Early marriage and pregnancy among Syrian refugees in Jordan in light of reproductive governance and justice

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Since the start of the Syrian refugee crisis, international development agencies and NGO's have attempted to curb the rise of early (underage) marriages among Syrian refugees who are displaced across the borders in Jordan. They aim to address the prevalence of early marriages as well as subsequent underage pregnancies and childbirth. Based on in-depth anthropological research, this article argues that apart of humanitarian concern, involvement with Syrians' underage fertility can be understood against the background of reproductive governance. Interviews with Jordanian health care workers reveal a dominant concern with Syrians' culture. By distinguishing different reproductive cultures, boundaries between both national groups are marked. Syrian women's experiences of perinatal healthcare in Jordan point at the importance of reproductive stigma and morality as tools of governance. These findings support the 'populationism' thesis, which argues that the international paradigm shift from population control to reproductive rights in postcolonial contexts has been incomplete.

Keywords: Syrian refugees; morality; reproductive stigma; reproductive governance; reproductive justice

Introduction

This paper focuses on the discursive politics of development interventions on the topic of early marriage and pregnancy (i.e. under the age of eighteen) among Syrian refugees who are hosted in the region, and particularly in Jordan. It is theoretically situated within critical development literature and critical feminist theory on reproduction. The paper engages with reproductive righteousness (Cromer and Taragin-Zeller, 2023) through a discussion of reproductive politics as underlying rationales behind development and humanitarian work. By doing so, it illustrates the discursive connections between historical colonial reproductive politics, contemporary

development work and political projects of reproductive righteousness that promote boundary marking between populations, in particular between ‘native’ and immigrant and refugee populations.

The harmful aspects of underage pregnancy and healthcare that Syrian refugees receive in neighbouring countries are more topically addressed in literature focusing on (the lack of) access to health care services (e.g. Tappis et al. 2017, Parkinson and Behrouzan 2015, Kabakian-Khasholian et al. 2017). This paper therefore does not focus on evaluating medical aspects of underage pregnancies but rather discusses the discourses that circulate about Syrian underage pregnancies and childbirth. Since the beginning of the refugee crisis Syrian in 2011 marriage practices attracted the attention from Jordanian and international policy makers. Humanitarian reports illustrated an increase in the number of registered Syrian underage marriages. The percentage of registered marriages rose from 18,4 % in 2011 to 34,6 % in 2015 (Higher Population Council Jordan 2017, xv - xvi, UNICEF 2014, Save the Children 2014), and 36% in 2018 (Al Jazeera 2018). The majority of Syrian women in Jordan is between the ages of 15-17 at the time of marriage (UNICEF 2014, 8), and 2% of all women in Jordan marry under the age of 15 (Department of Statistics/Jordan and ICF 2019).

Early marriage is a common practice in Syria, particularly in rural areas, that has been continued in exile. Studies of Syrian refugees in Lebanon argue that a lack of general safety, worsening economic conditions and disrupted education for girls are important reasons behind this recent regional rise (Mourtada, Schlecht, and DeJong 2017). This early humanitarian international interest framed as a ‘Syrian child marriage crisis’, served according to critical forced migration scholar Dawn Chatty, “to validate the perceptions of the service providers rather than the ‘targeted community’ or beneficiaries” (Chatty 2017, 27-8). She criticizes that needs and vulnerability

assessments are based in “Western conceptualizations of the individual, of personal agency and vulnerability” and argues that local understandings of needs ought to be taken in stronger consideration (ibid.). Chatty’s critique on the presentation of Syrian underage marriage as a child marriage crisis resonates with older concerns within a larger body of critical development scholarship (e.g. Valentin and Meinert 2009, Fiddian-Qasmiyeh 2010, Grabska 2011, Olivius 2016, Fassin 2013b, Hasso 2009).

Programs to increase the age of marriage and reduce the number of children produced by international agencies can be considered as international ‘scripts’ that are commonly used in gender and development projects (anonymized). Scripts are understood as standardized renderings of complex socio-cultural or religious practices. Engagements with these practices often result from international declarations that commit to certain principles such as human rights, women’s rights, violence against women, and children’s rights. Through the workings of NGO-ization (e.g. Bernal and Grewal 2014, Jad 2005), these universal principles become translated into standardized scripts for implementation across national contexts. Interventions against early marriages are often designed to empower girls by organising awareness raising activities, offering economic support or establishing laws and policies (Bessa 2019, 4). Scripts of transnational NGO programs can correspond to or differ from local understandings of social issues and their possible resolutions (Hemment 2014). Indeed, the focus of initiatives against early marriage/pregnancy on empowerment does not always resonate with local understandings of needs. The focus on informing and encouraging girls to act and speak out against their families or communities does not consider the affective importance and socially reinforcing aspects of family ties, kinship and social relations among practicing communities, especially in contexts of forced displacement (Bessa 2019, Van Raemdonck and de Regt 2020).

