

Parent–child communication about sexual and reproductive health: perspectives of Jordanian and Syrian parents

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Abstract: *Young people throughout the world face considerable challenges related to their sexual and reproductive health (SRH). The parent–child relationship is fundamental to shaping children's trajectories through adolescence and suggests considerable potential to improve youth SRH knowledge. Lack of parent–child sexual communication (PCSC) may cause youth to turn instead to questionable information sources, such as peers, the internet and social media. The limited research in this area, and specifically in the Middle East, led us to explore how parents discuss SRH issues with their children and pinpointed the potential role for parents in supporting their children's SRH needs. A qualitative research approach was used, with 20 focus groups stratified by nationality and sex of participants from four major communities in Jordan. Thematic coding and analysis was used. Parents described their willingness to “break the culture of shame.” Three primary strategies emerged: (1) the gender match, (2) mothers as a safe space and (3) seeking help from others, which included two sub-themes: incorporating others, and relying on the delivery of SRH information in schools. Strengths and challenges were inherent within each strategy, and discussion topics varied according to the strategy used. Evidence from this study provides an opportunity for future research and programming to improve adolescent health outcomes within conservative milieus to break the intergenerational cycle of shame. Interventions are suggested to target parents' knowledge and self-confidence to help youth achieve their sexual development. Using gender-matched PCSC strategies, school-based platforms and religious institutions are ways to destigmatise such topics. DOI: 10.1080/26410397.2020.1758444*

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Introduction

Youth throughout the world face considerable challenges related to their sexual and reproductive health (SRH). In resource-poor countries, the obstacles preventing a healthy transition to adulthood are the highest, placing youth at an increased

risk of sexual and reproductive morbidity and mortality.¹ In some countries, social and cultural norms may also create other barriers that prohibit youth from obtaining specific and timely SRH information and services.² Many young people approach adulthood faced with conflicting and

negative messages pertaining to their SRH that are often exacerbated by embarrassment and silence from adults, including parents.

The parent–child relationship is fundamental to shaping children’s trajectories through adolescence.³ Studies that examine the attributes of the parent–child relationship generally focus on three main domains: parental support (connectedness), control (regulation), and parent–child communication.⁴ Parent–child sexual communication (PCSC) is one of the most important ways in which parents influence their children’s SRH attitudes and behaviours, using it as a means to educate while also transmitting values, beliefs, information and expectations. Youth who have open communication with their parents on SRH have been found to initiate sexual activity later and to exhibit safer sexual behaviour through the use of birth control and condoms.^{5–9} A lack of PCSC may cause youth to turn instead to questionable sources such as the internet, to their peers or via social media for SRH information.¹⁰

Parents often believe that they should be their children’s primary source of SRH information;¹¹ however, many parents do not talk about important SRH topics with their children before their sexual debut.¹² The barriers that parents face in PCSC include having poor and inaccurate information regarding SRH, feeling discomfort or a lack of confidence in talking about sex and sex-related issues, and underestimating their children’s readiness to discuss SRH issues by thinking that they are too young.^{13–16} Youth often avoid talking with their parents about SRH-related concerns due to embarrassment and fear of a negative reaction or punishment.¹⁷ In addition, the perception among parents and children about the quality or frequency of the communication may differ. A recent study found that while most parents reported discussing SRH issues with their children, a much smaller percentage of children reported discussing such issues with their parents.¹⁸

