

Moral Work and the Construction of Abortion Networks: Women's Access to Safe Abortion in Lebanon

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Abstract

This study explores the intersectional effects of criminalization on women's access to safe abortion in Lebanon. Building on 119 original interviews with women who have had an abortion and physicians who offer safe abortion services, the article analyzes women's experiences through two themes: decision making and accessibility to safe abortion services. The article finds that a woman's decision to abort is morally conflicted and largely dependent on her partner: in the case of single women, this turns on whether the partner is willing to marry the woman and assume paternity of the future child, while in the case of married women, this turns on the husband's agreement with the wife's decision. Women use social networks to gain access to information and to clandestine abortion services. Most of the physicians offering abortion services act as moral gatekeepers, often condemning the woman and preserving certain social norms rather than advocating for women's bodily autonomy and free choice. This article argues that the right to safe abortion is a privilege rather than a right in the restrictive Lebanese context, since access to services hinges on a woman's social capital, networks, and ability to negotiate with partners and physicians. Single women from a lower socioeconomic background stand out as the most vulnerable.

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Introduction

This study explores the intersectional effects of criminalization on women's access to safe abortion in Lebanon. Lebanon's Penal Code, which dates back to 1943, bans abortion except to save the pregnant woman's life. The article explores how women experience abortion across marital status, religion, and socioeconomic status and how women who seek abortion create a space of autonomy in a clandestine context. Building on 119 original interviews conducted between 2003 and 2008 with women who have had an abortion and physicians who offer safe abortion services, the article analyzes women's negotiations with their partners, allies within their networks, and physicians through two themes that emerged from the data material: decision making and accessibility to safe abortion services.

Since 1969, there have been no attempts to expand the circumstances under which women can lawfully seek an abortion in Lebanon. The absence of liberalization of the law, combined with scant research on the effects of criminalization, suggests that abortion is not a public health issue of concern.¹ The scant research available has tried to calculate the number of abortions at one hospital in Beirut and has explored the attitudes of health professionals more generally. For example, William Bickers attempts to estimate the number of abortions in Lebanon based on the number of admissions for spontaneous or induced abortions at the American Hospital of Beirut.² However, there is still no accurate information on the number of legal *and illegal* abortions in Lebanon. (The total number of *legal* abortions, including spontaneous abortions, reported by hospitals to the Vital Data Observatory at the Ministry of Public Health was 10,913 in 2014.³) L. Zahed, M. Nabulsi, and H. Tamim assess the attitudes of health professionals in Lebanon toward prenatal diagnosis and termination of pregnancy for a series of genetic, non-genetic, and non-medical conditions, finding that the highest percentage of positive attitudes toward abortion (90.5%) relates to abortions following pregnancies resulting from rape, while the lowest percentage (20%) relates to abortions sought by pregnant married women without their husbands' knowledge.⁴ The prevailing

literature also emphasizes the fact that criminalization puts a huge burden on health professionals. For instance, Thalia Arawi and Anwar Nassar argue that the Lebanese law on abortion should be amended to allow for abortions based on prenatally diagnosed fetal malformations because they are justified in the interest of the fetus and the child.⁵ They note that "obstetricians are confronted with the burden placed on them under the law to refuse termination of pregnancy, or, when performing them, to forge records or deny having done them."⁶

Furthermore, empirical research on abortion in Lebanon, especially within the social sciences, is not currently available. This study is the first of its kind to explore women's experiences and physicians' practices. Unlike other contexts in the Middle East and North Africa region where restrictive laws lead to unsafe abortions, Lebanon's criminalization of abortion is not an insurmountable obstacle for women who want to safely terminate their pregnancy under medical supervision.⁷ However, the ability to obtain a safe abortion is a privilege in the restrictive Lebanese context, where access to services hinges on a woman's social capital, networks, and ability to negotiate with partners and physicians. Most physicians who offer abortion services act as moral gatekeepers, often condemning the woman and preserving certain social norms rather than advocating for women's bodily autonomy and free choice. Single women from lower socioeconomic backgrounds are particularly vulnerable in these negotiations, given that premarital sexuality is still prone to stigmatization. Thus, marital status and socioeconomic background shape the possibility of accessing safe abortion care and the kinds of experiences women have.

