second sexuality hotline report

Worries and fears, pleasures and joys:

The right to sexual, reproductive, and emotional wellbeing

THE A PROJECT
AGENCY
AUTONOMY
ALTERNATIVES

Hotline calls between Jan–Dec 2018

got questions on sexuality, gender, or sexual & reproductive health?

+ 961 76 680 620

hotline@theaproject.org

Open daily between 5–11PM

You can also check out the FAQs
on sexual and reproductive health and rights on our website

www.theaproject.org/faq

about the a project

The A Project is a non-profit non-governmental organization based in Beirut, working on issues of sexuality and sexual and reproductive health and rights (SRHR). We envision a society where women, trans*, and gender non-conforming people's sexuality and mental health are reclaimed, cared for, respected, recognized in their diversities, and not utilized against us. We know that sexuality and reproductive justice are core battles in reclaiming bodily autonomy and political agency, and believe that everyone has the right to decide the journey their body goes through in a harm-free and consensual space, from expressing gender, sexual preferences, and desires, to rejecting or accepting marriage, to having/not having children—the list is long. We aim to advance—through practice and theory—a political discourse around sexual, reproductive, and mental health, and to find alternatives counteracting all restrictive and reductive approaches towards the bodies of women and gender non-conforming people in Lebanon.

This publication is an annual report on The A Project's sexuality hotline. The hotline is one of our core projects, established to discuss all things sex, gender, relationships, and sexual and reproductive health, primarily with women, trans*, and gender non-conforming folks. In this report, we take a look at the data of the hotline: who's calling, what for, what the hotline tells us about SRHR more broadly, and our reflections on our work. The intention is to share this knowledge with the public, and most importantly, to give the data back to our callers.

* the asterisks in the term 'trans*' indicates that we are referring to all folks who identify as trans—not only trans women and trans men.

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about the sexuality hotline

Established November 2016, The A Project's sexuality hotline provides counseling, support, accurate information, and referrals to women and trans* folks on sexual and reproductive health (SRH) issues. The hotline provide s an outlet for people to talk to an engaging, well informed, and understanding person who isn't set out to give unsolicited advice, or to diagnose or categorize the fluidities of one's life experiences. The hotline is founded on the belief that women and trans* individuals—whether queer or not—are often given moralistic and socially constructed information about our bodies, lifestyles, and health, and we deserve better than that. Thinking more broadly about the socio-politico-cultural context we live in, we also believe that our experiences with sexuality, gender, relationships, and sexual and reproductive health cannot be isolated from the realities of ageism, racism, classism, and ableism.

In order to have conversations from different perspectives and fields of knowledge of SRHR, we train our sexuality hotline counselors by medical professionals, researchers, social scientists, and activists on the social, medical, psychological, and political contexts. Our aim is for women and trans* people to reclaim their place at the forefront of the discourse around body politics, and be the first and foremost experts on their bodies and lives.

It's important to note that we ourselves do not act as medical doctors or sexologists; so, while we do provide up-to-date information on a range of medical issues and procedures, and refer callers to sensitive healthcare providers, we do not diagnose medical conditions. We also obviously do not provide phone sex—so prank callers, get lost.

about the sexuality hotline

Why a hotline?

Because it's free, accessible, confidential, anonymous, and judgment free! You do not need an appointment, can be located anywhere, and can also text (WhatsApp or SMS) or email us.

What might we talk about on the hotline?

Some of the topics include (but are most definitely not limited to):

intimacy • health • virginity • transitioning • motherhood • puberty • relationships • disability • asexuality • violence • masturbation • body shaming • sexually transmitted infections • emergency contraception • gender affirming procedures • pleasure • unplanned pregnancies • living with HIV • sexual orientation • safety • contraception • gender identities

Who can call?

While we especially invite women and trans* persons to call, all are welcome, no matter what age, gender, nationality, status of formal education, socio-economic background, sexual identity, or disability.

Who picks up the phone?

We train women, transgender, and gender non-conforming individuals from many different educational backgrounds to become sexuality hotline counselors. They undergo intensive training and are assessed on various criteria, including their general openness and comfort on these topics. While all are trained on the same issues, some may have more insight on particular body/ gender/ relationship/ sexuality politics issues that they are impassioned about.

You can get to know more about counselors, what languages they speak, what their interest-topics are, and when their next shift is by: visiting **theaproject.org > Sexuality Hotline > Hotline Schedule**

Besides a hotline, are there other sources of information or support?

We will be hosting solidarity groups for women and trans* people for a variety of issues. These take the shape of intimate and private discussions based on our callers' requests and needs, so that people of similar questions and struggles can meet and process the issues they face. If interested, contact us for more info!

READ ME: your data & our documentation

When we ask callers to specify personal information for our documentation, whether it is gender identity, location, relationship status, or nationality, this information remains confidential and anonymous, and callers are free to refrain from telling us. We ask because it allows us to gain a deeper understanding of how different norms and structures affect people in their varying identities and contexts. Through this understanding, we are able to identify which systems and structures put people's bodies, sexual and reproductive health, and mental wellbeing at risk, and how they do so. We also ask because we understand that sexual and reproductive rights do not exist in a vacuum, and our counseling, referrals, and conversations are tailored to those persons' situations, capacities, and realities. We never ask out of curiosity.

We ask for preferred names/aliases only to know how to refer to someone throughout the call, and in case another counselor will follow up with them—and again, callers do not have to tell us. We never document callers' contact details, unless they give us permission to for follow up, or because they are interested in joining a solidarity group gathering, which we would contact them about later.

We document callers' concerns and conversation topics in order to keep track of the most prominent needs, common experiences, questions, and issues that women and trans* folks face. It also gives us insight into what issues we need to address, study up on, and learn to best tackle. All callers are notified that we document this data, and are free to refuse this.

Callers should know that all call logs, texts, WhatsApp chats, and emails are deleted between counselors' shifts—unless consent to keep a conversation was given by the caller for the purposes of follow up in a proceeding shift. Counselors do not have access to the sexuality hotline documentation database; access is given only to staff members who need the data for various aspects of our work—overseeing and evaluating counselors, understanding the pressing issues on the hotline so we may address them, evaluating the hotline's reach and shortcomings, and producing this report.

what's different about this report?

This publication reports on the data documented via our sexuality hotline from January—December 2018. It is dedicated to all those who have called our hotline, entrusted us with their experiences, and provided us with insight as to how sexual and reproductive issues affect their lives. Through this report, we first and foremost wish to give back to our callers the data we have documented from our conversations with them. Secondly, we want to dispel the clichés, vagueness, and taboos around these issues by providing numbers and analysis that encourage an honest conversation about what it is that people are facing in Lebanon. We want to exhibit and discuss how social, medical, cultural, and religious norms deny women and trans* people autonomy over their own bodies and restrict their physical and emotional wellbeing, in punishment for their genders and gender expressions, choices, desires, nationalities, and socio-economic statuses.

While this report pays special attention to issues around the (in)accessibility of sexual and reproductive healthcare in the country, what people need, and how all of this affects people's lives, we have decided to portray issues of accessibility and other discussions on sexuality, gender, relationships, and SRHR through a framework of mental and emotional wellbeing.

We have focused on emotional and mental wellbeing because in a majority of the conversations we have on the hotline, there is an underlying and ever-present notion of concern: concern for one's health, one's body, one's future, one's decisions, one's safety. Whether it's isolation from support, fear of discrimination, insecurity about health, shame and guilt for making certain decisions, or just an uncertainty of what's to come from unpaved paths, these intense emotions occupy the minds and hearts of women, gender non-conforming, and trans* persons who are seeking to attain their sexual and reproductive rights. Now more than ever, we are understanding the emotional and mental toll of marginalization, silencing, and discrimination, on those seeking sexual and reproductive healthcare. These stressors and fears are often trivialized and normalized as *what we must endure* in the process of achieving our physical and emotional wellbeing. Being on the receiving end of these conversations and emotions, we, at The A Project, are dedicating this report to these struggles to say to our callers: *you are not alone, this is unacceptable, we will not allow this silent emotional and mental suffering to be the default path to sexual rights and reproductive justice*. We feel it is our place to voice out that the societal belittlement of these bodies, their choices, and their circumstances is exhausting, exploiting, draining, and sickening—it literally makes us ill. What's worse is that we are expected to wither away quietly, so as not to disturb the normative peace. We hope this so-called peace is disturbed.

report summary

While our first sexuality hotline report was released last year, covering the first 15 months of the hotline, this second report covers January till December of 2018. Throughout 2018, we received 314 calls (and WhatsApp/text messages and emails)—**double the calls** from the first report!

The majority of callers were: cis women (76%); between the ages of 20 and 25 (50%); and in a (non-marital) relationship (56%). Callers represented 14 nationalities overall—though most were Lebanese (70%) and from Beirut (67%). The rest called from across Lebanon as well as from at least 14 other countries. More than half (52%) the callers contacted us through WhatsApp (calls and chats), and over a third (35%) of all callers had heard about the hotline through their peers. While most people called on behalf of themselves, we received quite a few calls from people calling on behalf of others—notably, cis men calling on behalf of women.

Most commonly, people called to ask about or discuss: unwanted pregnancies and menstruation-related issues, access to healthcare and resources, relationships and sexual pleasure, and contraception and sexually transmitted infections (STIs). The most common call topics varied between age groups—for example, *relationships* was the most popular topic among callers under 20, and *unwanted pregnancies* was almost always the most discussed for all age groups above 20. *Access to support, care, and resources,* were consistently relevant to all age groups.

Across call topics, age groups, genders, and nationalities, hotline callers shared the emotional elements of what they faced while navigating their sexual and reproductive health and rights. Overall, the feelings underlying the issues discussed on the hotline largely centered around callers' **agency and autonomy** over their bodies, their **access** to healthcare and resources, and **support** from friends, families, and lovers. Callers expressed feeling **uncertainty** about their ability to access medication or a non-judgmental physician, and feeling **scared and worried** for their sexual and reproductive health. However, they verbalized feeling **relief** when their health and wellbeing was ensured, **comfort** when myths around STIs and abortion were dispelled, and **reassurance** when they were able to access the resources they needed. Feelings of **shame and guilt** were often verbalized among callers who had desires, or made choices, conflicting with gendered social norms. In parallel, expressions of **joy and**

report summary

fulfillment were noted among the fewer callers who described being in loving relationships and being satisfied in sex. **Excitement** was voiced among those discovering their own and others' bodies. Feeling **isolated** came up among those whose identities were being erased due to a lack of understanding, or who were threatened with violence and had nowhere to turn. On the other hand, callers felt **validated** when they were supported in their choices, and **free** when they were accepted in their identities. Notably, 'positive' and 'negative' emotions were not mutually exclusive at all; within the same call people would express: feeling **anxious** because they were not sure about how to **pleasure** themselves/their partners, feeling **stressed** about a physical condition and then **relieved** to hear that it is nothing to worry about, and some felt **guilty** because they felt **oh-so-good.**

To concretely and effectively relieve some of the emotional stressors that callers feel, we take the time on the hotline to unpack misconceptions, dispel myths, validate the hardships of familial and peer rejection, discuss the subjectivities of discrimination and exploitation by healthcare providers, and think of alternatives together. It is clear that access to knowledge, support, and resources, as well as the freedom from gendered norms and expectations, are key to feeling comfortable in callers' health, relationships, bodies, identities, and choices. Most callers, either during their call or afterwards through the anonymous online hotline evaluation form (launched mid-2018), expressed having had a "good" or "very good" overall experience on the hotline—admittedly, there may be a reporting bias of satisfied callers. The hotline counselors themselves reported positive experiences on the hotline, but they also expressed distress, frustration, anger, or sadness after calls in which callers face dire situations and have limited options. Considering the emotional difficulties expressed on the hotline, it is necessary that we align mental and emotional wellbeing with sex, sexuality, intimacy, and reproduction, within our intrapersonal, interpersonal, community dynamics, and our advocacy and organizing, as part of our efforts to center self-determination, pleasure, safety, and wellness in our movements.

Who's calling?

Across the following data, there are gaps, as not all demographic data were captured for all calls. This happens for many reasons—

HOTLINE CALLERS: THE DATA

sometimes callers refrain from giving their information, there may not have been an appropriate moment in the call to ask all questions (especially if the caller is in panic or distress, these questions may be frustrating or plainly out of place), or the counselor got carried away with a good conversation and forgot to ask!

We are doing our best to ensure accurate and regular documentation, but we acknowledge that this is not always feasible. The following figures are derived from the data that we do have, which still constitutes a large majority of the calls.

this report:

total number of calls
JAN-DEC 2018

314 calls

previous report:

total number of calls
JAN-DEC 2017

166 calls

total number of calls

Between January and December 2018, we received a total of 314 calls. Compared to the 166 calls received in 2017, the number of calls has increased by 89%—almost double!

