THE A PROJECT
AGENCY
AUTONOMY
ALTERNATIVES

REPRODUCTIVE JUSTICE

a framework against systemic oppression

Sexuality Hotline Report 2020

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

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Published by: ***The A Project***
Beirut 2022

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ABOUT THIS REPORT

This report applies a reproductive justice framework to the data collected from The A Project's sexuality hotline in 2020. Its focus is to share and analyze the data collected from the sexuality hotline in a way that highlights the political nature of bodily autonomy, safety, and access to affordable and free health services and medication.

The report is presented in two major sections: quantitative and qualitative findings. The first section focuses on presenting demographic information, such as age, gender, location, and nationality of callers, while showcasing how callers reach out and for what topics. The second section gathers the textured details, or stories, shared on the hotline during the call and presents them under a reproductive justice lens. The report positions callers' stories under four themes: body, home, land, and clinic, and analytically dissects the impact of oppressive structures as seen from within the stories shared on the hotline. Some of the questions unpacked in this report include: how do patriarchal standards impact our perception of our bodies? How do we define home and safety? How does systemic racism in sexual and reproductive health operate against refugees and migrants living in Lebanon? And how can healthcare in Lebanon be accessible and inclusive? This report encourages its readers to critically think of how cis-heteronormative values sustain reductive traditions and oppressive institutions, and in what ways we can begin to fight the systems that oppress cis and trans women, trans men, and gender non-conforming people.

See page 46 to learn more about the sexuality hotline and what it's all about.

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. 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.

REPORT SUMMARY

This publication is the fourth edition of the sexuality hotline report. It offers an in-depth analysis of the data collected from calls made to the sexuality hotline in 2020 and uses reproductive justice as a framework to contextualize and unpack the content of the calls. This year, a total of 406 calls were made to the hotline between January 2020 – December 2020. Following the trend of previous years, calls this year have been mostly by people between ages 20-25, who are Lebanese, live in Beirut, and are cis women. This report also highlights the 73 conversations from non-Lebanese callers, of which 49 were made from within Lebanon. Despite not representing a majority number of this year's total calls, we find it important to emphasize the narratives that came from these calls because they speak to the layers of systemic discrimination refugees and migrants face while living in Lebanon.

There were over 64 topics explored on the hotline this year, with the most frequently mentioned topics being unwanted pregnancies, STIs and contraception. Often the concerns and questions of callers are contextualized with stories and experiences that reveal the all-encompassing nature of sexual and reproductive health concerns. Through the calls made to the hotline, the report shows how the Covid-19 pandemic and lockdown measures, as well as the deteriorating economic conditions in Lebanon, exacerbated already-existing issues around access to health services, medication, and resources, as well as the daily impact of cis-heteronormative standards on cis and trans women, trans men, and gender non-conforming people. We see topics like bodily autonomy, compulsory motherhood, abortion, intimate partner violence, workplace harassment, access to quality and affordable healthcare, etc., to be political issues, and when such topics are trivialized by institutions of power it is not by accident, but an intentional tactic of systemic oppression.

Callers contacting the hotline are not only looking for information, resources, referrals, or someone to talk to. Rather,

THEY are *demanding the freedom* to choose how to live in their bodies;

THEY are *demanding safety* from violence in their relationships, homes, and on the streets;

THEY are *demanding security* through civic rights while denouncing racism and class divide;

and THEY are *demanding access* to quality and affordable health services catered to their needs and attentive to their concerns.

The conclusions drawn from the data collected in 2020 critique the normalized invasive expectations that poke at our body, and in our home, land, and clinic. The data shows that callers wish to see, treat, and care for their bodies in the way they choose - which means deciding for themselves what is "beautiful," what sexual desires and preferences are acceptable, how to parent, and when (or if ever) to have children. Callers also challenged the misconception that "home" is safer than public spaces, by revealing how pandemic-experienced confinement in closed private spaces is more like prison than a sanctuary. Stories of feeling unseen and undervalued for the work completed at home, as well as cases of violence emerging during a year of Covid-19 lockdowns, show how far from true these pictures of homegrown safety really are. For migrants and refugees, being confined is not just about physical space and mobility, but also equates to being barred from resources, security and support. Calls from migrants and refugees highlight how their wellbeing, access and opportunities were restricted through systemic racism that infiltrates both their private and public space. This also includes access to sexual and reproductive healthcare in Lebanon. In fact, many callers this year expose doctors, pharmacists and other medical practitioners for being the eyes and ears of the state, thereby acting as checkpoints for patriarchal standards of normativity means that patients are left lacking the care they need.