The research on PCSC in the Middle East is very limited but, given the cultural emphasis placed on the centrality of the family unit across much of the region, interventions with parents have been identified as having considerable potential to improve SRH knowledge among youth.¹⁹ A few studies in Jordan, Saudi Arabia, and Egypt have found that parents are often young people’s preferred source of SRH information,^{20–22} but no studies were found that focused on parents’ perspectives. In Jordan and Saudi Arabia, low parental

knowledge of SRH issues appeared to be transmitted to their children. In Saudi Arabia, parental educational attainment was associated with girls’ SRH knowledge, so that the children of parents with lower educational attainment had poorer SRH knowledge.²³ In Jordan, youth who reported receiving HIV-related information from their parents or health centres had a lower level of knowledge than those who reported receiving information from informational materials (book, magazines, the internet, etc.) and those who received information from teachers.²⁴ Another study in Jordan highlighted that while youth want their parents to be a trusted source of SRH information, they recognise the limitations of their parents’ knowledge, and do not believe that their parents are well equipped to have such discussions.²⁵ Further, they are afraid of their parents’ potential negative reactions that may be fuelled by their limited SRH knowledge.²⁵

Given the lack of research in this area, the goal with this study was to describe how Jordanian and Syrian parents discuss SRH issues with their children with the purpose of pinpointing the potential role for parents in supporting the SRH needs of their children. Specifically, we examined: the SRH topics that parents report discussing with their adolescent children; the strategies parents use in discussing SRH strategies with their adolescent children; and the strengths and difficulties associated with the different strategies used by parents.

Research design and methodology

To accomplish our research objectives, we used a qualitative research approach and focus group discussions (FGDs) to collect data. Given the limited existing research in this area, FGDs were selected in order to engage participants in debate during data collection so as to understand a multitude of viewpoints.

Study setting and population

The target population for our study included Jordanian and Syrian parents (mothers and fathers) of youth aged 15–19 years old, who were residing in Amman, Zarqa, Irbid and Mafraq cities, in the northern and central regions of Jordan. Given the ongoing war in Syria, Jordan is home to more than one million Syrian refugees,²⁶ of whom only 16% live in official camps.^{27,28} More than 30% live in the capital, 30% in Irbid, 16% in Mafraq and 14% in Zarqa; thus, we focused the geographic

scope of our research on these cities. The participants for this study were recruited by convenience from local community centres that provide health and livelihood programmes to underserved youth and are run by a local, non-governmental organisation active in community development.

Data collection

FGDs were stratified according to national origin and sex of the participants to obtain adequate representation. Over a period of three months (December 2018–February 2019), a total of 20 FGDs were concurrently conducted with parents. At least four FGDs were conducted in each community with the following demographic groups: (1) Syrian fathers, (2) Jordanian fathers, (3) Syrian mothers, and (4) Jordanian mothers. We believed that FGDs were the most appropriate methodology in order to encourage active discussion about key issues among participants.²⁹ Parents participated in one single focus group. Each focus group consisted of 5–6 parents and lasted between 30 and 60 minutes. The FGDs were held at the community centres in a private room. Given that SRH is an uncommon topic to discuss, each FGD was started with a warm-up in which participants were asked to discuss how they define SRH. To ensure a common basis for discussion, this was followed by the facilitator presenting a definition of SRH obtained from UNFPA, as follows:

“Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.”³⁰

Following the warm-up, discussions were focused on probing parental answers related to their willingness to discuss SRH issues with their children, parents’ previous attempts to open such discussions, perceived challenges and how they could be supported to provide SRH information to their children.

FGD facilitators were selected from among the existing staff at the community centres where recruitment occurred. So that the study could gain community support and trust, the facilitators were members of the local community. The facilitators were gender-matched with study participants to ease communication around sensitive SRH issues and for cultural appropriateness. All

FGD facilitators participated in trainings specifically tailored to their role in the study, which focused on familiarising them with research ethics, principles of qualitative data collection, and the study procedures and instruments. During the training, facilitators had the opportunity to practice data collection methodologies in role-playing exercises.

All FGDs were audio-recorded and transcribed in the English language by a bilingual transcriber. For quality assurance purposes, researchers examined 25% of audio files to ensure both facilitators’ adherence to the interview guide and quality of transcription. Feedback was then provided to facilitators on an ongoing basis in order to ensure that the FGDs were conducted in a manner consistent with the protocol and study objectives.