The criminalization of abortion in Lebanon

The Lebanese Penal Code established in 1943 both outright prohibits abortion under all circumstances and bans the selling of substances used to induce abortion (arts. 539–546). Under article 541, a woman having an abortion is subject to imprisonment of six months to three years, and the person performing the abortion is subject to imprisonment of one

to three years. Nonetheless, article 545 stipulates that a woman who has an abortion to “save her honor” would benefit from an attenuating excuse. Although the circumstances under which an abortion is considered to save one’s honor are not stated in the Penal Code, they include various situations, such as pregnancy among unmarried pregnant women and pregnancy resulting from rape. The benefit of an attenuating excuse also applies to the person contributing to an abortion in order to save the honor of a family member or a relative with or without the woman’s consent.

Presidential Decree No. 13187, dated October 20, 1969, reaffirms the prohibition of abortion but modifies the Penal Code by permitting it if needed to save the pregnant woman’s life (therapeutic abortion). Therapeutic abortions are currently allowed based on the conditions specified in article 32 of Medical Ethics Law No. 288 of February 22, 1994, which indicates that the attending physician, before performing an abortion, must consult with two other physicians who have also performed a medical examination, and they all must agree that the woman’s life can be saved only through an abortion.

The government of Lebanon voted for the Universal Declaration of Human Rights and has ratified a number of international instruments dealing with health and human rights, including the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women.⁸ Lebanon’s ban on abortion is part of a legal architecture that limits women’s rights generally in the country. For example, Lebanese women do not have the right to pass on their nationality to their children or to a foreign husband. Depending on their sectarian affiliation, women also suffer from several inequalities within the country’s personal status laws.⁹ When ratifying the Convention on the Elimination of All Forms of Discrimination against Women, Lebanon therefore entered reservations against several articles:

- article 9(2) (equal rights with respect to nationality of the children);

- article 16(1)(c), (d), (f), and (g) (equal rights, divorce rights, parenting, custody of children, and the “same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation”); and
- article 29(1) (administration of the convention and arbitration in the event of a dispute between state parties).

In its concluding observations submitted to the Lebanese state in 2015, the United Nations (UN) Committee on the Elimination of Discrimination against Women called for the decriminalization of abortion, at least where the pregnancy poses a threat to the pregnant woman’s life or health and in cases of rape, incest, and severe fetal impairment.¹⁰ In 2018, the United Nations Population Fund, United Nations Development Programme, and UN Women issued a joint recommendation calling on Lebanon to develop a national human rights strategy related to sexual and reproductive rights, as well as to regulate abortion in line with the laws of some states, such as Tunisia.¹¹

Abortion in Lebanon cannot be studied without first understanding the country’s political and socioeconomic conditions. Since the end of the civil war in 1990, Lebanon has been highly characterized by political crises, systematic public corruption, and governmental disengagement from social problems. The population’s most basic human rights (medical care, food and shelter, education, and employment) are not being met, and social and gender inequities are commonplace. This is the context in which women’s rights organizations currently operate in Lebanon. These organizations’ main aims have been to protect women against gender-based violence, advocate for the right of Lebanese women to grant their nationality to children and foreign husbands, and address the flaws of the personal status laws (especially those related to divorce and child custody). Abortion has yet to be tackled as a major reproductive health right.

Method

I conducted my qualitative study in the five

mohafazat (provinces) of Lebanon (Beirut, Mont-Lebanon, South-Nabatiyeh, North, and Bekaa). I collected data during a six-year period (2003–2008) through semi-structured face-to-face interviews (with the exception of one phone interview) with women who have had an abortion and physicians who offer abortion services. My interview guide for women focused on the following themes: (1) the context of their discovery of their pregnancy; (2) their decision to have an abortion; (3) support received from others; (4) their search for a physician; (5) their interactions with physicians; (6) accessibility to medical care; (7) secrecy management; and (8) their personal experiences of abortion. My semi-structured questionnaire for physicians was based on the following themes: (1) reasons for agreeing to perform an abortion in a clandestine context; (2) cases encountered; (3) how women formulated their requests for an abortion; and (4) precautions and secrecy management.

