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Sectarianism and the problem of overpopulation: political representations of reproduction in two low-income neighbourhoods of Beirut, Lebanon

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The role of confessionalism in the Lebanese healthcare sector, especially since the resolution of the Lebanese civil war (1975–1990), has yet to discussed at length in reproductive health research. Using biopolitical and structural violence models to describe how community leaders in two low-income neighbourhoods in Beirut describe reproductive healthcare – specifically through judgments of perceived sect size vis-à-vis perceived use of birth control measures – this paper attempts to provide critical analysis of the state of reproductive health in this setting. By using a theoretical model of analysis, which we refer to as the political anatomy of reproduction, we hope to unmask how confessionalism is perpetuated through discussions of reproductive health and how public health and medical communities can challenge this technique of power.

Keywords: Lebanon; reproductive health; structural violence; biopolitics; sectarianism; community health

Introduction

[Lebanon] is not a homeland … it is just a place where people exist. (Elias Khoury, as cited in Hovsepian 2008, 40)

Reproductive health in Lebanon has been subject to a significant amount of analysis from public health and political perspectives (see El Kak et al. 2004, 2009; Kaddour, Hafez, and Zurayk 2006; Myniti et al. 2002; Zurayk et al. 1997, 2007). These analyses focus heavily on the gendered distribution of disease and the role of public health in providing for reproductive health needs, such as pre-natal care, contraception and routine gynaecological services. Little is known however, about the opinions of health providers, religious leaders and other health officials (defined henceforth as community leaders) regarding reproductive healthcare in poor communities in Beirut. This study aims to bridge the gap between the phenomenological experiences of poor women described in other studies (see El-Kak et al. 2009; Zurayk et al. 2007) and the structural analyses of healthcare services, through a focus on perceptions of the biomedical, psychological and social aspects of healthcare provision among community leaders.

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Our analytical framework draws on Michel Foucault’s notions of biopower and political anatomy. As described in his analysis of the prison system in nineteenth-century Europe,

A ‘political anatomy’, which was also a ‘mechanics of power’, was being born; it defined how one may have a hold over others’ bodies, not only so that they may do what one wishes, but so that they may operate as one wishes … (Foucault 1977, 138)

In the context of the present study, political anatomies focused on the reproductive process (i.e. the political anatomy of reproduction) may be seen as a tool of biopolitics, with the goal of the ‘subjugation of bodies’ (Foucault 1978, 140). Although Foucault’s initial analysis focused on the regulation of bodies for economic gain, this is merely one manifestation of biopolitical state power, with medicine and public health falling under the fold of these ‘techniques of power’ (see Bourgois 2000, 2002; Fassin 2007).

In Foucault’s theoretical model, any analysis of medicine and public health must be rooted in an analysis of the state and of how techniques of power, such as the political anatomy of reproduction, are manifested in the history and sociopolitics of a given region.

The concept of structural violence is of value in making sense of the translation of biopolitics from the state to the local level (see Green 2011; Quesada, Hart, and Bourgois 2011). As described by Farmer (2010) in his analysis of Haiti, structural violence is at once both,

… structured and structuring. It constricts the agency of its victims. It tightens a physical noose around their necks, and this garrotting determines the way in which resources – food, medicine, even affection – are allocated and experienced. Socialisation for scarcity is informed by a complex web of events and processes stretching far back in time and across continents. (369)

The importance of Farmer’s analysis is not only the emphasis on history and politics, but also its direct link to everyday suffering. Although the concept of structural violence has been criticised in the anthropological literature for being too broad (see Bourgois and Scheper-Hughes 2004; Wacquant 2004), the call for an empirical specification of suffering and its relation to other forms of violence is an arena in which we hope the present study will be able to contribute. The social order we are focusing upon here – namely community leaders and how they perceive reproductive healthcare – can shed light on the perpetuation of inequalities and violence in low-income communities. Furthermore, understanding the historical, gendered and political components of life in these impoverished communities provides a further contextualisation not only of the constraints under which community leaders provide services, but also how specifically the political anatomy of reproduction exerts its influence.

