Against Normality

THIRD SEXUALITY HOTLINE REPORT
2019

THE A PROJECT
AGENCY
AUTONOMY
ALTERNATIVES

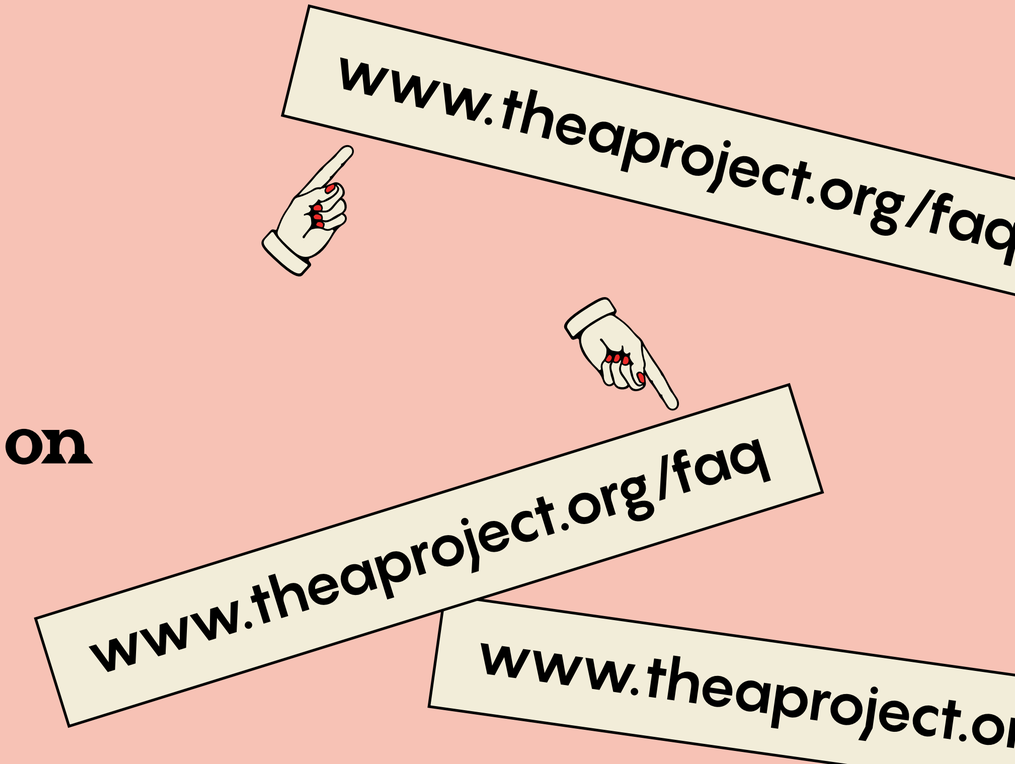
Got questions on sexuality, gender, or sexual and reproductive health and rights?

Contact our sexuality hotline.

+ 961 76 680 620

hotline@theaproject.org

Open daily between 5-11PM
Browse frequently asked sexual and reproductive health and rights questions on our website!



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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 cis and trans women, trans men, and gender non-conforming people's sexuality and mental health are not utilized against us, but reclaimed, cared for, respected, and recognized in their diversities. From expressing gender, sexual preference, and desires, to rejecting or accepting marriage, to having/not having children—the list is long! We know that sexuality and reproductive justice are core battles in reclaiming bodily autonomy and political agency, and we believe that everyone has the right to decide the journey their body goes through in a harm-free, consensual, and affirming space. 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 measures often used against the bodies of women and gender non-conforming people in Lebanon.

This publication

This publication is an annual report on The A Project's sexuality hotline. The hotline is a core element of The A Project, established to discuss, primarily with cis and trans women, trans men, and gender non-conforming people, all things sex, gender, relationships, and sexual and reproductive health. In this report, we take a look at the data of the hotline: who's calling, what about, what the hotline tells us about SRHR more broadly, and reflections on the hotline's work. With data on sexual and reproductive health and rights being scarce in Lebanon, we hope that this report is able to give a cross-sectional picture of what people are struggling with and fill some of the gaps in the literature. Feel free to use this data, animate it, advocate through it; our intention is to share this knowledge with the public, and most importantly, to give the data back to our callers.

About the sexuality hotline

Established in November 2016, The A Project's sexuality hotline provides counseling, support, information, and referrals to cis and trans women, trans men and gender non-conforming people on sexual and reproductive health (SRH) issues. The hotline also provides an outlet for people to talk to an engaging, well-informed, and understanding person who isn't set out to give unsolicited advice, to diagnose, or categorize the fluidities of one's life experiences. On the contrary, the hotline is founded on the belief that cis and trans women, trans men, and gender non-conforming people—whether queer or not—are often given moralistic and socially tainted information about our bodies, lifestyles, and health, and we deserve better than that. We know that the socio-political, cultural, and economic contexts we live in enforce sexism, ageism, racism, classism, and ableism and heavily influence our experiences with sexuality, gender, relationships, and sexual and reproductive health.

Our sexuality hotline counselors are trained by medical professionals, researchers, social scientists, and activists on the social, medical, psychological, and political contexts of SRHR. We ourselves are not medical doctors or sexologists, so while we do provide up-to-date information on a range of medical issues and procedures, we do not diagnose medical conditions, and do refer callers to healthcare providers if need be. Our main aim is to support cis and trans women, trans men, and gender non-conforming people with knowledge, access, and comradery so that they reclaim their place at the forefront of body politics discourse and be the first and foremost experts on their bodies and lives.

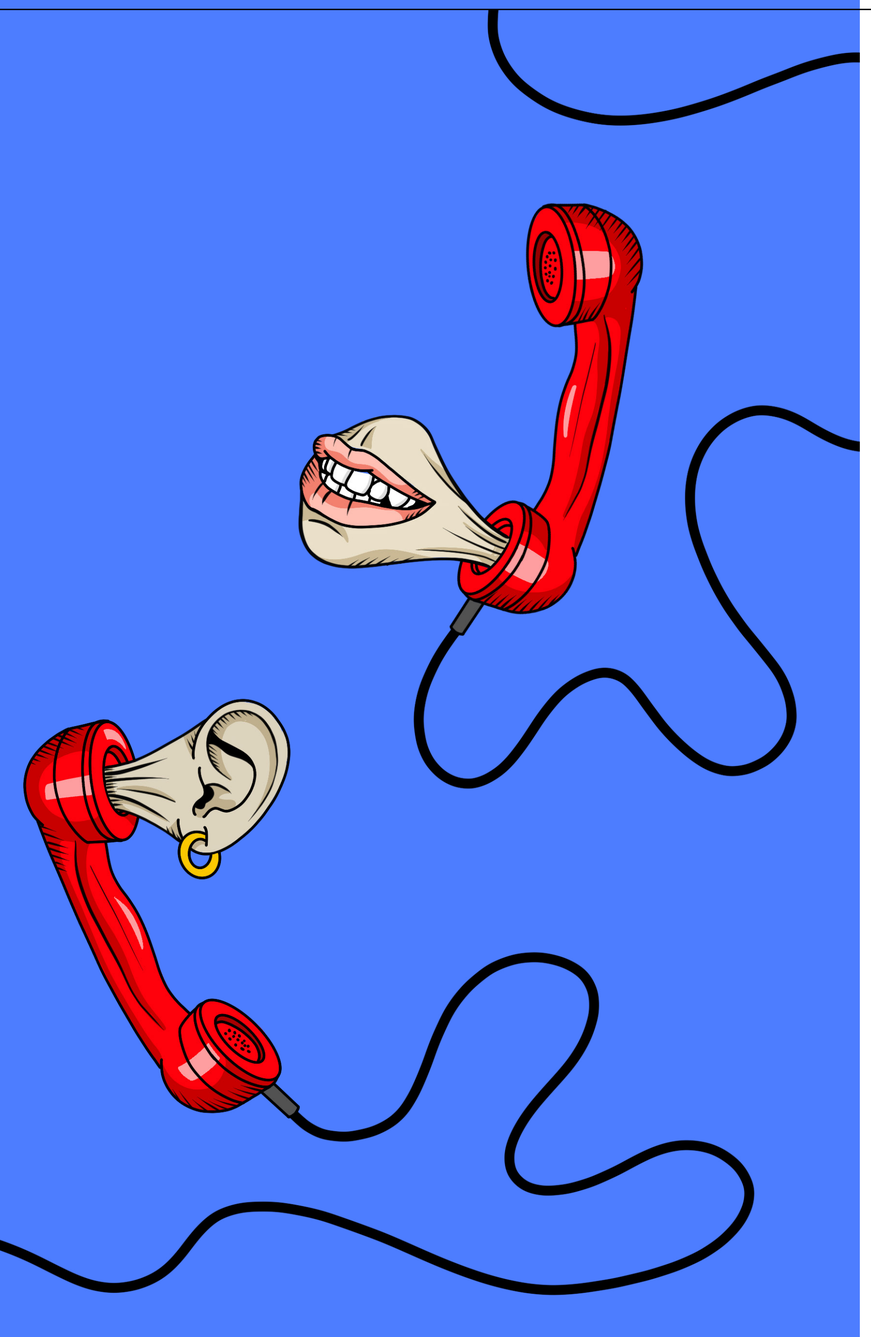
To answer some questions you may have about the hotline...

WHY A HOTLINE?

Because it's free, accessible, confidential, anonymous, and judgment free! You don't need an appointment, can be located anywhere, and can even write (email, WhatsApp, SMS) us.

WHAT DO PEOPLE CALL THE HOTLINE ABOUT?

So many topics, such as:
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



www.soundcloud.com/faslehpodcast

WHO PICKS UP THE PHONE?

We train cis and trans women, trans men, and gender non-conforming people from diverse educational backgrounds to become sexuality hotline counselors. They undergo weeks of intensive training and are assessed on their knowledge, approach, openness and comfort on these topics before being allowed to be on the hotline. While all are trained on the same issues, some may have more insight and passion regarding particular body/gender/relationship/sexuality politics.

You can get to know more about counselors, what languages they speak, what their interest-topics are, and when their next shift is by logging on to: our website
> The Sexuality Hotline > About the Hotline > Hotline Schedule

WHO CAN CALL?

Anyone can call, and we especially invite cis and trans women, trans men, and gender non-conforming callers of any age, nationality, sexual orientation, or socio-economic background.

BESIDES A HOTLINE, ARE THERE OTHER SOURCES OF INFORMATION OR SUPPORT?

Occasionally, we host solidarity groups, which take the shape of intimate and private discussions, whereby callers who have similar questions and struggles can meet to process and support one another. We've also been told that our podcast, Fasleh, feels like listening to friends thinking out loud about cool topics.

CHECK IT OUT!

www.soundcloud.com/fa

www.soundcloud.com/faslehpodcast

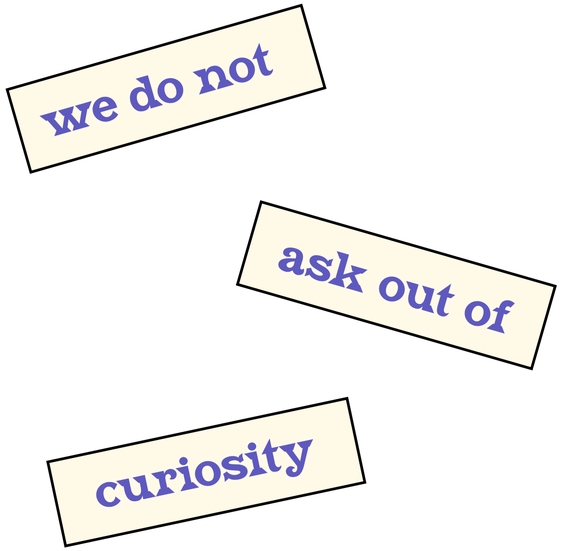
Read me: Your data and our documentation

When we ask callers to specify personal information for our documentation, whether it is age, gender identity, location, relationship status, or nationality, this information remains confidential and anonymous, and callers are free to refrain from sharing with us. We ask because it allows us to gain a deeper understanding of how different norms and structures affect people in their varying 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 must account for those persons' situations, capacities, and realities. We do not 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 follow up, or because they are interested in joining a solidarity group gathering, which we would later contact them about.

We document callers' concerns and conversation topics in order to keep track of the most prominent needs, common experiences, questions, and issues that they face. It also gives us insight into what issues we need to address, study up on, and learn to tackle better. 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 purpose of follow up in the next shift. Counselors do not have access to the database of hotline calls; 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.



About this report

In our 2018 sexuality hotline report we analyzed hotline calls through the lens of mental and emotional well-being. This year, we'll be looking at how the concepts of normal, abnormal, natural, and unnatural all deeply affect many aspects of sexuality, gender, and the sexual and reproductive health and rights of callers.

Normal is not as normal as we are told it is.

In fact, everything we have come to understand as natural is a social construction made to serve political interests that benefit the maintenance of the status quo. Even language to describe what normal is or isn't just ends up re-enforcing a characterization of natural vs. unnatural which alienates and disempowers those who fall out of the norms with regards to sexuality and gender.

Sometimes claiming something is normal or natural offers the illusion of comfort and perhaps an apologetic sense of belonging where one does not belong, but ultimately in doing this we are applying normative principles to the fluidities of sexuality and gender and not being true to the very essence of the diversities in these experiences.

Questioning what we have been taught and asking ourselves: "why is this perceived as normal or natural?", "did someone decide on my behalf if this is normal?", or "who is benefiting from this being labeled normal/abnormal?" allows us to rethink why normal is inherently seen as good, and abnormal as bad. To show the differences and world of possibilities within the abnormal, and maybe even to reconstruct a much less rigid normal, is so important as it establishes that there are no norms without exceptions.

Why would we ever believe a normal that is constantly betting against us when we can reimagine a new normal that encompasses our understanding of the world and that encompasses a greater range of experiences.

Our intention with this report is not to dismantle the norms of sexuality and gender in Lebanon (that would be unrealistic), and definitely not to replace an old norm with a new norm (that would be hypocritical); this report simply hopes to highlight how normativity cannot keep up with itself and is really quite abnormal, and to show how the question of normal manifests in the day-to-day dealings in sexuality, gender, relationships, and sexual and reproductive health.