The tension between social issues as they are locally defined and their representation on the international stage – between a local custom and translated as an international crisis – occupies a central place in this paper. In order to analyse this tension, I rely on Carole Bacchi's poststructuralist policy analysis that interrogates how social issues are represented (Bacchi and Goodwin 2016). By looking into the discursive presentation of a problem and its proposal of resolution, we better understand the underlying rationales and politics of how and why a social phenomenon has become a "problem". Drawing on qualitative interviews and grey literature, this paper looks into the presentation of underage marriage/pregnancy by Jordanian healthcare workers. A second set of data consists of Syrian women's narratives of reproductive healthcare experiences in Jordan. When examined together this paper shows how reproductive governance (Morgan and Roberts 2012), morality and stigma emerge as central themes. I will argue that these findings supports the thesis of 'populationism' (Bhatia et al. 2020), which claims that the international paradigm shift from population control to reproductive rights has been incomplete and that underlying reproductive governance concerns still emerge in contemporary development and humanitarian projects. This paper discusses the centrality of reproductive politics in a context of refugee reception in the Middle East. By focussing on local experiences with reproductive stigma and mechanisms of reproductive governance, the paper reveals connections to both historical (post)colonial concerns with population control and the more recent surge of right-wing reproductive righteousness in which immigrant and refugee reproduction are a central feature.

In the following sections, I first outline my theoretical and conceptual framework, and then turn to the analysis of fieldwork conducted between 2018-2019.

Methodology, methods and data analysis

This study is part of a larger anthropological research project examining the shifting meanings and contexts of underage marriage among Syrian refugees in Jordan. It contributes anthropological insight into the complex situation of Syrian refugee women across Syria's borders. Research was conducted with urban refugee population in the city of Zarqa and interviews with Jordanian health care workers were conducted in the cities hosting the greatest share of urban refugees, Irbid, Zarqa and Amman[1]. The analysis is methodologically informed by a critical ethnography approach with a vertical dimension, giving attention to a variety of social actors (Fassin 2013a). It brings together the results of fieldwork that aim to peel off different layers of the social problem that Syrian underage marriage in Jordan rapidly has become. The different layers consist of perspectives embraced by international aid agencies, international NGO's, Syrian refugees and Jordanian health care workers in NGO's and hospitals. In doing so, this study combines different 'critical social spaces' to reveal a more complex multifaceted picture than is offered by each of these groups separately (Fassin 2013a, 121).

The data of Syrian experiences with reproductive healthcare in Jordan are based on recurring participatory research group meetings with married and unmarried women over the course of one year. The series of recurring group talks consisted of 12 meetings lasting for two hours with a group of 8 married women and 7 meetings with a group of 7 unmarried women. All meetings were held in the city of Zarqa during 2018-2019.

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[1] The number of registered Syrian refugees by UNHCR in Jordan currently totals 662 790, making up about 12% of the Jordanian population. About 80 % live in urban areas in the Northern governorates of Mafraq, Irbid, Zarqa and the capital Amman (Lenner and Schmelter 2016, 124), while others live in five camps located in the Northern governorates.

Based on the method of Participatory Action Research (PAR), the meetings aimed at building a long-term bond of trust among the participants and gradually and creatively adapted to the possibilities and realities of the women involved. The participants in this research were invited from the start to co-determine the topics and questions to be discussed, while the researchers remained committed to examining core research questions concerning early marriage and pregnancy as agreed upon with the project funders (Dutch Research Council, NWO-WOTRO). Participants were invited to design strategies for social or public action towards the end of the project. We observed, however, a reluctance to use these opportunities and distinguished different reasons behind this seemingly lack of interest to actively co-design the research project. The overall sociopolitical circumstances in Jordan for Syrian refugees, in addition to dominant gender regimes, do not encourage refugee women (or men) to speak out on social or public matters, and articulate their social problems. Additionally, the uncertainty as a consequence of waiting in protracted displacement does not encourage refugees to design strategies for collective action. For instance, two of the eight married women returned to Syria two months before the end of the data collection phase, and several other women were considering returning as well. In sum, doing participatory research with vulnerable groups living in uncertainty such as refugees, within a frame of project funded research that requires clear objectives and research questions determined in advance, complicates the conditions of participation greatly (Van Raemdonck and de Regt 2020).