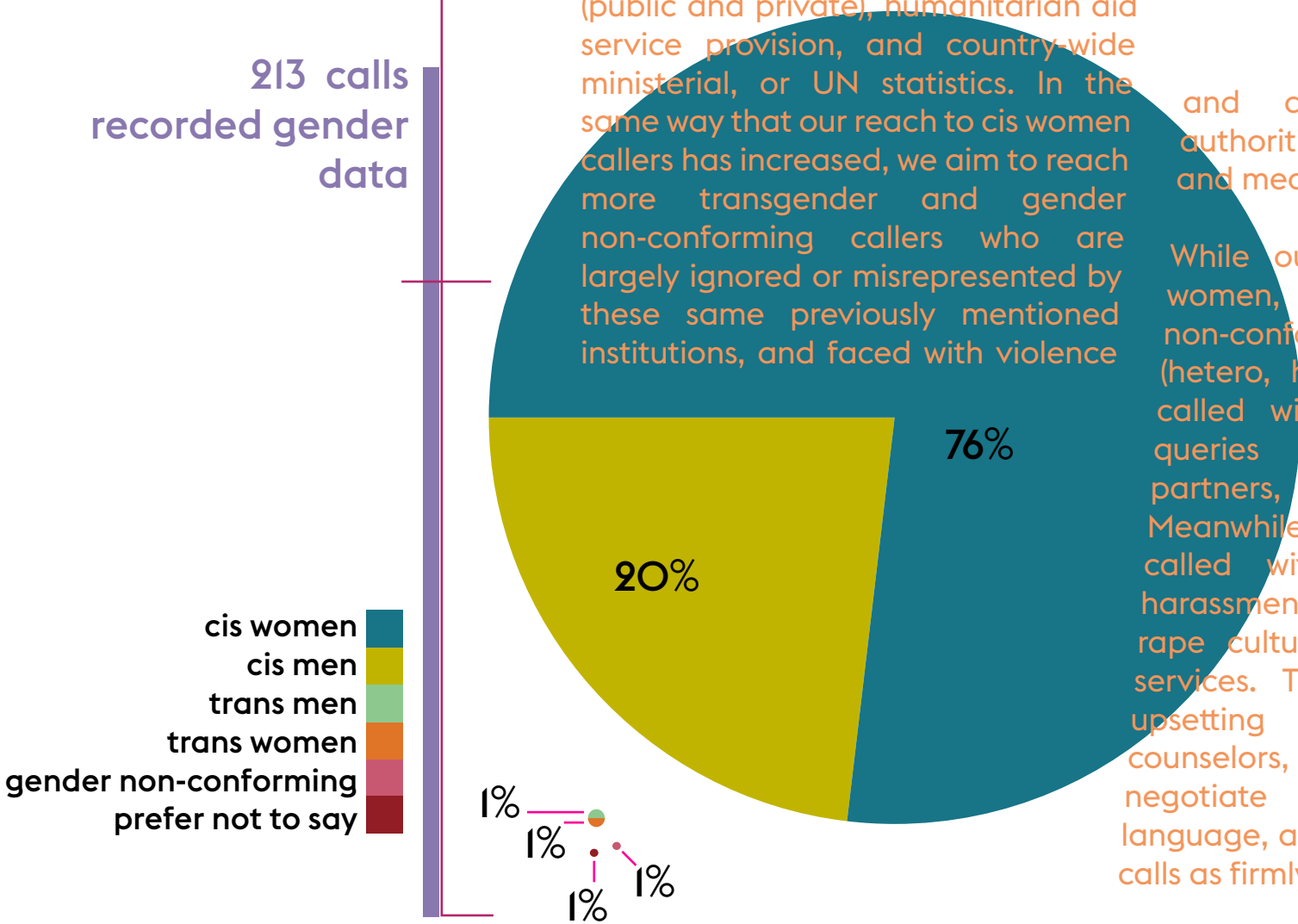
gender

total number of calls JAN-DEC 2018

314 calls

213 calls recorded gender data

Three quarters of our calls were from cis women. As compared to the first report, this approximate 25% increase in cis women callers is especially important to us, as the sexual and reproductive health of migrant, queer, refugee, poor, or unmarried women may be lacking in local healthcare facilities (public and private), humanitarian aid service provision, and country-wide ministerial, or UN statistics. In the same way that our reach to cis women callers has increased, we aim to reach more transgender and gender non-conforming callers who are largely ignored or misrepresented by these same previously mentioned institutions, and faced with violence and discrimination by society, authorities, medical professionals, and medical systems more broadly.



While our hotline is dedicated to women, transgender, and gender non-conforming folks, many cis men (hetero, homo, bi, and queer) have called with genuine questions and queries for themselves or their partners, which we have welcomed. Meanwhile, many cis men have also called with pranks, verbal sexual harassment, an oblivious condoning of rape culture, or in search of sexual services. These unwelcome calls are upsetting and violating to our counselors, who are advised not to negotiate or reason with violent language, and to deal with such abusive calls as firmly or dismissively as they wish.

age

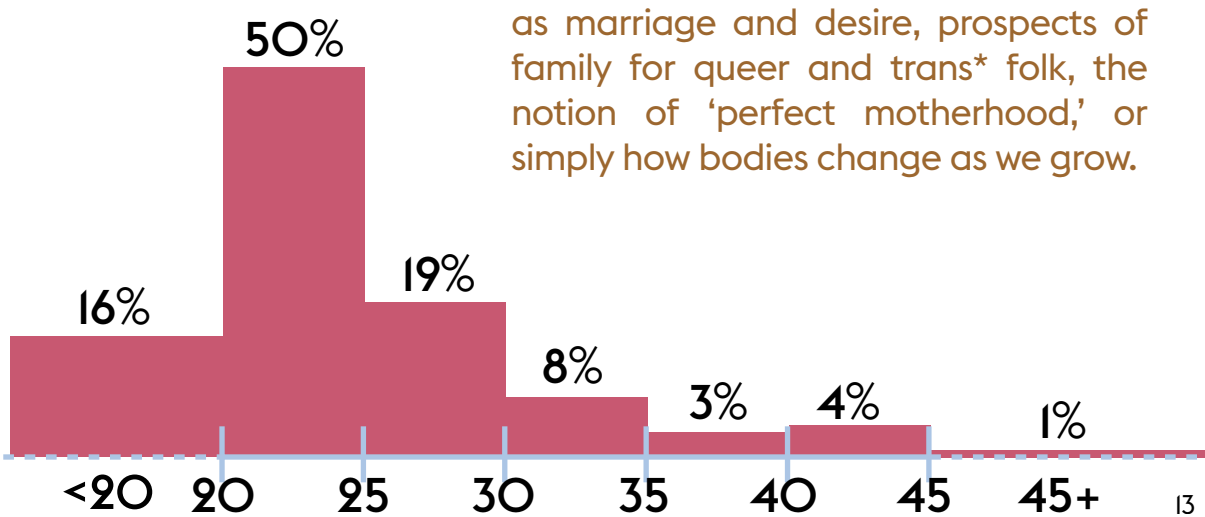
total number of calls
JAN-DEC 2018

314 calls

166 calls recorded age data

We're happy to see that we're reaching a wider age range! We are particularly pleased that the hotline is continuing to reach young people who have diminished support and resources, fewer places and people to turn to in their coming-of-age dilemmas, lack access to accurate or contextual information, and face socio-cultural pressures to not make "wrong and irreversible mistakes" or choices.

In the upcoming year, we want to reach more people above the age of 30. We may be invisible to people of this age bracket, partly because they may have been able to build better support systems with time, or have more access to services, resources, and information. However, refugee, migrant, poor, queer, disabled, and divorced women, transgender, or gender non-conforming people over 30 years of age do not have the same social and institutional support that cis-hetero, middle and upper class, citizens have. In addition to providing information or referral support, we also hope to have good discussions with people over 30 on issues they may be navigating, such as marriage and desire, prospects of family for queer and trans* folk, the notion of 'perfect motherhood,' or simply how bodies change as we grow.



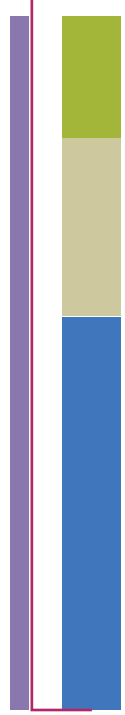
relationship status

total number of calls JAN-DEC 2018

314 calls

Our reach with regards to relationship status has not fluctuated since the first hotline report. It's not surprising that unmarried women in relationships are the most to contact us—they face stigma and judgement from healthcare providers for being sexually active and are barred access to quality services related to pregnancy, abortion, or STI management. We're happy that the sexuality hotline is acting as an alternative medium for them to access services and support. We are also especially interested in filling the gap in support provision to couples whose relationship statuses are illegitimatized by the state and/or NGO-services—couples who are queer, mixed-race, mixed-nationality, or of discordant HIV-status.

146 calls recorded relationship status data



21% single

23% married

56% unmarried; in a relationshp

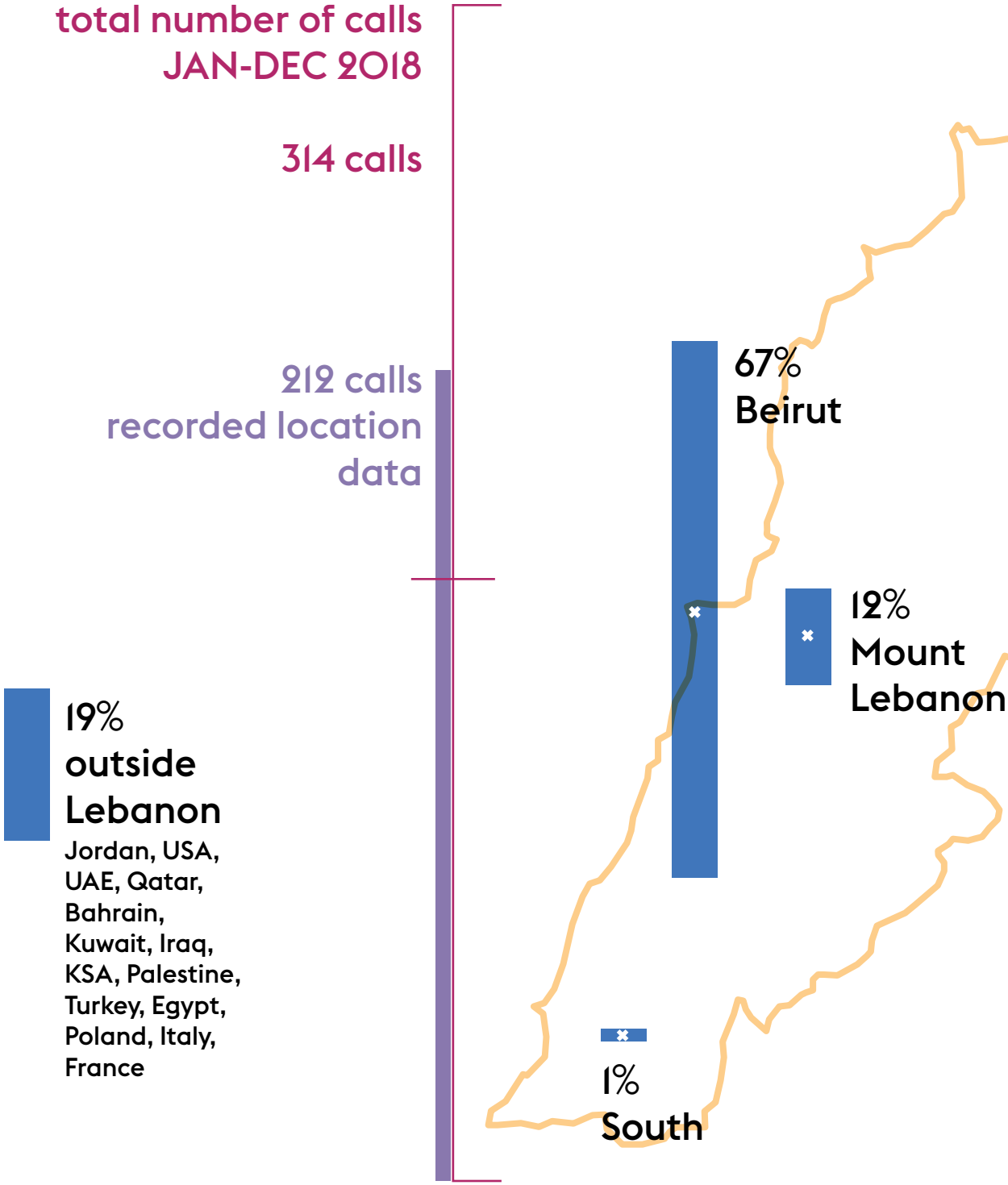
We also challenge the assumptions that married women have the support they need from their partners, and have their sexual and reproductive health needs met. Married women are still denied information about their bodies and health, face sexual coercion by their partners, are forced into motherhood, and carry the brunt of housework and reproductive labor. In parallel, single women are often expected to abstain from sex, and therefore assumed to not require access to sexual and reproductive care, support, or information. We want to reach more married and single people, and dismantle the harmful notions that deny both these groups adequate sexual and reproductive health (SRH) care.

location

total number of calls
JAN-DEC 2018

314 calls

212 calls recorded location data



Like last year, our largest reach by far is to people in Beirut—this is most likely because we are a small group, of limited resources, based in Beirut. We want to continue to grow our reach to locations across Lebanon in an effort to decentralize SRH-related information and care. We have found the hotline to be an effective way to do this, as it is freely accessible, and does not require physical presence. We are also happy to see that our hotline has spread to more countries in the region, but due to our own lack of knowledge of other countries' facilities, resources, and contexts, it remains difficult for us to support these callers.

nationality

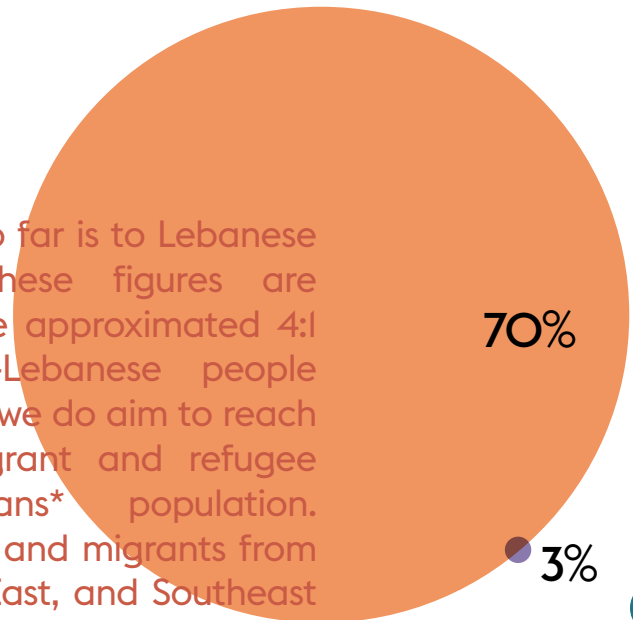
total number of calls
JAN-DEC 2018

314 calls

182 calls
recorded nationality
data

Lebanese
Lebanese + other nationality
other nationality

Our biggest reach so far is to Lebanese nationals. While these figures are proportionate to the approximated 4:1 Lebanese to non-Lebanese people residing in Lebanon, we do aim to reach a much larger migrant and refugee women and trans* population. Palestinians, Syrians, and migrants from African and South, East, and Southeast Asian countries are subject to racialized sexual violence, and racial discrimination in sexual and reproductive healthcare. Callers from these countries have professed to hotline counselors to having been excluded from healthcare for a variety of reasons: limited financial means, being undocumented, restricted mobility, inability to reach a healthcare center, or on the basis of skin color or nationality.