I recruited participants through personal networks I had fostered during my 10-plus years of work in the development sector, as well as through snowballing. This represents both the strength and the limitation of my study: while close relationships of trust gave me unique access in a clandestine context, they also resulted in a biased sample, which does not allow me to generalize my findings to the entire Lebanese population. All participants gave their informed consent and are anonymized in this article to ensure confidentiality. Interviews were conducted in Arabic and lasted between 45 minutes and three hours. Ethical concerns were addressed by the study protocol set under the supervision of my advisor within the context of my PhD dissertation.

Sample characteristics

The sample includes 84 women (ages 18–65 at the time of the interview) and 35 physicians. The physicians interviewed were all gynecologists who offered abortion services and were located in Beirut (11), Mont-Lebanon (8), South-Nabatiyeh (6), North (5), and Bekaa (5). They included 29 men and 6 women (ages 34–60 at the time of the interview) and included members of the following sectarian communities: Muslim (8 Sunnī, 9 Shī'ī, and 4

Druze) and Christian (14).

In sampling the women who had obtained an abortion, I took the following factors into account: (1) religious/sectarian community (Sunnī, Shī'ī, Druze, or Christian); (2) geographic region; (3) socioeconomic background; and (4) marital status. This theoretical sampling allowed for an intersectional analysis of women's access to abortion. In Lebanon, religious views related to the permissibility of abortion are diverse. Jurists of the Hanafi branch of Islam (followed by most Lebanese Sunnī Muslims) allow abortion at any time during the first four months of pregnancy (the period prior to "ensoulment").¹² For the Lebanese Shī'ī, abortion is also allowed (at any time during the pregnancy) to save the life of the pregnant woman. Druze and Christian religions do not permit abortion under any circumstances. Research on access to safe abortion suggests that socioeconomic background (often reinforced by an urban-rural divide) is also an important determinant. Women with fewer economic resources are therefore at a higher risk of seeking a less safe abortion.¹³

The most important attribute affecting the way women experience abortion in Lebanon is marital status. The sample of single women included 26 Muslims (12 Sunnī, 12 Shī'ī, and 2 Druze) and 15 Christians located in Beirut (13), Mont-Lebanon (8), South-Nabatiyeh (6), North (6), and Bekaa (8). This sample included different variations of being socially (and legally) considered "single" or "unmarried": women who have never been married; women who have concluded the *kitab*, which is the formal religious engagement preceding the wedding ceremony; women who have had a "temporary marriage"; and (iv) divorced women. (Temporary marriage is practiced within the Shī'ī community in Lebanon and is a contract between a man and an unmarried woman permitting sexual relations for a fixed amount of time.¹⁴ It does not require witnesses. At the end of the agreed-on period, the temporary marriage automatically terminates without any divorce procedure. This contract liberates the individuals involved from religious guilt, but not fully protecting the woman socially. The Lebanese state does not forbid temporary marriage

but it also does not recognize it, and it is also not accepted by all members of the Shi'i community.) The common characteristic among all of the single women interviewed was that their single status put them in a vulnerable situation when seeking an illegal abortion because their pregnancies were attached to stigma and shame.

The sample of married women included 26 Muslims (10 Sunnī, 10 Shi'i, and 6 Druze) and 17 Christians. They were located in Beirut (12), Mont-Lebanon (7), South-Nabatiyeh (10), North (6), and Bekaa (8).

Data analysis

I analyzed data using the grounded theory, whereby data collection and data analysis are conducted in parallel.¹⁵ I drew concepts out of each interview and then categorized them. I then performed a comparative analysis and axial coding. My analysis of patterns within the data yielded the two categories explored here: decision making and accessibility to safe abortion services.

Results and discussion

Inspired by Anselm Strauss's theory of negotiated order, I conceptualized decision making and accessibility to safe abortion services as moments of negotiation.¹⁶ Throughout the process of discovering the pregnancy and deciding to terminate it in a clandestine manner, women negotiated with their partners, allies, and physicians in order to have access to safe abortion. Following from Strauss's theoretical perspective, the decision to terminate the pregnancy is not predetermined but rather the result of a negotiation where women and physicians create, maintain, transform, and are constrained by the illegality and social status of abortion. My intersectional analysis shows that religious affiliation has little impact on this negotiation, while marital and socioeconomic status are the most important determinants in negotiating access. Unmarried women from lower socioeconomic backgrounds are the most vulnerable, but even this group is able to access safe abortion services in medical clinics.