INTRODUCING REPRODUCTIVE JUSTICE AS A FRAMEWORK

AN ILLUSTRATED SERIES

The struggles we face in Lebanon are complex and interconnected. How do we unpack and fight the different systems that oppress us? ***one way to start is by adopting a reproductive justice framework.***

Reproductive Justice is a framework that was developed by women of color in the USA as a rejection of the reductive "pro-choice" approach taken in Cairo during the 1994 UN International Conference on Population and Development. Substituting "abortion" with the word "choice" didn't make sense to women who were forced into abortions and miscarriages, and whose communities didn't have the socio-economic conditions to thrive.

These activists developed a framework to expose reproductive oppressions and to fight the systemic forces that limit their autonomy and access to sexual and reproductive health. Some of these women later formed SisterSong, the first collective to coin and work on Reproductive Justice.

BODY:
Bodily Autonomy

Girls are taught at a young age to believe that their value lies in how well they can fulfil their domestic role. In other words, they must remain abstinent until marriage, have children, and raise their children under patriarchal values. Under this oppressive structure, women do not have bodily autonomy and their bodies are treated as commodities. Due to these cultural expectations, women in Lebanon often feel pressured to conform to the discourse around virginity by pursuing hymenoplasty surgeries.

Reproductive justice rejects the idea that says the value of women lies in their ability to be "good" girls, wives, and mothers, and instead insists that a woman's value is not up for debate.

Cis and trans women, trans men, and gender non-conforming people are free to use their bodies in the way they choose without being reprimanded for their decisions. Choosing to stay abstinent or have sex, have children or not, get married or choose otherwise should be up to them. A reproductive justice framework unpacks how much of these decisions are influenced or determined by social expectations.

HOME:
Violence

Women leaving an abusive marriage are faced with social and legal obstacles that force them to remain vulnerable and dependent. Religious institutions in Lebanon punish women already in violent situations by prioritizing the institute of marriage and the words of men. Despite never carrying the burden of reproductive labor, men are often relieved from paying alimony and are granted child custody, where the care of the child is then assigned to other women within the family.

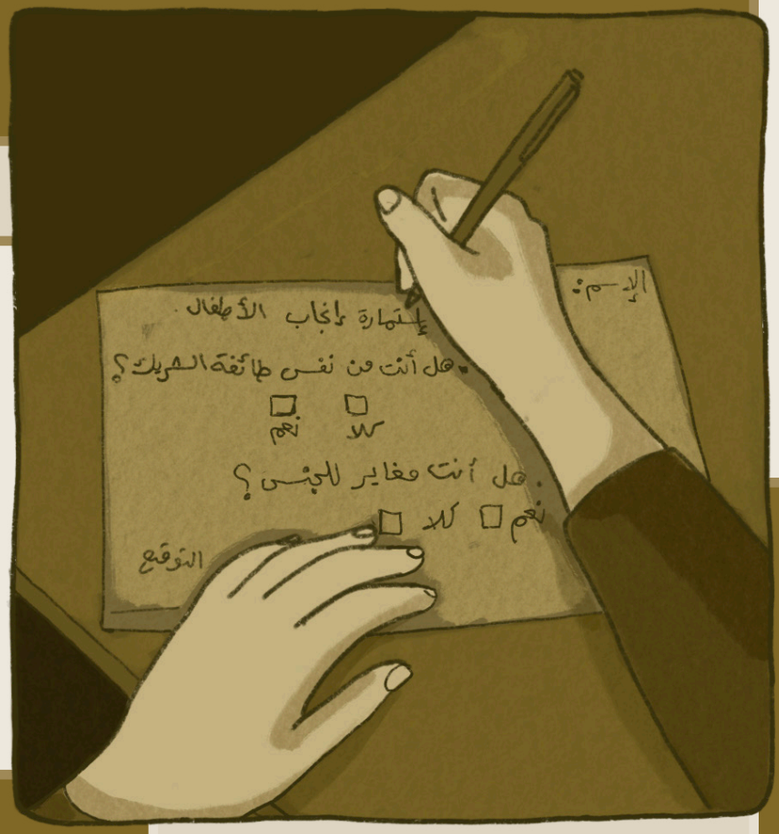
Intimate partners who fall outside legally recognized heterosexual marriage (whether queer or straight and cohabitating) have no legal resources to escape or pursue justice from a violent partner. Who has access to protection is linked to who is accepted as "normal," "natural," "good," i.e., is monogamous, procreative, marital, heterosexual, and non-commercial in their sexual experiences, or otherwise defined as cis-heteronormative.