10%
other
English, Bahraini, Ethiopian, Jordanian, Qatari, Malagasy, Palestinian, Polish, Swedish

3%

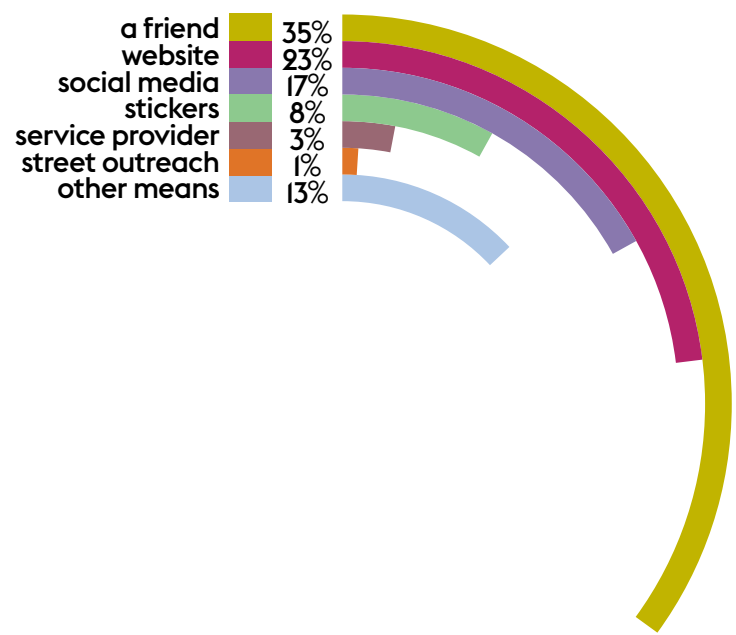
6% Syrian
4% Iraqi
3% Filipina

total number of calls
JAN-DEC 2018

314 calls

172 calls recorded this data

you heard about the hotline through...



It's wonderful to see that knowledge of the sexuality hotline continues to spread through word of mouth of callers. As important as social media and public outreach are, it's fantastic that the hotline number is being shared personally; it indicates a level of trust and good experience with the hotline!

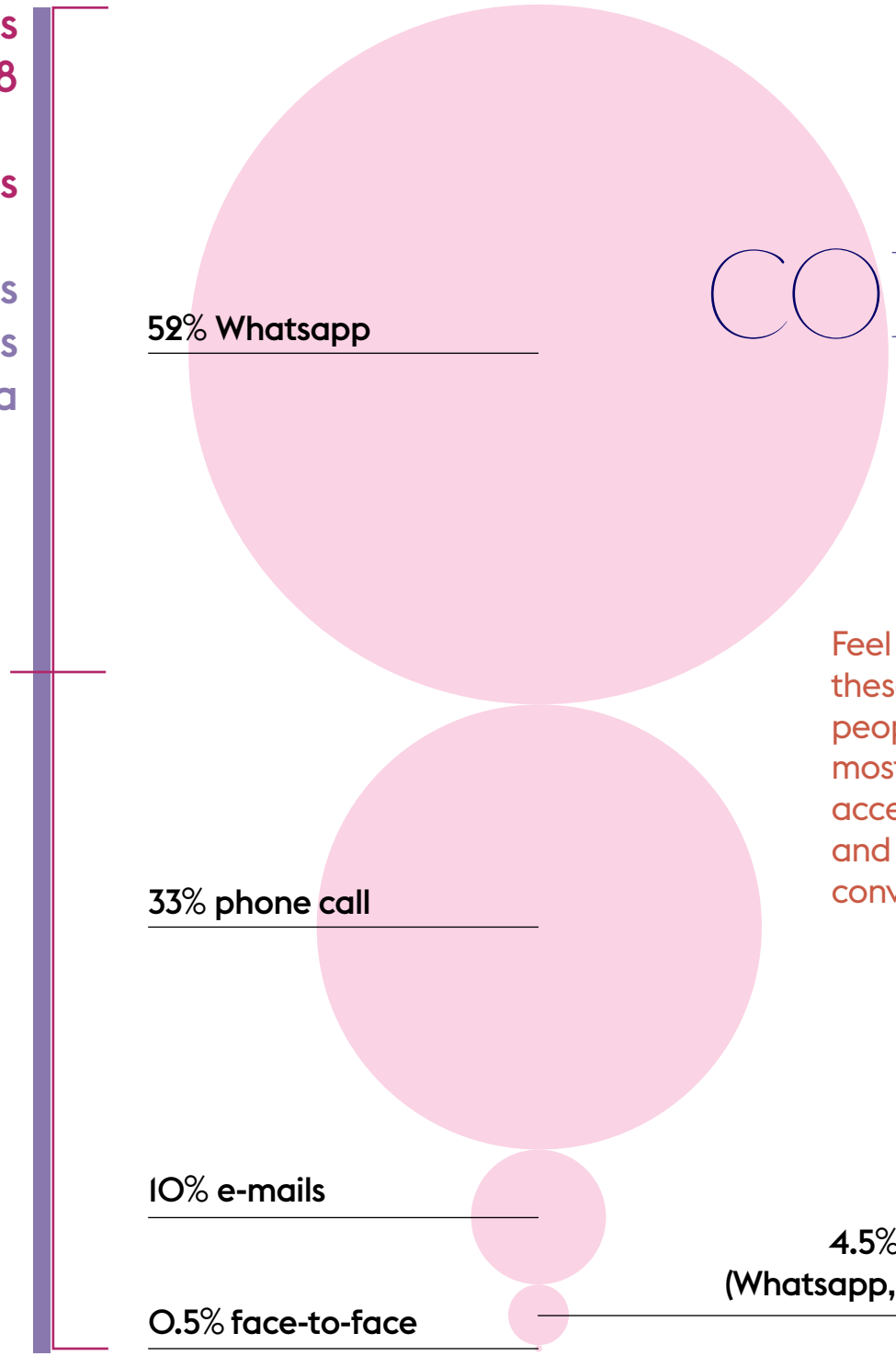
Compared to last year, there is a significant drop in the visibility of our hotline sticker outreach, and a significant rise in the visibility of our website. Moreover, there is a rise in our visibility through other internet sites and articles—we are happy to be mentioned on different platforms and hope it helps us reach different circles of people.

total number of calls
JAN-DEC 2018

314 calls

314 calls recorded this data

you contacted us by...



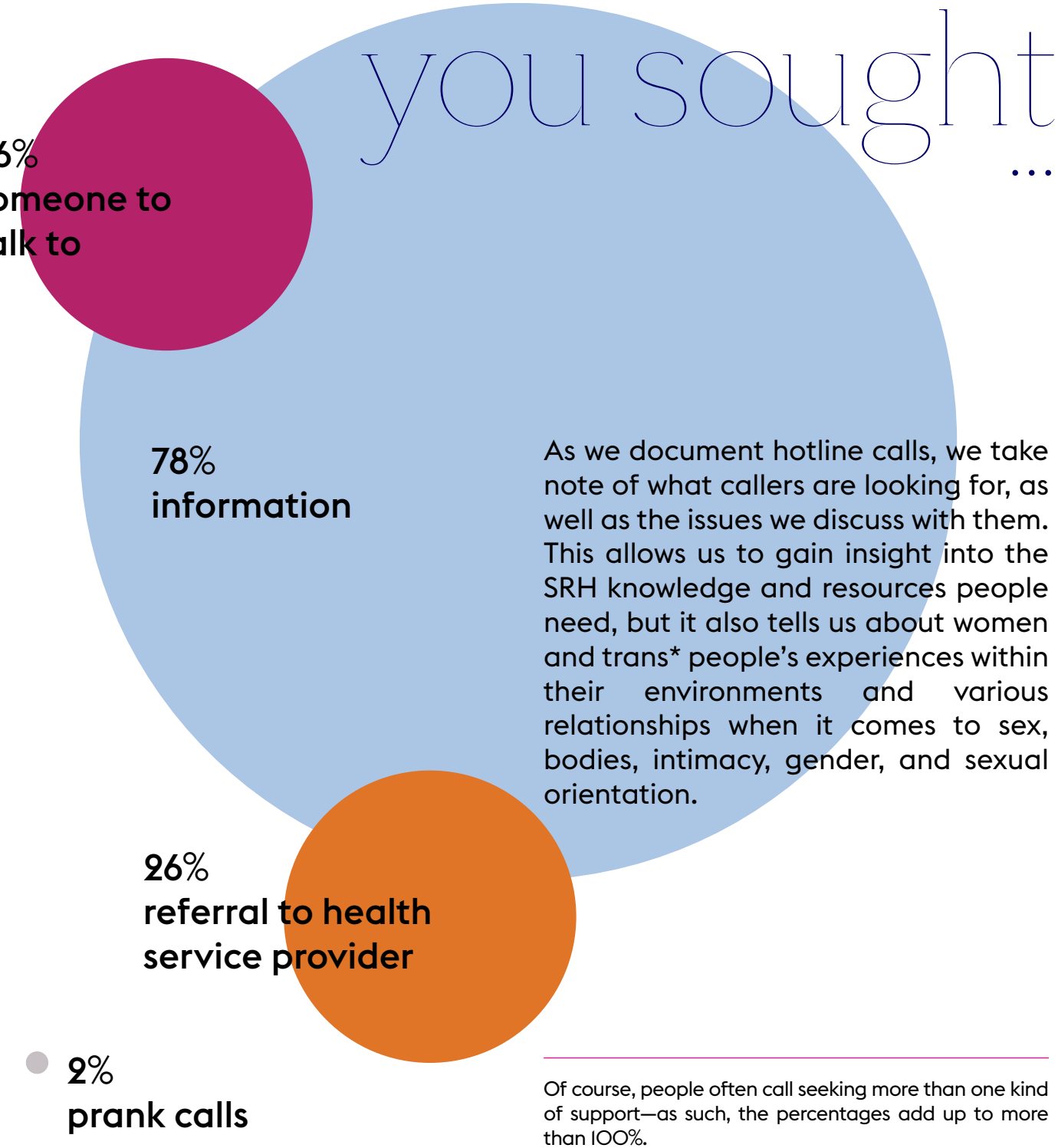
Feel free to contact us using any of these means! It's important that people use the platforms they feel most comfortable with, have best access to, and that best suits the pace and time they need for the conversation.

total number of calls
JAN-DEC 2018

314 calls

305 calls recorded this data

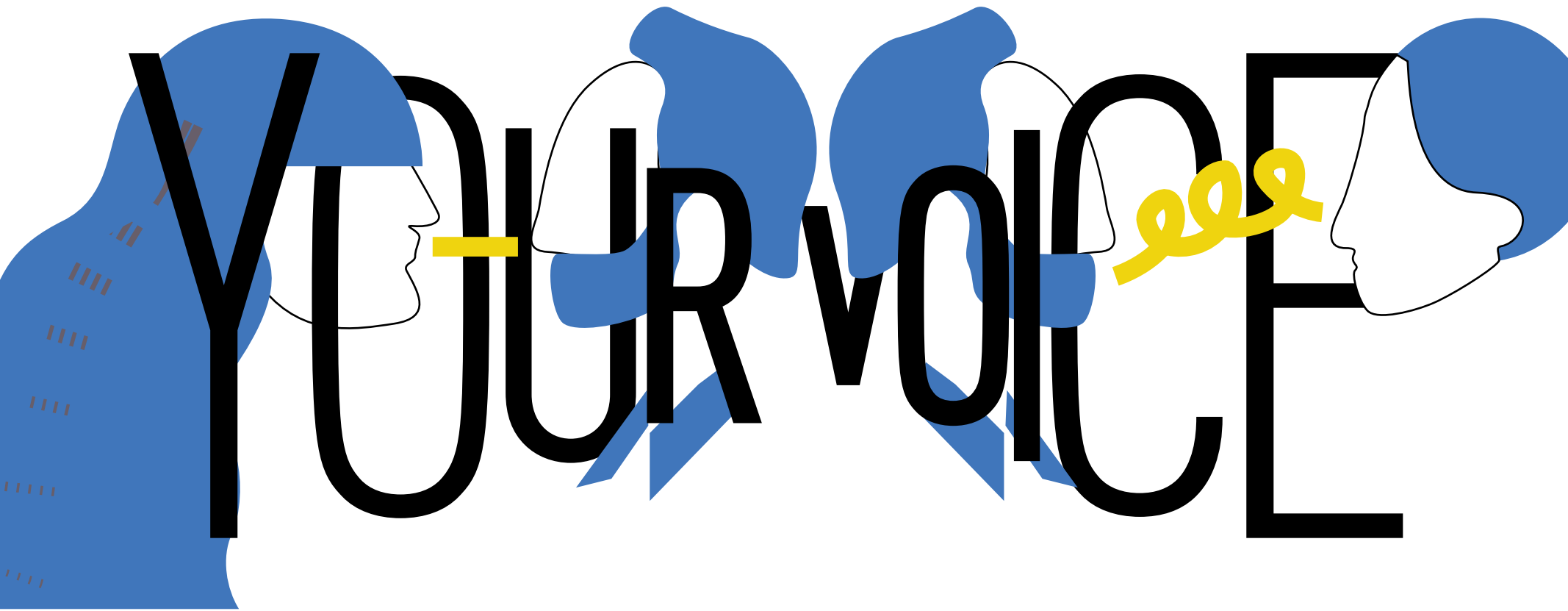
you sought ...