Decision making: Negotiation with the partner

For most of the women I interviewed, the decision to terminate the pregnancy was not made in isolation from their partner. In fact, it was largely dependent on the partner's decision to marry and assume paternity (in the case of single women) or to agree to the abortion (in the case of married women).

The most important element in all single women's trajectories was the nature of their relationship with their partner. Among those who were in a stable relationship, 7 continued the relationship and got married, while 26 ended the relationship following the illegal abortion. The seven women's reasons for seeking an abortion related mainly to finance, education, and the desire not to start childrearing at that precise moment. For women who wanted to continue the pregnancy, the possibility of an induced abortion was a source of conflict within the couple because their partners wanted them to terminate the pregnancy.

For the 26 women who ended their relationships, negotiations with the partner were crucial. They initially tried to convince their partners to marry them. They wanted to proceed with the pregnancy but were nevertheless faced with the partner's rejection, which then prompted them to resort to illegal abortion. The women's confrontation with their partner about the pregnancy, the decision of the partner regarding marriage, and the decision to terminate the pregnancy (or not) were key moments of negotiation. The discovery that the partner was not really committed to the relationship and did not have the woman's welfare as the primary concern was a painful process.

For example, 21-year-old Massa had been engaged to her partner for eight months. At the moment when she discovered that she was pregnant, she and her partner had already bought a house and were in the process of furnishing it. They had yet to set a marriage date. She recalled:

He told me he would think about it [the pregnancy and the need to get married as soon as possible]. After two days, without any response from him, I called him. He asked me to get rid of the fetus. I cried a lot, I begged him. ... He replied, "I do not

know, I'm not even sure the child is mine." I was depressed. I did not understand what he was saying, that the child was not his. Then he told me, "Maybe you cheated on me." I decided to have an abortion because my fiancé did not trust me. ... It was agreed that the fetus should not be kept, that he should accompany me to the physician and that he himself should pay for the operation. He knew I didn't have money and as soon as I had some money, I used it to buy things for the house.

Her partner, meanwhile, was rushing her to have an abortion because he did not want to lose face socially. Massa did not break up immediately, since her partner was an important ally in helping her access an illegal abortion. However, the relationship ended shortly after the procedure.

Another respondent, 36-year-old Nada, had an abortion a year before our interview. She had been hoping to marry her partner and give birth to their child, but these hopes were in vain. She described her turmoil:

I was completely lost. He called a physician, his friend. He told him that he knew a close person who has a problem, who is not married, and who needs to have an abortion. He did not even tell him that it concerned him personally. ... I called the physician on his mobile. I was crying. I could barely articulate my words. He set an appointment for me. I went there. ... When I arrived at the clinic, I said to myself, "I have to be strong, I should not cry." But as soon as the physician asked me what was happening, I started to cry. This is the time I cried the most in all my life! I cried over my wasted life. I could not even breathe. I remember crying like that once when I was five years old because someone hit me. The physician told me that it did not matter and that he had many such cases, that sometimes even the girl was still a virgin. I was still crying. I was in the waiting room. The secretary was sitting at her desk. She was an old woman, small in size. She said to me in a reassuring tone, "It's nothing, it's nothing, do not worry. It's really not worth it." It helped me a lot. This is the only support I have had in this whole experience.

Partners are also an important ally for married women. Unlike the single women I interviewed, only a minority of married women (six) terminated the pregnancy against their choice. These women

were pressured into an abortion by their husbands or families. The majority of married women, however, wanted to terminate the pregnancy. This group includes three main subgroups: women who already had at least one child and who did not plan for the additional child (they invoked reasons of birth spacing, finances, advanced age, and disagreement with their husbands); women who had no children and who did not want to have any at that particular moment (they invoked reasons of finances and a desire to pursue their education); and women who had gotten pregnant within the context of an extramarital relationship.

Rowayda was 35 years old, had been married for 18 years, and had four children. She explained the circumstances of her decision to have an abortion:

I did it because, thank God, I have four children. My house is very small. I have two rooms, one for my children and another for me and my husband. Financially, we are not so comfortable. And I have two children not so old; the nine-year-old and seven-year-old exhaust me a lot. I did not need one more child. I needed rest. When the operation was over, I was relieved. Before the operation, I felt a burden on my heart. I was desperate. I had two cases of death in the family. My mother and sister had died recently. I had a depression. ... I was relieved after the operation.