LAND:

Part one: Citizenship

Who can become a Lebanese Citizen? Do all citizens have the same rights? Patriarchy, racism, and sectarianism combine to produce citizenship laws aimed at maintaining the "sectarian balance," with total disregard to the lives of the people these laws affect. Children born without a nationality struggle to access education and employment, among various other obstacles.

Almost all family-building choices are limited by Personal Status Laws, Citizenship Laws, and religious courts; and reproduction is accepted only if it is same sect, different sex, Lebanese nationals of the same social make-up.



Part two: Environment

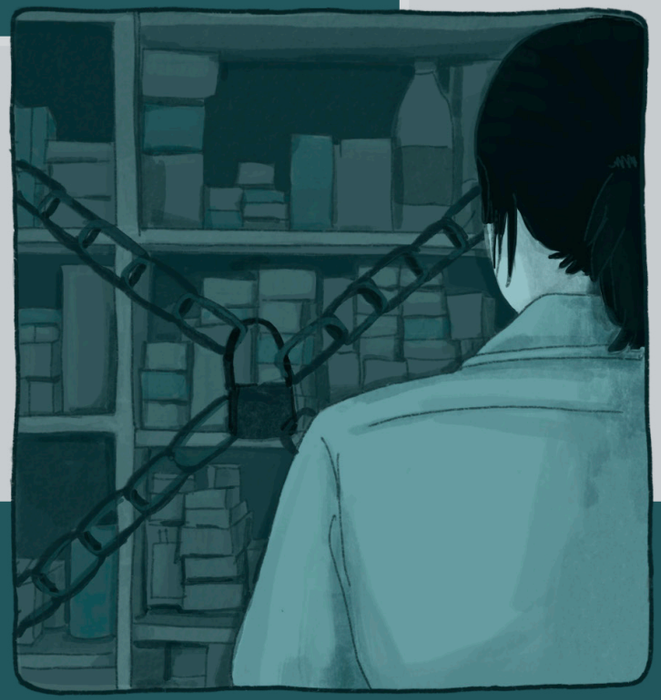
The government's repeated failure at waste management poses a risk to both body and land. Pollution from landfills and incinerators affects everything from the respiratory system to fertility to increased cancer risk. Low-income citizens, refugees, and migrants are blamed for overpopulation while they are trapped in overcrowded suburbs with horrible infrastructure. The state, as usual, blames the most vulnerable.

Natural ecosystems, in land and sea, are quickly being replaced by buildings, factories, and private resorts. Water is wasted and polluted, garbage is mismanaged and burned to toxicity, and environmental concerns are overall neglected by the state.

Reproductive Justice highlights the importance of conserving natural resources and being conscious of our consumption to sustain a healthy environment for future generations.

CLINIC:
Sexual and Reproductive Healthcare

Health services and medication have always been limited by law, stigma, high cost, unequal access to free and subsidized services, and the medicalization of childbirth. STI testing, cancer detection screening, abortion, prenatal care, maternity benefits, among others, have been difficult to access even before the current economic crisis in Lebanon.



Access to sexual and reproductive health services for lower-income families are often dependent on humanitarian aid organizations that tend to focus their support on limiting fertility. High-cost treatments, like assisted reproduction technologies (e.g., IVF), are not offered to lower income families or anyone who cannot pay the high cost. This begs the question of whether the purpose of these NGOs is to help women find agency or to maintain a population control agenda.

How are issues relating to body, home, land, and clinic linked to the reproductive justice framework?

Topics of sexuality and reproductive health are often isolated from standard political discourse and treated as secondary issues or ignored completely.

Applying a reproductive justice framework helps us break down current characteristics of systemic oppression including racism, sexism, classism, and sectarianism, to help us fight against reductive traditions and attitudes that limit and criminalize us for the sustenance of oppressive systemic norms.

WHAT DOES QUANTITATIVE DATA SAY ABOUT REPRODUCTIVE JUSTICE?

406 calls were made to the sexuality hotline this year.

Behind these 406 calls are different people with various curiosities and concerns, looking for information, referrals, and/or someone to talk to. The statistical data presented in the upcoming pages offers a window into who has been calling the hotline this year, and what reason and topics they were calling to explore. A mixed methods approach to the analysis of the data has been applied in efforts to capture the responses of our callers. This is specifically shown in the qualitative portion of the report, where the focus of our analysis is based on the stories shared by hotline callers (see page 26).