As we document hotline calls, we take note of what callers are looking for, as well as the issues we discuss with them. This allows us to gain insight into the SRH knowledge and resources people need, but it also tells us about women and trans* people's experiences within their environments and various relationships when it comes to sex, bodies, intimacy, gender, and sexual orientation.

Of course, people often call seeking more than one kind of support—as such, the percentages add up to more than 100%.

On the hotline, we like to talk directly with the person involved,

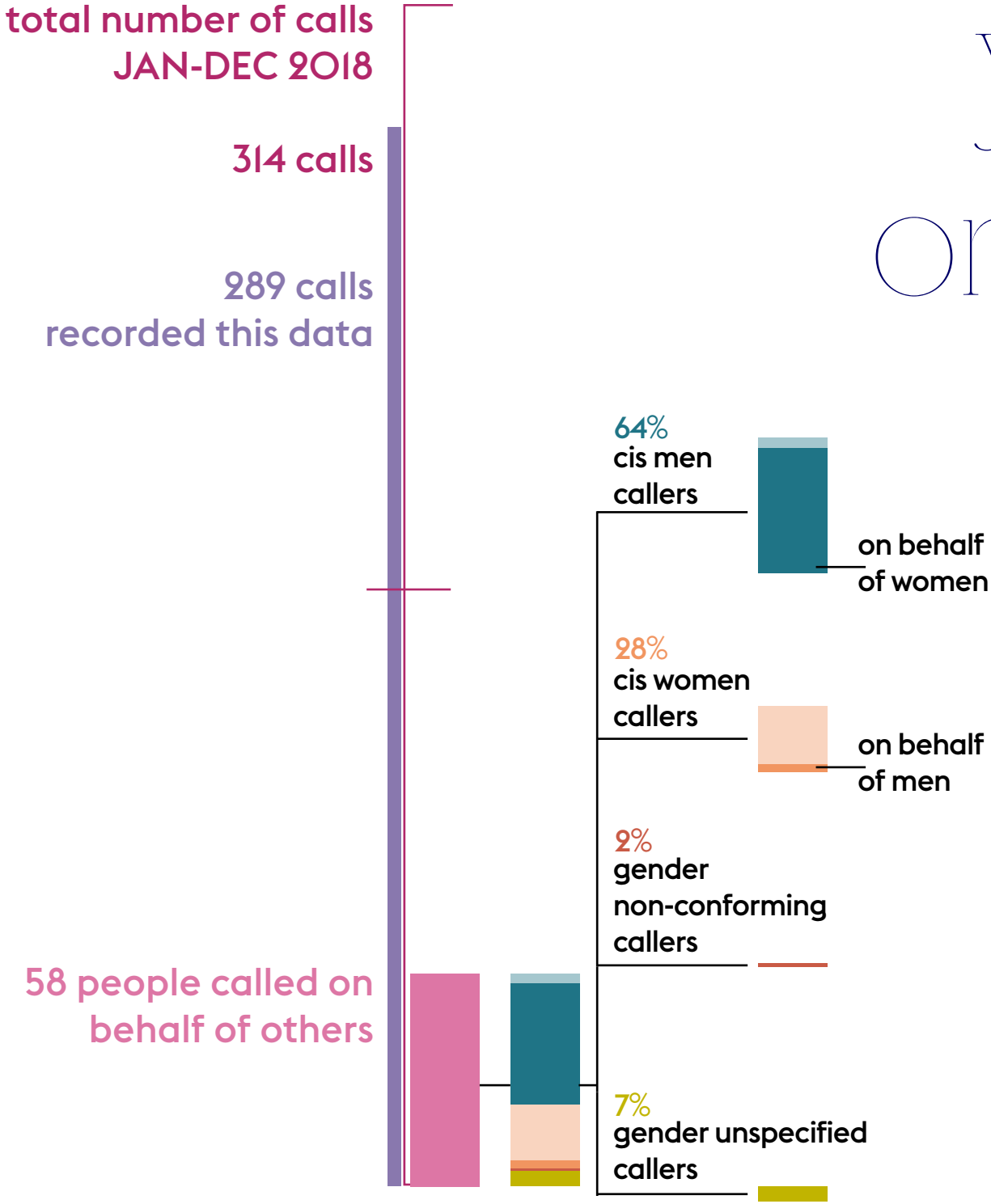


because it allows us to best understand the situation and to ensure the most transparency, honesty, privacy, and consent. The hotline encourages men to be allies to women, but not to speak for them.

Of all women who called our hotline in 2018, 3% called on behalf of others.

Meanwhile, 59% of all men who called us, called on behalf of others.

you called on behalf of ...



you called on behalf of...

Few cis men calling on behalf of women noted that they had asked for consent to do so, or had provided them the hotline number so they could contact us directly. Aside from the fact that callers' often-incomplete information (about women's menstrual cycles, physical symptoms, or past experiences, for example) makes it challenging for counselors to provide proper support, it's also very difficult for them to know whether the correct and complete information will reach the person, or to detect whether there is coercion of any kind. Some calls we receive from men on behalf of women imply a perceived lack of women's agency and autonomy—an infantilization of sorts. Oftentimes, when we do eventually speak to the women in question, we find that the original callers had completely misunderstood, ill-described the issue, or were calling to ease their own worries.

Many women who had given permission to men to call on their behalf because they were concerned or nervous, expressed relief when they spoke to counselors directly. Women have stated that they weren't aware the discussion would go smoothly, feared being blamed, thought they needed to over-justify (excuse) themselves, or feared they would get in trouble should their families discover their reasons for contacting the hotline. This, to us, speaks volumes to how often women are silenced, scrutinized, and made to anticipate harmful consequences when they reach out for support around SRH, sex, relationships, and other related topics.

There were 3 cases where non-migrant women called on behalf of migrant domestic workers. Migrant domestic workers, legally bound to their sponsors/employers, and often physically and emotionally isolated from others (locked in their workplace, refused the right to a phone, or threatened if found to have outside contact), are denied or very restricted in their access to any healthcare, let alone SRH support, resources, or care. This is especially disturbing considering that migrant women face racialized sexual violence in their workplace (their employer's private home) and in public, and are mostly forbidden by employers to have a partner, have sex, or start a family. This—alongside occasional language barriers—is why we are happy to work with those who support migrant women's needs and are calling on their behalf.

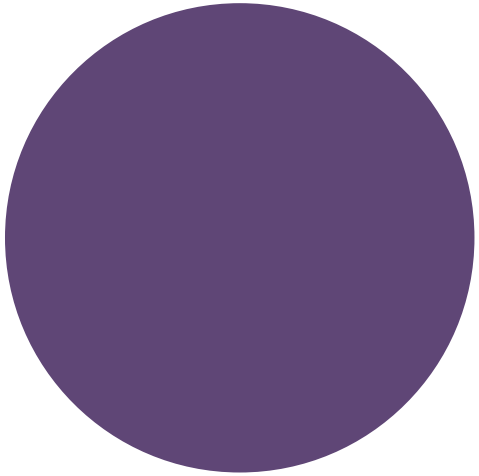
While we've quantified the data to more concretely represent the hotline conversations and tangibly understand the frequency, urgency, and interest in particular topics, the reality is more complex: people call for multiple

OH SO MANY

CALL TOPICS

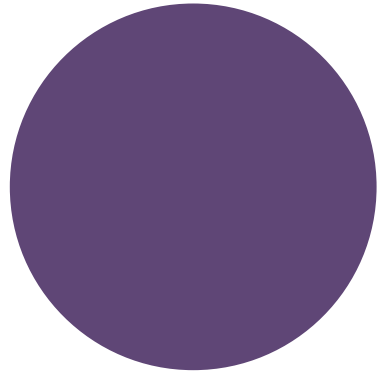
reasons at once, and the stories they tell cross-cut issues and contexts, manifesting intersections that simply cannot be detangled or ignored. Moreover, the nature of our approach on the hotline means that many calls grow into longer conversations that delve into new questions, topics, and experiences. As such, the percentages below do not add up to 100%—each need or topic is considered on its own, meaning that the same call could be double (triple, quadruple...) counted to truly represent the range of SRH, sex, relationships, and gender-related call issues.