This study was approved by the Institutional Review Boards at the Harvard TH Chan School of Public Health and the University of Jordan. All participants gave informed consent and all data was anonymised. Given the sensitivity of the topic, data collection activities occurred in community centres where youth and parents regularly participate in events on a variety of topics, such as livelihoods training, education, community discussions, etc. Thus, the participants’ presence at those sites would not attract any undue attention within their communities.

Data analysis

The process for data analysis was iterative and reflexive in order to better understand the data from an emic perspective while remaining cognisant of the perspectives of the outside researchers.³¹ We ensured validity by obtaining thick (a lot of data) and rich (many layered) data. Establishing trust and rapport between the participants and the facilitator was vital to achieve this. Working through community health centres, in addition to having FGD facilitators who were already part of the community centres, provided a strong platform to enhance the validity of our findings, while avoiding unrealistic and fabricated data.

We used a thematic coding process to analyse our data. We began the analysis by developing *a priori* codes to be applied as a means of organising text for subsequent interpretation based on the interview guides. The first five FGDs were coded independently by two Jordanian researchers and one international researcher to enhance reliability of the coding. After the initial coding process, a new codebook was developed based on emergent

themes, and data were recoded using the new codebook to ensure that the results remained grounded in the original data. The use of multiple coders also allowed for identification of initial themes. Finally, themes were revised during an iterative process of revisiting the data until the themes were fully saturated and data-based.

Results

Participant demographics

Demographic characteristics of parents are illustrated in Table 1. The sample for this study consisted of 90 mothers and fathers that were equally distributed from across the four study communities, Amman, Irbid, Zarqa and Mafraq. Most of the participants were more than 36 years old (81.1%) and had secondary education or less (85.5%).

Results from focus group discussions

Several themes relating to PCSC emerged from the data. Parents described wanting to use PCSC as a tool to “break the culture of shame”. In discussing PCSC, three primary strategies emerged: (1) gender match, (2) mothers as a safe space and (3) seeking help from others. The strategy “seeking help from others” included two sub-themes: (1) incorporating others and (2) relying on the delivery of SRH information in schools. Participants identified strengths and challenges inherent within each strategy, and the SRH topics that parents discussed varied according to the strategy used.

Break the “culture of shame”

A key theme that emerged throughout the FGDs with both mothers and fathers was that PCSC was a tool that parents of adolescents could use to break what they called “the culture of shame” that “makes most parents shy away from telling their sons\daughters what they have to teach them”, as pronounced by a Jordanian mother from Amman. Further, as described by a Jordanian father in Zarqa, strategies used by parents should “break the obstacle of shame [in order to] make youth feel like they are able to tell their parents anything that they face”. As one Syrian mother from Irbid described, “I always make sure to make my daughter feel comfortable when she talks to me, she is honest with me, and she tells me what goes on with her especially on the way to school”.

Table 1. Demographic characteristics of parents ($n = 90$)

	Frequency (% ^a)
Location	
Amman	20 (22.2)
Mafraq	24 (26.7)
Irbid	23 (25.6)
Zarqa	23 (25.6)
Gender	
Male	47 (52.2)
Female	43 (47.8)
Age^b	
26–35	15 (16.7)
36–45	56 (62.2)
more than 45	17 (18.9)
Education^b	
9th grade	29 (32.2)
10th grade	12 (13.3)
11th grade	8 (8.9)
12th grade	12 (13.3)
College	16 (17.8)
University	10 (3.3)
Nationality^b	
Jordanian	46 (51.1)
Syrian	43 (48.9)
^a Valid percent	
^b Values do not add up to 90 because of missing data	

Gender match

In general, fathers indicated that they primarily discuss SRH topics with their sons and mothers most often discuss such issues with their daughters. One Jordanian father from Amman said, “I discuss things with my son, but I think my daughter would be ashamed to talk to me about [these issues, so] her mother talks to her”. A Syrian mother from Zarqa confirmed “it is easier to talk to a female because she is close to you, for males it has to be their father who discusses such topics”. Another Syrian mother from Amman added “I tell my daughter everything, but I can’t talk to my son. I ask my

husband to talk to [him]”. Parents stressed that gender mismatch is a significant obstacle that hinders parent–child discussion. A Jordanian mother from Irbid said, “*when I talk to them about such things, I still feel shy*”. Similarly, another Jordanian mother from Amman explained “*let his father ask him. A son might be too ashamed to tell his mother, so the father has to step in and ask him and give him advice. He might as well take advice from the father ... better than the mother*”. This sentiment was echoed by a Jordanian father from Irbid who said that, “*as a father you can’t discuss such things with your daughter, her mother has to*”.