Perspectives of health care and development workers were obtained through 13 semi-structured interviews with health care workers from different Jordanian public and private hospitals and NGO's and the study of public health literature and grey literature produced by NGO's and international agencies. The sample of respondents was

purposive and targeted 6 different health care institutions that provided elaborate service provision to Syrian refugees, particularly in the field of reproductive health. The number of health care centers that offered care to Syrian refugees at reduced prices, or for free, had reduced drastically since the start of the Syrian refugee crisis. The sample included therefore the health care providers that were most visited by Syrians at the time of data collection, between March 2018-April 2019. One respondent in the Northern town of Irbid explained, for instance, that women travelled from Aqaba and Karak in the South of Jordan to receive free health care by the international NGO she works for. The frontline health care workers held diverse medical positions and included gynaecologists, nurses and midwives working in (inter)national NGO's, public and private hospitals in Jordan. All providers are located in the Northern cities hosting most Syrian refugees, Amman, Zarqa and Irbid.

All interviews with Jordanian health care workers and meetings with Syrian refugees were recorded and subsequently transcribed in Arabic and translated to English by a native Arabic speaker. Interviews were conducted by the author either in English or in Levantine Arabic. The meetings with Syrians were all held in Levantine Arabic in the presence of a Palestinian research assistant who assisted with translation to English where needed. Interviews were analysed with the aim to understand the perspectives of health care workers on Syrian underage marriage and pregnancy. The goal was to understand how healthcare workers discursively present the social issue of underage marriage/pregnancy, similar to poststructuralist policy analysis that examines the conditions in which different actors define social realities as problems that are in need of policy response (Bacchi 2009, Bacchi and Goodwin 2016). The transcripts of meetings with Syrians were thematically coded and comprise various aspects of refugee

life in Jordan. This paper thematically focuses on experiences with reproductive health care, morality and stigma.

Throughout the research project, reflection about my positionality as a white female researcher located in Europe had been ongoing as different groups perceived me in different roles. Jordanian NGO workers easily perceived me as an ally in humanitarian work, rather than as a researcher critically examining humanitarian initiatives. This perception likely facilitated obtaining access to healthcare workers. In contrast, with Syrian participants I invested greatly in breaking down hierarchies associated with racialised categories such as whiteness. Throughout the year of PAR meetings with Syrian women, creating trust and building a friendly bond with and among participants was an ongoing effort. I aimed to mitigate the power and privileges connected to my positionality by emphasizing my job as a researcher and anthropologist with a radically open attitude to listen and learn, placing this in contrast with the more normative development work. Additionally, as mentioned earlier, the PAR methodological vision explicitly considers participants as co-researchers, resulting in an ongoing invitation to bring participants' own knowledge, experience, critical questions and insights to the table.

The research team agreed that the signing of written consent forms might not be possible in many cases, especially for refugees who might feel more vulnerable signing official documents and those refugees who are illiterate. The rules of ensuring anonymity, confidentiality and data protection, the purpose of the research, its funding institution and the way in which the research would be used were verbally explained to all participants prior to the PAR meetings and interviews.

Reproductive governance, morality and stigma

Morgan and Roberts defined reproductive governance as referring to "the mechanisms through which different historical configurations of actors – such as state, religious, and international financial institutions, NGOs, and social movements – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviours and population practices" (Morgan and Roberts 2012, 241). Scholars theorized reproductive governance against the background of reproductive politics in Latin America (Morgan and Roberts 2012, Morgan 2019, Ramirez and Everett 2018, Singer 2022); the historical socio-political treatment of Black women in the US highlighting the role of race and class (Roberts 2014) and current global reproductive health governance (Suh 2021).

This scholarship situated reproductive governance within the larger theoretical frames of biopolitics, population control, and neo-Malthusean policy on the one hand and a politics of exclusion based on race, religion and culture on the other (De Zordo and Marchesi 2016). Concerns with population control intertwine with moral injunctions and together create multiple 'rationalities' that shape individual reproductive decision-making as much as (inter)national and local policies. Different rationalities easily co-exist within one national context, producing multiple 'reproductive stigmas' and ideas of what is considered 'rational' and 'irrational' reproductive behaviour. In Poland, women experience pressure from Catholic culture and state calls to increase national fertility, while at the same time, lower-income Polish women and immigrant women face a 'social pathology' stigma when they have families considered too large (Mishtal 2016, 26, 2015).

A similar paradoxical logic exists in other European countries where the 'native' population is encouraged to be 'rational' and reproduce, while migrant groups are

considered ‘irresponsible’ and marked by ‘excessive fertility’ (Marchesi 2016, Sargent 2011). Defining low fertility in Italy as a dangerous problem resulted in pronatalist and exclusionary politics aimed at strengthening the nation while clearly setting the boundaries of ‘desirable and nondesirable populations’ (Krause 2001, Krause and Marchesi 2007, 351, Taragin-Zeller 2023).