call topics



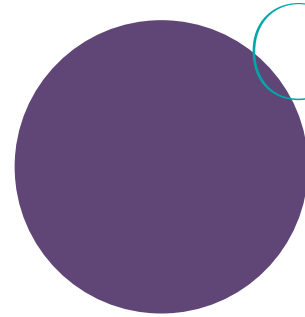
32%

unwanted pregnancy



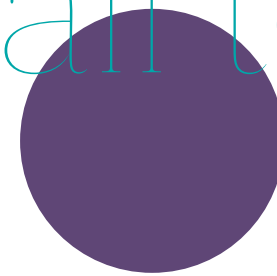
25%

access issues



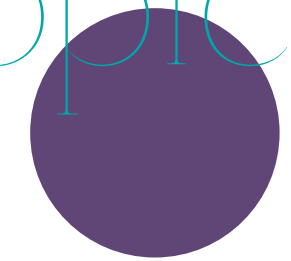
20%

relationships



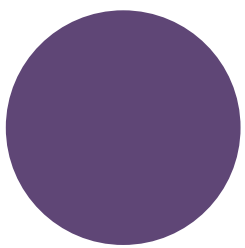
18%

contraception



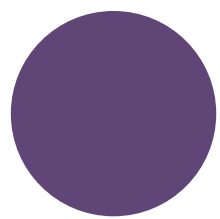
17%

pregnancy scare



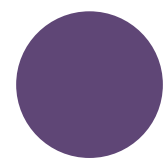
16%

menstruation-related issues



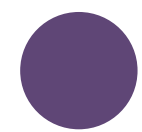
14%

STI symptoms & treatment



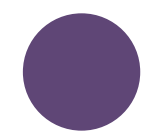
10%

pleasure



8%

unprotected sex



8%

vaginal dryness and/or bleeding

7%

factors impacting menstrual cycle

6%

referrals for SRH concerns

6%

sexual orientation

call topics

virginity

interpersonal communication

mental health

the calendar method

4%

gender & sexuality norms

privacy and confidentiality

pregnancy symptoms

comparing past and current pregnancies

anal sex & play

first-time sex

3%

non-penetrative sex

negative experience with healthcare providers

societal stigmas on sexuality and gender

lube

information on abortion

marriage

sexual violence

desire & attraction

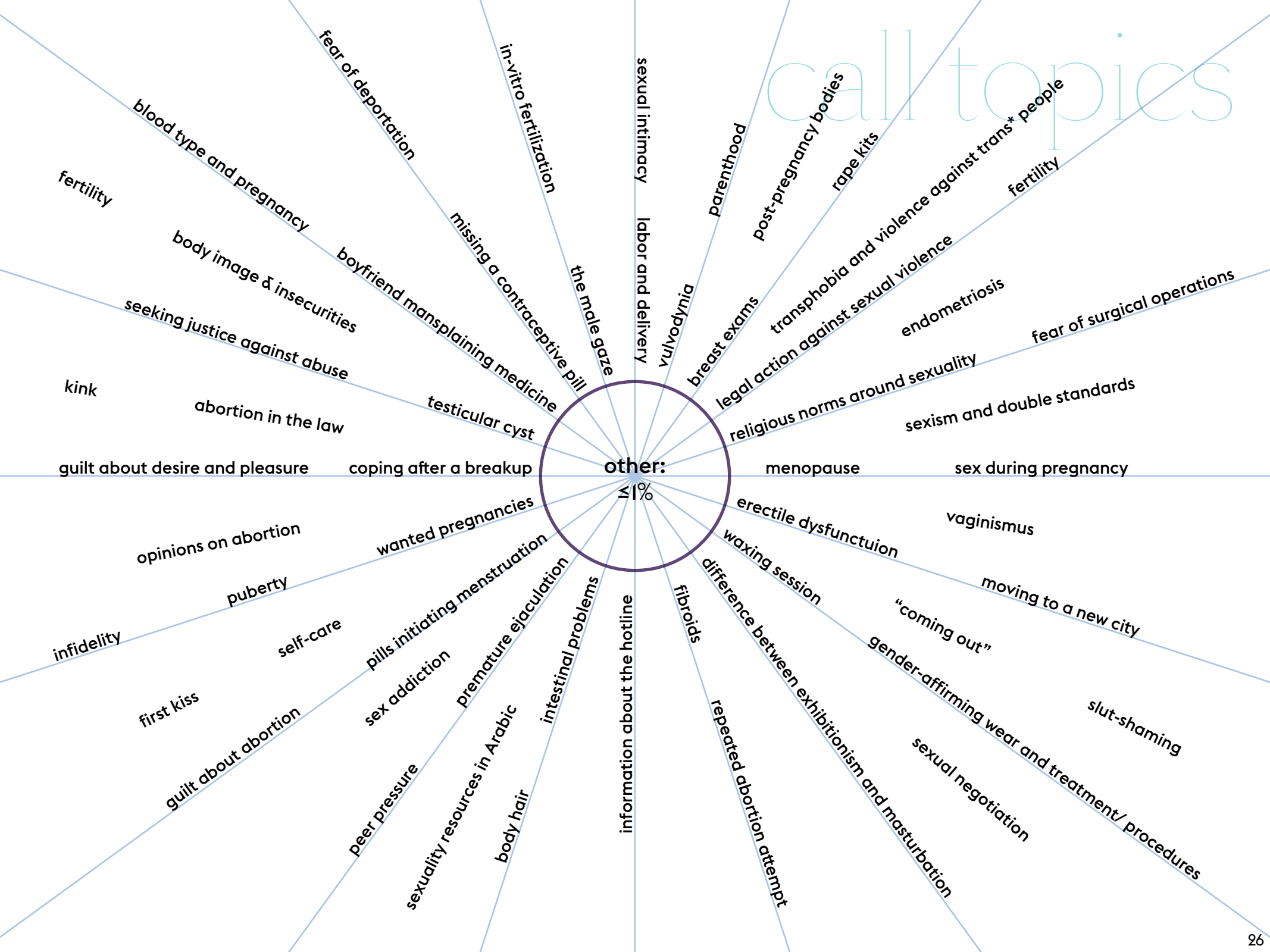
pap smears

distrusting support network

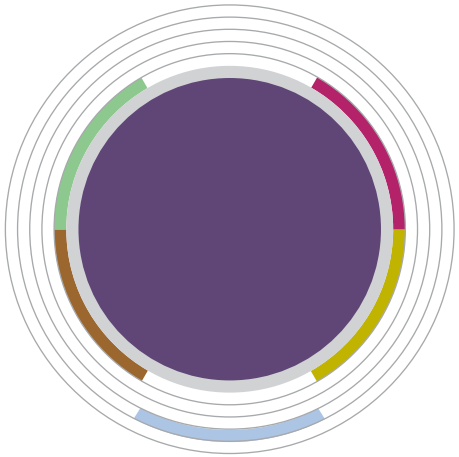
2%

pain or discomfort during sex

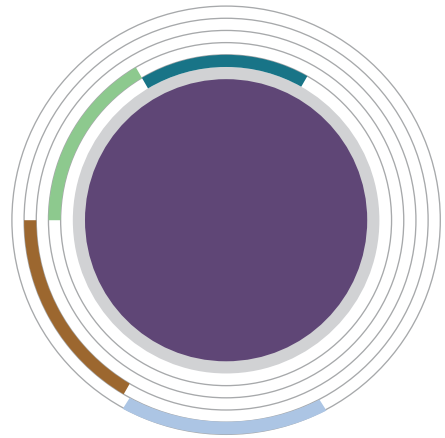
penetrative sex


call topics
other:
≤1%
fear of deportation
in-vitro fertilization
sexual intimacy
parenthood
post-pregnancy bodies
rape kits
transphobia and violence against trans* people
fertility
blood type and pregnancy
missing a contraceptive pill
labor and delivery
breast exams
legal action against sexual violence
endometriosis
fear of surgical operations
fertility
boyfriend mansplaining medicine
the male gaze
vulvodynia
religious norms around sexuality
sexism and double standards
body image & insecurities
seeking justice against abuse
testicular cyst
menopause
sex during pregnancy
kink
abortion in the law
coping after a breakup
guilt about desire and pleasure
erectile dysfunctuion
vaginismus
opinions on abortion
wanted pregnancies
waxing session
moving to a new city
puberty
pills initiating menstruation
difference between exhibitionism and masturbation
“coming out”
infidelity
self-care
premature ejaculation
fibroids
gender-affirming wear and treatment/ procedures
first kiss
sex addiction
intestinal problems
repeated abortion attempt
slut-shaming
guilt about abortion
peer pressure
sexuality resources in Arabic
body hair
information about the hotline
sexual negotiation

top 5 topics across age groups



unwanted pregnancy

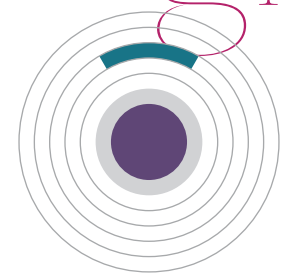


relationships

contraception

pregnancy scare

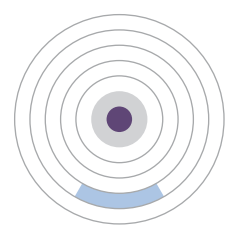
STIs



menstruation issues

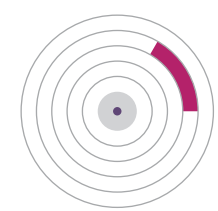
pleasure

unprotected sex

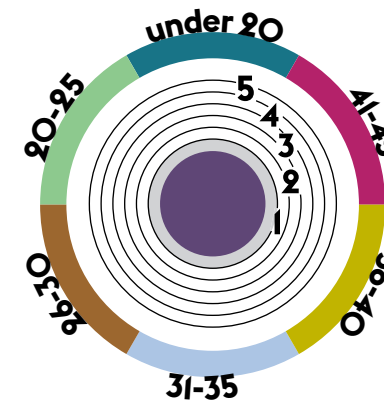


sexual orientation

trans issues



menopause



top 5 topics across age groups

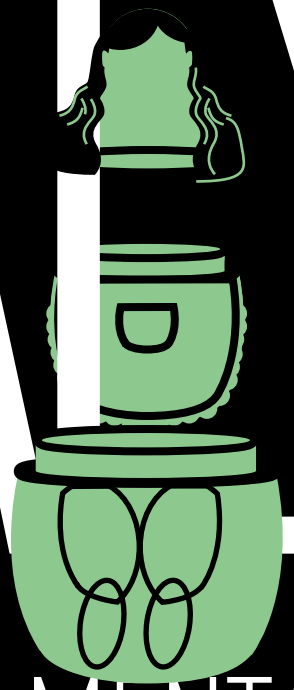
Callers under 20 years of age have mostly called to discuss issues related to relationships—whether that be partners, love, sexual negotiation, parents, family members. As they negotiate their intimate, romantic, and sexual relationships with their surroundings, they are often not supported with information, guidance, or financial and medical resources, and are assumed to not be engaging in any sexual activity. However, our conversations with young people show that they do have questions and that they struggle with the negative outcomes of unsupported sexual activity (such as pregnancy scares, or contraception). Between this infantilization, the absence of resources and sexuality education in schools, and their limited financial capacities, it's no wonder that they face negative experiences and express stress, confusion, and isolation on the hotline.

The 20s are riddled with comprehensively restricted access to SRH—with unwanted pregnancies, contraception, and sexually transmitted infections being the top issues these callers face. Relationships also feature in this mix, though more amongst the early 20s than the later 20s.

Moving into the 30s age bracket, we see pleasure, sexual orientation, and gender identity emerging as new call topics—a bigger assertion of the self and intrapersonal experiences. While these things of course matter for younger callers too, we saw on the hotline how they are invalidated in their sexualities and genders, denied information about their bodies, shamed for exploring them, and assumed to be straight and striving for cis-hetero marriage and parenting. This indicates to us that the more popular SRH topics for under 30s are part of a gradual learning, unlearning, and discovery of one's body, health, needs, options, and desires.

While we don't have many callers over 40 years of age, those who did contact us also discussed more intrapersonal issues, and were facing issues of access—and one caller introduced the issue of menopause, a largely mystified and neglected topic in terms of expectations, pleasure, and bodily changes. We wish to reach more callers of this age group who can shed light on topics and experiences too often invisibilized.

ANALYSIS



EMOTIONAL & MENTAL WELLBEING
×
SEXUAL REPRODUCTIVE HEALTH & RIGHTS

analytical framework

All documented hotline narratives comprise both **implicit and explicit references to the ways in which sex, sexuality, gender, family, reproduction, bodies, relationships, and sexual and reproductive health/care intersect with emotional and mental wellbeing.** We explicitly record mental health as a call topic when a caller discusses or requests a referral to therapy (psychotherapy, psychiatry, or counseling). However, a large majority of callers not contacting us about mental health referrals have expressed a wide range of emotions such as: fear, panic, anxiety, worry, shame, guilt, confusion, uncertainty, loneliness, and insecurity. It is, of course, immensely upsetting to be faced with sexual and reproductive health and rights issues and not know where to go for assistance, who to talk to about it, what information is accurate or true, and whether or not you'll be faced with discrimination or understanding. It can also be difficult and lonely to navigate identity and relationships where no space is made for them, and in a society that can easily retaliate with violence for those who violate social expectations (or rather, threaten social norms).

While these emotions weigh heavily on a person, they're also not the only feelings that define callers' experiences with sexuality, gender, and SRH. Later on in this section, we will also expand on the pleasure, satisfaction, love, joy, relief, lust, and feelings of freedom that callers expressed in the exploration of their bodies, identities, and relationships. Though we recognize that a majority of calls referred to difficulties more than pleasure, we want to do justice to the joy our intimate and personal lives can bring us.

Throughout the calls on the hotline, we notice how issues of sexual and reproductive health and rights instigated in callers feelings of fear and panic; uncertainty and concern; guilt and shame; and isolation. Here, we will expand on how these emotions are evoked by a debilitating denial of autonomy to the bodies, choices, and decisions of women, trans*, and queer people. This autonomy is at risk as a result of both the **lack of access** to resources and support, as well as the **cis- and heteronormative*** expectations of gender expression and roles, sexual behavior and desire, procreation, family-formation, and relationships. These social conditions restrict people's knowledge about and decisions over their own bodies, and they directly and indirectly inflict violence (sexual and otherwise) to coerce these bodies back to the pre-established order and norm.

* the assumption that being cisgender and heterosexual is the norm, and the expectation that this norm is socially and institutionally maintained

intrapersonal	interpersonal	socio-cultural	institutional
personal histories, internal conflicting values	direct interactions, mostly with families, friends, partners	social attitudes & norms, informal institutions (e.g. media)	medical & governmental institutions, amongst others (e.g. educational)

fears & panic

She has been going out with a guy for six months although she's known him for two years. They are thinking about having sex for the first time soon. She's worried that if she does, people are going to find out. She is worried that someone would refuse to marry her because she's had sex. She doesn't fully trust the guy that she's with. He says that he's not going to judge her if she has sex with him, but she's afraid that he might change his mind.

There was a strong sense of fear from the judgment and unsafety people might face from others around them when it comes to their sexual desires, behaviors, orientations, and gender expressions or identities. Fear of casting shame on the family, or fear of familial retribution or abuse, surfaced multiple times as an instigator for anxiety. Notably, some callers asked about the confidentiality of the hotline before beginning the conversation, indicating their worry of somehow being identified for discussing 'taboo' topics, and having to deal with dangerous social consequences. Others asked about healthcare facilities that provide HIV testing, gender-affirming hormone therapy, and STI testing that uphold confidentiality. We often spoke to callers about the difficulties of fostering healthy and open communication with friends, family, and partners—a conversation that stemmed from their fear of getting hurt from disclosing personal information. Some callers expressed a fear of exploring certain sexual desires or acts, such as penetrative vaginal or anal sex, concerned that these behaviors were 'wrong.' In these calls, women and queer people expressed feeling pressured to engage/not engage in certain sexual acts because of gender roles and sexual orientation.

Many cis women who had engaged in or were considering first-time sex with cis men, struggled with personal beliefs about sex and virginity. Although they recognized that their conflicting emotions stemmed from misogynistic societal views and upbringing, many didn't feel quite comfortable with the idea of 'losing their virginity.' They had fears about tearing their hymen, not bleeding at penetration, being questioned about their 'virginity,' or being discovered/rejected/shamed by their families and communities for not being 'virgins.' A few callers expressed that they had concerns that they were 'abnormal' for enjoying masturbation, or that masturbating would break their hymens and impact future sexual relations. These are prime examples of how societal stigmas and expectations impact immensely personal decisions, affect women's experiences of pleasure, and only accept women and their bodies under the conditions that they are 'pure' and 'good.'

intrapersonal	interpersonal	socio-cultural	institutional
personal histories, internal conflicting values	direct interactions, mostly with families, friends, partners	social attitudes & norms, informal institutions (e.g. media)	medical & governmental institutions, amongst others (e.g. educational)

These fears and anxieties are reinforced by medical systems, as women profess a strong fear of judgement and consequences of judgement that they expect from healthcare providers. Many contacted the hotline asking for referrals to doctors who were non-stigmatizing when dealing with STIs, contraception, premarital sex, and unwanted pregnancies. Some directly stated that they avoided visiting healthcare providers for SRH issues altogether, and others recounted their negative experiences with providers, specifically with regards to accessing abortion services.

Indeed, fear was most pronounced when callers were contacting the hotline about pregnancy scares, unwanted pregnancies, failed abortions, and repeated abortion attempts. A palpable fear of the worst-case scenario of being stuck with an unwanted pregnancy was present even when a pregnancy was unconfirmed, confirmed negative (not pregnant), or simply unlikely to occur—such as not having missed a period yet, or that in the questioned sexual activity semen was nowhere near the vagina or vaginal opening. Even more revealing is that fear was expressed even when callers called to discuss hypothetical future unwanted pregnancies, and wanted to know what their options would be should they ever find themselves in this position.

If such information was taught and discussed properly in school sexuality education, readily available in healthcare settings, and normalized as a topic of conversation, women would feel more assured about their health and bodily changes. They would be better able to choose and negotiate what is best for them with healthcare providers. They would be less subject to the worry and panic-inducing myths and misconceptions that social discourse and medical professionals spread (intentionally or not). This applies to several SRH issues: one healthcare provider gave erroneous information to a caller about an STI treatment, and then denied any responsibility, telling him that the use of the treatment is "at his own risk." Some callers contacted us out of fear that they may have contracted a fatal STI, while others called to ask if having multiple (safe) abortions affects their health or fertility—misinformation that, if left uncorrected, could plunge the former into a depressing and shaming isolation, and coerce the latter into unwanted motherhood.

From these conversations, it is clear that the panic we hear on the hotline is mobilized by the fear of having let down the people who love them, and the consequences and judgment cast by medical professionals, family, friends, partners, co-workers, peers, and even distant acquaintances who undermine and transform into gossip the difficulties others face.

uncertainties, confu-sions, & concerns

She wanted to know more about sex so she would "know what she's doing" when she and her girlfriend decide to take their physical relationship further. She was concerned about seeming inexperienced and not "in control" when it happens.

When seeking sexual and reproductive healthcare, callers often felt concerned and uncertain about the care they would receive. They often asked where they could find cheap, subsidized, or free services. Even if they knew what to do and where to go, they were concerned with whether they would get what they needed, if they could afford it, or if medication or sensitive providers would be available. In urgent cases, callers asked about where else to access care when the clinics they knew to be safe and affordable did not have timely appointments or were fully booked. One caller noted that the dosage of the gender-affirming hormones she had been prescribed were not available in Lebanon, and was confused as to whether the available substitute was appropriate/safe for her—information she should have received from her physician. Several trans* callers asked about finding gender-affirming materials such as binders or silicone vaginal strings in the areas they lived. These are direct examples of how trans* people's health and needs are deprioritized and dismissed, leaving many people without proper care and unsure about where or how they can access what they need.