Souheir was a 43-year-old teacher who had been married for 17 years and had daughters aged 8, 10, 13, 14, and 16. She always wanted to have a boy. She recalled:

I felt that I was carrying a burden on my back, I was afraid of the pain because it was the first time I had an abortion ... the physician was understanding and kind, I was comfortable in his clinic. I did not feel anything during the operation. ... I felt relieved, but I was bothered by the fact that it might have been a boy.

Her husband was at home when she returned:

When I came back home, he said to me, "Thank God you are safe!" And he started crying. So, I cried with him. ... He thought like me, that maybe it's a boy, many times, he wanted a boy. ... At the time of the operation, I did regret it. But it's over.

... Sometimes I think about it when it comes to my mind, but I stop immediately.

Marital status is an important determinant in women's decision-making process. Whereas most of the single women who were in a stable relationship wanted to continue with the pregnancy, they felt forced or pressured by partners to undergo an illegal abortion. These women ultimately made the decision to abort to avoid the stigma of single motherhood. The married women who terminated their pregnancies had a variety of reasons for doing so. However, in both groups, the decision to proceed with the pregnancy was clearly not the women's decision alone.

Negotiating access to safe abortion services

Allies who help women find a physician. Explaining their pregnancy (and consequently their sexuality) is a burden experienced by many single women seeking an abortion. Their pregnancy constitutes a confirmation of a sexual relationship; both of these elements (or at least the pregnancy) have to be kept secret to avoid stigma. In fact, these elements form an important part of a single woman's negotiation with her allies and later her physician in terms of presenting her case for an illegal abortion.

Married women may already have access to a gynecologist, but most single women do not and therefore must rely more heavily on their networks and social capital to access safe abortions. Compared to their single women counterparts, married women interviewed were more at ease in asking for help and disclosing their situation to a range of allies. It was only when their regular physician refused to induce an abortion that married women truly relied on the help of relatives or friends to access safe abortion services. In contrast, single women had to choose their allies with great care in order for their secret (pregnancy and/or sexual relationship) to be kept confidential.

These women's networks were based on kinship and friendship. For example, single women might ask a family member or friend to help them find a physician who would perform an abortion.

Family members who became allies most often included the woman's mother, sister, or sister-in-law. Allies outside of the family included friends and work colleagues who were aware of the existing relationship. The women describe these allies as "true friends."

For example, 23-year-old Salma had an abortion three months before our interview. She described the support provided by a friend who was a nurse:

Initially, I wasn't aware of anything, I was feeling dizzy. I asked my friend; she told me that I had to do a pregnancy test, that maybe I was pregnant. We bought the test—she bought it. I was afraid to go to the pharmacy. ... My friend found the doctor, she talked to him. She explained my situation to him, she talked to him and made an appointment.

Salma trusted the physician because she trusted her friend. After the operation, Salma stayed overnight at her friend's house. She explained:

She did not blame me. ... She is the only one who knows my story. She is the only person that I trusted and she helped me in everything. I just told her and she offered her help.

Aya, a 23-year-old divorced woman, had entered a temporary marriage. She did not have children from her first marriage. After her divorce, she lived with her parents in her village. She had an abortion seven or eight months before our interview. Her sister helped her find a physician. Now remarried (to a different partner), Aya recounted her experience:

I told my sister. I told her everything. My sister and I are very close friends. She's married. At first she was shocked. ... I stayed at my sister's house all the time. My brother-in-law was not aware of anything [surrounding my circumstances]. He comes home late in the evening. Every day, I used to ask my sister if she had managed to find a doctor. The doctor that I usually go to knows her husband; she was afraid he might tell him. We had to find another doctor. Honestly, I do not trust anyone else; your sister will support you more than anyone else. If something happens to you and people start talking about you, it's as if they are talking about her, while your friend will leave you in a second. ... When I

entered the clinic, I was afraid of dying ... I hugged my sister, and I begged her, "Take care of yourself and your children, and give mom a big hug for me ... and please do not tell her how I died." ... My sister started crying.