Applying these modalities of thought to Lebanon, it is important to note that throughout Lebanese history, national ideology versus confessional identity has given rise to conflicting and, at times, confusing dialogue in the sociopolitical arena (Hovsepian 2008; Makdisi 1996, 2008; Saadeh 2007; Salibi 1988; Traboulsi 2007). Personal identification with a certain religious sect, though the core principle of confessionalism, is made more complicated by the political, social and economic manifestations associated with a given policy. In line with the 1943 National Pact, 18 confessionals occupy different leadership positions within the government. This allocation is rooted in the last known national census of Lebanon, conducted in 1932. At that time, Maronites were the majority, constituting 28.8% of the population, justifying the provision of the seat of presidency to this group (Hourani 1946, as cited in Sen and Mehio-Sibai 2004, 531–2). Similarly, other confessional sects were given differing positions in the new Lebanese governmental structure. Under the Ta’if Accords of 1989, the powers of the Maronite president were
reduced and changes in the confessional proportion of Parliament were instituted. However, the confessional system continued relatively intact, despite calls for the secularisation of government structure with the Cedar Revolution in 2005, in the wake of Prime Minister Rafik Hariri’s assassination, and the March 14th Alliance, which continues to advocate for governmental reform.4

The calls for secular reform and the role of confessional power are rooted in the changing demographics of Lebanon. Current estimates demonstrate that of the current population, 60% are Muslim, with only 25% being Christian, mostly Maronite (Jawad 2008, 144). Significant concentrations of Shi’a continue to live in southern Lebanon, with dense populations also inhabiting the southern suburbs of Beirut. The importance of governmental power equated with a given confessional size, as elucidated by the failure to conduct another formal census since 1932, points towards the role of reproductive health – if confessional size equates with potential governmental power, the fertility and birth rates of a given sect are of great political and social consequence. Our study was conducted from this standpoint and attempts to demonstrate how community leaders perpetuate this mentality through perceptions of reproductive health.

Against the background of these historical and political events, and especially the consequences of the Lebanese civil war (1975–1990), we focus on the southern suburbs, known as al-Dahiyya (the suburb) in Beirut. Commonly described as ‘the Shi’a ghetto’ (Deeb 2006, 42), the area is a conglomeration of multiple neighbourhoods outside Beirut. Al-Dahiyya is both socioeconomically and confessionally diverse, although a significant proportion of the neighbourhoods are known for crippling poverty and majority Shi’a populations. The area is also known for high levels of Hezbollah and Amal activity, specifically social service provisioning in the form of schools, clinics and hospitals. However, both neighbourhoods have their distinct qualities, such as Bourj al Barajneh’s proximity to its namesake Palestinian refugee camp, which has been the site of multiple struggles throughout the Lebanese civil war to the present (see Sayigh 1994). The two neighbourhoods in which this study was conducted, Bourj al Barajneh and Hey Es Sallom, form part of al-Dahiyya and were chosen for convenience, as our host non-governmental organization (NGO) runs clinics and community programming in these areas.

Regarding the demographics of these two regions, Jawad (2008, 321) notes that approximately 28–32% of the Lebanese population is described as poor, with half concentrated in urban areas and al-Dahiyya described as the poorest area in Lebanon. In a study of 1869 women living in Hey Es Sallom, Zurayk et al. (2007, 621–622) found that 42% of women reported an elementary-school level of education, with an average yearly household income of USD $5459. Placing these values in the context of reproductive health, the mean number of live births per woman (aged between 30 and 50) was between three and four, higher than women in ras Beirut (Zurayk et al. 2007).5 Likewise, data from the Pan Arab Project for Family Health (2006, 199), collected in 2004, indicates that only 50% of women in Lebanon will receive postpartum care after the birth of their last child, indicating poor follow-up in gynaecological management of women. With respect to contraception, approximately 58% of women use some form of family planning, while 34% of those use ‘modern methods’ (i.e. hormonal or barrier). Intent-to-use rates for birth control methods indicate that one out of eight women will use within one year, with education being a significant predictive factor.