Demographic concerns and efforts to regulate fertility thus intertwine with socio-cultural boundary marking and, in the process, produce different moral injunctions and regimes. The notion of moral regimes refers to acceptable sexual behaviours, forms of family formation, religious or secular commitments or otherwise ‘idealised forms of social reproduction (such as education or social security)’ (Morgan and Roberts 2012, 242). Despite the essential role of political economy for understanding reproductive behaviour and fertility decline, local understandings of what is considered rational and irresponsible reproduction find their expression through moral imperatives, stigma or taboo (Schneider and Schneider 1996).

Moreover, the role of morality and stigma is well recognized in reproductive justice theory, which conceives reproductive policy and practice as an interconnected system that “regulates people’s reproductive futures through *assessments of worthiness* originating in assumptions about race, class, and disability (among other dimensions)” (Luna and Luker 2013, 329, own emphasis). Indeed, the assessment of worthiness is a moral evaluation process that judges whether people are deserving or not of certain care and treatments.

Colonial legacies and ‘populationism’, or the incomplete paradigm shift

This study of the politics of morality of reproductive behaviour is situated in a postcolonial and non-Western context. The legacies of population control policies manifest most clearly in postcolonial contexts and for non-white, poor and rural women.

The ‘language, assumptions and norms’ associated with population control have been replaced by the register of reproductive rights and health since the International Conference on Population and Development (ICPD) in Cairo in 1994 (Eager 2017, 2). This moment provides a turning point in international language. Policies that aim to regulate fertility or control population are abandoned for new commitments that underscore human and reproductive rights and health as a universal good (Ginsburg and Rapp 1995). Feminist critics, however, have more recently investigated how old biopolitical concerns of population control and other forms of reproductive governance continue to persist and interweave with reproductive rights discourse (e.g. El Kotni and Singer 2019, Bhatia et al. 2020, De Zordo and Marchesi 2016). Some examined current family planning programs in order to reveal the ongoing logics of population control (Hendrixson 2019). It is argued that dominant indicators used in the scientific study of contraceptive need in the Global South overlook or ignore individuals’ stated reproductive choices not to use contraception (Senderowicz and Maloney 2022, 716). A comparison between former German colonial policy and contemporary development programs in Tanzania demonstrated common concerns to change population size, fertility rates and gender relations (Bendix 2016, 65).The fact that racialized and gendered bodies remain considered as the target and solution of reproductive policy through family planning illustrates the ongoing importance of race and persisting presence of earlier colonial logics (Sasser 2014, Ali 2002). It is therefore clear that the paradigm shift from population control to reproductive rights has not been a one-dimensional completed process but rather resulted into the coexistence of contradictory and competing rationalities (De Zordo 2016).

Feminist scholars Bhatia et al. have sought to theorize the ongoing manifestations of population control despite the paradigm shift to rights. They advanced

the term ‘populationism’ to refer to the ways in which humanity is placed in opposition to nature or the economy, which are binaries that ‘identify problems of surplus or scarcity that provide a logic of remediation, a rationale for intervening in ways that conceal and reinforce systems of power and inequality’ (Bhatia et al. 2020, 336). Indeed, in current policies and practice, interventions are designed in the new lexicon of rights but may reveal underlying mechanisms of governance and power inequalities. The authors differentiate between ‘demopopulationism’, i.e. interventions to ‘optimize’ population size and composition (e.g. the ratio of native-born to immigrants) through for instance the promotion of particular sexual and reproductive norms (Bhatia et al. 2020, 337); ‘geopopulationism’, i.e. practices of space making such as surveillance ‘to include or exclude particular people from particular places’ (Bhatia et al. 2020, 339) and ‘biopopulationism’ that refers to ‘technoscientific means that are marketed and sold as consumer products’ in order ‘to live particular kinds of (more valued) lives’ (Bhatia et al. 2020, 341). This paper will argue that interventions against early marriage/pregnancy in the non-Western context of Jordan and among the Syrian displaced population can be best understood within a ‘demopopulationist’ frame, as they reveal a strong desire to change social behaviour and reduce the number of refugee childbirths.

Stratified reproduction, place and displacement

The importance of place and location is well expressed through the understanding that reproduction is stratified. The term stratified reproduction was initially articulated in a context of migrating West-Indian domestic workers employed in middle class white households in the USA (Colen 1986). It indicates that existing socio-economic structures (in)directly encourage certain groups to reproduce while discouraging others. Feminist anthropologists continued to connect global influences to local practices (Ginsburg and Rapp 1995).