Report summary

This third edition of The A Project's sexuality hotline report reflects on the data collected via calls/chats/emails made to the hotline in the year of 2019. From January 2019 to December 2019, the hotline received a total of 441 calls. The majority of callers are cis women, Lebanese, and between the ages of 20-25. Similar to previous years, the majority of our callers are based in Beirut. However, unlike years before, the hotline counsellors witnessed an increased number of calls from North and South Lebanon, and almost half of all the calls made to the hotline this year were by first-time callers looking for information and/or someone to talk to.

This year, the sexuality hotline report is evidence of limitations to health knowledge and access created by social expectations that try to maintain heteronormative ideals, morals, and paths. **Every call made to the hotline this year may be classified as challenging/questioning the social structures that are imposed on us.** Topics on gender identity, relationships, sexual orientation, sex, pleasure, and virginity consisted of over two hundred calls to the hotline. Forty-one conversations actively discussed the morals and ideals of medical patriarchy and compulsory heterosexuality. Two hundred and twenty calls were about unwanted pregnancies and contraception — a defiance of heteropatriarchy's procreative expectations of those who are assigned female at birth. Other calls discussed sexual violence and challenged the gendered expectation of keeping quiet, staying silent, and normalizing it as a taboo topic. On topics such as sexually transmitted infections (STIs), which are highly shamed and associated with deviancy and amorality, callers sought knowledge that is inaccessible or purposefully kept from them about their bodies. They questioned how to secure what they wanted for their wellbeing while bypassing religion, family authority, and the legal system: all entities of power we're taught not to disobey. Overall, the hotline witnessed the burden callers feel from attempting to juggle abiding by and not abiding to expectations of sexual norms, and how, in fact, there is nothing natural about it. This report is a modest reflection of the contradictions of sexual normalcy, and the repressive reality attributed to the many individuals who seek to challenge such "norms."

'Topics on gender identity, relationships, sexual orientation, sex, pleasure, and virginity consisted of over 200 calls to the hotline.'

Deconstructing 'the norms' of sexuality

To use the framework of deconstructing normativity in this report, we need to clarify to readers the theory behind this framework. It is important to trace back the root cause of why hotline callers are excluded from accessing a range of sexual and reproductive healthcare services, pursuing societally forbidden intimacies and/or gender expressions, accessing bodies of knowledge regarding their own bodies and well-being, practicing their notion of motherhood or parenthood, and having spaces where they feel physical and emotional safety. The language constructed around what is (un)natural and (ab)normal in sexuality is moralistic and ancient, it heavily dictates what is considered (un)healthy and (im)possible, and influences the objectivity of knowledge produced and the options laid out for us; therefore, influencing the decisions we take.

So, what is 'normal' or 'natural,' anyway? And who decides this? What are the social repercussions that come with being 'abnormal' or 'unnatural'?

Luckily, we are neither the first nor will we be the last to ask these questions. Scholars, such as Jeffery Weeks and Gayle Rubin suggest that **sexuality** — as an all-encompassing headline including gender, relationships, and sexual and reproductive health — **is always political.**[1] As a product of political maneuvering, sexuality is therefore a social construction designed with inequalities and many features of oppressions (Weeks, 15).[2] In other words, sexuality is an invention of humans — and any law/policy/social expectation that enforces a normal/natural approach to sexuality is politically motivated to reinforce an imagined idea of what is natural and acceptable and what is not (Rubin, 267).

Sexuality norms are often justified as being a "natural force" existing previous to the creation of institutions and social life (Rubin, 276). This approach is known as sexual essentialism, and suggests sex to be a concept and practice that is fixed, never changing, and unaffected socially or historically. The fields of medicine, psychiatry, and psychology have historically adopted a sexual essentialism approach, often searching for underlying biological and physiological understandings of how sexuality came to be. Non-medical fields, such as religion as a social institution, have also adopted a biological and physiological approach to understanding sexuality. Rubin and Weeks suggest

1. Rubin, Gayle (1984) 'Thinking Sex Notes for a Radical Theory of the Politics of Sexuality', in Carol Vance (ed.) Pleasure and Danger: Exploring Female Sexuality, London: Pandora.

2. Weeks, Jeffrey. (2011) The Languages of Sexuality. New York, NY: Routledge.

that claims of "naturality" are most convincing when justified with biological reasonings that imply the health of an individual is impacted by their "unnatural" or "abnormal" sexual practices (e.g., in the 19th century, medical practitioners argued that masturbation at a young age is an unhealthy practice because it impairs the health and maturation of children. This proclaimed "health risk" allowed parents or guardians the liberty of "protecting" their children from further "health risks" by employing techniques that forcibly prohibit masturbating. Such techniques, that apparently were detriments to the health of their children, included tying the limbs of the child to the bed so that they physically were unable to touch themselves at night or forcing them into genital mutilation surgeries) (Rubin, 268).

Sexual essentialism discourse reaffirms sexual oppression through a value system Rubin refers to as the "hierarchy of sexual value[s]" (Rubin, 280). We are familiar with this sexual value system as one that dictates the "normal" versus "abnormal" practices of sexuality. Labels such as good, normal, and natural are traditionally attributed to heterosexual, marital, monogamous, procreative, and non-commercial/free sexual experiences that occur in the home; are relational and practiced within couples of the same generation (Rubin, 280). On the other side of the spectrum is what is perceived as bad, abnormal, or unnatural sex — characterized as homosexual, unmarried, promiscuous, non-procreative, and for pay (Rubin, 281). "Bad" sex is often inclusive of masturbatory practices, casual sex, sex between more than two people, sexual experiences in public places, and may include toys, objects, or "unusual" roles.

These values are socially organized to implement and maintain a "norm" that truly isn't "natural" at all — and unfortunately, much of the language we use when discussing sexuality is grounded in the normative values imposed on us that have been prescribed to us. However, language is not the only culprit maintaining gender and sexual norms. These norms are deeply ingrained in social and legal systems, and while changing the language that surrounds these issues or addressing them in "nice ways" helps a bit, it still fails to stop the harm that the large systems that monitor and maintain them cause to those who do not conform.

So, we must ask ourselves, if in fact these 'norms' were so natural, why does it take so much effort from the state, religion, and medicine to maintain this 'normality'?

7. 2019 sexuality hotline data

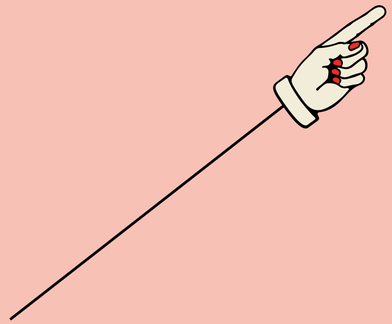
A quantitative peek

The data presented in this report comes from the information collected by our sexuality hotline counsellors in the year 2019. With the consent of the caller, counsellors jot down the caller's demographic information to get a sense of who is calling, and where/how our outreach can be improved. With this information, we are also able to share with you what topics, concerns, and questions were explored most this year.

To analyze the data, we applied a mixed-methods approach of inductive and deductive analysis. This means that a large part of our analysis is formulated around the patterns that are drawn from observations and information collected during calls (i.e., inductive approach), while the direction of the data is deduced from years of implementing the sexuality hotline and our understanding of the sociolegal, economic, and political realities of cis and trans women, trans men, and gender non-conforming people who live in Lebanon.

We have had a total of 441 calls made between January 2019 and December 2019. **However, the statistics shared in this report may not consistently be reflective of all 441 calls.** Look to the bottom left page for the total documented figures of each demographic category. The gap in demographic data may be due to callers refusing to give some of their information, counsellors unable to capture these details, or calls not allowing for an appropriate moment to ask such questions (especially if the caller is in distress) or the conversation becoming too captivating for both the counsellor and the caller. The hotline is all about having interesting and honest conversations around all-topics sexuality and gender, and this gap in the demographics is a small price to pay in return for a smooth conversation. Despite these gaps, the numbers shown in this report are still largely representative of our callers.

441



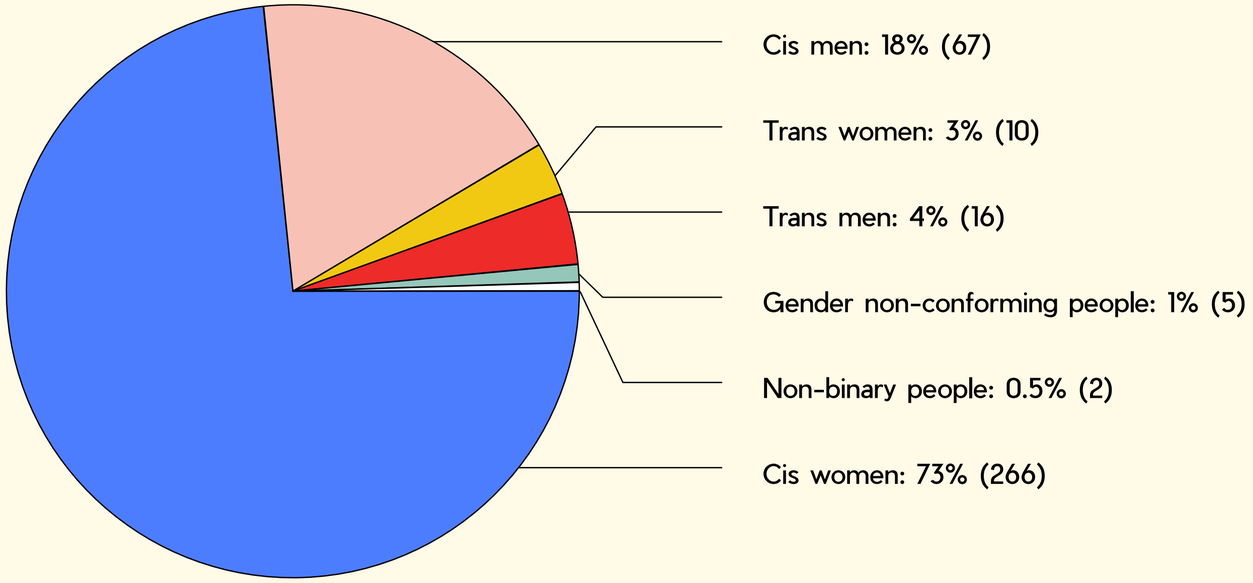
314

=

40.5%

increase -in total calls- from last year!

GENDER



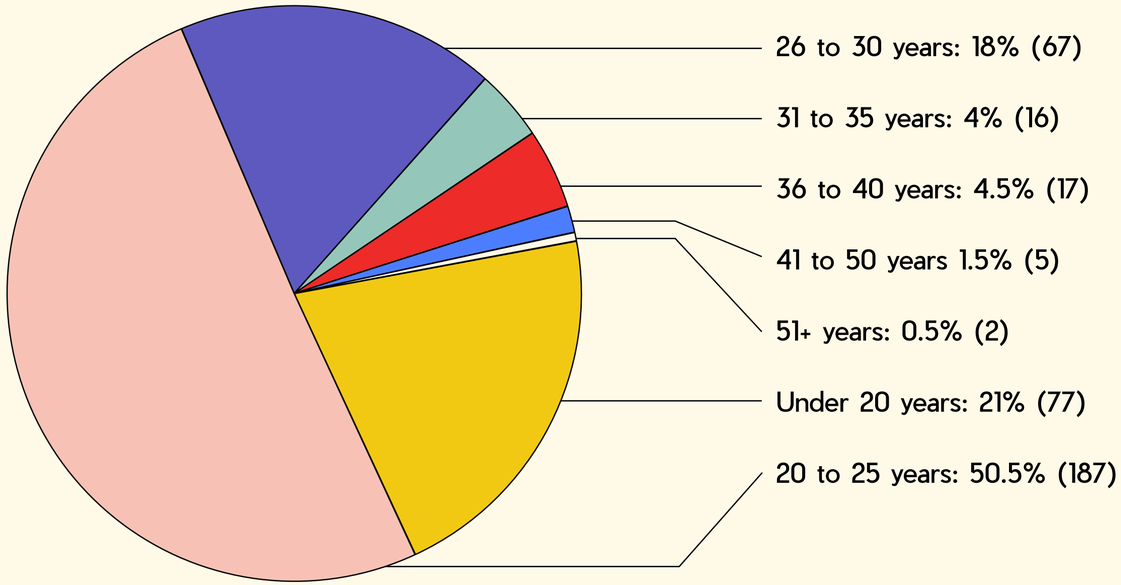
*** 366/441**
documented gender data

The hotline welcomes all callers regardless of their gender. Our explicit aim is to ensure the hotline is an accessible resource to cis and trans women, trans men, and gender non-conforming people.

Like previous years, 2019 also witnessed that cis women were our most frequent callers, where 266 (73%) of the total 366 gender-documented calls were made by them. A total of 7% of the hotline's calls were made by trans identifying callers, with 16 calls (4% of all calls) being made by trans men, and 10 calls (3% of all calls) by trans women.

Cis men were our second most frequent callers this year, averaging a total of 18% of the hotline's calls, (67 out of 366 total calls). Most of the calls made by cis men were on behalf of other people. Calls made to harass, prank, or obnoxiously discuss matters using misogynistic violent language are flagged and counsellors have the full liberty to shut down these calls in however way they wish.

AGE OF CALLERS



*** 371/441**
documented age data

For two years in a row, callers between the ages of 20-25 have constituted half of the hotline's annual callers; in 2019, 187 of 371 age-documented calls were made by individuals between this age bracket. The 26-30 age bracket has also remained at a stable 18% of all callers for the past two years. The hotline has witnessed a significant increase from 16% in 2018 to 21% in 2019 among the below 20 age bracket, and simultaneously seen a decrease from 15% to 10% in calls from those older than 30 years of age. Callers between the age of 30 to 50 made up only 10% of the hotline's total calls. Only 2 calls were made by people above the age of 51. You can find the categorization of topics discussed by different age brackets on page 28.

RELATIONSHIP STATUS

Hotline counsellors do not ask callers to share their relationship status during the call. However, if the topic comes up, it is noted as part of our demographic statistics.