Discussions between mothers/daughters and fathers/sons were primarily focused on basic needs related to puberty and self-care practices, such as hygiene. Both Jordanian and Syrian mothers freely explained how they were able to discuss pubertal changes with their daughters. A Jordanian mother from Irbid mentioned “*when my daughter got her period for the first time, she was crying because it is a new thing to her, I taught her what to do and how to clean herself*”. A Jordanian woman from Irbid said in reference to discussing certain issues with her daughter who is in the sixth grade: “*I feel comfortable not shy when I talk to her and I tell her about the changes that will occur to her body and how she should deal with them*”.

Safety from sexual violence and harassment were also described as being of critical importance in gender-matched parent–child discussions. Parents emphasised even starting such discussions at very young ages as early as 6–7 years. A Jordanian father from Amman mentioned in reference to conversations with his son,

“Most of sexual harassment cases [involve] the supermarket owner, the janitor at the school, the vegetables shop owner, or their older friends in school ... especially the ones who have failed classes because they are close to youngest children. If they don’t understand, they might think that the [sexual harassment] is a game, but [we discuss it] so that they know to scream so no one can harm them.”

A Syrian mother from Mafraq also advocated, “*you have to give her advice when she tells you something, for example if she says that boys verbally harassed her on the way back from school, you have to advise her*”.

Mothers as a safe space

Although gender match was a dominant theme in describing strategies for PCSC, some mothers

described feeling as though they were considered to be a “safe space” for their sons. Some mothers described being able to broach topics about puberty with their sons, even if it was perceived as embarrassing, despite most study participants indicating it was the father’s job to discuss such sensitive topics with their sons. A Syrian mother from Irbid mentioned that:

“my son is 14 years old. He likes to ask questions like: why do I have this pimple? Why is my mustache growing? Why don’t I have friends? He even asks me about his body. I tell him it’s normal because he’s growing up and he replies with a question; how long will I be growing? To what age? How tall am I going to be? Why does my chest look like this? He asks me because he is too embarrassed to ask his father”.

On some topics, mothers described either shying away from discussion, or asking fathers to take the lead. One Jordanian mother from Irbid was able to tell her son that “*there are bad things on the internet that he shouldn’t be watching ... and that watching such things may lead him to do things that will have a bad effect on him and his health in the future,*” yet she wasn’t able to discuss other issues with him. For example, she preferred to refer him to his father to explain issues around sexuality with him, saying, “*because I’m too shy to talk to him about sexual matters*”.

In general, mothers had more experience in discussing SRH issues with their children than fathers. Mothers perceived themselves both to be better prepared and more approachable by their children. As a Syrian mother from Irbid explained, “*sometimes kids go to their mother more than their father because their father yells at them as soon as they start talking*”. A Syrian mother from Zarqa expressed that “*fathers can’t connect well with their children on such topics because the child is a teenager, and they are not easy to talk to. Fathers don’t accept that*”. She continued by adding that “*mothers tend to attend sessions and such things more [often than fathers], so when there is an awareness-raising activity [in the community] about sexual maturity, she asks [questions] and learns to be able to talk to her children*”. Another Syrian mother from Zarqa continued the discussion by agreeing that mothers can be easier to approach about SRH issues “*because [fathers] don’t have enough information and they lack the skill of managing a conversation with their sons*”.