Place and displacement identify the position that subjects occupy within different reproductive governance regimes or reproductive rationalities. The Middle East saw a great increase in demand for labour migration from female domestic workers coming from especially Sri Lanka, the Philippines and Indonesia since the mid-1970s (Frantz 2008, 609-610). Jordan's demand for migrant domestic workers has risen considerably in the last decades and this increase is partially due to the country's increased integration into global capitalism resulting in a higher demand for consumption goods and domestic services (Frantz 2008, 614), similarly to its neighbour Lebanon (Jureidini and Moukarbel 2004). Asian migrant domestic workers are employed through Jordan's *kafala* (sponsorship) system, making them highly dependable on their employers. While these women's statuses and paths of entry differ from Syrian forcibly displaced women and refugees, neither groups are particularly expected or encouraged to create families of their own. In several European contexts, refugees and migrants' reproductive behaviour are shown to be evaluated and measured against different rationalities than native women's reproduction (e.g. Mishtal 2016, Marchesi 2016, Sargent 2011). The new host society often considers refugees and migrants as 'out-of-place' with 'the right place' meaning 'home' in the country of origin (Brun and Fabos 2015). Childbirth and family expansion can therefore be perceived as undesirable or unsuitable by the host society because of refugees' displaced status. Indeed, marriage and childbirth by Syrian refugees in Jordan has been perceived as rather undesirable by the host society but can also be understood as acts of home-making by the forcibly displaced (Van Raemdonck 2021).

Discussion of findings

Narratives of Jordanian health care workers: Syrian 'excessive fertility' and the role of culture

None of my Jordanian health care workers interlocutors had encountered major, life-threatening medical complications for mother nor child in their experiences with early childbearing in Syrians. They identified, however, a higher risk at miscarriage and preterm delivery under the age of 18. They differentiate between girls aged 13-15 and older. In Jordan, the overwhelming majority of Syrian early marriages occur between the age of 15-17 at the time of marriage (UNICEF 2014, 8), and 2% of women in Jordan get married under the age of 15 (Department of Statistics/Jordan and ICF 2019). Hala is a midwife from Zarqa and works at the local branch of a national women's organisation. She explains that the center encountered Syrian married women aged 13-17 in a particular period during the refugee crisis.

> 'During this period, we have been giving lectures on reproductive health focusing on subjects such as early marriage since we are receiving girls as young as 13 and 14 years old who are married. We know that there is a health risk on the girls and their bodies because their bodies and uterus have not fully developed yet and some girls have irregular periods.'

The center started to organise activities to warn about health risks after receiving Syrian married women from age 13 onwards. When asked about the most important medical complications that adolescent Syrian pregnant women experience, virtually all respondents mentioned a lack of personal hygiene leading to infections (vaginitis), anemia, low blood pressure, and bad nutrition. They connected these conditions to Syrians' low economic status, lack of access to (clean) water and delayed seeking of

prenatal care. When asked whether there was a higher occurrence of mother and child mortality, and medically necessary abortions, answers were negative. Nour had been working as a gynaecologist for two years and a half for a major international NGO located in Irbid serving refugees, combined with another job in a private hospital. When asked whether adolescent pregnant women were at a higher risk of medical abortion, she explained the following:

> 'In the books yes, but with refugees no. The highest rates of abortions I see are among women between 20 and 32. We did a study with IMC [International Medical Corps]. Most of the patients who abort are older. In the books they say it happens to younger people, but we do not see this in the real world.'

Respondents stated that mortality rates for mother or child in early Syrian pregnancies is not significantly higher. These findings correspond to literature on the consequences of underage pregnancy in Jordan that argues that 'age is difficult to be considered as an independent risk factor' for medical complications in early pregnancies (Khader et al. 2019). Others have similarly suggested that social and environmental factors such as low socio-economic status and inadequate prenatal care are crucially contributing factors to reproductive health complications, rather than age (e.g. Yuce et al. 2015, Mahfouz et al. 1995).

A great majority of respondents pointed to 'Syrians' culture' as a problem. For them, early marriage and pregnancy among Syrian refugees was constructed as 'mainly a problem of culture and education'. Rather than elaborating on medical complications, respondents discussed the importance of education and cultural norms regarding modern family formation. Nour, for instance, continues:

> ‘Syrians are refusing family planning while we have everything, we have IUDs, but they refuse, they refuse contraception. […] They want to reach to 10 babies, I don’t know why. [pauses] I think it’s a cultural thing. I don’t know perhaps it is also the war phase, and the men, mostly the men are sitting at home, and there is a lot of, *ya’ny*, they are sitting at home, they are doing nothing so there is more sexual intercourse and more babies. This is one of the causes. Or they want to have babies to work in the future, and to replace those who died in the war.’