Together this data suggests that issues in reproductive health are focused on adequate routine care, high birth rates in al-Dahiyya and use of modern birth control methods. Moreover, the complexities added with regards to female education and poverty make healthcare and social initiatives the focus of many endeavours by political parties, NGOs
and faith-based organizations (FBOs). The importance of understanding not only how reproductive healthcare is described by those helping to provide it but also how those perceptions reflect certain sociopolitical and gender biases, can impact on the provision of patient-centred services and better-tailored programming for the populations NGOs, FBOs and political parties serve.

Methods

In June and July 2010, the first three authors conducted semi-structured key informant interviews with a convenience sample of 30 community leaders in Hey Es Sallom and Bourj al Barajneh. These individuals provided a variety of services, ranging from direct community involvement with health issues (i.e. community health workers and physicians) to policy management and reproductive health education (see Table 1).

Individuals were identified with the help of a local NGO’s clinical staff in both study sites. Participants were interviewed using a standard series of open-ended questions, with up to two individuals from the research team present for both translational and note-taking services. These questions focused on participants’ descriptions of reproductive healthcare (defined as obstetrics/gynaecological services, contraceptive services and psychosocial counseling services) and their suggestions for improving the healthcare system in Lebanon. These interviews were audio-recorded and transcribed, with the initial audio recording destroyed to maintain the anonymity and confidentiality of the subjects. A total of nine interviews were conducted in Arabic, with one author (KS) serving as a translator, while two interviews were translated by an anonymous member of our hosting NGO and a trusted contact fluent in Arabic. The rest of the interviews were conducted in English. These transcripts were then analysed to elicit key public health, medical and anthropological themes. All names presented in this paper have been changed to maintain the anonymity of the subjects involved in the study. Institutional review board approval of the study was obtained from Boston University and Lebanese American University.

Results and analysis

The social representation of reproduction

Confessionalism and the modern healthcare system of Lebanon

The modern healthcare system in Lebanon is both the product of the Lebanese civil war and an unfettered emphasis on laissez-faire economic principles, promoting the rise of a strong private and charity-led healthcare sector (Kronfol and Bashshur 1989; Mehio-Sibai and Sen 2006; Sen and Mehio-Sibai 2004; van Lerberghe et al 1997a, 1997b). With the rise

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Male</th>
<th>Female</th>
<th>Average age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>6</td>
<td>1</td>
<td>50.5</td>
</tr>
<tr>
<td>Nurse</td>
<td>0</td>
<td>2</td>
<td>38</td>
</tr>
<tr>
<td>Community health worker</td>
<td>0</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Public health official</td>
<td>2</td>
<td>6</td>
<td>43</td>
</tr>
<tr>
<td>Medical social worker</td>
<td>0</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Public school employee</td>
<td>1</td>
<td>2</td>
<td>43</td>
</tr>
<tr>
<td>Religious official</td>
<td>1</td>
<td>0</td>
<td>undisclosed</td>
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<tr>
<td>Total</td>
<td>10</td>
<td>20</td>
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of private healthcare, there has been a substantial contribution of services from FBOs, political parties (see Flanigan and Mounah 2009; Silverstein 2007) and other social organisations with religious links (see Deeb 2006, 2009). Recent research in Lebanon indicates that over 78% of all outpatient reproductive-healthcare visits occur in private health facilities and only 9% of the population uses public facilities (El-Kak et al. 2009, 60). However, access to private healthcare is not necessarily stratified by socioeconomic status, as El-Kak and colleagues note:

The selective use of private services, even among women living in poor communities, is related to historical preference of the widely available and dominant private sector over the relatively weak, marginal (in coverage), and neglected public health services, and to other community factors. (63)

This public-private dichotomy is associated with political, social, economic and confessional factors that were discussed in interviews with study participants.