This year, we collected the relationship statuses of 178 out of the 441 callers. Out of the 178, ninety-nine callers (56%) were in a non-marital relationship, 3 callers stated being in an open relationship (2%), and 22 callers shared that they're married (11.5%). Our second largest group of callers, following those in unmarried relationships, are people who are single who amount to a total of 47 callers (26%).

*** 178/441**
documented relationship status data

56%

In a relationship
unmarried
99

11.5%

In a relationship
married
22

2%

In a relationship
open relationship
3

26%

Single
47

0.5%

Divorced
1

2%

Separated
3

2%

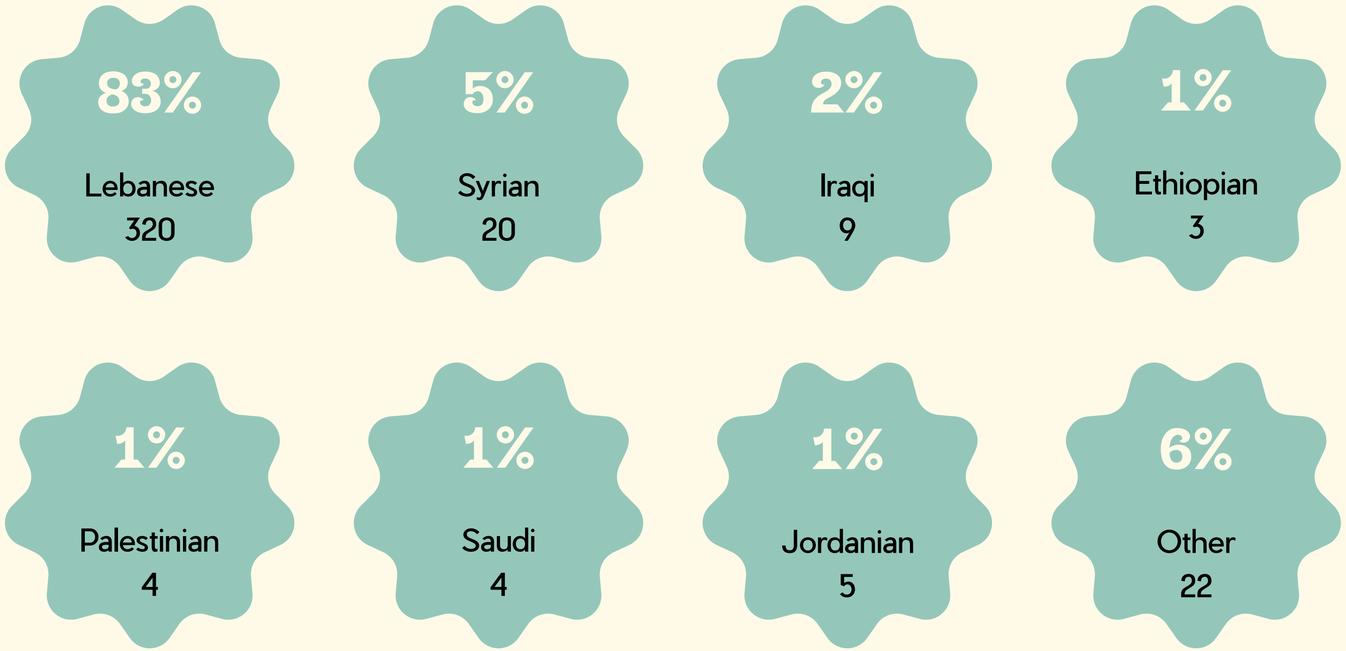
It's complicated
3

NATIONALITY

The hotline aims to be accessible to all residents of Lebanon regardless of their nationality — and specifically caters to individuals who face gendered, class-based, racial and xenophobic exclusion and discrimination.

This year, our most frequent callers continue to be Lebanese people (83%), who amount to a total of 320 callers out of 386 (22 of whom mentioned having dual citizenship). The second most frequent callers by nationality, for the second year in a row, were Syrian people (7 of whom mentioned having a dual citizenship). There is also a significant number of Iraqi, Ethiopian, Palestinian, Saudi, and Jordanian callers this year.

*** 386/441**
documented nationality data



Other 6%

Sri Lankan (1)
Filipina (1)
Congolese (2)
American (1)
Canadian (1)

Kenyan (1)
Irish/Croatian (1)
German (2)
Dutch (1)
Sierra Leonean (1)

Iranian (1)
Emirati (2)
New Zealander (1)
Mauritanian (2)

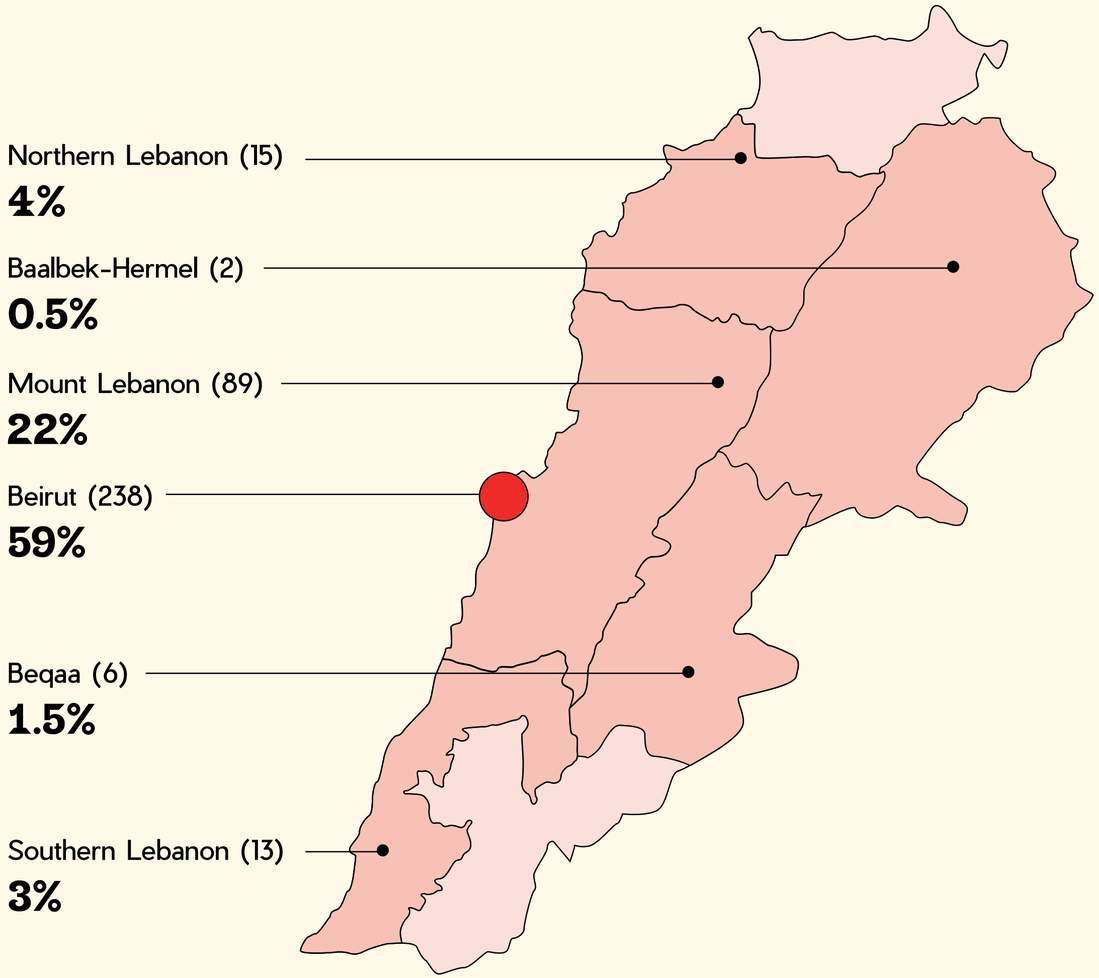
Greek (1)
Egyptian (1)
British (1)
Togolese (1)

LOCATION

While the majority of calls (59%) made to the hotline continue to come from Beirut (238 / 403 calls), there has been an overall increase in the percentage of calls that come from across the country. Mount Lebanon saw a 20% increase in total callers between 2018 and 2019, calls from South Lebanon increased by 2%, and for the first time, the hotline has received calls coming in from the Beqaa and Baalbek-Hermel. The data shows a decrease in the percentage of calls coming in from the North of Lebanon — with a total decrease of 7% from 2018 to 2019. The overall data capturing the location of our callers suggests a slight shift from Beirut and a slow (but steady) expansion to more areas in Lebanon.

Interestingly enough, 10% of the total calls made to the hotline came from outside Lebanon, with most of these calls from countries across the South West Asian and North African (SWANA) region (i.e., Jordan, UAE, Qatar, Kuwait, Iraq, Saudi, and Egypt).

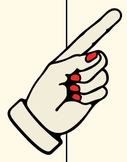
*** 403/441**
documented location data



Outside Lebanon: 10%; 40
(ref. total %; number)

Jordan 1%; 3
USA 1%; 5
UAE 4%; 16
Qatar 0.25%; 1
Kuwait 0.25%; 1
Iraq 2%; 7
Saudi Arabia 1%; 4
Egypt 0.25%; 1
France 0.25%; 1
South Korea 0.25%; 1

YOU HEARD ABOUT THE HOTLINE THROUGH...



This data is collected only from first-time callers to the hotline, excluding previous callers.

Since the initiation of the hotline, word of mouth has been how callers have found us. This year, 94 callers (34%) heard about the hotline from a friend, implying that the hotline is a trusted source of support shared among friends. Online sources (22.5%), social media (15.5%), and stickers (12%) also still prove to be effective ways that callers find out about the hotline. Least effective approaches appear to be SMS (1%) and posters/flyers (0.5%).

HOW	%	#
WORD OF MOUTH	39	94
ONLINE + WEBSITE	22.5	54
SOCIAL MEDIA	15.5	37
STICKERS	12	29
SERVICE PROVIDERS/NGOS	5	12
OUTREACH AT EVENT	3	7
FRIENDS OF THE A PROJECT	1	2
SMS	1	3
POSTER/FLYER	0.5	1
TV	0.5	1

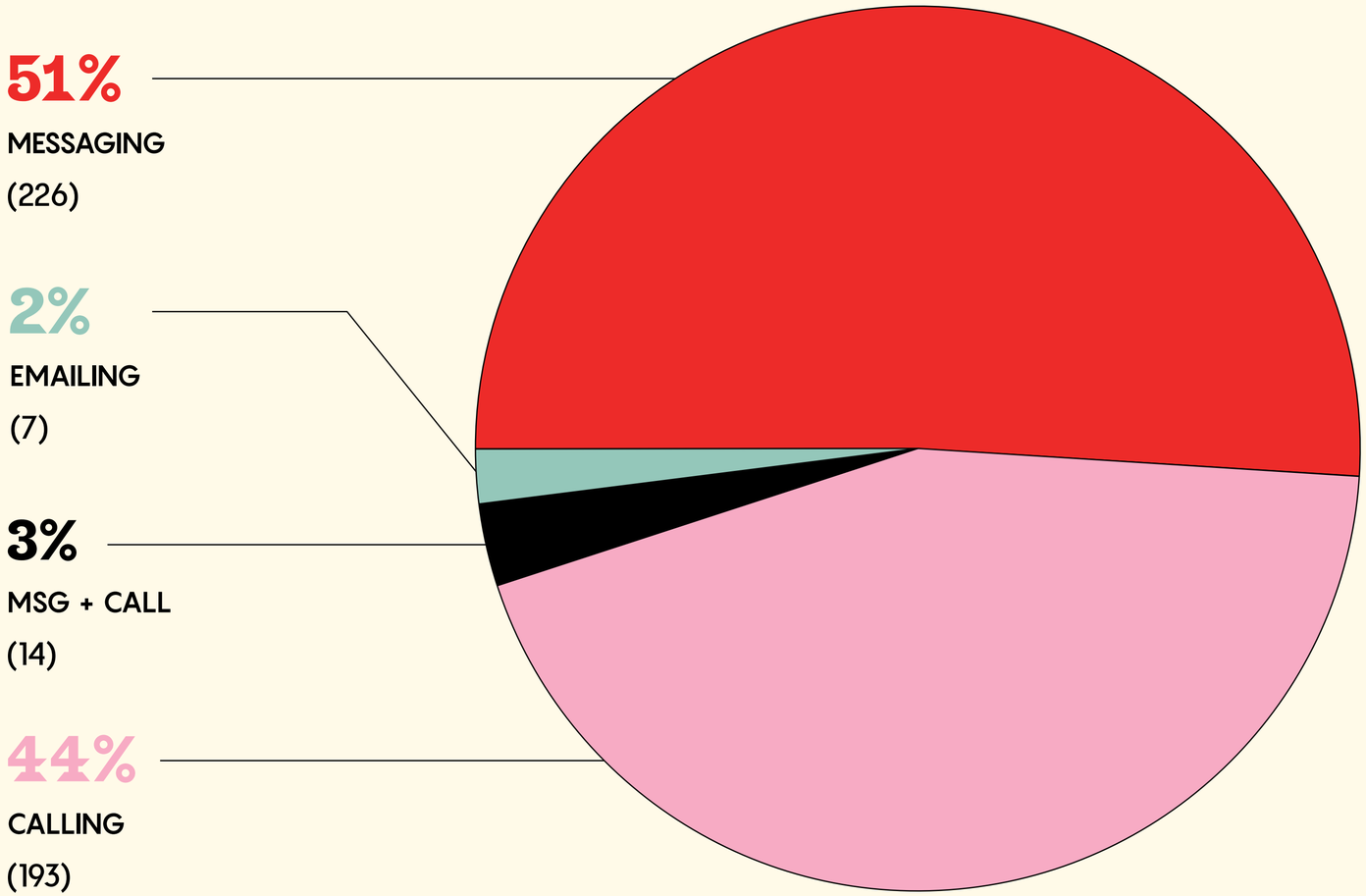
*** 240/271**
documented how first-time callers heard of the hotline

YOU CONTACTED US BY...