Seeking help from others

In general, PCSC was described as being challenging by both mothers and fathers. Parents said that they sometimes would draw upon other resources outside the immediate family to help them break the “culture of shame”. Parents described relying primarily on relatives and religious figures, while advocating for teachers to offer SRH information in the school setting. For some parents, involving an aunt or an uncle was used as a mean to avoid embarrassment around the sensitivity of some issues. *“There are things they might not receive from me as a mother so I used to tell my sister to explain things to them”*, offered a Jordanian mother from Irbid.

One father from Zarqa said that he is not willing to have a discussion with his son about SRH issues and *“would rather someone else to talk to him because I don’t want to embarrass him”*. Similarly, another father from Amman suggested this approach to help parents who *“are ashamed to talk to their children ... so they can ask an uncle for help with boys, and with girls they can ask an aunt to talk to her”*. A Jordanian mother from Zarqa suggested:

“if the father isn’t able to discuss [SRH issues with his son], [the son] can get information from the older brother or maybe an uncle, but someone who is close to the family, who is trustworthy, and cares about your child”.

Engaging religious figures and institutions was perceived by parents as an important strategy to overcome the shame in having SRH discussions. A Jordanian father from Zarqa testified that *“there is no shame [regarding SRH] in religion, but you have to talk to [youth] in a scientific way and include the religious aspects”*. Another father from Amman also suggested that it would be useful to *“have the support of religious people and focus on religion classes that include reproductive health”*. Another father explained that the same education programmes should also be implemented in churches for Christians, and not just through Muslim religious institutions, stressing that *“we have to consider [that] we aren’t only talking about Muslims”*.

Both mothers and fathers were generally supportive of introducing SRH topics through school in order to overcome their own lack of information and lack of confidence in discussing such issues. A Syrian mother from Mafraq explained the difficulties in discussing SRH topics because of her own

embarrassment, saying that *“[we] lack adequate information ... our generation is different”*; another woman from the same group used her own daughter as an example and added that engaging teachers may be one way to help overcome such challenges in that *“maybe she will talk more comfortably with her teacher”*. Another Syrian mother from the same FGD advocated to start:

“sexual and reproductive health lessons to students by the age of 15, because if a mother doesn’t tell her children what they need to know by that age, they will get the information from somewhere else that might be a bad source of information that could encourage her to try [sexual activity], this is why I encourage adding it to the [school] curricula”.

In terms of fathers, a father from Amman claimed that *“learning [about SRH issues] helps when they learn [it] in schools”*. A father from Zarqa expressed a similar sentiment in that, *“it would be good to have guidance in schools too”*. However, there was some reluctance to support sexual education in schools, especially among fathers, over concern that such ideas represent outside influences. A Jordanian father from Zarqa emphasised that there is a need to ensure cultural and religious sensitivity in providing SRH messages to youth by saying:

“the sources that discusses such things are western and don’t include the religious values in the book. We need people who are aware of our religious beliefs and culture to discuss such things with our children. Our culture is different than theirs”.

Discussion

The results of this study indicate that Jordanian and Syrian parents acknowledged the need for PCSC, however, the majority of parents did not feel confident or comfortable in engaging with their children on such topics, partially due to what they described as a culture of shame surrounding SRH issues. The findings from our study highlight several important points that are useful for designing interventions to improve SRH knowledge among Jordanian and Syrian youth. First, parents perceive PCSC challenging for several reasons. They struggle with their own lack of SRH information and they are often too shy or embarrassed to discuss SRH topics with their children because of the overarching “culture of shame”. Second, while the results of this study highlight gender differences in PCSC, parents thought that

a gender-match strategy could alleviate some of the difficulty in discussing certain topics. Third, although parents advocated for PCSC and even gave examples of pubertal development and sexual harassment discussions, they sometimes relied on, and wished for, outside resources to provide SRH information to their children about what they perceive as sensitive topics, such as sexuality.