Amir, a public health official working in Bourj al Barajneh, described the relationship between public and private sector health systems as inherently combative: ‘The private sector will usually talk about how the public sector – the government – is bad. . . . So they see themselves as providing a better quality service compared to the government.’ Throughout the interview, he made references to the confessional nature of the private sector and the health services niches delineated in the community by Shi’a, Sunni, Druze and Christian organisations. These observations were not unique to Amir, but were raised by multiple participants throughout the study. Zahra, a young, eloquent public health official working with both Palestinian and Lebanese communities in Beirut, described the status of confessionalism in the healthcare system as follows:

Confessions themselves are like stand-alone entities – for example, the Catholics. They have their own hospitals, charities, social services. But Catholic social services are not open just for Catholics, but to everyone. But Catholics might feel that they get better care there, which may or may not be the case.

There is an assumption here that although the private health sector is open for all to use, the confessional alliance of a given hospital or clinic influences which populations are served (see Cammett and Issar 2010). Sen and Mehio-Sibai (2004, 530) attribute the rise of private health industry to the destruction of the public health sector during the Lebanese civil war; this process has become entrenched within confessional politics and private business. Ultimately, an individual’s confessional identity, described as the overriding marker in modern Lebanese culture and politics, directly influences decision-making regarding access to healthcare services.

Yet, the fractured nature of private sector healthcare based on confessionalism is made more complex given the inability of the national government to formulate a cohesive, comprehensive health policy (van Lerberghe et al. 1997a, 1997b). Amir’s description of the public-private interaction as competitive, with descriptions of the inadequacy of governmental policy, is one such critique of the Lebanese health system. Zahra elaborates:

In Lebanon, you see no national policies and strategies in the health sector. . . . And the government also doesn’t have a clear vision; you keep seeing endeavors replicated by different actors. There are no consolidating efforts; there’s a lack of coordination.

The public-private split in the modern healthcare system, the inadequacy of the public sector to adapt or formulate health policy and the fracturing of the private healthcare sector by confessionalism have led to a lack of communication and leadership in health policy and politics in Lebanon.
Reproduction and sectarian balances – the political anatomy of reproduction

As a result of the confessional nature of the private healthcare system in Lebanon, reproductive healthcare has adopted elements of sectarian politics. The underlying power structure of the private healthcare system upon which a majority of Lebanese depends manifests itself through unique discourse regarding fears of changes in the sectarian balance. These fears are communicated through stereotypes regarding reproductive patterns, sexual activity and use of contraceptive services of certain confessional groups. Lea, a public health official working in Bourj al-Barajneh, described reproductive choices of the Shi’a sect via an interaction she had with a young man in southern Lebanon, near the border with Israel. Although he had five children, he told Lea that he wanted to have more. When asked why, he said ‘I want to have more kids in order to resist Israel.’ This addresses two major issues facing modern Lebanese politics: the role of the ‘minority’ Shi’a population and continued Israeli influence in southern Lebanon. While these issues have been explored through multiple other works, both aspects continue to influence and shape reproductive healthcare provision and perceptions. As a result, political resistance and confessional balance are inherently intertwined with discourse on reproductive healthcare.

Suad Joseph (1997) has described the concept of ‘patriarchal transportation’ in Lebanon, or a patriarchal ‘state-imagined sphere deployed to define and police householding arrangements’ (79–80). The descriptions of reproduction as a form of resistance against both Israel and the confessional balance within Lebanon reflect a ‘confessional transportation’ regarding reproduction. Solwa, a pediatrician and public health advocate, highlights this issue:

Solwa: In general, reproduction is a political issue and it’s promoted. Some political organisations – [they say] people get married, they reproduce …

Interviewer: For sheer numbers?

Solwa: Yeah. This is one aspect of it. The other aspect is that sexuality should be controlled. It should be about family. It relates to the theology of the sect. And in that way, it is an issue, [especially] how much control you have over the population.