Nour struggles to convince her Syrian patients to implement family planning and limit and space children, even when such services are offered for free to both Jordanians and Syrians. In her view, a long-term investment in education can help to create behavioural change in Syrians. Indeed, she wishes to change Syrian social norms by reducing what is perceived as their irrational and ‘excessive fertility’ (De Zordo and Marchesi 2016), while she looks for reasons that might explain Syrians’ rejection of family planning. Her viewpoints are in agreement with other respondents. Zayd works as a gynaecologist in a private hospital in Amman that was founded by his grandfather, a Palestinian refugee moving to Jordan after 1967. He works at the only hospital in Amman that offers treatments at reduced prices to Syrian refugees at the time of research. Ninety percent of the hospital’s activities are related to obstetrics and gynaecology. Here, Syrian women can undergo gynaecological operations at about half of the regular rate. Zayd is strongly committed to helping Syrians. He expresses concern about Syrian women’s early pregnancies:

> ‘We don’t like to see young women getting pregnant, but unfortunately this is what we see. It is part of their culture. We try to tell them.’

His concern stretches from the medical realm to a larger apprehension about young women's well-being. In his understanding, culture is the most important factor determining Syrians' wish for early marriages and pregnancies. He says:

> 'Now everyone is getting educated, we know it is not right, but some families especially in the rural areas are not well-educated, they think that when the woman gets her period, she must get married'.

A doctor in his sixties, Abdallah, working in Zarqa as the main GP at the local branch of an international NGO, articulates his concern with education to change reproductive behaviour in a similar way:

> 'At the age of 15-16, from a medical perspective, we do not encounter problems, but there are greater problems, problems from other perspectives, such as socially, carrying the responsibilities, the lack of medical knowledge and sexual education, many things like this. […] The way I see it, the most important problems are social and have to do with ignorance and lack of education.'

In agreement with other respondents, Abdallah shows a great concern with the larger socio-cultural environment that produces early marriages/pregnancies and believes that more investment in education is needed. Culture and education are prioritized as social issues that need improvement. The focus on culture as the underlying ground to explain marriage and childbearing practices has been observed in numerous other contexts of development work (e.g. Pigg and Adams 2005). For instance in Malawi, development interventions equally explain early marriage/pregnancy in highly culturalized terms, considering 'culture' as the sole or main factor that explains social behaviour (Pot

2019). Following poststructuralist policy analysis as proposed by Carole Bacchi, it is then crucial to interrogate the ways in which a social problem is represented in proposals for social change (Bacchi 2009). My interlocutors most clearly represented the problem of early marriage and pregnancy as a cultural problem that could be solved through education. The idea that societies can become modern by changing family behaviour and creating smaller families has been shown to be an underlying cultural foundation of global development work (Thornton, Dorius, and Swindle 2015, Ali 2002). Moreover, this powerful belief has been shown to originate in colonial imperial politics and function as a core legitimization of foreign rule (e.g. Bryder 1998, Stoler 1989, Sinha 2006).

Jordanian healthcare workers who participated in this study embraced the development ideal to modernize Syrians' family behaviour by creating smaller families as they found this practice more fitting within modernized Jordanian society. In this sense, their views on incoming refugees' culture reflect earlier studied responses to migrant minorities in Western states. In the view of healthcare workers, Syrians' reproductive choices are indeed seen as irrational, testifying of ignorance and demonstrating a lack of education, similarly to perceptions of migrants' reproductive choices in France (Sargent 2011), Italy (Marchesi 2016) or Poland (Mishtal 2015). For them, marriage delay and lowering the number of children is the best outcome for both refugees and Jordanian society. In their discursive evaluation of Syrians' reproduction, we can discern, similarly to Western contexts, a differentiation between Syrians' reproductive behaviour and overall Jordanian reproductive behaviour, drawing socio-cultural boundaries between both national groups (Krause and Marchesi 2007).

Syrian women's narratives of health care experiences: reproductive stigma

Syrian women repeatedly discussed their negative experiences of giving childbirth in Jordanian hospitals. More than half of Syrian deliveries take place in a public hospital (Tappis et al. 2017, 1801). Syrians enjoyed subsidized rates in Jordanian public healthcare facilities until 2017, allowing them access on equal grounds to Jordanian nationals, and in the process considerably burdening Jordan's health care infrastructure (Al-Fahoum et al. 2015, 4). Complaints about disrespectful treatment and inadequate care in Jordanian public hospitals was therefore not limited to refugees but was a well-known phenomenon for all inhabitants at the time of fieldwork. Both Syrians and Jordanians understood that healthcare facilities could often not receive the high number of patients with proper attention and care. A legal change in 2017 changed Syrians' status to external parties and multiplied healthcare rates to twice or thrice the previous rate (Human Rights Watch 2018). Refugees have therefore most experience with public health centers, public hospitals and NGO clinics and less with private hospitals which are generally not financially accessible.