Our findings are consistent with those of other studies among Middle Eastern populations. A study in Iran found that parents exhibited considerable misinformation about SRH topics, and mothers believed themselves to be neither adequately prepared nor competent to have discussions on sexual topics with their children, highlighting an intergenerational pattern where mothers draw on their own experiences growing up where such issues were not discussed within families.³² Similarly, a study on mother–daughter communication about sexuality among Muslim immigrants into the United States found that while mothers viewed it as their duty to have discussions on SRH issues with their daughters, the majority did not proactively engage in discussions about issues beyond puberty, as they also described there being shame in discussing such issues with their daughters.³³ Other studies in Jordan have found that, in general, discussing sex-related issues within families is taboo until marriage, including topics related to puberty, from the belief that learning about such topics may pique their children’s interest in sexual activity.^{34,35} The results of our study, however, suggest a more nuanced picture where parents recognise the importance of teaching their children about SRH topics, but feel intimidated by their own lack of knowledge and confidence to engage in discussion with their children. Interestingly, studies suggest that parents are a preferred information source for both Jordanian and Syrian youth, especially mothers among daughters, but that youth also acknowledge that their parents are ill-equipped to have such conversations and, as a result, are afraid to approach their parents about their SRH questions and concerns.²⁵ Thus, the intergenerational silence on such topics stemming from a lack of parental knowledge may further contribute to reproducing the “culture of shame” surrounding these topics from generation to generation. Interventions should work with parents to help them develop the confidence, knowledge and skills to discuss SRH information with their children in order to destigmatise PCSC.¹¹

Our results also highlight important differences related to PCSC between mothers and fathers with their children. We found that fathers rarely gave examples of either responding to their children’s SRH concerns or initiating PCSC. In contrast, mothers frequently cited examples where they engaged with their daughters in such talks. Mothers identified themselves as safe, accepting, and relatively well prepared for such roles with their children in comparison to fathers. Mothers even wanted to be sure that their sons had answers to their SRH-related questions, despite their own discomfort in discussing such issues. Mothers’ responses suggest that fathers’ interactions with their children may reflect patriarchal norms that cause fathers to interact in a more authoritative way with their children, that ultimately may limit fathers’ engagement with their children, especially on sensitive topics. Despite the mothers’ more prominent role in PCSC, they still felt underprepared to engage in discussions beyond physical maturation and protection from sexual harassment and abuse, and as such, their role was limited.

Other studies have found that fathers’ adherence to masculine norms negatively influences their ability to engage with their children on SRH topics³⁶ and that fathers are less likely than mothers to communicate with both their daughters and sons on topics related to sexual development and sexual behaviour.^{37,38} In other regions of the world, studies have shown similar findings. For example a study on PCSC in Uganda found that adolescents perceived their fathers to be stricter, intimidating, unapproachable and/or unavailable.³⁹ A review of research on PCSC in sub-Saharan Africa found that there appeared to be slight preference among both male and female children to discuss SRH issues with their mothers, but some studies reported that parents preferred to have same sex discussions with their children.⁴⁰ In Jordan, a study found that more young women (50.4%) than young men (33.5%) reported receiving HIV-related information from their parents,²⁴ which may reflect how the preference for gender-segregated PCSC combines with fathers’ limited engagement with their children to further limit young men’s knowledge of SRH issues. Interventions that strive to engage fathers in PCSC with their children may be beneficial.

The scope of topics parents described discussing during PCSC was primarily limited to issues related to pubertal development and protection from sexual harassment and abuse. A study in the United

States found that nearly all parents discussed issues related to bodily changes during puberty, but there was much less focus on teaching children how to refuse unwanted sexual advances.¹⁵ Within this study population, the strong focus on ensuring that children are prepared to deal with sexual assault and harassment may not only relate to a genuine desire to protect their children, but it may also reflect a cultural value centred on a desire to protect the family's honour. Sexual assault in Jordan is considered to be one of the least socially tolerated forms of abuse, and its perpetration brings shame on the victim and the victim's family.^{41,42}