Solwa touches on both the religious aspects of the sect itself and the political outcomes of a confessional system to describe both power and control. Noor, a public health official, described the control that religious leaders have over the domain of reproductive healthcare and sexuality:

Well, let’s talk about these communities and consider the fact that a single woman should [not] be having sex, but religiously it’s a community that’s run – even if it’s political – the political leaders are somehow attached to their communities religiously. … They don’t want to bring revolutionary ideas or anything in terms of even contraceptives or condoms.

Reproduction, in effect, becomes a political activity and the role of reproductive healthcare embodies the sociocultural environment in which it is embedded. The imposition of sociopolitical values creates a sphere wherein judgments about reproduction can be fine-tuned to the social climate and used to exert power and control. This is the political anatomy of reproduction.

Sectarian judgements of population size

Population size, reproduction and birth control

The lack of a census since 1932 and the subsequent struggles for political representation among multiple groups make population size a complicated topic. The perceived reproductive rate of a given sect, described in terms of population size, becomes a marker
both for sectarian balances and a moral barometer for sexual activity, a theme brought up by multiple respondents:

I think that … Christian communities, they tend to have less children than in Shi’a communities or in Sunni communities or Druze. [Pause] And this is related to the religious background [of the group]. (Sara, a public health professional)

… [Y]ou know some religious people – like for the Christian, the Catholic – it’s forbidden to use the contraceptive – it’s considered haram [forbidden]. They use it less. But from what I hear, it’s a personal matter. (Ida, a public health worker)

People don’t consider limiting their children. … [T]hey say, in Islam, it is haram to decide how many children you want to have and limit your offspring. (Mahmoud, a public school employee)

In these narratives, it is apparent that a judgment of the reproductive capacity of a sect is measured directly by perceived population size and indirectly by assumed birth control usage.9 Justifications, ranging from contraceptive policy to the nebulous ‘religious background’ of an individual, are used to explain why sects are increasing or decreasing in perceived size. Reproductive healthcare and birth control, then, become natural targets for analysis within the framework of confessional politics.

But where is the individual woman in our subjects’ analyses? Ida hints at the topic, relegating the choice of contraception use to a personal space. Yet the importance of the individual woman in this sociopolitical framework is crucial to understanding how the issue of sectarianism manifests itself in the everyday reproductive lives of women in these low-income communities. To attempt to assess this question, we asked our subjects whether or not an individual woman had the right to choose to use reproductive healthcare services. Two-thirds of our sample stated that it was her right to do so.10 However, given the aforementioned confessional politics behind reproductive health in Lebanon and the patriarchal family system in place throughout much of the country, can reproductive health be a decision made solely by an individual woman?

Female autonomy and confessionalism – applying the political anatomy of reproduction and modes of resistance

Despite the presence of the political anatomy of reproduction, many respondents described the importance of individual decision-making regarding use of reproductive healthcare services.11 Yara, a community health worker, described the importance of having an individual woman control her own reproductive health in the context of a sexual relationship:

I am a separate entity. I am a woman, I can decide on my own. … If we are talking, for example, of the decision of abortion, here you could involve your partner because, after all, it’s a partnership you have together and your kid together that you might have or might not have together. So here it could be open for discussion, but this does not mean if your husband tells you to keep it and you know you cannot leave your job, you don’t want to leave your job, you don’t want to make this sacrifice here …

Yet the socioeconomic and gendered pressures of the hypothetical situation proposed by Yara demonstrate the political anatomy of reproduction exerting force on female autonomy and reproductive capabilities. To frame the problem another way, Lara, a 28-year-old public health official working in Bourj al Barajneh, said, ‘I wonder about her [an individual woman’s] autonomy, and how much of a role it plays. It’s just the atmosphere of violence there doesn’t really support the woman and autonomy.’

The ‘atmosphere of violence’ that Lara describes is the policing framework that enforces the political anatomy of reproduction. Violence – structural, symbolic and
normalised – routinises the suffering experienced by poor women in Bourj al Barajneh and Hey Es Sallom. As noted by Al Riyami, Afifi, and Mabry (2004) and Chamie (1977), women of low-socioeconomic status are those hardest impacted by policies that promote gender discrimination. As Lara describes:

I see religion [in the context of confessionalism] as being . . . discriminatory against humans – they [women] don’t really have their rights, which is of course an issue in all of Lebanon. But it’s usually worse in communities where everyone is at a disadvantage, where everyone [is in] an underserved community.

