for it. On the other hand, having a baby was perceived as a distraction from the participant's daily routine, and so was anticipated:

When I got pregnant, I began to worry about how I was going to raise the baby . . . I didn't know. I still do not know how to deal with my baby. If it is sick and starts to cry, I cry too . . . But I wanted to have a baby, I was happy but also scared. But I did want to have a baby to play with and to keep me busy. (Married adolescent)

A contrasting theme in terms of pregnancy experiences was the psychological turmoil experienced by participants who were unable to conceive within the first few months of marriage or could not carry their first pregnancy to term. Within the Syrian refugee community, pregnancy is expected and desired to happen soon after marriage, and so there is a lot of social pressure on newlywed girls to get pregnant quickly. These participants were eager to get pregnant as soon as possible and even sought medical advice after only a few months of trying. The following account illustrates the agony and torment a participant experienced until she got pregnant 7 months following marriage:

After I got married, it took me seven months to get pregnant. And my husband wanted to have a baby and I wanted to. My period was not regular and every time I was late I thought I was pregnant. I would get a pregnancy test but the result would be negative. Then I went to see a doctor and he told

me that there is a drop of blood but it is not clear whether there is pregnancy. Then I got my period and [my husband] would get upset because I was upset that I am not pregnant. He would try to console me and tell me that we are young and have our lives ahead of us . . . It took me seven months to get pregnant. (Married adolescent)

**Contraceptive use.** Married participants' experiences with pregnancy were also shaped by prevailing views of contraception in their communities. Social and cultural factors put pressure on newly married women to get pregnant soon after marriage, so the use of contraception before the first child is frowned upon even for those who would have preferred to delay their first pregnancy. Concerns about the effects of contraception on women's—and especially young women's—fertility contributed to the negative view of contraceptive use prior to having at least one child, as indicated by the following quote:

Here [in our community] they say that if a girl gets married young, she should not take contraceptive pills because they cause the ovaries to dry out . . . She should immediately have children, and then she can use contraception. (Married adolescent)

Although contraceptive use after the first baby is more socially accepted, fears and misconceptions about contraception, as well as negative experiences with the contraceptive pill, similarly discouraged use among married adolescents. This was true even among those who actively wanted to delay a second pregnancy after having their first baby. Some of these participants had experienced a difficult first pregnancy and delivery and wanted to delay repeating the experience for as long as possible. Others wanted to delay a second pregnancy to ensure that their full-time and physical energy were dedicated to raising their first child. Nevertheless, only one participant reported using condoms at the time of the interview; others were using withdrawal, breastfeeding, or no method at all. Participants expressed a reluctance to use modern contraceptive methods other than the male condom because of fears of side effects and impacts on future fertility. The two quotes below are illustrative of a predominant theme related to contraceptive use among married adolescents:

Many women advised me that the pill affects a woman's body. [After she stops the pill] it would take her long to get pregnant, and she might not be able to get pregnant at all. I mean if a woman took pills for seven or eight months, then it might take her two years to be able to have a baby. (Married adolescent)

They say that [contraceptives] are all bad. Pills do something to your nerves; they make you constantly nervous. They say that the IUDs should only be used after having two kids . . .

They say that if you put an IUD you cannot get pregnant anymore. And I hear that pills are not good. Even doctors say so. They're all bad. (Married adolescent)

Participants who had tried the contraceptive pill were also discouraged by their actual experience of side effects. They reported experiencing depression or feeling generally unwell while on the pill and had discontinued the method. In some cases, misunderstandings about the mechanisms of contraception also led participants to believe that they were ineffective. The combination of misinformation about and negative experiences with modern contraception led to a preference for withdrawal, which participants referred to as the "natural" method. Participants did not express any concerns about the efficacy of withdrawal and reported not receiving information about contraception from health facilities or sources other than their personal circles. In this context, complete and accurate information about contraception, its risks, benefits, and management of side effects was largely unavailable to them.

### Sources of Information on SRH

As in other LMIC and refugee contexts (Ivanova et al., 2018; Sooki et al., 2016), adolescent Syrian refugee girls in our study received information on SRH from a variety of sources. Although the mother was clearly the preferred source of information for both the married and unmarried, adolescents also received some information from schools and NGO sessions, and their peers. Yet, regardless of information source, there were clear gaps in adolescents' access to complete information about puberty, menstruation, and SRH.