Finally, parents described relying on outside resources to aid in discussions on topics that they felt unprepared to have with their children. The results of our study suggest that parents generally seem supportive of introducing SRH topics in public or religious schools, which could be designed in a way to better support parents in order to foster increased PCSC.^{16,33} Using school-based sexual education as a launching pad to open up discussions with parents about sexual issues may be a particularly salient intervention in the study population. More importantly, interventions designed to coach parents in order to equip them with clear and practical tools could also be a way to improve parental capacity for PCSC. Such interventions could even take place through religious institutions, as suggested by the participants, as a way to destigmatise such topics, and ensure that they are discussed in a way that is in line with religious teachings. In Jordan, the introduction of comprehensive sex education in the school setting remains very limited and it is thought to be a contentious matter.⁴³ The results of this study, however, suggest that parents may be more supportive than generally thought and many may actually welcome the introduction of sexual education in the school setting. In addition to formal intervention programmes with parents, physicians, nurses and other health care professionals who interact with parents and youth are in a unique position to encourage beneficial communication about sexual topics. Specifically, clinicians can have professional conversations about sexual health issues in varied settings to model proficient sexual communication skills.

This study represents a first attempt to understand the perspectives of mothers and fathers on PCSC in a conservative setting, and there are several strengths and limitations worth noting. In terms of strengths, data was collected by trained

facilitators who were trusted by the community, which helped parents feel more comfortable discussing such sensitive topics in a group. In order to ensure that emergent themes were rooted in the data, data analysis was conducted through an iterative process with three researchers, which helped to ensure both reliability and validity of the findings. Despite these strengths, there remain some limitations. While we had hoped that the use of FGDs, as opposed to in-depth interviews, would enable participants to engage in deeper discussion and debate, individuals who were less vocal or had minority viewpoints may not have felt comfortable expressing themselves. Further, participants tended to share hypothetical stories rather than speaking about their own families directly, so as not to bring any dishonour to their families. Facilitators also had more difficulty in probing with male participants, who thus represent an important population for future research. At this nascent stage, in-depth interviews may be more effective in gaining a richer perspective on certain issues, such as preferences as to what age is appropriate to start SRH-focused discussions with children, what are key factors that trigger such discussions, and so on, which should also be addressed in future research. Last, our study did not find any notable differences by nationality, as Jordanians and Syrians represent fairly similar cohorts from a cultural perspective. This could be an area for future research. Our purposive sampling approach is not meant to be generalisable to either the Syrian or Jordanian populations. In choosing the sample size, we focused on ensuring a large enough population to obtain adequate depth in responses and reach the point of saturation, rather than reflecting the distribution of both nationalities within the population. Further, we focused our research on the Northern regions of the country, as the Southern regions are culturally different and have a smaller population of Syrian refugees. Last, as our sample was recruited from relatively economically disadvantaged areas in Jordan, we expect that our study population was more reflective of the experience of lower to middle class individuals, rather than higher income segments of the population.

Implications for policy, practice and research

The results of our study add to the global PCSC literature by shedding light on a conservative

culture; in particular, our results add to the nascent literature focused on adolescent SRH in the Middle East, where the parent–child relationship is critically important, and provide an opportunity for future research and programmes to improve adolescent health outcomes. Our study findings recommend multiple points of entry for interventions targeting parents’ knowledge, skills, and confidence, which are vital to helping youth achieve healthy sexual development,²³ and may help to break the intergenerational cycle of shame. We strongly advocate for interventions that engage parents, and especially fathers, to help them develop their confidence, knowledge and skills to discuss SRH information with their children in order to destigmatise PCSC. Furthermore, we suggest using gender-matched PCSC strategies in addition to school-based platforms and religious institutions, as a way to destigmatise such topics. More importantly, interventions designed to coach parents, equipping them with clear and practical tools, could also be a way to improve parental capacity for PCSC. Such interventions could even take place through religious institutions as a

way to destigmatise such topics, and ensure that they are discussed in a way that is in line with religious teachings. Finally, future research is called for that engages males, utilises quantitative research methods and includes other populations in Jordan and the region.