Syrian childbirth narratives before and after the change in legislation show a pattern of experienced bad treatment that was not only attributed to the exhaustion of infrastructure and medical personnel. Apart of their own childbirth experiences, most women knew about events that had occurred to relatives. One recurring complaint was not being helped when in urgent need of health care and being sent away to another hospital. Besan, a mother of four and originally from Dar'a, lives on the outskirts of Zarqa. She explains:

> ‘When I went to give birth, the doctor left me with a nurse and she didn’t know what was going on. She asked me whether I came out of the operation room. I said, no I was in labor and she said “even if the head came out we will do nothing for you”.’

She was assisted eventually but was left in doubt and waiting for a considerable time and treated in a demeaning way. Her fear of what could have happened if she had been left by herself haunts her until years after the event. Lina similarly experienced being sent away at a time of urgent need: ‘When I was pregnant, I started bleeding, but no one wanted to see me from the doctors, and I was about to give birth. They said “go to the public hospital because we don’t take in Syrians”.’ In most extreme cases, hospitals’ rejections of Syrians who cannot afford the costs of delivery have life-threatening consequences. Zahra, a 28 year old mother of five children explains what happened to a relative:

> ‘A relative of mine was pregnant in her seventh month when she found herself in a very bad situation. She went to the nearest hospital, a private one, and they asked her if she had enough money. She said no, so they said “go to the Bashir [public] hospital” but she had delivered before reaching it and the baby died.’

Apart from not being accepted in hospitals, women testified about receiving delayed care and complained about the lack of professional, adequate care. Asma lives in the center of a newly built district to the North-East of Zarqa. She characterizes her experience in the public hospital as ‘very bad’:

> ‘After waiting for a while, I called the nurse and told her I need to give birth. She called the doctor but the doctor refused and said that he only delivers Jordanian women and

> not Syrian women, so the nurse was the one who helped me deliver. However, she did not clean me up well and I had bleedings so I took medication, but it didn't help. Then I went back to have it checked and the doctor got angry, why the nurse didn't clean up well, but I told him that I didn't know how these things go and he cleaned up my wounds.'

Experiences of being sent away, neglect and delayed care were common, just as receiving negative comments and questions about the number of children. The desired family size by Syrians before and after the conflict is 4 to 6 children based on qualitative research among Syrians in Lebanon (Kabakian-Khasholian et al. 2017, S79). Jordanians generally prefer smaller sized families and according to the Population and Family Health survey, Jordanian women have an average of 2.6 children (Department of Statistics [Jordan] 2019). Syrian women received comments that disapproved of their pregnancy and family size. This includes making reference to their nationality and refugee status by disapproving looks, humiliation and insult. Besan said: 'Some of them even blame us and tell us "why do you get pregnant during such conditions?".' Lina received remarks while seeking health care to give birth, saying 'Look at you, why do you want yet another baby?'.

Women were directly questioned why they wanted to have more children implying their behaviour was irresponsible or irrational. The disapproval is double, pointing at their refugee status and what is considered an appropriate family size. Studying access to healthcare by Syrian refugees in Lebanon, Parkinson and Behrouzan observed 'hierarchies of eligibility and deservingness' (Parkinson and Behrouzan 2015, 329). Hierarchies differentiate Syrians from Lebanese, UN registered refugees from the unregistered, and the financially capable from the poor. Similarly in Jordan, nationality, UN protection and financial capability largely determines one's access to healthcare.

Women reported, however, to experience an additional moral evaluation relating to their status as displaced refugees, age or family size.

Similar observations were made in Lebanon where Syrian refugee women testified of “discriminatory treatment” and “humiliation” experienced in health facilities (Kabakian-Khasholian et al. 2017, S82). Syrian women in Lebanon talked about the “judgmental approaches of care providers” (ibid.) and researchers state that health care “[p]roviders’ discourses revealed negative attitudes that confirm women’s reported experiences of discriminatory treatment when seeking R[eproductive] H[ealth] care” (ibid. S83). Experiences of moral stigma by Syrian women are therefore in agreement with Syrian experiences with healthcare facilities in Lebanon.