There are several ways to get in touch with our hotline counsellors. Callers' comfort on the hotline is key, and any of these mediums are available throughout hotline shifts. Callers can spare phone credit by letting the hotline counselor know at the beginning of a call or through text that they need to be contacted.

In 2019, 226 out of the 440 conversations (51% of all calls) were held over WhatsApp, 193 (44%) were phone calls, 14 (3%) were both call and text, and 7 conversations (2%) took place via email.

*** 440/441**
documented medium of contact



NEW/RETURNING CALLERS

363 conversations (82%) of the total 441 conversations held on the hotline in 2019 documented whether the caller was contacting the hotline for the first time or not. In 2019, 193 calls (53%) stated they were first time callers. Most first-time callers tend to call to discuss medical, SRH issues, particularly pregnancy-related issues, whereas returning callers tend to delve into longer, more drawn-out conversations on personal, sexual, and relational topics. Calls for the sole purpose of discussion, ranting, and unpacking politicized understandings of sexual and reproductive health issues are always welcome!

53%
First time
(193)

47%
Previous caller
(170)

***363/441**
documented callers' familiarity with the hotline

SAME/DIFFERENT ISSUES

Almost half of the calls made by returning callers tackled the same issue they had the first time they called, while a third of the calls were to discuss similar issues; these are mostly follow-up calls. Meanwhile, a quarter of returning callers reconnected with us to discuss completely new topics/issues. Do keep us on our toes, we love it!

42.5%
Same issue
(62)

23%
Absolutely diff issue
(34)

34%
Similar issue
(50)

***146/170**
documented returning callers' needs

YOU SOUGHT...

Since the initiation of the hotline, people have primarily called for information: 49% in 2017, 78% in 2018, and 81% in 2019. Referral to a provider increased from 18% in 2017 to 26% in 2018, and 33% in 2019. This may be affected by our online campaign to locate sensitive healthcare providers across Lebanon.

Which reminds us, if you do know decent physicians that we can refer to for sexual and reproductive health, please help us by filling this survey (**English**), survey (**Arabic**).
Someone to talk to refers to calls that don't have a specific information question or request for referral, and it is a quarter of the reason why callers reach out. It is safe to assume that while looking for information, callers are seeking someone to talk to, but here we are depicting the caller's initial interest in the hotline.

*** 441/441**
documented what callers sought

CALL TOPICS MADE ON BEHALF OF OTHERS

UNWANTED PREGNANCY	20
PREGNANCY SCARE	10
EMERGENCY CONTRACEPTIVE PILLS	6
LEGAL ASSISTANCE	5
CONTRACEPTION, SEXUAL VIOLENCE	4
IRREGULAR VAGINAL BLEEDING, VIOLENCE, MENSTRUAL CYCLE	3
STI, MENTAL HEALTH, POST ABORTION CARE, FERTILITY, CIS HET NORM	2
TRANS HEALTH, MENSTRUATION, INFO, HIV, VIRGINITY, RELATIONSHIPS, ASYLUM, HORMONE THERAPY, FERTILIZATION	1

***32/441**
documented calls made on behalf of others

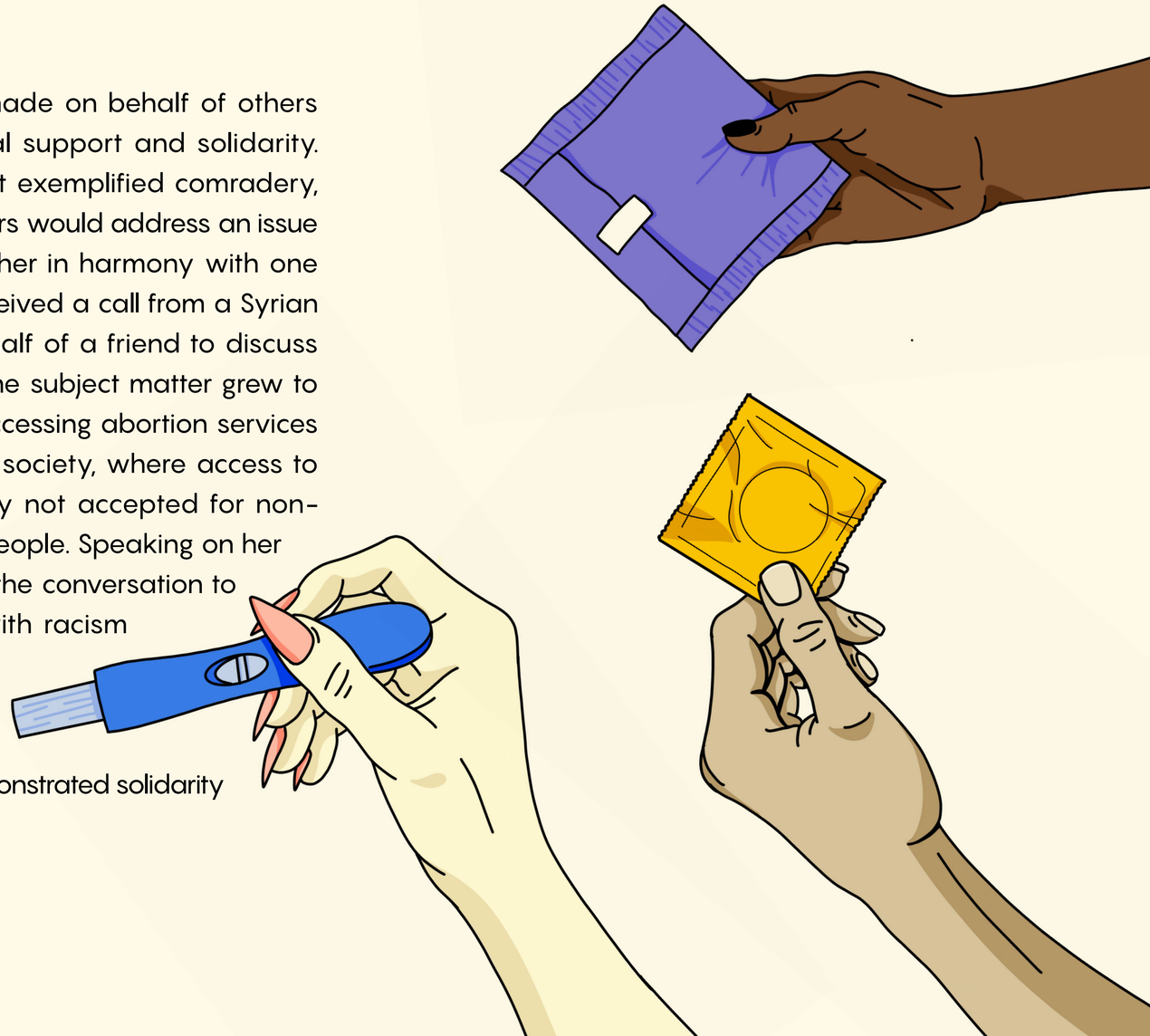
This year, 32 calls were made on behalf of others, which means that the person calling the hotline was doing so to gather information or ask a question pertaining to someone else. Of the 32 calls, 23 were made on behalf of cis women, 2 were made on behalf of cis men, and 7 were made on behalf of others whose gender is unknown. Many topics were discussed during calls made on behalf of others and similarly to the total call topics, unwanted pregnancy and pregnancy scares feature as two of the most frequently discussed topics.

Questions of access and agency cross our minds when we receive calls made on behalf of others. These reflections are usually important for us to ponder over when we see calls made by cis men, as we assess if there is entitlement over their partners choices and bodies. We've seen this entitlement by those who keep speaking over their partners and continuously interrupt them; by a man caller whose concern was finding a support group for his girlfriend while she was seeking an abortion; men who called to get information on pregnancy and contraceptives so they could pass their (dis)approval; and the many men who asserted that the women concerned could not or did not want to make the call themselves.

CALL TOPICS MADE ON BEHALF OF OTHERS

The limitations of the hotline do not allow us to definitively grasp the full context of such situations, but counselors do note the clash between what these callers want and what the persons who they are calling on behalf of want. Such calls allude to larger social dynamics that regularly strip women of their autonomy and decision-making capacity. The expectation is that cis women and gender non-conforming people are to remain under supervision or to be subjected to gatekeeping, i.e., by remaining isolated from primary information and support. When counsellors eventually do speak directly with the person concerned, conversations about the politicization of sexual and reproductive health often unravel from the original question/topic that the original caller had raised. This occurs organically because topics of sexuality, SRH, and gender are often subjected to oppressive structures like paternalistic healthcare, patriarchal pressures and expectations, misogyny and transphobia, etc., that limit the space in which cis and trans women, as well as trans men, are able to discuss these topics freely.

On the other hand, calls made on behalf of others also do show interpersonal support and solidarity. There were a few calls that exemplified comradery, whereby friends and partners would address an issue or handle a situation together in harmony with one another. One counsellor received a call from a Syrian woman who called on behalf of a friend to discuss an unwanted pregnancy. The subject matter grew to explore the difficulties of accessing abortion services in a xenophobic Lebanese society, where access to sexual health is particularly not accepted for non-Lebanese and non-white people. Speaking on her own behalf, she continued the conversation to discuss her experiences with racism in Lebanon. This was one of many conversations that politicized sexual and reproductive health and demonstrated solidarity and care in friendship.



ALL CALL TOPICS

There are so many topics to be discussed! Below is a list of all the topics covered this year between counsellors and callers. The data shows the exact number of calls — out of the total 441 calls — that were made in dedication to the mentioned topics.

The most popularly discussed topics also feature the percentages ranked highest this year. Some of these topics include unwanted pregnancy, sexually transmitted infections (STIs), contraception, pregnancy scares, relationships, emergency contraception, menstrual cycle, pleasure, post-abortion care, mental health, legal issues, irregular vaginal bleeding, sexual relations, and HIV.

***441/441**
documented call topics

topic / # calls / %

TOPICS	#	%
UNWANTED PREGNANCY	96	22%
STI	79	18%
CONTRACEPTION	76	17%
PREGNANCY SCARE	65	15%
RELATIONSHIP	63	14%
EMERGENCY CONTRACEPTION	48	11%
MENSTRUAL CYCLE	47	11%
PLEASURE	45	10%
POST ABORTION CARE	42	10%
PARTNER	38	9%
MENTAL HEALTH	33	7%
CIS HET NORM	28	6%
SRH	27	6%
LEGAL ISSUES	27	6%
IRREGULAR VAGINAL BLEEDING	26	6%
SEXUAL RELATIONS	25	6%
FAMILY	24	5%
HIV	17	4%

CALL TOPICS

3%	#
MENSTRUATION	15
HPV	15
TRANSPHOBIA	14
BODY IMAGE	14
VIRGINITY	13
MASTURBATION	13
COMMUNICATION	13
MEDICAL PATRIARCHY	13
SEXUAL VIOLENCE	12

2%	#
GENDER IDENTITY	11
COMMUNITY	11
ANAL SEX	11
SEXUAL ORIENTATION	11
VAGINAL INFECTION	10
TRANS HEALTH	8
OVULATION	8
HORMONE THERAPY	8
VIOLENCE	7
VAGINAL DISCHARGE	7
RELIGION	7
INFORMATION ABOUT A PROJECT	7
FRIENDSHIP	7
EMOTIONAL ABUSE	7

CALL TOPICS

1%	#
PHYSICAL HEALTH	6
POLYCYSTIC OVARY SYNDROME	6
LANGUAGE	6
INTIMACY	6
GENDER AFF. PROCEDURES	6
COMING OUT	6
HYMEN	6
INTIMATE	5
PARTNER NOTIFICATION	5
URINARY TRACT INFECTIONS	4
HYMENOPLASTY	4
FERTILITY	4
INFORMATION ABOUT ABORTION	4
WANTED PREGNANCY	3
MENSTRUAL PRODUCTS	3

1%	#
VAGINISMUS	2
SEX TOYS	2
SEXUAL BLACKMAIL	2
POLYAMORY	2
FERTILIZATION	2
FIRST TIME PENETRATIVE SEX	2
ANAL BLEEDING	2
1 CALL EACH	1

SOCIAL SERVICES

SEXUALITY BASED ASYLUM

PORN

PENILE DISCHARGE

BDSM

ARTIFICIAL INSEMINATION

UNKEPT WANTED PREGNANCY

UNWANTED BUT KEPT PREGNANCY

CALL TOPICS BY AGE:

UNDER 20	
1. pregnancy scare	**23**
2. emergency contraceptive pills	**16**
3. contraception	**15**
4. menstrual cycle	**14**
5. sexually transmitted infections	**13**

20 - 25	
1. sexually transmitted infections	**45**
2. contraception	**36**
3. unwanted pregnancy	**31**
3. pregnancy scare	**31**
3. relationships	**31**
4. menstrual cycle	**23**
5. emergency contraceptive pills	**22**

26 - 30	
1. unwanted pregnancy	**27**
2. contraception	**15**
3. post abortion care	**10**
4. sexually transmitted infections	**7**
4. sexual and reproductive health	**7**
4. relationship	**7**
5. cis hetero norms	**6**

We take a look at call topics across different age groups to understand what are the most common issues that arise among that group of callers. Younger callers, between the ages of 20-25, call the hotline most regularly to have conversations about STIs, contraception, unwanted pregnancies, pregnancy scares, relationships, the menstrual cycle and emergency contraceptive pills (ECP). Our youngest callers, under the age of 20, share the same queries except that the order of their greatest concerns start with pregnancy scares and emergency contraception, reflecting less knowledge and an urgency for action more than their above 20 peers. While all callers above 20 and in the reproductive age have the same underlying concern of unwanted pregnancies, a legally restricted issue in Lebanon leading to trickier access regardless of age, the conversations around sexual health and rights really shifts as the age brackets increase towards less access-oriented ones and more discussion-based; such as body image, relationships, gender identity and sexual orientation, legalities, and medical patriarchy. **The differing interest in topics makes sense when considering the type of social and physical changes women experience as they grow older, and the kind of access they would have learned to maneuver and gain with time.**

CALL TOPICS BY AGE:

31 - 35	
1. unwanted pregnancy	**7**
2. pleasure	**5**
3. relationships	**3**
4. sexual and reproductive health	**2**
4. post abortion care	**2**
4. mental health	**2**
4. body image	**2**
5. 1 call each: menstrual cycle, pregnancy scare, post abortion care, contra, emergency contraceptive pills, mental health, sex, legal, body image, gender identity, intimacy, trans health, hormone therapy, gender affirming procedures, sexually transmitted infections, anal sex, cis heteronormativity, vaginal infection, language, info on abortion	**1**

36 - 40	
2. sexually transmitted infections	**4**
2. legal aid	**4**
2. post abortion care	**4**
3. sexual orientation	**2**
3. gender identity	**2**
3. cis heteronormativity	**2**
3. medical patriarchy	**2**
3. relationships	**2**
4. 1 call each: transphobia, unwanted pregnancy, sexually transmitted infections, HIV, physical health, info about the A project, polyamory, sexual violence, legal issues, body image, sex, anal sex, cis het, community, pleasure, wanted pregnancy, fertility, religion, post abortion care, menstruation, mental health, medical patriarchy, relationship, info on abortion	**1**

40 - 50	
1. unwanted pregnancy	**3**
2. legal	**2**
3. cis heteronormativity	**1**
3. menstrual cycle	**1**
3. SRH (sexual reproductive health)	**1**
3. irregular bleeding	**1**
3. physical health	**1**

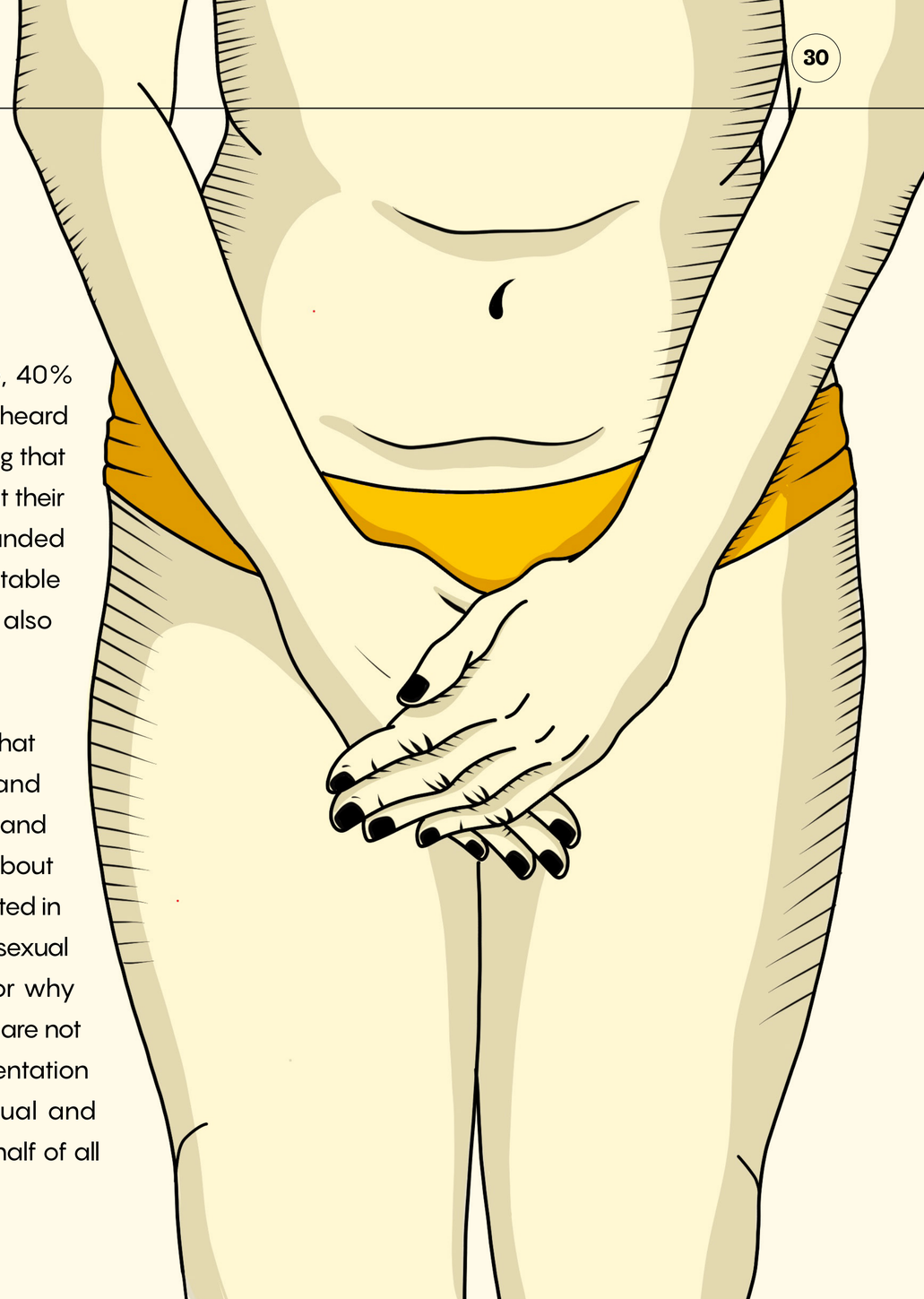
50+	
1. physical health	**1**
1. sexually transmitted infections	**1**
1. sexual relations	**1**

AGAINST THE NORM

We can see through our quantitative data that what is socially accepted and believed to be normal by cis-hetero standards does not reflect peoples' experiences or reality. Many of the topics that people call about, and the frequency in which we receive these calls, already shows that the norm that is being inflicted on society is at a mismatch with reality, and is barring people from gaining support, information, or healthcare — these norms are harmful.

A common assumption, for example, is that women are too shy or naïve to talk about sex, relationships, and their sexual and reproductive health needs. These "norms," or what can be considered expectations of cis-heteronormative standards, are built around a Lebanese standard of respectability that claims it is inappropriate and shameful for women to discuss sex and that Lebanese girls are not having sex before marriage. In reality, 73% of the hotline's calls were made by cis women, many of whom contacted the hotline to specifically unpack questions about intimacy and sex. Meanwhile, 40% of all first-time callers mentioned that they have heard about the hotline through word of mouth, meaning that people are not as afraid or reserved to talk about their sexuality and SRH needs with others as is demanded and assumed of them. Rather they are comfortable enough to share not only their experiences, but also resources that have been helpful to them.

Normative expectations tend to also decide at what age it is appropriate to be interested in sex and intimacy, and whether we are entitled to sexual and reproductive health services or not. Arguments about older women being modest and no longer interested in sex and young people being "too young" to have sexual thoughts to begin with, are common excuses for why young unmarried women or menopausal women are not given consideration in the planning and implementation of big-scale public or non-governmental sexual and reproductive health programs. In reality, almost half of all



the calls made to the hotline were from people between the ages of 20 and 25, and 21% were from callers under the age of 20. Among this age group, the most discussed topics included pregnancy scares, STIs, contraception, unwanted pregnancies, and the menstrual cycle, demonstrating that there is a demand for SRH services for young people. While women's specific sex and reproductive health needs may change as they get older, that interest does not disappear, it just needs to be addressed in its progression.

Another example of normative expectations is the assumption that gender is a binary and trans people do not exist. Those who argue for the nonexistence of a people do so with the desire to erase and shame those who challenge their narrow view of the world. Contrary to the belief of many, trans and gender non-conforming people made up 8.5% of this year's hotline calls, attesting in existence that this binary is false. Whether that is to be called a minority, normal, or abnormal is beside the point, we are not here to make a case for how tipped the scale of society's normal and natural is — we are saying you said there were only two genders — and that is just plain false.

The attempt to erase or shame people who challenge normative expectations is also seen in the way assumptions are made about migrants and refugees. A common claim is that migrants and refugees should respectively be either too preoccupied with work or with trying to survive and seek refuge to even think of sex, and therefore do not need reproductive health services. Despite laws and societal attitudes that dehumanize and erase the sexuality and health needs of migrants and refugees, we know that irrespective of what the norm would like, people who aren't citizens, while grabbling with structural racism and xenophobia, yes still do have sexual relations, seek intimacy, have children, and need sexual and reproductive healthcare. These assumptions that sexual pleasure is only sought in monogamous marriage and for childbearing purposes is proven unrealistic by the data collected that shows 56% of all callers said they were in unmarried relationships, 2% were in open relationships, and 26% who were not in a relationship, all who called to think through and discuss relationships, sexual well-being, and attainment of sexual pleasure.

A qualitative peak

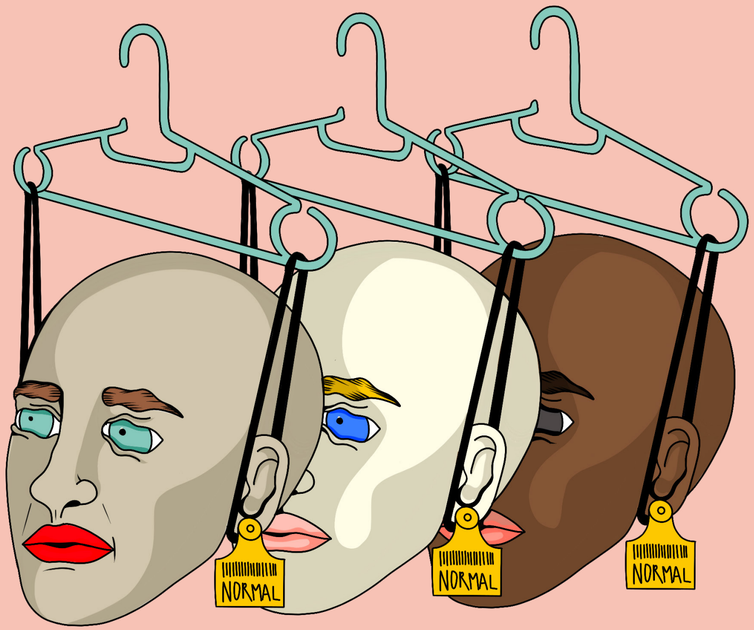
Exploring our callers' struggles with 'normal'

Our ability to decide for ourselves how to live our lives is constantly challenged by the normative patriarchal expectations of society. These expectations influence how we should look, speak, feel, behave, and be, which automatically dictate and shape our family, workplace, and intimate/non-intimate relations and dynamics. Norms influence — and restrict — how we navigate public spaces, our access to medical care, access to justice, and limits our ability to live by our own value systems which may clash with religious, cultural, familial, and/or societal value systems.

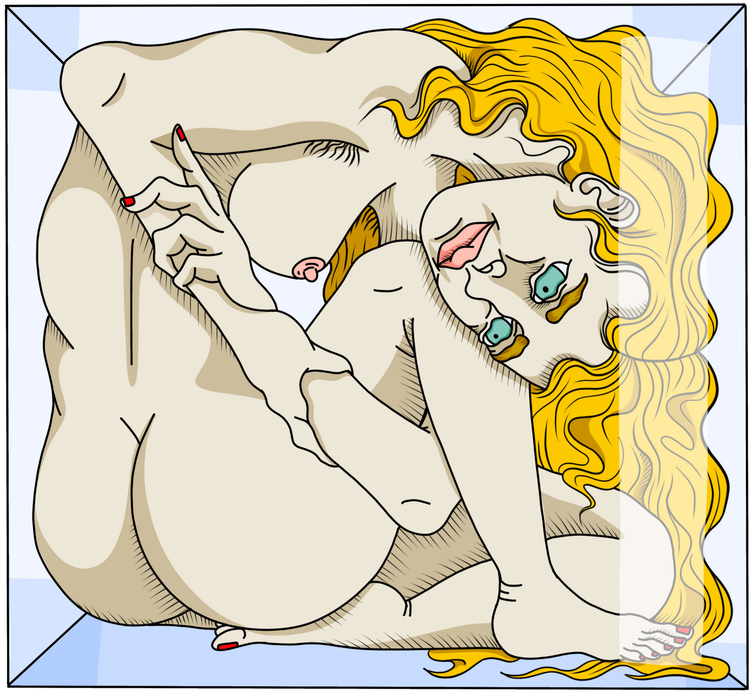
The various institutions that shape the social order of society are responsible for the design and enforcement of norms that restrict the freedom of our sexual expression.

Political, legal, economic, religious, educational, medical, and civil institutions maintain a mold of sexual and gender "normalcy" upholding the patriarchal system of oppression through subtly portraying their restrictions of sexual expression as merely a preservation of the "natural" order of things (Rubin, 1984; Weeks, 2011). Norms of sexuality sustain a profit-driven capitalist agenda, whereby people assigned female at birth are expected to provide free domestic and reproductive labor ensuring that resources, opportunities, and power remain in the hands of those assigned male at birth.

Disguising social constructs as fundamental, "natural," and self-evident (aka heteronormative) compels people who do not fit the "norm" to believe that the reasons



for their "abnormal-ness" are internal, personal, and exceptional, rather than politically and institutionally hidden. It alienates individuals who challenge the norm from both society and each other, causing them to place blame and the burden of change on themselves rather than holding institutional and structural systems of oppression accountable.