**School and NGO sessions.** Unmarried participants who were still in school at the time of the study reported that they received information about puberty and the period during a biology class. However, the girls' description of such sessions revealed their inadequacy, both in terms of providing girls with accurate information and giving them space to ask questions. The quote below describes a common experience when an unprepared male biology teacher is tasked with the responsibility of teaching girls about puberty:

P1: [The biology teacher] explained a little. He said that when girls [reach puberty], they become mature. Girls grow armpit hair, boys start to have deep voice, girls get their period, boys . . . I forgot what he said . . .

P2: Here he got embarrassed and left the classroom to call the [female] teacher.

P1: And he told us to read the lesson at home.

P2: The lesson does not cover the topic in detail anyway. And that's all what [the teacher] told us. We were in grade 6 at the time. (Exchange between unmarried adolescents)

Girls also reported having been exposed to information about puberty and menstruation during sessions offered by NGOs. Although these sessions were described positively in terms of allowing girls to ask questions, they were critiqued for focusing on hygienic practices and providing little scientific information about female reproductive functions. Moreover, these sessions are oftentimes given to girls who have already reached puberty and began menstruating.

*Mothers.* Both unmarried and married adolescent participants viewed mothers as the best and preferred source of information on puberty, menstruation, and SRH concerns following marriage. Although unmarried participants acknowledged that speaking with their mothers about sensitive topics can be embarrassing, the data revealed a clear preference for the mother as a reliable source of information. Some participants described the mother as the go-to person in general but especially when an adolescent wants to know “what is right and what is wrong” (unmarried adolescent) when it comes to menstruation and other SRH issues. Furthermore, unmarried participants maintained that mothers often provided more detailed information to their daughters compared with school and are therefore a more reliable source:

I: Who should tell the girl about these things [issues related to puberty]?

P1: The mother preferably.

P2: The mother of course.

I: Not an older sister?

P1: An older sister.

I: Not someone at school?

P1: The mother explains better than someone at school. They don't explain things in detail at school. The mother explains the details. (Exchange with unmarried adolescents)

I: When it comes to obtaining information about women's reproductive health, who do you turn to when you have a question?

P: I would ask a doctor or my mother, who else!

I: Who do you prefer, a doctor or your mother?

P: If my mother does not know, then I would ask the doctor. (Exchange with a married adolescent)

Adolescents' preference for receiving information from their mothers did not match with reality as the mothers themselves reported that embarrassment and social taboos prevent them from communicating directly with their daughters about sensitive topics and that they oftentimes arranged for another female family member to provide this critical information. The narratives of unmarried adolescent girls in the FGDs revealed limited mother–daughter communication around puberty and menstruation. Oftentimes, a quick and superficial conversation took place around the time the girl got her first period. Girls reported that their mothers emphasized the relationship between menarche and maturity, and advised them on menstrual hygiene and how to manage religious duties when on their period. The mothers' accounts corroborated the girls' narratives, confirming that mother–daughter communication around the period lacks detail and focuses mainly on how a girl should manage religious obligations such as praying and fasting when she is on her period:

[The mother] does not tell you everything. She tells you what to do, how often to change the pad, when the period ends, and what to do when it's over, when to take a shower, what [prayer] to recite. These things. (Unmarried adolescent)

I didn't tell my daughter much when she got her period. I just told her about how long the period lasts, that it comes every month, and that during Ramadan she should break her fast [during the few days she is on her period] and make up for these days later. (Mother)

Mothers articulated several barriers to their ability to provide early and comprehensive information to their daughters about SRH. Embarrassment was a key barrier discussed. Moreover, social norms that prohibit open discussion about women's sexual and reproductive functions, even between mother and daughter, contributed to a generalized silence and a delay in relaying information about puberty and menstruation. Some mothers rationalized that they themselves were not given adequate information when they were young and were taught that speaking about certain subjects, for example, women's bodies and SRH, was wrong:

The mother is too embarrassed to discuss these matters; she feels that it is not acceptable. And our parents have taught us that it is not acceptable to talk about it, or that it is wrong. (Mother)

In light of these barriers, the mothers preferred that someone else talk with their daughters about SRH matters.