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Résumé

Les jeunes dans le monde font face à des difficultés considérables relatives à leur santé sexuelle et reproductive (SSR). La relation parent-enfant est fondamentale pour façonner les trajectoires des enfants pendant l'adolescence et possède un potentiel considérable pour améliorer la connaissance de la SSR des jeunes. Le manque de communication sexuelle entre parents et enfants peut inciter les jeunes à se tourner plutôt vers des sources d'information discutables, comme les pairs, Internet et les médias sociaux. La recherche limitée dans ce domaine, et précisément au Moyen-Orient, nous a conduits à étudier comment les parents parlent des questions de SSR avec leurs enfants et a mis en lumière le rôle potentiel des parents à l'appui des besoins en SSR de leurs enfants. Une approche de recherche qualitative a été utilisée, avec 20 groupes de discussion stratifiés par nationalité et sexe des participants issus de quatre communautés majeures en Jordanie. Une analyse et un codage thématique ont été utilisés. Les parents ont décrit leur volonté de « briser la culture de la honte ». Trois stratégies primaires sont apparues: (1) l'association par sexe, (2) les mères comme espace sûr, et (3) demander de l'aide aux autres, point qui comprenait deux sous-thèmes: associer les autres et compter sur la diffusion des informations de SSR dans les écoles. Des forces et des faiblesses étaient inhérentes à chaque stratégie et les sujets de discussion variaient selon la stratégie utilisée. Les données produites par cette étude offrent des possibilités de futures recherches et de programmes pour améliorer la santé des adolescents au sein de milieux conservateurs, afin de briser le cycle intergénérationnel de la honte. Des interventions sont suggérées pour cibler les connaissances des parents et leur assurance pour aider les jeunes à réaliser leur développement sexuel. L'utilisation de stratégies de communication sexuelle entre parents et enfants appariées selon le sexe, de plateformes scolaires et d'institutions religieuses est une façon de déstigmatiser ces questions.

Resumen

A nivel mundial, las personas jóvenes enfrentan considerables retos relacionados con su salud sexual y reproductiva (SSR). La relación padre-hijo es fundamental para definir las trayectorias de los niños hasta concluida la adolescencia y sugiere considerable potencial para mejorar los conocimientos de la juventud sobre SSR. La falta de comunicación sexual entre padres e hijo (CSPH) podría causar que las personas jóvenes recurran en vez a fuentes de información cuestionables, tales como sus pares, internet y las redes sociales. Las investigaciones limitadas en esta área, en particular en el Oriente Medio, nos llevaron a explorar cómo los padres discuten temas de SSR con sus hijos y señalaron el posible papel que pueden desempeñar los padres para apoyar las necesidades de SSR de sus hijos. Se utilizó el enfoque de investigación cualitativa, con 20 grupos focales estratificados por nacionalidad y sexo de los participantes provenientes de cuatro principales comunidades de Jordán. Se empleó codificación y análisis temáticos. Los padres describieron su disposición a “romper la cultura de humillación”. Surgieron tres principales estrategias: (1) que correspondan a cada género, (2) madres como espacio seguro y (3) buscar ayuda de otras personas, que incluyó dos subtemas: incorporación de otras personas y dependencia de la entrega de información sobre SSR en las escuelas. Cada estrategia tenía fortalezas y retos inherentes, y los temas de discusión variaron según la estrategia aplicada. La evidencia de este estudio ofrece la oportunidad de realizar futuras investigaciones y ejecutar programas para mejorar los resultados de salud de la adolescencia en entornos conservadores, con el fin de romper el ciclo intergeneracional de humillación. Se sugieren intervenciones dirigidas a los conocimientos y autoconfianza de los padres para ayudar a la juventud a lograr su desarrollo sexual. Utilizando estrategias de CSPH que correspondan a cada género, las plataformas escolares e instituciones religiosas son maneras de desestigmatizar esos temas.