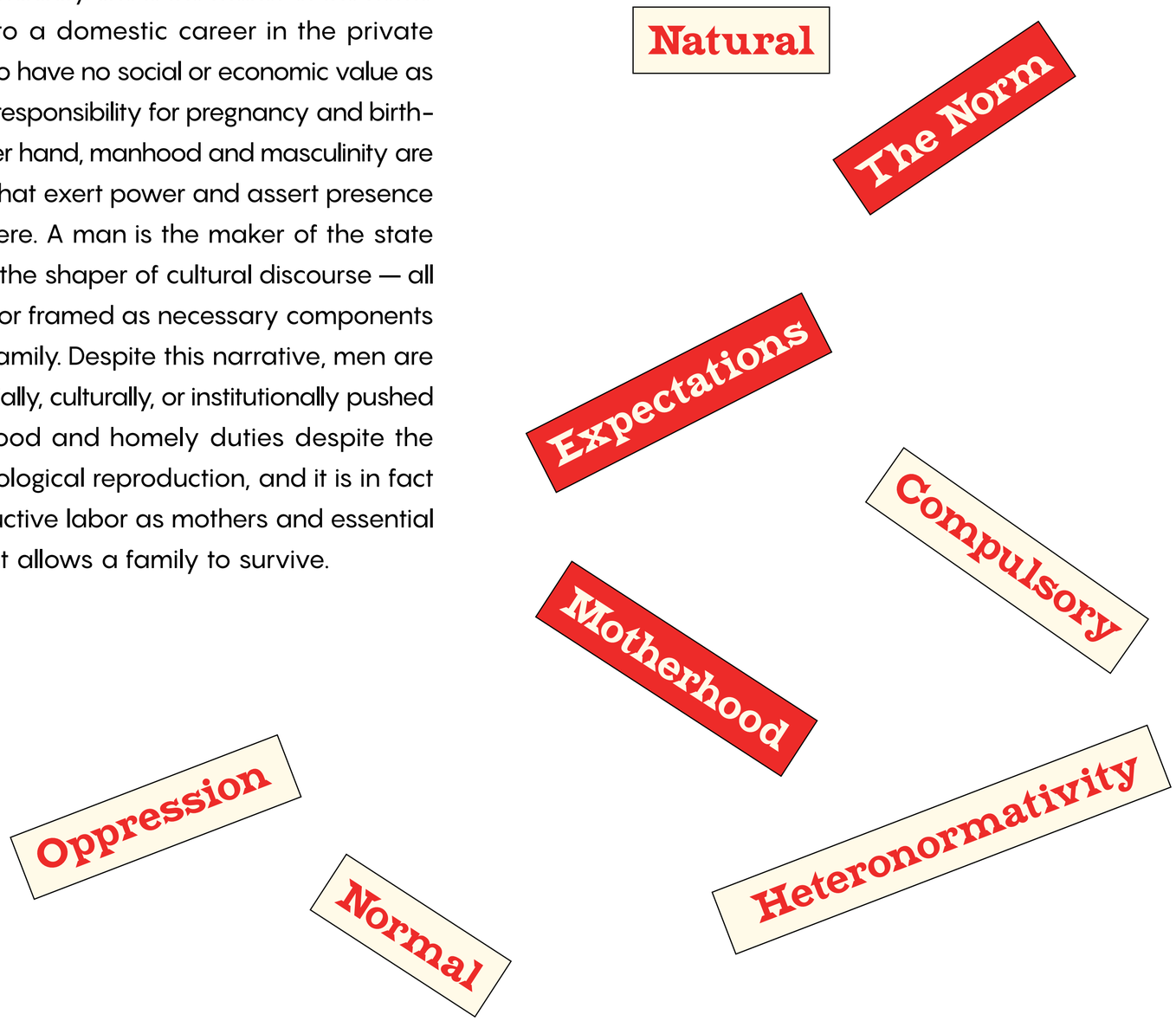
Much of what we are taught is normal/abnormal, good/bad, natural/unnatural, etc., is founded by cis-hetero establishments that push these norms further into categories of "good citizen" and "bad citizen." These categories serve to sustain neoliberal capitalist advancement by enforcing the exclusion of non-"good citizens" or "bad citizens" (i.e., migrants, refugees, and individuals who challenge the sectarian system in Lebanon), from freedom of expression, mobility, access, etc. "Natural" sex, in the context of the "good citizen" is therefore synonymous to marriage: a sexual relationship, sanctified by religious institutions, to ensure cis, heterosexual, monogamous, and most importantly procreative sexual encounters are taking place in the privacy of the home. Any explorations of sexuality outside of this confinement is considered bad and "abnormal." The social expectation to maintain "the norm" was a burden shared implicitly and explicitly in almost every call made to the sexuality hotline in 2019.

The following qualitative section aims to highlight the most frequently discussed topics and how normative expectations surrounding these topics were unwarrantedly imposed on hotline callers. This segment will thematically analyze the 2019 call topics by examining how the notion of normalcy affects the three A's held dearly at the A project: one's Autonomy when resources and knowledge regarding their bodies and health are concealed and mystified, their Agency in accessing sexual and reproductive healthcare, and their ability to live differently/Alternatively in the face of society's rules and expectations. The segment begins with looking at callers' struggles to find Alternatives to two majorly recurrent themes: cis heteronormativity and motherhood.

Cis heteronormativity (aka cis-het) tells us that anatomies are strictly binary (male / female) and that these define gender (man / woman). It translated the body assigned-female-at-birth's ability to biologically reproduce into the notion of motherhood, making it women's inherent function and their ultimate desire; and it translates the body assigned-male-at-birth's penetrative (active) role in reproduction into the notion that men's bodies have power over women's (Rich, 1986). Depicted as opposites, heteronormativity pits masculinity and femininity - in gender expression and roles - against each other. These "opposites"

are expected to attract each other making an ideal partnership, the sexual relations of this partnership are sanctified in a monogamous, phallocentric, clean, gentle, private, free, and of course, procreative environment. It does not take much to see that these rules are very much social interpretations of nature, but this becomes all the more evident when relationships are assigned higher value if they're between two of the same sect, class, nationality, race, and more so, if the couple is of a wealthier class, white(r), of western citizenship, and from a dominant faith. By extension, this means that migrants and refugees do not fit these equations as their sexualities jeopardize the unnatural order of things.

Meanwhile, the woman = mother image is considered "normal" due to cultural and social expectations assigned to women. Compulsory motherhood is a political maneuver that exerts a normative narrative that tells of a woman's role in the family, society, and state. Compulsory motherhood begins at birth, when young individuals assigned female are also assigned women — and with that, are shaped to embody all of society's expectations and responsibilities of being women. Traits centered around softness and caretaking are crutches of femininity. She is the maker of the home and is reduced to a domestic career in the private sphere, deemed to have no social or economic value as a "natural" result/responsibility for pregnancy and birth-giving. On the other hand, manhood and masculinity are prescribed roles that exert power and assert presence in the public sphere. A man is the maker of the state and society, and the shaper of cultural discourse — all highly valued labor framed as necessary components to supporting a family. Despite this narrative, men are not nearly as socially, culturally, or institutionally pushed towards fatherhood and homely duties despite the implications in biological reproduction, and it is in fact women's reproductive labor as mothers and essential care workers that allows a family to survive.

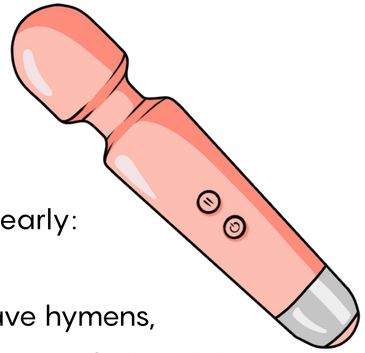


SEEKING ALTERNATIVES

Under cis heteronorms

"Norms" take two biological imperatives: sexual anatomy and reproduction. When institutions mobilize these imperatives, they dictate people's gender identity and expression to be cis gendered whereby assigned sex a birth and gender are seen as the same, and they also dictate sexual behavior and roles of these bodies to enact heterosexuality. This manipulation and conflation of "normal" regarding sexual and gender roles within society is widely known as heteronormativity, and it is through heteronormativity that understandings of what is "natural" are established.

The hotline data revealed that conformity to cis-hetero norms is often intentional and performative; obeyed in fear of social ostracization — and sometimes even legal punishment — from defying the rules of "natural" sexuality. We can unpack the topic of virginity to understand this point more clearly:



socially,

(1) women are expected to have hymens,

(2) these hymens rip when they "lose their virginity",

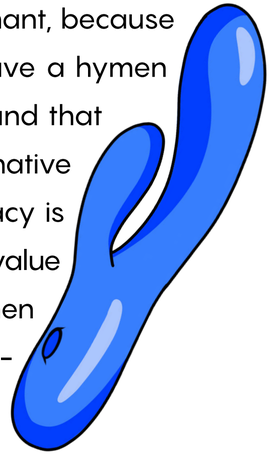
(3) whereby blood spills during/after first penetrative vaginal sex which indicates that they'd never had sexual experiences previous to this encounter.

The truth however is that

(1) many people are born without hymens,

(2) some hymens are so elastic that they may not tear during a sexual encounter, and

(3) therefore many women who have penetrative vaginal sex for the first-time do not bleed (also patriarchy is so phallocentric and possessive, not considering all the sexual experiences that could be enjoyed, that do not revolve around vaginal penetration). Despite these facts, society continues to impose its understanding of the function of a hymen and its relation to women's virginity and overall goodness. Many callers who want to discuss this restrictive norm do so by asking about hymen reconstruction surgeries, or how to masturbate and/or have sex without tearing the hymen. One caller who had never had penetrative vaginal sex, but was enjoying sexual intimacies with a partner, found out that she was pregnant and feared that the abortion would risk tearing her hymen. She was afraid that her family would hurt her if they found out she was pregnant, because that would indicate that she doesn't have a hymen (which might still be there and intact), and that she has had sexual activity. Finding alternative ways of enjoying sex and having intimacy is hard under heteronormativity, where the value of women is located in whether that hymen tissue - and therefore her "marriageability"-



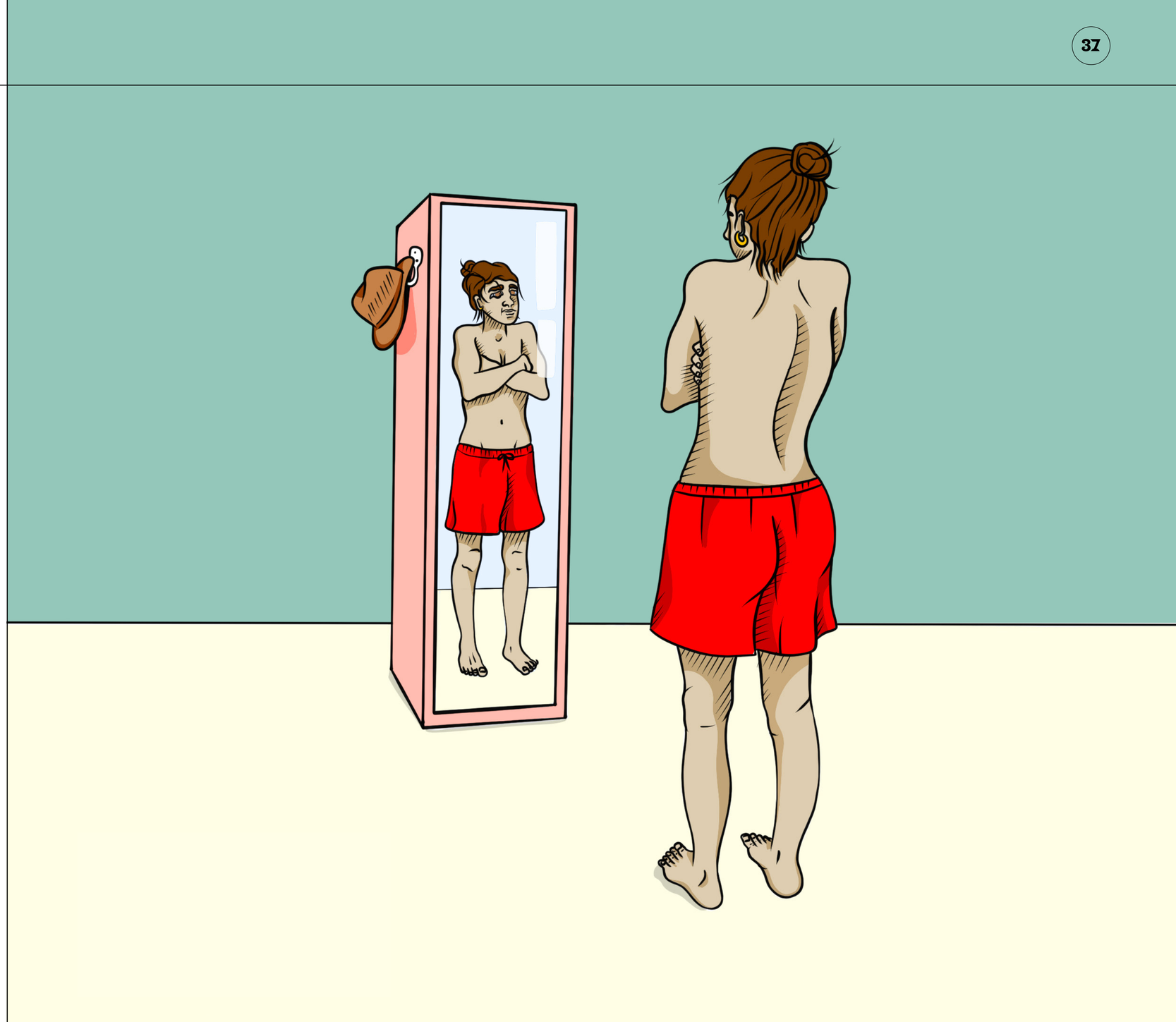
‘Sexual norms also force us to question whether our behaviors, feelings, or thoughts are ‘normal’ when in truth, there is no such thing as ‘correct’ sexual expression; there is socially acceptable and unacceptable, and more importantly, consensual or non-consensual.’

are intact. Figuring out how to navigate these sociomedical contradictions and live under these social expectations and pressures is a tough spot that requires thinking outside the box and being creative, and there is nothing to be ashamed of or to frown upon in doing that. The reality is that belonging within the limitations of the “norm” is a survival tactic for some, and the decision of whether to abide by normative standards or challenge them is one that can solely be made by the individual concerned who ultimately bears the consequences.