They expressed a favorable view toward scientific sessions offered in schools or by NGOs and mentioned the aunt as a trusted and empathetic source for relaying information to girls at the time of menarche:

When my daughter found out about the period [during one of the pilot intervention sessions], she was shocked. She came home all blushing, she told me that she was scared . . . I told her that it happens to all girls, and I got her aunt to explain things to her because she can convince her. Her aunt explained everything to her and thankfully she is feeling much better about it now. (Mother)

In contrast, aunts were never mentioned as a preferred source of information by unmarried adolescents. In fact, in one FGD, adolescent participants explicitly said that they would not like to have this conversation with their aunts. The discordance in mothers' and daughters' views on the preferred role for mothers in conveying information about puberty and menstruation is particularly important in light of the role that information played in shaping girls' experiences.

The findings on mother–daughter communication about marriage and “the wedding night” highlight similarities, in that the conversation revolved around cultural and social aspects of marriage only. Oftentimes, the mother merely tells her daughter that the marriage institution will change her life and require her to commit, take responsibility, and respect her husband and in-laws. The following quote from an interview with an adolescent who married her cousin at age 14 demonstrates how young prospective brides are “sent off” by their mothers with advice on how to respect and obey the husband but little else about other aspects of marriage:

When I got engaged, my mother told me: “you have to commit. You must accept everything your husband tells you. You made your decision.” When I was at my parents' house, I used to be stubborn. My mother told me that I could not stay like that; I should do as [my in-laws] ask. (Married adolescent)

In the private setting of the IDIs, married participants often confided that they wished they had received advice from family about the sexual, emotional, and intimate aspects of marriage, or what one participant referred to as “how a husband should treat his wife.” Although young married adolescents identified the mother as the most trusted source of information about SRH after marriage, they mainly obtained information about sex and what to do on their wedding night from an older sister, friend, or even the husband due to lack of communication with their mothers around this topic.

Mothers agreed that prospective young brides should learn about sex from a trusted source before their wedding night and to be given ample time (e.g., a week) to get

over the shock and prepare for sex. However, they believed that, as the mother is a figure of authority, she is less suitable than other female family members in discussing issues related to intimacy and sex. Embarrassment and the nature of the mother–daughter relationship were two reasons provided by mothers themselves as to why the daughter would not agree to talk about sex with her mother:

When the girl is getting married, the mother might send relatives like an aunt or the girl's cousin to talk to her, and then after she gets married, the doctor gives her information. It is better that she learns from someone other than the mother, because she might be embarrassed if she learns about it from her mother. And maybe because the mother disciplines and scolds her daughter, [the girl feels that] the mother might not accept to talk about marriage. This is why the mother is not accepted [as a source of information]. (Mother)

**Age-mates and the internet.** Unmarried adolescents sought support and information from each other on topics related to menstrual symptoms, whereas married adolescents turned to sisters, cousins, and friends for detailed information and advice about sex. In a context where it is taboo for adolescent girls to ask questions about sex, age-mates, particularly sisters and cousins, provide a confidential and trusted source of information about sex to a curious unmarried adolescent:

Before I was married or engaged, I asked [my cousin] to tell me about [sex]. So she told me everything and she told me about what happened with her [on the wedding night] . . . I did not tell my mother because it is not acceptable for [unmarried] girls to talk about these things . . . But I got curious about what happens, so my cousin told me a little bit and my mother [later] gave me the rest of the information. (Married adolescent)

On the contrary, the internet was not perceived as a trusted source of information about SRH matters among adolescent participants in the study despite the fact that they reported spending long hours on their mobile phones browsing social media. Unmarried and married adolescents invariably stated that they do not look for information on the internet. Moreover, mothers held negative views of the internet and did not trust it as a good source of information for their daughters:

It is okay if girls learned scientific information [about menstruation and fertilization] in grade 9. But you cannot trust the internet, it contains educational things but also non-educational things. The book is better than the internet. (Mother)

Married adolescents were similarly skeptical of information posted on the internet but reported that they begin to browse it after getting pregnant for videos on the

development of the fetus in-utero or the process of giving birth. Other than watching videos, married adolescents relied primarily on information from their mothers or medical professionals only when the mother did not have an answer.