Conclusions

The question of how Syrian refugees hosted in the region of the Middle East can receive adequate reproductive health care, including assistance with decisions on timing of childbirth and the number of children, are important and deserve the needed attention and financial support. This paper, however, did not seek to evaluate the quality of existing health care but sought to understand the discursive politics behind current initiatives that address Syrian early marriage and pregnancy practices. Based on long-term anthropological research I analysed discourses on early marriage and pregnancy by Jordanian care givers and Syrian receivers. I have argued that from these discourses, concerns of reproductive governance, morality and reproductive stigma appear as central themes. The paper demonstrates the similarities with tropes belonging to European discourses on reproduction and anti-migration. In this way, it engages with reproductive righteousness by indicating various discursive connections between development work, historical colonial heritages and contemporary politics of reproduction as promoted by right-wing authoritarian actors across the globe.

Reproductive governance can take the shape of legislation or direct coercion, or work more indirectly through dominant discourses and "moral injunctions that aim to produce, monitor, and control reproductive behaviours and population practices" (Morgan and Roberts 2012, 241). The narratives by Syrian women illustrate the central role of morality and stigma in reproductive governance. Stigma appeared through comments about their pregnancies and number of children and by not receiving adequate care. Jordanian health care workers emphasized what they saw as the role of culture in Syrian practices of underage childbearing and making large families. In their view, more education is needed to alter Syrian customs of family making and to bring this new refugee community more in line with what is perceived as modern Jordanian society. Syrians are portrayed as ignorant and "irrational" for wanting to have (more) children, showing an "excessive fertility" (De Zordo and Marchesi 2016), similarly to disapproving Western European attitudes of migrant communities' reproductive choices (Sargent 2011, Marchesi 2016). Reproductive, pronatalist politics have not always but often been put in opposition to immigration in national population policies (Solinger and Nakachi 2015). The influx of immigrants and refugees is most often seen as a negative stimulus that spurs encouragement of native reproduction, especially among right-wing actors in the global North. At the same time, representations of non-Western refugees as in need of education and modernization through changes in marriage practices, family size and composition (e.g. Alhayek 2014, McKinley 2003) are deeply rooted in colonial imagery and policy (e.g. Stoler 1989, Ali 2002). Seemingly value neutral modernizing health policies and programs on sexual and family practices in the Global South are underpinned by morality and population management concerns (Pigg and Adams 2005).

Both sections of findings together demonstrate that the discursive shift from population control to reproductive rights has been incomplete. Health care workers aimed to elevate Syrians' reproductive behaviour to be more aligned with international standards and befitting modern Jordanian society. In doing so, they wish to "optimize" population size and composition by promoting particular sexual and reproductive norms, a process coined as 'demopopulationism' (Bhatia et al. 2020, 337). The shift from population control to reproductive rights is incomplete when "some lives are systematically treated as being redundant or excessive" (Bhatia et al. 2020, 338).

The reproductive justice movement seeks to reveal and redress power inequalities. Black women's fertility has long been perceived as both a problem and potential solution to perceived social problems (Roberts 2014). This leads to a tendency to assess, judge, measure and regulate Black women's reproduction. The movement's overall insights resonate with the plight of disadvantaged groups globally such as immigrant, poor, and racialized groups. From within this movement, the notion of reproductive oppression has been advanced to indicate "the controlling and exploiting of women and girls through our bodies, sexuality and reproduction (both biological and social) by families, communities, institutions and society" (ACRJ Asian Communities Reproductive Justice 2005, 3). In contrast, reproductive justice would entail "imagining a world in which people's human rights are respected and protected when they make decisions about whether to become a parent" (Ross and Solinger 2017, 6).

In the context of early marriage and pregnancy among Syrian refugees in Jordan, reproductive justice would entail that women no longer face discriminatory or judgemental treatment when seeking medical reproductive care. It would also mean expanding women's choices to marry (early) or not, and to have large or small families, or no families at all (Sahbani, Al-Khateeb, and Hikmat 2016). In sum, a reproductive

justice lens points at the need of taking individual context and women's stated reproductive choices more into consideration, rather than applying general measures against all underage pregnancies.

Finally, limitations of this paper include the lack of insight into the actual medical needs and questions that Syrian early pregnant women have and raise during medical consults. Data documenting such socio-medical needs seemed largely unavailable and unregistered by the NGOs that were approached during this project. Second, the experiences of Syrian women with the Jordanian healthcare system could be complemented and enriched by data of Jordanian users' experiences. Experiences of differential treatment would perhaps become more clearly articulated after a comparative study. Most of all, more research inquiring into reproductive governance, and the blending of governance and rights discourse in projects with refugee populations is needed to understand better what makes refugees in particular a target group of moral judgements on their reproductive behaviour.

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