The narratives of the oppressed and marginalised elucidate the political anatomy of reproduction in its many forms (see Zurayk et al. 2007). Lara’s blunt descriptions of autonomy and violence in these communities and Yara’s description of autonomous female decision-making ultimately provide us with a complex look at how reproduction occurs on an individual, local and national level.

However, despite the political anatomy of reproduction, women have found ways of subverting gendered control of their bodies. In Martin’s (2001) famous study of reproductive health in the USA, she states: ‘Every taboo on something shameful has the potential for rebellion written in it: if what my body does must be kept secret, then I can use that opportunity to keep other things I do secret also’ (97). Since confessionalism and patriarchy promote a system of moral judgment regarding reproduction, exercised through the political anatomy of reproduction, individual women can exploit taboos surrounding sexuality and normal female bodily functions. Similar to Martin’s documentation of the politics of micro-resistance among menstruating women in the workforce (94–5), many women in Bourj al Barajneh and Hey Es Sallom visit clinics to avoid gendered frameworks of oppression, socialising in an environment separate from their husbands and male relatives.

During our participant observation, few men accompanied women to their gynaecological examinations. Moreover, one woman came to the clinic multiple times, but never saw a physician or nurse. When the head nurse was asked why the woman came, she said, ‘She just comes here to gossip.’ Although these findings are not unique in the context of reproductive health in a highly patriarchal and gendered area as Bourj al Barajneh or Hey Es Sallom, we note that autonomy, in this circumstance, can be supported by the clinic system. Likewise, the clinic can be a safe haven for women to discuss important issues relating to their lives, including their health. Despite these actions on the part of women, if the inequalities promoted by a confessional and patriarchal structure influence social and health interactions from the top down, how can community leaders and women break the cycle of injustice permeating the very act of reproduction?

Discussion

The initial question of the study – namely how community leaders perceive reproductive healthcare services – ultimately elucidated multiple observations: the confessional divisions inherent in the health sector, the fear of sectarian imbalances, judgments related to contraceptive use in the context of perceived sectarian imbalances and, ultimately, the question of female autonomy. Though these issues coalesce and constitute the political anatomy of reproduction, this entire framework is derived from interviews from community leaders – individuals who constitute the medical, social, economic and political system that can be both at odds and in harmony with these very themes. Moreover, the question of whether our informants’ translation of their responses to actual interactions with women has not been elucidated in this study and may prove to be a confounding factor in further analyses.
Yet what can be gained from the data presented in this paper is how power structures, specifically confessionalism, are routinised in the discourses on reproductive health among low-income populations. These politics of representation are crucial in framing public health, activist and biomedical debates regarding healthcare and its potential provision, as recently described in discussions of health-related ‘deservingness’ among im/migrant populations in both the US and international contexts (see Viladrich 2012; Willen 2012). Therefore, the question becomes how to translate these findings to policy and clinical changes, with the hope of providing more precise and holistic care to women in the communities studied and potentially finding applications to other situations in different contexts worldwide.

The individual woman, in this circumstance, becomes the focus of any intervention in these communities. Female empowerment, despite the burdens described by the political anatomy of reproduction, is the ultimate goal of any reproductive-health intervention. As described by Zurayk et al. (2007) in their study of female health issues in disadvantaged neighborhoods in Beirut, the role of women in this process must not be understated:

Women’s evocative words underline emotion and its connection to bodily health, emotions that are a lingering response to the horrors of war and a reaction to the daily degradations of poverty. The way women themselves link the problems of bodily health to their problems of daily life points out the total inadequacy of medical-only solutions. (633)