Many callers were uncertain about sex, sexuality, SRH, and gender because of a lack of support in discussing these 'taboo' issues, with friends, family, and partners, as well as medical and mental healthcare providers. The lack of public conversation and information about sex and sexuality mystifies these issues, leaving people with insecurities and many unanswered questions.

intrapersonal	interpersonal	socio-cultural	institutional
personal histories, internal conflicting values	direct interactions, mostly with families, friends, partners	social attitudes & norms, informal institutions (e.g. media)	medical & governmental institutions, amongst others (e.g. educational)

For example, when anticipating their first sexual experiences, some callers talked about feeling nervous that they were not "sexually experienced enough" or that they would not be able to perform up to a certain standard. Seeking support, discussion, and validation on matters that are deemed too private, too shameful, or too vulgar is important.

The societal and media-driven pressure placed on women and trans* people to impress, to "be good" in sex, to be desirable, and to be experienced, incites a nervousness that, as we heard on the hotline, makes people question their adequacy and value and leaves them feeling concerned and uncertain about how to navigate their sexual lives.

Another issue that many callers discussed with us was about whether there was a 'right way' to be LGBTQ, or if they or others were 'abnormal' for not presenting or behaving in gender-stereotypical ways. There was an insinuation (but also a critical questioning) that there are rigid and absolute categories to which they have to adhere. Some callers implied that they felt they were required to 'come out' to their friends and family. Part of the uncertainty around these questions comes from pervasive compulsory heterosexuality and erasure of all forms of queerness. The confusion of how to express or understand one's gender and sexual orientation also largely comes from the fact the little queer and trans* visibility that is shown often replicates heteronormativity in its assumptions of rigid gender identities, gender expressions, and desires (**homo-normativity**). This includes the assumption and expectation that butch must be drawn to femme (and vice versa), that trans women must represent femininity, that trans men must represent masculinity, that the latter two must express heterosexual attractions and desires, and that queer relationships must replicate hetero gender roles, family structures, and sexual behavior. We know that desires, attractions, and gender expressions must not be prescribed and rigid, and we support callers who voice these frustrations from within queer circles.

guilt & shame

She is experiencing conflicting feelings about wanting to have sex with her partner of 5 years and "saving herself for marriage." She sees virginity as a social construct, but would still feel guilty about having sex before marriage.

During many calls, counselors had conversations that revolved around the shame callers felt or were subject to regarding their sexual orientations and gender identities. Many named religion as one major force of this feeling, but there was also the general fear of familial or social shaming should they 'come out' or be 'outed' as queer or trans*. In cases where callers had already talked to family members or friends about their sexual orientations or gender identities, some experienced rejection, tension, and lack of support—which exacerbated feelings of shame and guilt as well as isolation—and were calling the hotline to seek support.

Many callers also stated feeling ashamed of their sexualities: shame of being sexually inexperienced or shame for having had multiple partners, the former leaving them feeling undesirable, while the latter instilling a feeling of a looming punishment 'by the universe' for this enjoyment. Some felt that their preferences in porn, sex, or masturbation were shameful, simply because they do not comply with more 'acceptable' heteronormative ideas of sex and pleasure. This demonstrates the extent to which guilt and shame can seep into our private lives, make us question ourselves and our desires, and shape our preferences and behaviors.

Many mentioned feeling ashamed about their lack of knowledge of sex-related information, such as STIs or contraception. Not having this knowledge made callers feel that they were not educated enough about sex while still engaging in it. They reflected on how this lack of information increased the likelihood of unwanted consequences, such as STIs or pregnancy, which they would also be shamed for. There is a need to normalize and destigmatize conversations related to sex, so that information particularly pertaining to one's health and safety, is properly relayed.

Many callers discussed the potential shame of being discovered to be pregnant outside of wedlock, as well as guilt they felt for choosing to terminate a pregnancy. Other calls were about virginity and the feelings of shame and guilt around the issue of first-time or out-of-wedlock sex; these calls all came from cis women, and highlighted the pressures placed by society on them to abstain from sexual activity. Some of the callers expressed their own conflicting feelings around virginity, noting that while they are aware that it is a social construct that unjustly attempts to control their bodies, they felt uneasy at the thought of 'losing' it. We navigate this idea with callers in different ways depending on what they want—we open

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personal histories, internal conflicting values	direct interactions, mostly with families, friends, partners	social attitudes & norms, informal institutions (e.g. media)	medical & governmental institutions, amongst others (e.g. educational)

discussions on the alternatives to penetrative sex and ways to masturbate without hymen-breaking, and we give information on what hymens looks like, that hymens don't all look the same, that many people are actually born without a hymen, and what hymen reconstruction surgeries (hymenoplasties) entail.

The guilt and shame that callers expressed more generally was clearly reinforced by their experiences with unsupportive healthcare providers and the lack of accessible services that could address their needs, and several callers had experienced being shamed by service providers. One caller, a nurse, was looking for accessible and non-judgmental care and treatment for HIV-positive patients, specifying that he often sees patients being dismissed and "treated with disgust and fear." Though doctors may not always shame someone so explicitly, their denial of information, support, and care is in itself a form of punishment and shaming. This can have a large impact on people's wellbeing—we heard callers often express an internalized shame and guilt about their choices, identities, and desires as a result of healthcare provider stigma. For instance, some women with unwanted pregnancies called us for information after being dismissed and denied abortions by their doctors. While we do not ask for their reasons to terminate their pregnancies—nor feel that any reason is more valid than another—these women felt obliged to justify themselves and their choices. Simultaneously, some women felt pressured into ending their pregnancies because of fear of backlash or stigma for being unmarried and with child, or because they lacked financial security. These variables interfere with a women's choices around pregnancy and parenting; if there was no shaming of young and/or unwed mothers, and financial security was ensured for would-be parents, callers would have more autonomy in considering all their pregnancy options.

Shame and guilt also find their way into issues of lack of access to justice and needing safety from violence and abuse. The shaming that women, queers, and trans* people bear for the abuse that they face is normalized: if they are sexually or physically assaulted, the blame falls on them. With the widespread culture of victim-blaming and shaming, people who have faced sexual or physical abuse or assault are discouraged from seeking justice or access to mental, sexual, or reproductive healthcare. Several callers wanted to know if any legal recourse could be taken against their abusers, with one specific caller wondering if they might face shame from law officials if they sought their help to stop an abuser who is threatening to publish nude photographs.

It is clear from the hotline that guilt and shame are strong emotional forces of control, strongly impacting mental and emotional wellbeing. We recognize that these emotional elements can impact how people decide to live out their sexualities, genders, and relationships. We also recognize that people constantly negotiate these feelings and socio-cultural forces, to own their fantasies and realize their wishes, desires, and safety.

intrapersonal interpersonal socio-cultural institutional

isolation & erasure

The caller wanted help as she is "stuck in a homophobic household" and cannot come out to her parents. Her parents keep setting her up with guys and she has tried telling them before, but they were very dismissive and hostile.

Queer and trans* callers frequently referred to the lack of support from people and communities around them with regards to their sexual orientations and gender identities. More specifically many experienced direct neglect and isolation from their family and friends, and feared reactions of violence, shame, or ostracism from these same entities. In many instances, callers told us that because of this, they did not have anyone around them to confide in, and that they were struggling to deal with the issue at hand alone. There was a definite sense of urgency on the hotline with regards to people's desire for emotional care and validation when it comes to these personal matters. This need is amplified by the fact that there is a hegemonic heteronormative culture and presence, as well as a lack of information and conversation about marginalized and non-normative identities; indeed, many people also called us to discuss what it 'means' to be queer or trans*, and how they can express these parts of themselves.

On the hotline, we also noticed the desire for representations of sex that do not involve virginity until marriage, the submission of women and/or feminine persons, and pleasure centered around cis men. Many of these calls came from women asking about how to physically engage in other forms of sex, or whether they were 'abnormal' for not complying with these mainstream portrayals and expectations. It was clear from the hotline that women, queers, and trans* people are very much left behind in accessing resources, care, support systems, and knowledge that could help them navigate whatever choices they want to make. In many ways, they create their own spaces and find alternatives to discover desire, sex, relationships, gender, and sexual orientation.

intrapersonal	interpersonal	socio-cultural	institutional
personal histories, internal conflicting values	direct interactions, mostly with families, friends, partners	social attitudes & norms, informal institutions (e.g. media)	medical & governmental institutions, amongst others (e.g. educational)

Many callers turn to medical professionals when they need information and support they cannot access otherwise—this is partly because of the authority of healthcare institutes when it comes to matters of bodies and health, but also because it can feel like one of the only options when personal care and support is lacking. However, medical providers can further isolate people—one very common issue across the hotline is the affordability of healthcare, where simply being unable to pay for an appointment, treatment, procedure, or medication is a reason to be turned away from a medical institution.

Access to care is also affected by the discrimination that marginalized and institutionally vulnerable populations face. One trans woman was told by a healthcare provider that she "needed God," and another trans woman said she was once refused dental treatment, implying that it was because of her gender identity. One migrant woman was worried that she could be denied care due to lack of legal papers, meaning her legal status would outweigh her health needs and render her categorically 'ineligible' for care. When racialized discrimination seeps into medical institutions, it isolates migrant women and trans* people from accessing the sometimes-urgent SRH care they need. This shows us that not only do healthcare providers discriminate against people for their deemed-unworthy identities on an interpersonal level, but also that medical institutions systematically reinforce ideas of who is/is not inherently deserving of healthcare. This systemic and social racism leads migrant women (documented and undocumented) to face great health risks and racialized sexual violence, as their legal status takes priority over their wellbeing.

There is also a discriminatory isolation from alternative, non-institutional spaces of support and knowledge-sharing, such as our sexuality hotline. This manifested in cases where some folks called on behalf of others—mostly cis men on behalf of women, or Lebanese and white people on behalf of migrant workers. If having someone gain information on your behalf is easier than accessing it yourself, it becomes clear that privilege determines a person's access (or lack thereof) to support. On the hotline, we saw this advantage sometimes turn into an entitlement that reinforced women's isolation from information and support. For example, men would become upset or defensive when counselors asked to speak to the person involved directly. One agitated man said, "we are married so I know everything about her," and ended the conversation when the counselor insisted that his wife be involved in the discussion.

sexual violence

The systematic, social, and interpersonal structures and dynamics that infringe on women, queer, and trans* people's emotional and mental wellbeing are also what perpetuate a normalized violence against them and their bodies. This violence takes on many forms: sexual assault, intimate partner violence, coercion or manipulation into sex, emotional manipulation and abuse, revenge porn, non-consensually shared sexual content, or the threat of revealing personal information. Violence also stems from the enforcement of rigid notions of sexual orientation, gender identity, and gender norms, such as denying someone gender-affirming resources, misgendering someone, coercing trans* and queer individuals to 'come out,' steering the type of sexual play, or forcing non-conforming persons into situations where their wellbeing, safety, or life may be at risk. While there is a desensitization to how outrageous and unacceptable these forms of power, entitlement, and harm are, we want to reiterate that all forms of the policing of women, trans*, and queer persons' bodies is violent.

Violence and exploitation are often enacted by a person or entity who has power over another and their body—whether for lack of choice, security, political power, or access to support, or merely for the fact that certain identities, bodies, or positions in society hold more value than others. The socio-cultural, religious, familial, and institutional systems that we navigate formalize and normalize this authority and entitlement. For example, in accessing support, understanding, or justice, those more vulnerable to violence are often blamed. We've heard countless times that "we asked for it" or should have "expected it," 'it' being violence, because of what we look like or who we are. We've heard that violence 'puts us in our place,' for acting or appearing 'inappropriately.' We've heard the narrative that to avoid sexual violence, it is our duty to not 'entice' men—but that as wives, consent becomes irrelevant, as it is our duty to please and pleasure them.

Sexual and gendered violence in all its forms can have a deep impact on people's mental and emotional states and health, and can further manifest in people's relationships and sexual lives. However, we want to reiterate that the violence we endure does not define us. We can have been violated without wanting to be victimized, and we can explore sex, identities, relationships, and desires while we are still healing. Healing can take time, and finding the space or support for it can be difficult, but we reclaim our bodies, sexualities, genders, and spaces in countless ways every day, and this reclamation can exist alongside the bigger fight for justice, safety and wellbeing, autonomy, and agency.

intrapersonal	interpersonal	socio-cultural	institutional
personal histories, internal conflicting values	direct interactions, mostly with families, friends, partners	social attitudes & norms, informal institutions (e.g. media)	medical & governmental institutions, amongst others (e.g. educational)

but also, on feeling good!

We spoke about pleasure during sex, and she said she has been having very enjoyable experiences with her girlfriend, and that she has orgasms often without penetration.

As a hotline, almost by definition, people will call us in search of support or information. But we cannot characterize the topics we deal with only by the heavy, sad, frustrating emotions that emerge. We want to give space for the positive as well—both on the hotline, and in this report—because explorations of sex, sexualities, relationships, bodies, and genders are full of excitement too.

The caller was calling for information on how to ease pain and enjoy anal sex. She wants to try it both to please her partner and to enjoy it herself.

It is clear that many callers strive to achieve fulfilling physical and emotional intimacies. However, the emotional stress and burdens, harmful norms and expectations, silencing and judgment, and absence of information, place hurdles on women and trans* people's pleasures. Combating these hurdles, callers spoke to us about what they enjoy and how to take these joys further. They opened discussions around pleasurable non-penetrative sex, and posed questions about particular sexual acts that could satisfy them and their partners. Others shared with us what they enjoy in masturbation and kink. They talked about their expectations and experimentations, and how they could learn and communicate what they want in intimacy and partnership. Some people expressed a desire to feel free in further exploring their sexualities, gender expressions, and bodies. Others referred to feeling in love or lust, and the complexities around how this relates to sex, sexuality, commitment, and communication.

intrapersonal	interpersonal	socio-cultural	institutional
personal histories, internal conflicting values	direct interactions, mostly with families, friends, partners	social attitudes & norms, informal institutions (e.g. media)	medical & governmental institutions, amongst others (e.g. educational)

She soon got her period and texted us again updating us about the "joyous" appearance of her menstrual blood.