Sexual norms also force us to question whether our behaviors, feelings, or thoughts are “normal” when in truth, there is no such thing as “correct” sexual expression; there is socially acceptable and unacceptable, and more importantly, consensual or non-consensual. Several callers reached out to the hotline to ask if there is anything “wrong” with the way they are navigating their sexual and romantic relationships in their non-monogamous, non-heterosexual, or non-normative setups. Many also called contemplating if there is anything “wrong” with defying gender roles in their relationships. Much of these conversations were tied to the topic of pleasure. This year, the hotline had a total of 45 calls from women who wanted to know: why penetrative sex was not pleasurable for them, whether certain pleasures were “normal,” how they could communicate their pleasure points with their partners, or how to enjoy non-penetrative sex. While different people seek different and multiple things from sex — pleasure, reproduction, routine, transaction, among others — these callers are exploring their own pleasure, thereby challenging the misconceptions that women are not sexual beings by nature, that they enjoy sex less than men, or that penetration is their greatest source of pleasure. Oftentimes, the topic of women’s pleasure is completely disregarded, making it difficult to access resources that help women explore their sexual likes and dislikes, furthering their confusion about the “rights” and “wrongs” of their sexual experiences.

Adapting to the expectations of normative identity is nearly impossible for trans and non-binary individuals. This was made clear by a caller to the hotline, who discussed how she neither feels like a gay man nor a trans woman. While she presents herself as more masculine to avoid society’s scrutinization, she identifies with being a woman and

feels more at ease with feminine expression, which she especially enjoys in her sexual expression. Unpacking these complexities meant discussing the idea of gender non-conformity — a concept she was eager to explore. There is a need for non-normative representation and language to discuss gender, not only through normative sexual roles, but also in presentation, identity, and expression. The pressure of expressing an assigned gender at birth can be further explored with another caller who contacted us in the early stages of her gender-affirming transitioning. She called to express that her transition was hindered when her parents found a diagnostic report from her psychiatrist for gender dysphoria. Her parents were accepting of this diagnosis, so long as she did not "change anything about her appearance." Her parents' concern and acceptance of the matter was clearly conditional to their daughter keeping up with normal social appearances, not becoming an outlier, and maintaining a respectability standard for herself and her family's reputation. Many gender non-conforming and trans persons are coerced into biting down on their dysphoria to keep up with the norm, but what's normal about keeping up with appearances for the safeguarding of everyone else's status quo?



2019 highlight

Moral panics fight for cis heteronormativity

A violent police raid of a local bar in Dekwaneh took place back in the year 2013 and is still remembered today for its derogatory arrest and mistreatment of four people, who upon arrest were verbally assaulted, physically harassed, and beaten. One of the arrested was a Syrian trans woman who was humiliated, undressed, and photoed nude to expose her deception and "true sex". The raid was called upon by the mayor of Dekwaneh, who issued the permanent closure of the bar, while cautioning that the mere existence of ambiguity in sex, gender, and therefore attraction would bring upon a "public moral degradation." In 2019, another moral panic took place when a group of people protested against the prospected performance of Mashrou' Leila, a local pop band which is associated with queerness and holds a special place among many non-normative circles in Lebanon and the SWANA region, at the Byblos International Festival. The initial protest was against some of the band's playful lyrics, which were deemed blasphemous by Christian groups. Rapidly, the call for banning the performance became about what the band's existence represents: an offense and threat to good respectable family values (the cis hetero kind). The organizers of the festival agreed to cancel the performance "to prevent bloodshed and preserve security.""

The normalization of shaming, humiliating, and aggression against trans people as a structural tool to keep cis normativity looking natural and normal is not working. This violence does not erase gender diversity from existence, but doesn't its degree and vileness tell us just how much is at stake here? How is it that institutions that forcibly uphold cis-hetero normalization have not realized that quashing representations of non-normative gender and sexual expression does not erase people of non-normative sexual and gender expressions? Us alternatives will always find alternatives.

SEEKING ALTERNATIVES WITHIN MOTHERHOOD

The expectations that motherhood is womanhood revolves around physically carrying a child to term, and to care for the child once it is born. This expectation is made clear by the criminalization of abortion in Lebanon, as well as by sectarian laws that discriminate based on gender and marital status. This is also evident in the values that preach that the purpose of sex is procreation to make gender-organized nuclear family-units. There are many callers who express that they simply are uninterested in being mothers (for the time being at least), however are constantly barraged with counter arguments that suggest their approach to womanhood is "abnormal" because they are not fulfilling their "role" as women. The idea that womanhood and motherhood are a united entity, which is "natural" and "inevitable", is what assigned female at birth people face in compulsory motherhood.

Heteronormative images of motherhood showcase women to be nurturing — i.e., to be with child/a mother to many children, is also to be benevolent, sacred, pure, asexual, nourishing, tender, sacrificing, and submissive. This image is most often shared within the mainstream media outlets, as well as by both public and private institutions. A caller to the hotline shared her discontent with media's allegiance to these heteronormative characteristics by reflecting on the comment sections she read online when googling "pregnancy" and "abortion." The overwhelming congratulatory messages under the headline "pregnancy," as opposed to comments expressing guilt and shame under the headline "abortion" suggests societal and familial pressures that suggest to terminate a pregnancy is to end a life. This narrative prioritizes an unborn life over a fully developed one, and renders women's bodies as mere hosts, no longer belonging to them once they are carrying.

Some individuals embrace the "benevolent mother" character willingly, but then struggle to balance the emotional, physical, mental and practical work it takes to fulfill this role. Despite the work being hard, many women find enjoyment and even pleasure in being mothers. Issues, however, arise in the weight and quantity of the work, rather than the work/task itself. Several women who call the hotline share that it is not only the desire to parent, but the ability to do so, that makes playing the role of the benevolent mother impossible. Socio-economic reasons often influence an individual's desire to have a child, and when women offer their reasons for terminating a pregnancy, they usually calculate personal, social, and material circumstances that influence their final decision. This is exemplified by many callers who spoke about the need to be more financially secure before parenting. A call received by an overworked mother looking to terminate a pregnancy, divulged how she felt no need to justify her decision to anyone, as she already provides cares for her disabled daughter and oversees her medical needs, with little help from her unemployed, unsupportive, and "lazy" husband. In seeking an abortion, she explicitly discussed how she was in no state nor had any interest in taking on the additional care labor work that would fall on her with a second child. Another woman, who had just given

birth, called with a pregnancy scare and was seeking emergency contraception. She spoke of how she was manipulated into keeping her first pregnancy by the father of the child, and how these circumstances left her with no support, little financial means, exacerbated mental health issues, and a daughter she felt distant from and found hard to care for. According to her own assessment, she neither had the ability nor desire to mother a second child and wished for the decision of terminating to be solely her own.

Norms that dictate the shape of "the family" (nuclear with both mother and father present) also influence people's decisions to continue with their pregnancies or terminate. One hotline caller, unmarried and without stable financial means, was interested in keeping her pregnancy, despite her family's wishes. She called in hopes of finding an organization that could help her attain an income, shelter, so that she may be the good mother/ person/ woman that she is expected to be, and have her family. Another caller, interested in continuing her pregnancy, felt pressured to terminate because she was in an unstable relationship and did not want her child to grow up in a "bad environment." The possibility that her child would not grow up in a traditional nuclear family made her reluctant to become a mother, despite her desire to be one, because she was convinced that raising a child in an alternative family model to the norm would be an injustice to her baby.

This introduces the antithesis to compulsory motherhood: demonized motherhood, i.e., "the bad mother." Women whose motherhood would burden and tarnish the image of their families, society, and state are often considered demonized mothers. These are women who do not constitute the "good citizen," let alone the "good mother," and who are deemed "naturally" unmotherly because their motherhood is not the desired type. The state sabotages motherhood, sex, and relationships to these — unmarried, refugee, migrant, trans, lesbian, disabled, poor, too young, too old — women, some of whom are argued to be serving society in more appropriate ways, and others who would disrupt the heteropatriarchal and capitalist hegemony. In Lebanon, migrant domestic workers are strongly demonized for becoming mothers. The migrant worker's primary value to Lebanese society is to serve wholesome, state-sanctioned families with cheap, if not free, domestic and care labor — and so having children of their own jeopardizes their prescribed role and purpose. Racism, nationalism, border control, and discriminatory immigration and work policies dehumanize and exploit migrant women, barring them from fulfilling this "natural" higher calling to motherhood as they are not the desirable mothers that the state has in mind.

'The expectations that motherhood is womanhood revolves around physically carrying a child to term, and to care for the child once it is born. This expectation is made clear by the criminalization of abortion in Lebanon, as well as by sectarian laws that discriminate based on gender and marital status.'

2019
highlight

Hypocrisy in the sanctified right to motherhood and family

In Lebanon, there is endless news of custody battles petitioned by mothers fighting for the right to be with their children. Nadyn Jouny's case stands out as a strong example, as her vocalness against her abusive ex-husband made her fight for the custody of her son known across the country. Unfortunately, Nadyn's sudden death in October 2019 came before the end of her battle, and she did not gain custody. However, her comrades and other mothers have since challenged the religious court's laws evermore loudly. Nadyn has since been commemorated, and after her death a public mourning was held in front of the court that did her and so many others injustice.

In August 2019, a Sri Lankan-Sudanese family was detained by General Security — the state entity that oversees all issues of migration and that enforces the Kafala system (i.e., sponsorship system). The family was threatened with deportation - the Sri Lankan mother to Sri Lanka, and the Sudanese father to Sudan along with their five children. Protecting and upholding heteronormative two-parent family households is a Lebanese societal value granted to Lebanese families only, whereby the state uses its institutional legal power to construct one type of family and motherhood while rejecting another.

If motherhood is a woman's "natural" role, then why is Nadyn demonized for wanting to be with her child? How is it that religious courts glorify motherhood as essential to childcare while swiftly casting away this status by granting the custody of children to men? Are women to endure violence and keep up heteronormative family units in order to stay with their children? And if the highest value is granted to families staying together, why is this value not granted to migrant families?

AUTONOMY OF OUR BODIES

Normalizing the denial of cis and trans women's, trans men's, and non-binary people's bodily autonomy is maintained by withholding information that would grant us the knowledge, confidence, and power to challenge the lies we are fed about our bodies, attractions, and desire. Much of the information and knowledge produced around our bodies and minds, how they are ill, and how they must be treated are often in the hands of physicians or scholars who work within the confines of (and in complicity with) state-law and religious authorities who also conceive and regulate society's sexual norms (Rubin, 1984; Weeks, 2011). This means that demanding sexual reproductive health (SRH) information as well as (the often deemed-immoral) healthcare, challenges society and medicine's plans for our bodies, and this often requires a monumental search for purposefully hidden information and care.

Resources that may support us in making informed decisions about our bodies and learning about our sexuality are scarce, and when found are censored and heavily influenced by social norms. The resources available are sponsored and approved by healthcare providers, parents, media, sex-ed programs, and search engines. Many of our callers recognize the knowledge vacuum that exists around SRH and express skepticism towards the information they do have, which is often repackaged with normative and moralistic values of those disseminating it; e.g., such as swiftly mentioning that STIs are treatable and curable yet deliberately dwelling on how they are a result of deviant sexual behaviors.

This year, approximately 80% of hotline callers sought information. That's a total of 350 conversations for gaining knowledge on topics of SRH and sexuality - all are imperative to understanding one's own body and how to care for it, from posing questions about menstruation, pregnancy, contraception, STIs, treatments and procedures, to the availabilities of services or resources related to them. Many questions surrounding ovulation, calculating fertility periods, uncovering what contraceptive methods exist and their impact on the menstrual cycle, reveal just how mystified knowledge on women's bodies really is. How is something so commonly used, or so commonly expected to be used, be something we don't know about? How is that even possible?

However, access to SRH information does not only offer us the capacity to make decisions about our bodies. It rather gives us more confidence to control our interactions with others. On the hotline, topics of virginity and sex show how autonomy can be reclaimed and power can be removed from people who use medical patriarchal standards to oppress us. During one call to the hotline, the caller mentioned that "the first of [her] three hymen layers is not there anymore." This was something that was told to her by two different men, who were certain that "someone tried to open" her. On another call, a caller shared how her boyfriend had accused her of lying about her virginity because

he “didn’t feel anything while fingering [her].” These men not only felt entitled to each woman’s sexuality and virginity, but also felt that they had authority to create and spread fake information to judge, shame, and control these women’s bodies.

Calling the hotline is a method of claiming autonomy. Through reaching out and challenging information, callers also challenge the isolation that plays a role in keeping non-normative people marginalized. Topics of sexuality and SRH are quite hushed and deemed private matters. When discussed more openly, people in non-normative setups know they are not alone and are able to learn and teach (us) new ways to navigate reclaiming bodies and navigating cis hetero-patriarchal land mines. When people call to unpack gender, ask about where they can meet other queers, vent about family, or negotiate their relationships, they are telling us that they know that conversation and discourse is a huge part of gaining knowledge and being able to make better-informed decisions. Being deprived of these space and discussions is to be kept in the dark about issues that directly relate to their, their wellbeing, and survival even. When callers reach out to discuss their mental health, whether it is to seek validation, queer-friendly therapists, or a listening ear, they are refusing to internalize and individualize negative or difficult feelings as the normal consequences of who they are, or their experiences, with regards to sexuality, gender, and relationships. In these ways, we see that callers are looking to gain knowledge in a way that their values are not compromised, resources are not drained, feelings are not silenced, and decisions are not made for them.

‘These men not only felt entitled to each woman’s sexuality and virginity, but also felt that they had authority to create and spread fake information to judge, shame, and control these women’s bodies.’

2019 highlight

Knowledge is power, and they know it

"Children in school turn to an NGO to help them with their sexual concerns," this was the title of an LBC network episode of talk show Hawa al Horriya, which criticized a school administration and parent-committee for reaching out to The A Project to give pre-approved age-appropriate sexuality education sessions to their school's students. Hawa al Horriya capitalized on the anger of parents who were upset that their children were receiving information about sexuality outside the home. The episode which turned into an 'exposé' about The A Project and the sexuality hotline also included secretly recorded and fabricated conversations from the hotline one with a teenager questioning the normality of her homoerotic desires, and another with that teenagers mother who reproaches the hotline counselor for not morally disciplining and shaming her daughter away from sex, watching porn and questioning her sexuality.

The sensationalization and demonization of asking "who is talking to our children about sex?", is also a form of moral panic that assesses if society's innocents are still on the right path of cis heteronormative teachings. The fear is that the speculations around nature and normality are being voiced and seriously discussed. Are we only encouraging youth to learn and challenge what they know when it doesn't interfere with cultural and social norms and morals of sexuality? How is it more acceptable to give young girls a quick and dirty version of "the talk" just before their wedding night, rather than informing them in advance so that they have confidence to negotiate what they want for their bodies, health, fertility, and pleasure?