Physicians' gatekeeping role: Negotiating "fault" and "morality." Physicians who offer abortion services do not want to face legal problems later on and do not want to be recognized as physicians who offer abortion. Marwan, a physician from Beirut explained:

Sometimes the girl's father or someone else files a complaint against the doctor. It doesn't happen frequently, but it does happen. We cannot fully give our trust. ... Some colleagues have had problems. They helped a woman, and the next day the father or a family member threatened to sue them.

Physicians' consent to perform the procedure is based on their personal assessment of the woman's situation, especially her marital status, and the circumstances surrounding her pregnancy. The physicians I interviewed mentioned taking the following factors into consideration for single women: (1) the possibility (or impossibility) of marriage and (2) the stage of the pregnancy. Majed, a physician from Mount Lebanon, stated:

At the beginning I used to refuse. Later on, I accepted doing the operations because the patients were doing self-medication.

The majority of physicians (26) used the term "fault" in describing the situation that single women were in because of their sexual relationships. Hyam, a female physician from the South, said:

Once a girl arrived. She came from school. She was carrying her schoolbag. ... She was 16 to 17 years old. I knew her mother, a decent person. ... She told me, "Auntie, it has been two months since I haven't had my period." ... I explained to her that she was pregnant. She was terrified. She begged me to help her. She told me that her mother could kill her. You feel she's like your daughter. I made her cry a lot. I do not want her to have other sexual relationships. Sometimes I meet her at the market. She lowers her head. She feels ashamed.

The degree of the pregnant woman's "fault" is the point of departure for negotiation for most of the physicians. As soon as an unmarried pregnant woman enters a physician's clinic, she must provide an account of her behavior, especially if she is young. She must often admit to having made a mistake (the sexual act), but the circumstances surrounding the relationship may help mitigate the perceived "fault." According to the physicians I interviewed, the most commonly used argument by these women is that they loved a man who promised her marriage and then abandoned her. The woman presents herself as a double victim: the victim of the man she loved and the victim of her own naivety and love.

Some physicians even suggest hymenoplasty to women to restore their virginity and thereby increase their marriage prospects after the illegal abortion. For example, Diana, one of the women I interviewed, said that her physician called her a few months after her abortion and offered to perform a hymenoplasty free of charge:

I refused. She asked me why. I told her that I was against this idea. She told me that she herself was against it, but that if I wanted she would do it.

All physicians I interviewed stated that if the partner is present and seems committed to the relationship, they try to convince the couple to get married. Some even recommend that the partner declare that the newborn was born at seven months instead of at nine months to suggest to the public that the pregnancy occurred after the marriage, and some physicians will even leave a newborn in the hospital incubator for one or two days to give the impression of a premature delivery. In such cases, physicians are acting as moral gatekeepers by preserving social norms related to the expectation that women should not engage in sexual activity before marriage.

For married women who have many children, physicians who are aware of the impact of socioeconomic conditions are often willing to terminate the pregnancy. In addition, if a married woman becomes pregnant by a man other than her husband (six physicians cited this situation), physicians will

also perform the operation to preserve the marriage. However, physicians, out of fear of possible legal consequences, will generally refuse to induce an abortion if there is disagreement within the couple.

Thus, physicians also operate as moral gatekeepers to preserve social norms related to married women's role in reproduction. Physicians indicated that they do not terminate the pregnancies of all women who approach them. Rather, they make their own moral choices based on the circumstances of the pregnancy and the woman's relationship with her partner. Interestingly, religious identity does not affect this "moral" decision making, since physicians of all major religious denominations offer abortion services, in spite of the fact that the permissibility of abortion varies according to the different religions. However, some physicians must separate their role as a doctor from their religious beliefs, while others are able to reconcile the two. Of the physicians I interviewed, the Sunnī and Shī'ī ones were able to reconcile their religious beliefs and the practice of abortion, while the Druze and Christian ones, recognizing that abortion is not allowed in their religion, had to separate their role as physicians from their religious beliefs.

Financial constraints. Socioeconomic background limits access to safe abortion because the price of a clandestine abortion can be very high. In Lebanon, the price of an illegal abortion varies between US\$150 and US\$2,400. A number of factors determine the cost: the physician's status (that is, credentials and reputation), the location of the medical clinic (urban versus rural and economically privileged versus disadvantaged neighborhood), the client's financial means, and characteristics of the demand (for example, early versus late pregnancy). Considering that the minimum wage set by the government is only US\$633 per month, for some women, the cost of an illegal abortion is almost insurmountable.