The very notion of female perceptions regarding bodily health is larger than the concept of sickness, but exists in the context of the political anatomy of reproduction. Therefore, confessionalism and patriarchy, combined with the past violence of the Lebanese civil war and the everyday violence of poverty, all contribute to gendered oppression. In this circumstance, historical and everyday violence blend, providing another aspect of the political anatomy of reproduction. Opening the discussion to health, violence and history – forces inherently tied to the struggle of women in these areas – allows for unique opportunities to find better health initiatives. Moreover, using these broad concepts to inform community-wide health initiatives may provide a contextualisation to health that is at once unique and politically challenging. For example, by using public health campaigns to emphasise the importance of routine gynecological screening and contraceptive use in the context of health access issues during the civil war, community leaders could steer away from the confessionalist schema we had previously described. By inscribing history and modalities of violence into the discussion, we think that the impact had on the population could be more significant, yet controversial. To quote Paul Farmer (2010): ‘If we cannot study structural violence without understanding history, the same can be said for biology’ (369). Without acknowledging the political anatomy of reproduction in all of its manifestations, women in these low-income communities become an ‘ahistorical people’, with no grounding of their health issues in sociohistorical frameworks of power and oppression. Ultimately, this situation culminates in the erasure of true biological causality of disease (Farmer 1999, 2010).

In order to promote reproductive healthcare and women’s rights, further analysis and community initiatives must be undertaken with the political anatomy of reproduction in mind. The theoretical framework can not only shed light on controversial and important issues, but can emphasise the fact that sociopolitical structures have a tangible effect on the perception of health issues in a community. Questions of female autonomy, violence, history and resistance became foci of discussion – they should become targets for community-wide initiatives aimed at both understanding and bettering women’s reproductive lives. By using the political anatomy of reproduction to critically analyse
these problems and to propose responses, techniques and the rationality of power can be unmasked and rectified (Foucault 1979, 254). By confronting these issues with community-wide initiatives informed by the political anatomy of reproduction and rooted in both public health and ethnographic data, a true cultural epidemiology (DiGiacomo 1999) can be put into practice. Ultimately, this can help community leaders provide more specific and beneficial services to the women most dependent on the social safety net provided by FBOs and NGOs.

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Notes
1. Portions of this paper were presented as two posters – entitled ‘Reproduction in poverty: How community leaders describe the female body in two low-income suburbs of Beirut, Lebanon’ and ‘Health and the politics of representation: How community leaders describe reproductive health in two low-income suburbs of Beirut, Lebanon’ – at the American Medical Student Association’s Annual National Convention in Washington, DC, on 11 March 2011.
2. Though this definition of community leader is narrow, we chose it based on the convenience of our host NGO and its relations with the communities in which we were working. Likewise, our definition includes individuals who had direct, and oftentimes daily, interactions with both women and the topic of reproductive health in a medical, social, economic and political capacity.
3. Given the fact that the Lebanese state is, for many academics and activists, just as much of an idea as a tangible political entity, we interpret the word as implying ‘the policy of the state’ (i.e., confessionalism).
4. Since the assassination of Rafik Hariri in 2005, the Lebanese government has gone through significant changes and crises. The year 2006 heralded the war with Israel, in which much of southern Lebanon and the southern suburbs of Beirut were destroyed by Israeli bombing. Under these circumstances, Hezbollah, a Shi’ia political-military organization with ties to Syria and Iran, became one of the primary groups providing social services and rebuilding initiatives (Deeb 2007). A tense standoff between the Lebanese government and Hezbollah occurred in 2008, culminating with the Doha Agreement. This effectively gave Hezbollah the power of veto in the national cabinet (BBC 2008). With the UN Special Tribunal investigating Hariri’s assassination issuing indictments in 2011 for individuals associated with Hezbollah, Hezbollah and its political allies withdrew from the cabinet, forcing a governmental collapse (Bakri 2011; Samaha 2011). The reformation of the Lebanese government included the installation of a Hezbollah-backed president, Najib Mikati, and the parliamentary majority gain of the Hezbollah-led March 8th Alliance.
5. It is important to note that this value, quoted from Zurayk et al. (2007), is higher than data from the Pan-Arabic Project for Family Health in 2004 would suggest (approximately 1.9 births/woman in Lebanon). However, the median Lebanese birth rate is lower than the Arab region median of 3.9 births/woman (Casterline 2009).
6. The revolving door of powerful Lebanese families associated with private business ownership, paramilitary group leadership and confessional political leadership has been well documented. See Fisk (2002) and Traboulsi (2007). For a further discussion of neoliberal policies surrounding the rebuilding of Lebanese infrastructure post-civil war and 2006 war, see Klein (2007, 459–62).
7. For a more detailed description of Israeli influence during the Lebanese Civil War, see Fisk (2002), Sayigh (1994) and the film Waltz With Bashir (2008). For a further discussion of the role of Shi’a political parties in modern Lebanon, see Norton (2007).
8. The political anatomy of reproduction manifests in other arenas as well. Eich (2010) describes Sunni debates in Egypt regarding the role of hymenorraphy in promoting and protecting female chastity and honour. Applying this concept to men, Marcia Inhorn, in her research on IVF and infertility in Egypt and Lebanon, has defined ‘emerging masculinities’ and religious authority as a modalities of masculine control (Clarke & Inhorn 2011; Inhorn and Wentzell 2011). These aspects broaden the concept of the political anatomy of reproduction and should be targets for further theoretical and empirical analysis.