## Discussion

This study examined the SRH knowledge and experiences of Syrian refugee adolescent girls and the sources of information available to guide them through these experiences in a context of strong sociocultural barriers to effective SRH communication. Our findings indicate that adolescents do not receive sufficient information about puberty and SRH and have many misconceptions about menstruation, sex, pregnancy, and contraception. Inadequate knowledge leads to fears and negative experiences with menarche and sex. Although the transition to adulthood is challenging for all adolescents, it is particularly difficult among Syrian refugee adolescent girls who drop out of school at a young age and therefore do not receive even the limited SRH information that is usually offered in school.

Our findings are consistent with studies in nonhumanitarian settings in the region and other LMICs in showing that adolescent girls receive little information about puberty and menstruation prior to menarche and that only a small proportion know of the physiological changes associated with puberty for boys and girls (Alquaiz et al., 2012; Chandra-Mouli & Patel, 2017; Jaffer et al., 2006; Roushdy & Sieverding, 2015). Also consistent with findings from other LMICs (Gausman et al., 2020; Sooki et al., 2016), our young participants perceived mothers as a trusted and preferred source of information about menstruation and SRH issues. However, embarrassment and sociocultural factors hindered effective mother–daughter communication as mothers tended to avoid these important conversations by relegating them to female relatives. Similar findings were reported in a recent study in Jordan, in which both Jordanian and Syrian refugee mothers expressed discomfort with communicating SRH information to their children due to what they described as a “culture of shame” and opted to rely on relatives and religious figures (Othman et al., 2020). Similarly, in studies carried out in Iran and India, parents identified barriers to SRH communication, such as embarrassment, lack of information, and beliefs that talking about SRH within the family is not appropriate (Guilamo-Ramos et al., 2012; Merghati-Khoei et al., 2014).

We therefore found considerable discordance between mothers’ views and practices with regard to SRH communication with their daughters and what adolescent girls wanted from their mothers. Mothers focused their communication with their daughters on religious rituals and

social aspects of puberty and marriage, and rarely if ever broached the subjects of intimate or sexual relations, pregnancy, or contraception. This is not uncommon as, even in the context of the United States, mothers of adolescent girls find it challenging to provide developmentally appropriate information to their daughters and revert to cultural scripts or focus on practical issues with little reference to SRH (Teitelman, 2004). Adolescent girls, by contrast, spoke about their mothers as their desired go-to source for information and support following menarche and before and after marriage while acknowledging that the information they received from their mothers in reality was not necessarily complete. This discordance in views, and lack of quality mother–daughter communication, contributed to adolescent girls’ anxiety around menarche and first sexual experience. Importantly, lack of open mother–daughter communication may also discourage adolescents from disclosing important health and protection issues such as menstrual problems or sexual violence.

Throughout our study, the theme of expectations conflicting with reality was prominent in discussions around marriage, pregnancy, and raising children. Discordance between expectations and reality following marriage was expressed irrespective of whether the respondent entered into an arranged marriage or married someone with whom she had a romantic relationship. Adolescent girls expected marriage to make their lives better but were shocked by the weight of the gendered responsibilities they faced upon marriage. Those who had hoped to improve their economic conditions through marriage continued to live in poverty and became mired in disappointment. In juxtaposing these findings with the prevalent discourse on early marriage as a coping mechanism against poverty (Cherri et al., 2017; Mourtada et al., 2017), one discerns a contradiction between what parents believe is better for their adolescent daughters and what the daughters experience in reality. In addition to disappointing economic realities, adolescent girls were expected to bear children shortly after marriage. Studies in other cultural contexts have shown a similar pattern of discrepancy between what young married women expect and what occurs in reality, particularly with respect to pregnancy planning (Tinago et al., 2018). Combined with their limited understanding of the relationship between sex and pregnancy, and prevailing norms against contraceptive use, married Syrian adolescents end up with little agency in terms of planning their pregnancies.

Another key theme across our findings was the degree to which social norms filtered the information received by adolescents around SRH topics. Parent–child communication around SRH conveys values and expectations in addition to information (Othman et al., 2020). Our findings suggest that this is true not only in terms of the information that is provided to adolescents but also in the

information that is not. Information that adolescents received about SRH topics, particularly from mothers and family members, focused on the sociocultural and religious dimensions of key milestones such as menarche and marriage. In these discussions, the more intimate and emotional aspects of these major life transitions appeared to be largely left out. Adolescents were therefore unprepared for experiencing these dimensions of their transitions, and an intergenerational pattern of framing sex and intimacy as “shameful” to talk about was perpetuated. Another example of how norms shaped the provision and interpretation of SRH information within the study communities was around contraception. Many of the negative views expressed around modern, specifically hormonal, contraceptive methods were framed in terms of fears for women’s future fertility, in a context where early childbearing is highly valued.