AGENCY THROUGH ACCESS TO HEALTHCARE

Restrictions on access to healthcare are heavily linked to restrictions on movement, access to information, and access to legal recourse. In this way, frameworks that examine access to healthcare tend to omit the necessary intersection of race, sexual orientation, class, citizenship, and gender identity that would support the positive advancement of healthcare access. Callers often call searching for referrals for affordable, nearby, private, and non-judgmental healthcare options. They tell counsellors of the unacceptable encounters they've had with medical providers and the difficulty of getting medical attention at all. In seeking alternatives, they acknowledge that the discrimination, double standards, and the utter disillusionment and disappointment in this field that claims to be good. Many callers seek non-normative alternatives in hopes that they can find kind, competent care while not being demonized for their non-marital and non-hetero sex, non-cis and non-confirming genders, unwanted pregnancies, or their positive STI or HIV statuses.

Making contraception, abortion, and knowledge about reproduction or STIs difficult to access, makes it harder to practice sex confidently and informedly without worrying about unwanted consequences. Making it difficult for trans people to access the healthcare they need directly places their lives in danger and reinforces the gender binary. Refugees are mostly only given access to humanitarian aid-based healthcare, limiting their healthcare access and framing their healthcare as a good deed rather than a basic right. This holds the implications that to be worthy of good deeds — or good healthcare — one must be a good person, which creates a cycle of dependency and an unspoken policing of behavior, particularly of refugee women's sexual activity and reproductive choices.

In parallel, migrant women's access to healthcare is dependent on their employers, who are expected to cover the costs and secure insurance, but who are not held accountable if they do not. Migrant women are further restricted if they are undocumented; and we know of many women who have been handcuffed to hospital beds, because while they do need urgent care, their lack of residency papers criminalizes them. While medical research is prized for its objectivity and its empirical evidence rooted in "the natural world," nothing is natural about bodies in need of care being discriminated against.

Almost half the calls on the topic of healthcare access concern pregnancy. Many women call frustrated, knowing that they were made to pay exorbitant fees for their abortions, while also knowing that there isn't anything they can do about it. One caller asked whether only married women are "allowed" to take pregnancy tests, in fear of being turned away for such a basic ask due to her relationship status. Another call came from a migrant woman who was worried because she could only take a few hours off of work to get an abortion, could not afford much, and was anxious that her employer might find out about it. Money, movement, and the 'madame' in the way, this caller not only faces physical barriers, but also must consider how her employment status as a domestic worker puts her under the constant surveillance. In such a situation, her employer can be just as much of a threat as the state itself. Callers who face major difficulties accessing safe abortions often resort to ineffective and often unsafe methods to terminate their unwanted

pregnancies, some of which can have lasting negative impacts on their health and well-being.

Cis and trans women, trans men, and gender non-conforming people often have to deal with judgement and outright aggressive healthcare providers who impose their religious patriarchal values on their patients. There is a common assumption that unmarried women do not have sex and therefore would not need services such as STI testing and treatment or pregnancy related needs while those who are married are not expected to seek STI-related testing and care as they are assumed to be in a monogamous relationship and not having had other sexual partners before. For people whose gender identity and expression clashes with social expectations, it can be extremely challenging to find healthcare providers who will not shame them or treat them in a demeaning manner as they seek necessary healthcare services regardless of their nature.

Many hotline callers contact the hotline to reflect on the chastising they receive in clinics when they visit their doctors to test and treat STIs. Callers also contact the hotline prior to their doctors' visits to discuss their anticipation of judgement and shaming from their doctors. Other callers get in touch anticipating discrimination for their unwanted pregnancies or past abortions, gender identity or expression, and even sexual practices. These callers seek healthcare providers that will quite simply provide good care that is judgement-free. One caller seeking a prescription for abortion pills "visited around 25 pharmacies and was rejected and treated poorly by many of them." She was seeking a referral to a doctor who "wouldn't be shitty" to her because she was running out of time. Unfortunately, this is a common concern and experience for many women. There was another caller who called the hotline to discuss a concerning side-effect as a result of her hormone gender affirming treatment and her need for an examination; she was specifically calling for a referral to someone who would not be transphobic. The caller and counsellor went on to discuss how difficult it is to find "trans friendly" doctors. Access to healthcare is not only about reaching a medical provider, it is about sensitive care as a right that should be accessible to women and trans and gender nonconforming people.

Callers to the hotline are aware that medical care shouldn't be this difficult to access, and that it is because established healthcare infrastructure operates in a discriminative, normative, and invasive way. Callers often contact the hotline to strategize loopholes to facilitate the access they need. A caller who wanted to see a doctor to confirm the termination of her unwanted pregnancy said that her plan when attending her next doctor's appointment is to "act stupid and say that it must have been a natural miscarriage" that brought an end to her pregnancy. Other callers search for strategies to deal with being overcharged, given false information, denied care, or manipulated into unwanted or unnecessary procedures. The role of hotline counsellors in these calls is to provide callers with the information needed to decide what approach they would like to take with their healthcare providers, and to then offer suggestions on what responses might lead them to the outcome they're looking for. Aside from decentralizing information and vocally challenging barriers to healthcare access, finding ways to 'play the system' is a way to subvert authority and reclaim autonomy from institutions that proudly exercise bodily control. Nevertheless, "playing the system" is only a means to an end, and accessible healthcare should not be the individualized responsibility of the patient.

2019 highlight

Moral panics restrict agency and access

In January 2019, The Ministry of Health, acting with Internal Security Forces, forcibly shut down several doctors' clinics after determining they were carrying out abortions. Action was taken after a report emerged on Al Jadeed News network, which documented a covert investigation aiming to expose several abortion clinics operating in violation of the law in Lebanon. Part of the report attempted to draw attention to how women in need of an abortion are taken advantage of within the healthcare system, with the legal restrictions on abortion allowing providers to overcharge women or subject them to unsafe practices with no accountability. However, this was lost through the report's dangerous conflation between safe abortion and legal abortion. In a misguided effort to expose/scandalize clinics, this journalistic hunt led to the curtailing of access to safe abortions among practitioners who ultimately feared criminalization.

All over the world women have navigated imperfect systems and legal barriers to gain access to abortions. In many countries where abortions are legal, they are not necessarily accessible nor are they safe. Are we to carelessly assume that what is legal, by definition, is also considered safe?

Tools of normalization

The concept and practice of punishment in its various forms is introduced to our lives from a very young age and maintained throughout our lives to uphold the status quo. This is seen through the misinformation and malpractice of medical practitioners and institutions that claim expertise over our bodies, as well as the shaming and blaming that extend past medical institutions and characterize our relationships with society, family, partners, and even ourselves. Punishment is also exemplified through gendered and sexual violence against those who go against what is deemed socially acceptable. It is through these tools of punishment that patriarchy can enforce normativity and "natural" limitations on our sexual and gender expression.

MISINFORMATION AND MALPRACTICE

False sexual and reproductive health information given by medical practitioners (whether intentional or not) impacts our medical decisions, our security, and our relationships with ourselves and others. Many callers tell of being given inaccurate medical abortion protocols, while others tell of being manipulated into expensive and unnecessary curettages (surgical abortions) by doctors exploiting their desperation, lack of knowledge, and fear for their health. Even if this was for lack of better knowledge rather than malicious intent, this begs us to question what medical practitioners do not know and why they cannot/do not make the effort to gain this knowledge before treating a patient.

Many callers contact the hotline to unpack myths that have contributed to the control of their sexual expression. Masturbation, for example, is an experience often discouraged for being unhealthy, unacceptable, or inherently unpleasurable. On another note, the hotline received callers who shared their concerns about penetrative sex "stretching" the vagina or anus, adding to the fear of being "found out." Additionally, the myth that women and men are inherently different in how they pursue sexual relations -usually with women being expected to be monogamous and emotionally attached, while men are expected to be the opposite plays into a biological discourse that deems women to be maternal and to want "naturally" to foster a family, while justifying and normalizing harmful physical and emotional behavior from men that often includes dismissiveness and entitlement to sex. These kinds of myths police sexual pleasure and freedom, and impact how people interact with their sexual partners, interests, and their own bodies.

STIGMA AND SHAME

The denial of medical and bodily autonomy ensures that people's sexual decisions and experiences are open for scrutiny by everyone around them from medical professionals to friends, family, and strangers alike. Much of this scrutiny takes the form of shame and stigma around sex and sexuality, both external and internalized. Several STI-related misconceptions relayed by hotline callers indicate how heavily the guilt and pressure associated with STIs weigh on them. These fears translated to difficulties navigating sexual relations, mostly palpable in their much-expressed concern of transmitting an STI or facing judgment upon notifying their partners. This is perpetuated by the stereotype that people who have STIs are reckless, unclean, and have many sexual partners.

Some callers contact the hotline in anticipation of discrimination for their unwanted pregnancies, gender identity or expression, or sexual practices in healthcare spaces. Many callers carry a sense of guilt into their conversations with our counselors, where they ask whether they are "sharing too much" or say that they "should have known better". While they are first and foremost reassured that this is never the case, counselors sometimes also unpack this with them, and usually callers feel relieved to know that their questions and experiences are normal and that they're not alone.

GENDERED AND SEXUAL VIOLENCE

The notion that female sex is intrinsically passive, receiving, and responsive — in comparison to male sex, which is characterized as aggressive, sexually charged, and persistent — is often used as ideological justification for gendered and sexual violence against women. Providing a biological explanation allows perpetrators of gendered and sexual violence a clause to fall back on, allowing them to abuse their position within society knowing full well that no penalty would come from their actions. Concerns of abusive power dynamics and exercised entitlement are not only reflected in relationships between cis women and cis men but also within queer relationships. This abuse of power is allowed to occur and continue due to many factors including less social support and resources, pressure and shame within one's social circles, and safety and legal concerns that hinder cohabitating unmarried women and people in non-normative setups from reporting abuse to law enforcement.

Reflections from callers and counselors

We always leave room for reflection, accountability, and self-improvement on the hotline. Callers are asked to **fill out a survey** that details their overall experience during the call. The survey asks them to reflect on the pace of the conversation during the call, connectivity difficulties, whether their main concern was tackled, if they are satisfied overall, whether they found the counsellor to be knowledgeable, if they were uncomfortable, and if they received a referral that was useful/not useful to them. These surveys help us reflect on our own ability to support callers and to see what needs improvement. Counselors also have room to reflect in their documentation of each call on how they felt the call went and what thoughts came to them on improving their performance, the hotline's, and the organization's at large; whether that be through requesting trainings for themselves and their peer counselors or to urge our knowledge production team to create and share content on specific topics that need a public discussion.

This process of constantly asking our callers and ourselves, how are we doing?, is our attempt at not falling into a norm, a routine, a way of doing things, but to always look to learning, growing, and developing our thoughts and message.

Callers' evaluations via online survey

Out of 441 calls in 2019, 334 evaluation surveys were sent out to callers. A total of 129 evaluation surveys were completed and sent back with the following feedback:

ANY DIFFICULTIES REACHING US?

No	Connection Issues	Late reply
71	5	5

WAS YOUR MAIN CONCERN TACKLED?

Yes	No	Kind Of
109	1	4

OVERALL SATISFACTION WITH THE HOTLINE?

Very Satisfied	Satisfied	Neutral	No Answer
100	14	3	12

DO YOU FEEL THE COUNSELOR WAS KNOWLEDGEABLE ON THE TOPIC YOU BROUGHT FORTH?

Yes	No	Kind Of	No Answer
111	3	6	10

HOW WAS THE PACE OF THE CONVERSATION?

Good Enough Time	No Answer
109	20

WERE YOU UNCOMFORTABLE AT ANY POINT IN THIS CONVERSATION?

No	No Answer
111	18

DID YOU GET A REFERRAL TO A PROVIDER?

Yes, but not useful	No, but I wanted	Yes, useful	No, didn't want
2	3	44	38

HOW WOULD YOU RATE THE SEXUALITY HOTLINE?

Excellent	Very good	Good	Fair	No Answer
99	14	3	1	12

WOULD YOU RECOMMEND THE HOTLINE?

Yes	Not sure	No Answer
113	2	14

Counsellors' self evaluation

The care generated during hotline calls brings out emotions for both callers and counsellors. Conversations can sometimes be emotional, sensitive, and/or intimate — and the nature of these calls may cause feelings of anxiety, worry and frustration to counsellors. Oftentimes, these emotions are directed in response to the situation the caller is in — and whether they were able to support them or not, counsellors still find themselves feeling concerned for the caller after ending the call. **In 355 of the total 441 calls that took place in 2019, sexuality hotline counsellors said that after calls they felt:**

SATISFIED	111/355	31.3%
NEUTRAL	102/355	28.7%
HAPPY	53/355	14.9%
CONFIDENT	27/355	7.6%
FRUSTRATED	26/355	7.3%
ANGRY	11/355	3.1%
WORRIED	8/355	2.2%
SAD	5/355	1.4%
CONFUSED	3/355	0.8%
UNCOMFORTABLE	1/355	0.5%
NERVOUS	1/355	0.3%
AVERAGE	1/355	0.3%
DISGUSTING	1/355	0.3%
GUILTY	1/355	0.3%
ANXIOUS	1/355	0.3%
RELIEVED	1/355	0.3%
WEIRD	1/355	0.3%

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 3 reading retreats (The Politics of Sexuality, The Politics of Mental Health, and Reproductive Justice). At these retreats, we delve into the theory and practice of topics at hand, through a series of articles and collective discussions.

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 cis and trans women, trans men, and gender non-conforming people —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.

Access our quickie Sexual and Trans Health Survey **English** and **Arabic.**

Join Us!

We love meeting new people! If you're interested, fill out this volunteer/member 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. The faster ways of joining us though would be to apply and join us in one of our reading retreats or at our annual sexuality hotline counselors training!

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!

EVENTS

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

KEEP UP WITH US!

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