10. It is important to note that Pan Arab Project for Family Health (2006, 199) data shows one out of every 10 married women report that they are the sole decision-maker regarding birth control choice, while one out of six women reports that her husband is the decision maker.

11. See Al Riyami, Afifi, and Mabry (2004) and Chamie (1977) for discussion regarding female socioeconomic status, education and sexual autonomy in the Lebanese and Omani context, respectively.


13. In regards to the implementation of a national birth control policy in Iran in the late-1980s, Hoodfar and Assadpour (2000, 23) cite a two-pronged approach used by the government: generating public support and educating government officials with historical and gendered contextualisation of reproductive health. This approach had a significant impact on public health policy and structural change regarding improvement in women’s health within the confines of fundamentalist Islam.

References


Résumé

Le rôle joué par le confessionnalisme dans le secteur de la santé au Liban, en particulier depuis la fin de la guerre civile dans ce pays (1975–1990), doit encore être abordé par la santé publique. En s’appuyant sur des modèles de violence biopolitique et structurelle pour expliquer comment les leaders communautaires de deux quartiers à faible revenu de Beyrouth décrivent les soins de santé reproductive – en particulier à partir de leurs perceptions sur le rapport entre l’importance des sectes et le recours aux méthodes de contrôle des naissances – cet article porte un regard critique sur la santé reproductive dans ce contexte. En employant ce modèle théorique d’analyse, auquel nous nous référerons comme « l’anatomie politique de la reproduction », nous espérons révéler comment le
confessionnalisme est perpétué dans les discussions sur la santé reproductive, et comment la santé publique et les communautés médicales peuvent remettre en cause cette stratégie du pouvoir.

Resumen

Hasta la fecha, el papel del confesionalismo en el sector de salud en Líbano, en especial tras el fin de la guerra civil libanesa (1975–1990), no se ha debatido en el ámbito de la salud pública. Mediante el uso de modelos biopolíticos y de violencia estructural para explicar cómo los líderes comunitarios de dos barrios de bajos ingresos de Beirut describen la atención a la salud reproductiva –en particular a través de criterios sobre el tamaño percibido de una secta frente al uso percibido de métodos anticonceptivos– el objeto de este artículo consiste en realizar un análisis crítico del estado de la salud reproductiva en este contexto. Al usar este modelo teórico de análisis, llamado “anatomía política de la reproducción”, los autores pretenden revelar cómo se perpetúa el confesionalismo en los debates sobre la salud reproductiva y cómo los profesionales de la salud pública y los médicos pueden hacer frente a esta estrategia de poder.