In the midst of emotions such as fear of the operation, regret, guilt, fear of punishment, and relief, women must consider the financial cost of the abortion. Here too, marital status and socioeconomic background are important determinants.

Of the women I interviewed, married women from the middle and upper classes were more often able to have an abortion in a hospital setting because they were affiliated with health coverage schemes (for example, the National Social Security Fund or private insurance plans). In those cases, the abortion would be registered in the medical files as a miscarriage. Married women from disadvantaged socioeconomic backgrounds who did not have access to health insurance often had to seek an illegal abortion at a private clinic.

Feyrouz was a 42-year-old woman who had been married for 13 years. She had three children, ages 3, 11, and 12. She had undergone two abortions, and explained her first:

I got pregnant before having my youngest daughter. ... I told my husband, and he did not allow me to keep the fetus because he was unemployed. ... I told my story to the pharmacist. He sold me a medicine and told me to put two tablets in my vagina. I put two tablets and started bleeding. We were scared. My husband accompanied me to my physician. He [the physician] blamed me. ... I had consulted him before to ask about getting an abortion, but he had refused, so that's why I consulted the pharmacist. ... [The physician] did the operation without anesthesia.

She then recounted her second abortion:

I was afraid of a second hemorrhage. I contacted my physician and told him that I had taken the pregnancy test and that the result was positive. I informed him that if he was not going to do the abortion, I would take the same medicine. So he gave me an appointment at the hospital. I went to the hospital, and my husband accompanied me to formalize all necessary papers, since I was insured by the National Social Security Fund. The physician did not say that it was a voluntary abortion but an abortion because of bleeding.

However, most single women cannot seek an illegal abortion through their health insurance or their family physician because doing so would expose their double secret of the sexual relationship and (or at least) the pregnancy, thus causing them shame. They therefore must seek a clandestine abortion at a private clinic. The cost sometimes constitutes a

huge burden.

For example, Nawal, a 23-year-old, had an abortion about a year before our interview. She had to secure the funds in a way that was at odds with her ethics and morals. She explained:

My friend took me to a physician she knew. She made the appointment for me. Everything was already set. She said, "Don't worry. Just bring the money." She took care of everything; she spoke to me, then spoke to the physician. ... The price was a big problem. At the first visit, I did not have money. When he set the date for the next day, I had not looked for it yet. I did not even have US\$10 of the US\$400 he requested. Imagine that I had to steal: Mom had a golden bracelet. I stole it to secure the money.

Marital status and socioeconomic background are important factors in determining women's access to safe abortion in the clandestine context of Lebanon, with single women from disadvantaged socioeconomic backgrounds standing out as the most marginalized.

Conclusion

In contrast to women in other developing countries with restrictive abortion laws, women in Lebanon are largely able to access safe abortion services in medical facilities. Nonetheless, access to safe abortion is not a right but a privilege, with access hinging on a woman's ability to negotiate with partners, allies, and physicians. The process of negotiating access to safe abortion reinforces socioeconomic inequalities and patriarchal structures that constrain women's options. Against the legal backdrop of a state that denies women basic citizenship rights, women cannot make this crucial decision about their reproductive lives without first getting a green light from their partners, who hold an upper hand in the decision-making process. Whether or not single women continue with a pregnancy depends largely on their partners' willingness to marry them. Meanwhile, married women must negotiate with their husbands when deciding whether to continue a pregnancy, thus making the decision one based not only on the

woman's personal choice but also on factors such as the family's financial situation.

Physicians play both a medical and a social role in offering abortion services. They allow women to negotiate access to abortion only under certain circumstances, which are almost always in line with prevailing social norms related to preserving the institution of marriage. Without a husband's consent, most physicians will not perform the operation unless the pregnancy results from an extramarital relationship.

On October 17, 2019, anti-corruption protests erupted throughout Lebanon. The grassroots movement gained momentum and called for a revolution (*thawra*). Women have been at the forefront of these protests, and sexual and reproductive rights are on protestors' agenda, making the possibility of social change in the near future a real one.

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