Notably, a few callers explicitly mentioned feeling relieved, happy, and joyous when they realized they were not, or no longer, pregnant. We can only expect that women feel this way when a possible unwanted pregnancy, which brought panic and stress, is non-existent, and they don't need to be forced into pregnancy, labor, motherhood, or have to navigate familial, financial, legal, and emotional responsibilities and traumas. With this in mind, we rejoice with women calling us about this experience, and we feel their relief with them.

He mentions how happy he feels when he is in drag.

She has been trying to explore her body and what pleasures her.

She was in the mood, turned on and excited about having sex for the first time.

It is clear how prominently and diversely joy manifests in women, trans*, and queer people's sexual and intimate lives, despite society's strong determination to oppress this. We want the hotline to be a space where it is centered and celebrated, where self-care, self-love, and bodily autonomy can be freely expressed, where all questions are welcomed, and where knowledge is reclaimed, in a context in which all this is regularly punished. An essential part of our work is to contend—to callers and to the world—that autonomy and satisfaction in our experiences, bodies, relationships, and identities, is rightfully ours. And beyond the politics of pleasure behind all this, sometimes people just want to casually chat about what makes them feel good, and we are also absolutely here for that, too.

Centering and seeking these good feelings is somewhat of a statement of resistance against the norms that continuously restrict our self-expression, our choices, and what we should like and who we should love. It is a statement against the ways in which we are labeled "shameful," "wrong," or "abnormal." Asserting our right to self-determination in these matters allows us to make our own spaces for alternative ways of learning and loving our bodies, intimacies, identities, and needs. The hotline is here to support folks in claiming these rights by sharing knowledge and providing understanding and support, but we also think of it as being a reclaimed and self-owned space itself, that we want to extend to you.

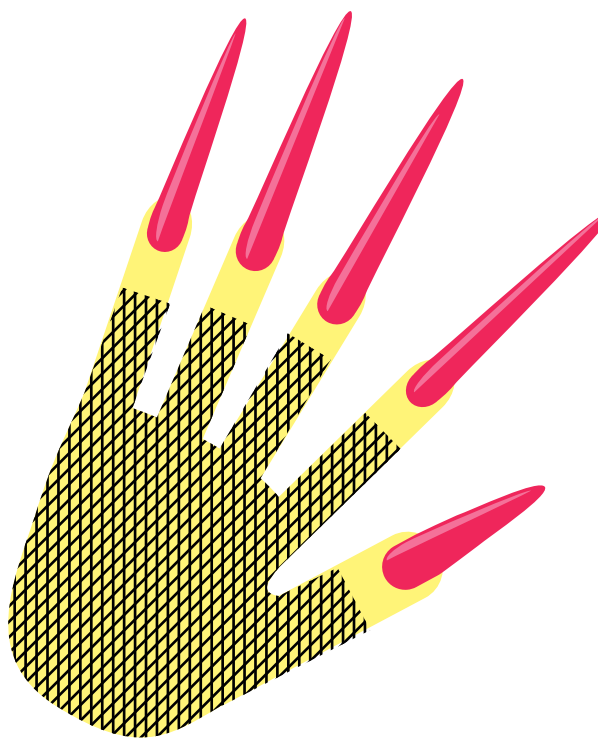
intrapersonal interpersonal socio-cultural institutional

She was asking if it is normal for her to enjoy masturbation more than sex with her husband, and she was feeling guilty for doing that.

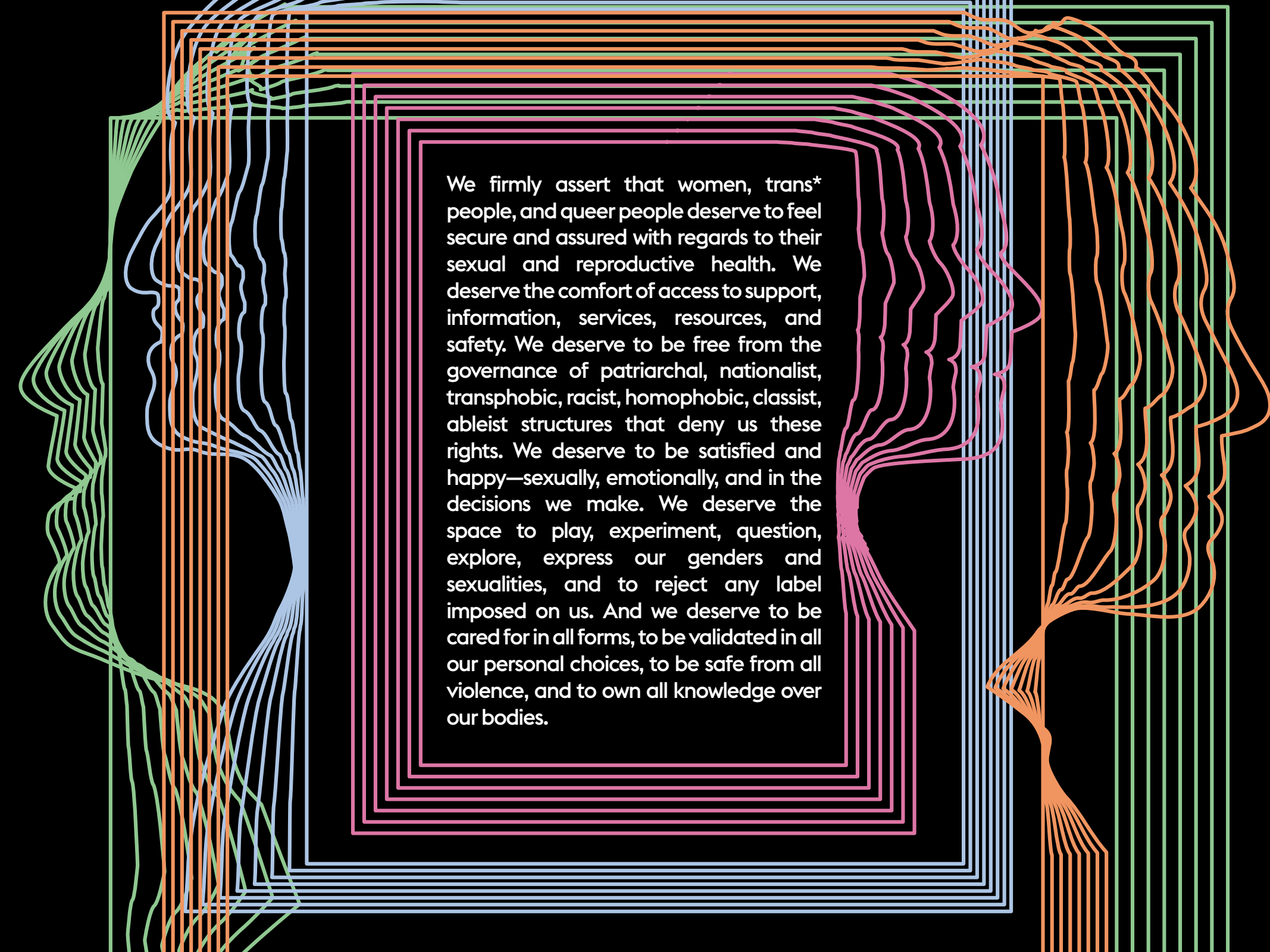
She likes watching / trying rough sex more than vanilla and is worried this is not normal.

It was evident from the calls that 'positive' and 'negative' emotional states are not at all mutually exclusive, as many seemingly opposing feelings are brought up in the very same call. While queer love is demonized, queer lovers told us about how they find pleasure in private. We talked to women who were shamed for having multiple sexual partners, but continued to enjoy their non-monogamy nonetheless. Though some were made to feel guilty for masturbating, they didn't deny themselves the pleasure it brings them. We also saw how new and exciting things can be scary; how the choices we make can be riddled with guilt; how freely expressing your identity can be isolating; and how feeling confident in knowing exactly what your body needs (e.g. in health and affirmations) can be harmfully hindered by lack of accessibility, affordability, and availability.

Pleasure and comfort—both emotional and physical—need to be normalized as a part of our sexual and reproductive education and upbringing. If school classes on the biology of sexual organs and reproduction, consultations with SRH medical professionals, or parents' 'sex talks' did not skip over these aspects of sex, relationships, and identities, people would be much more equipped to understand and explore their own bodies and all their potentials. The silencing of sexual pleasure, gender diversity, or queer relationships maintains some kind of social peace and order, at the stake of our emotional, sexual, and physical wellbeing. On the hotline, we encourage these conversations because we believe they are just as important as any other question on sexual and reproductive health. So, do not hesitate to chat about your likes and loves with us—we're here to listen non-judgmentally, support you in your explorations, and celebrate feeling good with you!



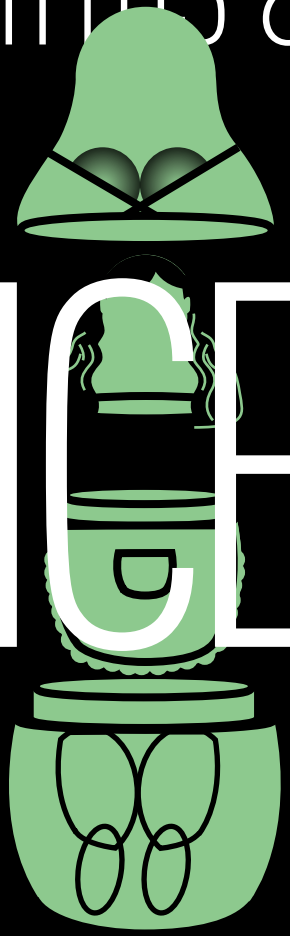
intrapersonal interpersonal socio-cultural institutional



We firmly assert that women, trans* people, and queer people deserve to feel secure and assured with regards to their sexual and reproductive health. We deserve the comfort of access to support, information, services, resources, and safety. We deserve to be free from the governance of patriarchal, nationalist, transphobic, racist, homophobic, classist, ableist structures that deny us these rights. We deserve to be satisfied and happy—sexually, emotionally, and in the decisions we make. We deserve the space to play, experiment, question, explore, express our genders and sexualities, and to reject any label imposed on us. And we deserve to be cared for in all forms, to be validated in all our personal choices, to be safe from all violence, and to own all knowledge over our bodies.

On the hotline, we encountered many myths and misconceptions about SRH, sex, bodies, and identities. These instigated fear, anxiety, and confusion amongst callers, and led us to hear the harmful stereotypes that arise from such misinformation.

MORALIZING MYTHS & MISCONCEPTIONS



It's important to highlight how these myths and misconceptions serve the medical patriarchy*, perpetuate patriarchal social values, and are used to deny women and trans* people autonomy.

We want to expose the falsity and the moralizing basis of these claims to readers, with the hope of extending knowledge about SRH and encouraging conversations that work towards the liberation of women, trans*, and non-conforming individuals.

* a term referring to how medical systems are built on, and further reinforce, patriarchal values, norms, and governance

Misconceptions rooted in the medical patriarchy

On contraception

Intrauterine devices (IUDs—a type of contraception) can cause future miscarriages or infertility

Emergency contraception pills (ECPs) are the same as abortion pills

ECPs are not effective if taken during or after ovulation

On pregnancy and abortion

Abortion with pills causes infertility, and is more dangerous and less effective than surgical abortion

Abortions should take place at a hospital or clinic

It's impossible to get pregnant on a period, from first-time sex, precum, or non-penetrative sex

On sexually transmitted infections - STIs

Non-penetrative sex cannot cause STIs

Herpes is dangerous and uncommon

Women cannot get STIs from unprotected anal sex

On our bodies

Excessive masturbation can cause vaginal dryness and decreased pleasure among cis women, and infertility in cis men

Hymen-bleeding consists of a few drops of blood and only occurs during first-time sex

Not desiring a partner is certainly a medical issue

These misconceptions stem from many places. Some are used as techniques of fear-mongering; telling women that certain contraceptives are dangerous or ineffective, for example, serves to control their fertility and scare or manipulate them into having (more) children. Others come from rumors we are told by educators, family members, and peers, that insinuate that our sexual acts, bodily explorations, desires, or our bodies themselves, are 'wrong,' 'obscene,' and 'controversial.' More concerningly, doctors might share deceptive information, perhaps to impose their own moralizing agenda (such as promoting childbirth, virginity, or heterosexual sex), or to ensure financial gain (such as promoting one type of contraceptive over another, or claiming that abortion with pills is ineffective, to encourage more costly surgical interventions). When even 'experts' could be jeopardizing our sexual and reproductive health by decisively shaping what knowledge we do or do not have, we understand the extent to which our wellbeing and bodily autonomy are compromised.

Myths rooted in social patriarchal beliefs

These statements are based on ideas of sex, gender, and sexual orientation that are categorical, restricted, and not to be defied. They're based on the conception that sex is for reproduction or part of a dutiful romance, and not for pleasure and joy. They're based on notions that equate sexual orientation with sexual preferences, looks and bodies with gender identities, and sexual acts with moral codes. These claims are made in attempt to convince us that hetero and cis ways of the world are—and always have been—inherently correct and fixed, demonizing those who can't or don't conform to such standards. Many challenge these myths every day, sometimes quietly in their private lives, sometimes outspokenly, visibly, and unapologetically. However, they remain dangerous in their effects; this includes the mental and emotional burden that comes as a result of being told that such identities, practices, decisions, or relationships are illegitimate, but also the physical violence and denial of support that arise from people's surroundings.