There are several limitations and strengths to this study that are worth noting. First, our FGDs with unmarried participants included only a small number of participants who were currently enrolled in formal education. It is likely that if more respondents had been continuing their education, they would have had more experience with curriculum-based learning around SRH. Second, all of the mothers who participated in our FGDs had at least one adolescent daughter who was attending school. They are therefore likely to be different than the mothers of the adolescents who participated in the study, both socioeconomically and in terms of their views on adolescent SRH. Finally, cultural factors limited our ability to probe on certain sensitive SRH-related issues, such as sexual assault, or explicitly asking about the link between missing a period and pregnancy during FGDs with unmarried participants. On the contrary, our data collection methods responded to the realities encountered when researching a sensitive topic with an adolescent population. For example, we adopted vignette-based data collection tools in FGDs with unmarried participants to encourage them to talk about puberty in a one-on-one setting. To the best of our knowledge, this study is the first to explore in depth the experiences of adolescent Syrian refugee girls with important SRH milestones, including menstruation and sex. Despite the fact that numerous studies have identified the mother–daughter relationship as key to adolescent girls’ experiences with puberty, ours is one of a few to compare mothers’ and daughters’ perspectives on communication around puberty in an LMIC and specifically among a refugee population.

### ***Recommendations for Future SRH Programs and Conclusion***

The present qualitative study was carried out to inform the design of an early-marriage intervention that has a

strong focus on enhancing adolescent girls’ access to SRH information and services. First and foremost, we advocate for the full inclusion of refugee children in formal schooling in Lebanon where they learn about reproductive systems and functions. Meanwhile, the role of parents is important to strengthen in SRH programs that aim to improve refugee adolescent girls’ SRH and rights. Evidence suggests that supporting parents to improve the quality of communication with their children about puberty and sexuality improves adolescents’ ability to challenge cultural norms, make informed decisions, and avoid risk (Svanemyr et al., 2015).

We offer the following recommendations to improve the quality of future SRH programs with adolescent girls in refugee settings. First, programs should engage with mothers and invest in enhancing their basic knowledge of SRH and communication skills. Based on our findings, mothers are important entry points in the provision of accurate and timely information about puberty, menstruation, sex and marriage, and pregnancy and contraception. These efforts would require enhancing the competence of mothers to challenge social norms that prohibit communicating with unmarried adolescents about SRH. Second, programs should emphasize that the mothers’ role is not limited to providing information about the physical and cultural aspects of puberty and marriage but to also address the emotional, cognitive, and intimate facets of transitioning into adulthood. Socializing adolescent girls to recognize their emotional needs and rights before and after marriage is also an important step toward empowering them. Third, as our study revealed that Syrian refugee adolescents used the internet for entertainment but not to obtain SRH information, and mothers were wary of using it by unmarried adolescents, internet-based SRH interventions should be carefully tested for their cultural acceptability and usability prior to scale-up. Finally, intervention programs should also aim to address the many misconceptions related to contraceptive use that discourage young married adolescents from using family planning methods, as well as encourage young women to seek counseling to understand the possible side effects of each method and make informed decisions.

In a context of displacement where girls’ risk of early marriage is high, withholding SRH information deprives them of the ability to make informed choices that affect their health and well-being throughout the life course. Expanding choice is a prominent theme in conceptual writings on women’s and girls’ empowerment, with education promoted as a human capital resource that enables the enactment of these choices (Kabeer, 1999; Stromquist, 2015). The lives of refugee adolescent girls in our study are constrained by material hardship and social norms that promote a culture of silence around puberty and sexuality. Furthermore, these girls’ limited access to formal

schooling restricts their acquisition of systematic SRH information and the use of this information to make informed choices that affect their lives. Because refugee girls drop out of school at a young age, they are deprived of learning about basic biological aspects of menstruation and the relationship between sex and pregnancy, let alone discussing in a structured setting the cognitive and emotional aspects of transitioning into adulthood. This loss is detrimental to their ability to enact reproductive choice, which has been recognized since the International Conference on Population and Development of 1994 as an important contributor to improved maternal and child health (Center for Reproductive Rights, UNFPA 2013).

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