As The A Project, we want the hotline to be a space through which we can politicize and expand the conversation around these issues. But also, we want to assert that while the myths spelled out here represent dominant social discourse and values, it is not at all uncommon to 'defy' the strict and narrow definitions of what our bodies, attractions, choices, and identities look like. Even those who seemingly do comply with dominant values and identities tend to disrupt the boundaries of these norms, because, quite frankly, they are unrealistic and often unachievable.

On sexual orientation

- ***Not liking penises and/or penetration means you cannot be attracted to cis men***
- ***Watching lesbian porn means you are a lesbian***
- ***Being transgender means you cannot be attracted to a person of your same gender***

On sex

- ***Anal sex certainly injures the person receiving it, and makes them weak and sex-crazed***
- ***Having sex while on your period is "animalistic"***
- ***Only penetration is 'real' sex***

On gender

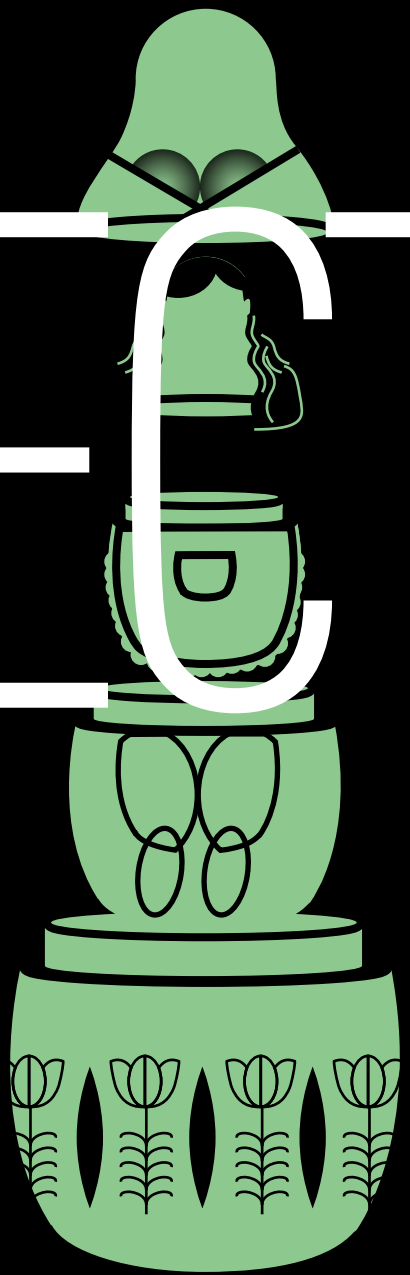
- ***Your gender identity is illegitimate if it does not align with your gender expression***
- ***Being transgender means you have to undergo surgery***
- ***Sexual preference dictates your gender identity***

On pleasure

- ***Pleasure should first and foremost come from sex with someone else***
- ***Certain fantasies are just wrong***
- ***Penetration is the primary form of pleasure for cis women***

Our counselors are asked to reflect on their impression of how the caller felt by the end of the conversation, as well as their own feelings. These questions contribute to the counselors' self-evaluation, development of their counseling methods, and more broadly to The A Project's evaluation of the hotline and wellbeing of its counselors.

REFLECTIONS



Though trained to counsel on all manner of issues, including more practical and information-based ones, counselors are never trained to be robotic or neutral. We cannot—nor do we want to—deny that they are affected by the sometimes heavy, sometimes joyful, sometimes sad, sometimes fulfilling nature of the stories they hear.

feedback from callers

In mid-2018, we created an evaluation survey for callers to anonymously tell us how their experience with the hotline was. Since then, we have done our best to disseminate the survey, so that as many callers as possible can openly give us feedback and recommendations. We cannot grow based solely on our own self-reflection; we need callers' thoughts on how to better the hotline and the support it extends!

Throughout the second half of 2018, 39 callers shared their feedback with us. Overall, a large majority cited that they did not have difficulties reaching us, that their main concerns were tackled, and that they were comfortable throughout the call! Most feedbackers stated high satisfaction with the hotline, that they would recommend it to others, and that they felt it was helpful, informative, friendly, non-judgmental, private, and trustworthy —all of which are hotline qualities that we value and prioritize.

However, some callers did state having trouble reaching the hotline and feeling uncomfortable during calls. While few, we keep in mind that in relation to the 219 calls we received since launching the evaluation survey, a minority (18%) evaluated their experiences. Moreover, we recognize that there may be a reporting bias; it is likely that those with positive experiences are more inclined to evaluate us through this survey. We want to emphasize that we value hearing from all callers, so we can adequately hold ourselves accountable, strengthen counselors, take in your suggestions, and introduce new trainings. This hotline is, and always will be, a project of constant growth and learning.

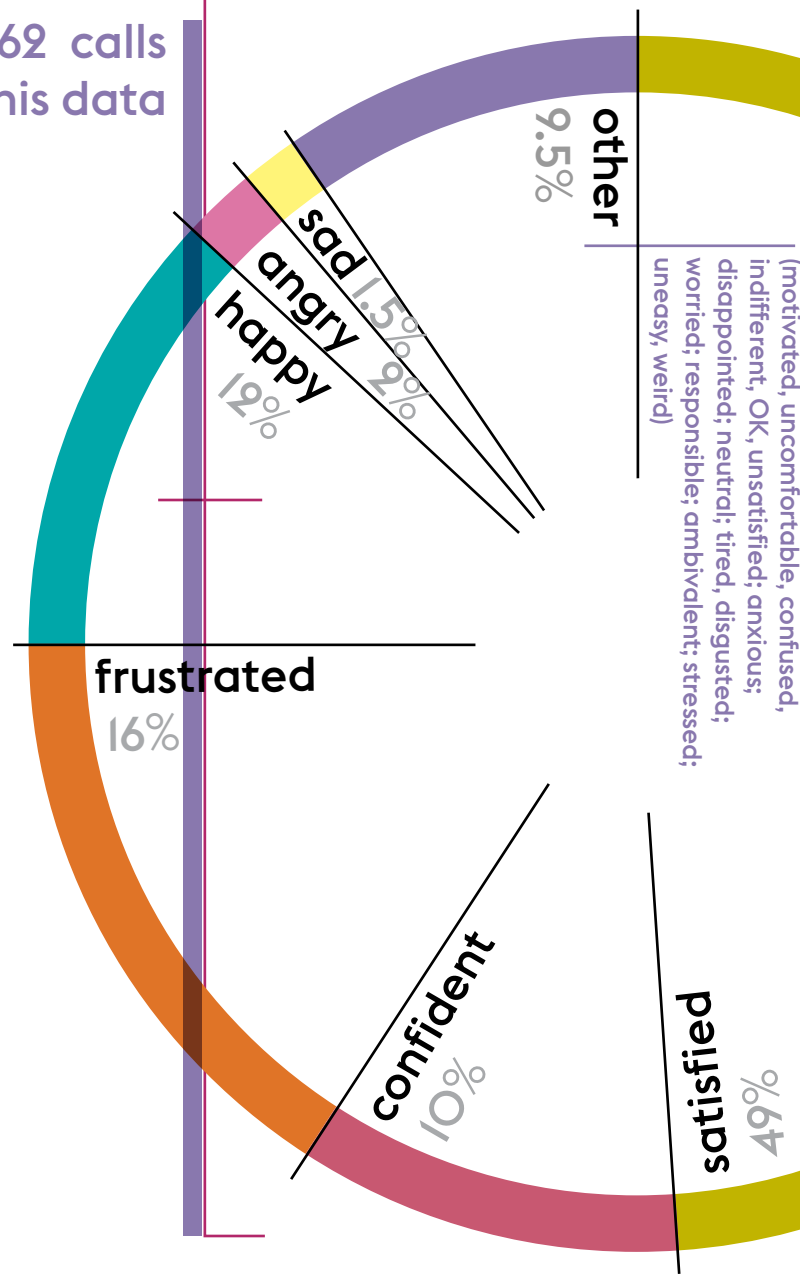
If you have ever contacted the hotline and not filled in an evaluation, here is your chance! Go to **theaproject.org › The Sexuality Hotline › Ever Called Our Hotline?**

counselors' post-call feelings

total number of calls
JAN-DEC 2018

314 calls

262 calls
recorded this data



There is a duality in these post-call emotions, for both counselors and callers: for example, some callers felt more informed and validated but still anxious or shocked, and some counselors felt worried for the caller, or frustrated by the situation the caller was in, although the call itself was satisfying. It's important to note these overlaps, because it allows us to bring out the emotion embedded in the interaction between caller and counselor. Whether it's the care created in that space, the frustration that emerges when little can be done, the validation that comes from an understanding ear, or the anger and sadness that arise as counselors and callers rant together about the general (deplorable) state of SRHR affairs in the country, the conversations can be very sensitive, intimate, and, indeed, very emotional in nature.

counselors' thoughts on hotline praxis

- Encountering language barriers with callers can allow us to form new ways to produce/share knowledge, for example through drawings!
- Being a counselor is a learning experience. We face new scenarios, develop new communication skills, and gain new knowledge and ideas about how to deal with certain issues and situations.
- It is key that we do not project what we feel is significant about a caller's life, identity, or experience if they themselves are not centering it in what they are sharing. For example, though early marriage, or someone's queerness, can stand out to us as something to discuss, it may not be relevant to them in the issue they are describing.
- Context is key: for example, young people cannot necessarily be referred to certain doctors, or may not be as aware of possible misinformation given to them.
- It's important to be honest and not give false hope or promise.

We do aim to be a source of support, and we are happy with the expressions of gratitude and affirmation that we receive from some callers;

COMMUNITY BUILDING

however, it is essential that we build towards communities and structures that provide support so that callers do not have to rely on an anonymous interaction with a hotline counselor to have the conversations and receive the emotional care we all need.

the rest of our work

Beyond the hotline, The A Project works on achieving our vision through the following projects:

Trainings and Workshops

We do workshops in schools, universities, and community centers to discuss SRHR, and we particularly try to host these with groups who have less access to SRH information and care.

Reading Retreats

Inspired by CREA, The A Project hosts 2 reading retreats (The Politics of Sexuality & The Politics of Mental Health), and we have one on the way (Reproductive Justice)! At these retreats, we delve into the theory and practice of topics at hand, through a series of articles and collective discussions.

Multimedia and research

To contribute, in diverse and accessible ways, to the body of knowledge on sexuality and reproductive justice in Lebanon, we: write articles; publish blog posts; translate works we love to Arabic; present on various panels; and produce a (super cool) podcast, *Fasleh,* on which we invite people to talk about a number of topics concerning body politics and sexual and reproductive health, rights, and justice.

Events

We host events such as film screenings and discussions where we can expand the conversation on sexuality issues, the social and political aspects of the work we do, and learn from each other and from other resources and knowledge out there.

going forward: things we'd like to do

Solidarity groups

We are working to develop, confidential and as-safe-as-possible, solidarity groups wherein people with similar experiences can come together, share stories, find solidarity, and feel less isolated. These would take the form of intimate and private discussions, led and defined by those who attend them, and serve as a space for asking questions and exploring issues without judgement.

Expanding our research and knowledge base

As a team of staff and members, we are always exchanging ideas for all the things we'd love to write, learn, publish, make, and do—together, and with you. We want to concretize some of these ideas and put ourselves to work to make content that produces knowledge in accessible, playful, and interactive ways. We have some plans in the making, including a creative writing retreat, some research-based zines, and—as always—some new podcasts and blog posts. We're always thinking about new projects to take on and new topics to delve into, so please do get in touch if you'd like to get involved!

Building on our referral database

We receive countless requests for competent, decent, affordable, and accessible health services on the hotline. It is very clear to us that women and trans* individuals—and especially those who are young, poor, queer, migrants, or refugees—urgently need this care. But too many times, we have found ourselves at a loss as to where to guide folks for safe and decent healthcare.

We are building a reliable and accessible collective referral database, where we crowdsource information on healthcare providers from **you.** We are asking people throughout the country to fill out surveys that give an overview of their experiences with certain healthcare providers—whether good or bad—so that we can grow this database. **This is not a research study!** The data will not be used for research purposes or end up in a publication. The survey is anonymous, and will feed into an ever-growing database of trusted (and not-so-trusted) healthcare providers, whose practice align with our politics and values.

going forward: things we'd like to do

We currently have two surveys for people who use SRH healthcare services:

Sexuality & Sexual Health Survey: A general survey for healthcare service users of all genders to reflect on their experiences with service providers on multiple issues related to sexuality and SRH.
[Eng | Ar]

Trans* Health Survey: A survey addressed to trans* service users with questions specific to their experience of receiving services particular to their needs.
[Eng | Ar]

Are you a healthcare provider?

Of course, two people can have opposing experiences with the same medical practitioner; to ensure this is addressed to the best of our ability in the referral system, we have created a survey for medical healthcare providers themselves. In it, we ask technical details (prices, location, specialties...), attitudinal questions about various SRHR issues, as well as whether there are clientele restrictions, as many providers may not be welcoming of migrants, refugees, queers, or trans* folks. This survey also asks healthcare providers whether they want to be part of our referral database. Such information is essential for us to refer callers to non-discriminating healthcare providers all over Lebanon.

Healthcare Providers' Survey: A survey addressed to healthcare service providers to assess certain attitudes and willingness to take part in our referral database.
[Eng | Ar]

We love to have new folks on board. If you're interested, fill out this volunteer / members form. The form gives us an idea of who you are and what you're interested in doing with us :) After we have a look at it, we'll get in touch, find a way to meet you, and see where/how/when you can get involved.

Apply for our Sexuality Hotline Training! Each year we host a 6-day intensive sexuality hotline training to train new counselors. We train you on SRH issues, counseling skills, and the political and social aspects of sex, gender, and sexuality. We share the call on our social media platforms, newsletter, and website - so keep an eye out for the next one!

Join one of our reading retreats! In our retreats, we discuss a series of texts that you will have read in advance, and delve into the topics at hand in depth. Like our other calls, we post the application form for the retreats on social media, newsletter, and the website, so stay tuned if you're interested!

join us!

Keep up with us!

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