The quantitative data captures the gender, age, relationship status, nationality, language, and location of hotline callers. This demographical data is presented within the framework of reproductive justice to expose who suffers under barriers that restrict bodily autonomy and agency, as well as who has limited access to affordable and quality healthcare. It is also telling of who has been looking for – and is in need of – alternative resources and quality sexual and reproductive healthcare and support. Examining the demographics of hotline callers allows us to better grasp the massive gaps and inequalities in Lebanon's current healthcare systems. The layers of reproductive oppression are not limited to patriarchal medical practices that exclude cis and trans women, trans men, and gender non-conforming people, but also are part of a wider multi-system model of oppression that ensures the frailty and socioeconomic disadvantage of many groups, especially migrants and refugees.

Disclaimer: *Not all statistical figures cover all 406 calls. Each call is unique, and counselors are not always able to capture the demographic information of all calls made to the hotline.*

Find these blue boxes to take a deeper read of our qualitative data through a reproductive justice analysis.

TOTAL CALLS

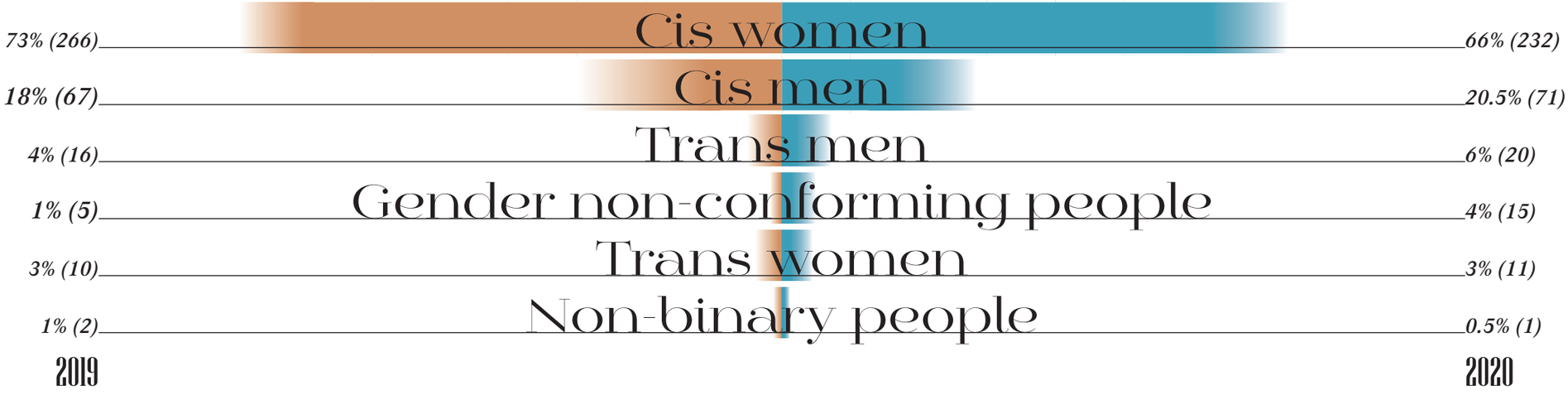
Total number of calls in the year 2020: **406**
Total number of calls in the year 2019: **441**

Between January 2020 and December 2020, the hotline received a total of 406 calls. Throughout the year, there has been a stable number of calls across each month. The median value of calls per month averages to 42 (detailing the midpoint frequency distribution for the year's total calls). January and June had the exact same number of calls (45), as well as the highest percentage of calls per month: 12%. The least number of calls occurred in November, totalling 5.5% of the total calls made in the year 2020.

	Calls	
January	45	12%
February	31	7.5%
March	27	6.5%
April	31	7.5%
May	32	8%
June	45	12%
July	39	9.5%
August	41	10%
September	34	8%
October	28	6.5%
November	23	5.5%
December	30	7%

GENDER

350 *out of* **406** *calls recorded in 2020*
366 *out of* **441** *recorded in 2019*



Cis and trans women, trans men, and gender non-conforming people are made to seek alternative platforms that offer space to explore and discuss sexuality and sexual and reproductive health freely, without the bias of patriarchal standards.

In the past two years, cis women have been the hotline's most frequent callers. This year, they made 232 calls, amounting to a total of 66% of the total gender data collected. There has been an increased number of calls by trans men and gender non-conforming individuals in the year 2020. Trans men made 6% of this year's calls, which is an increase of 2% from 2019. However, the largest increase from 2019 to 2020 is seen by gender non-conforming callers, who jumped from 5 calls in 2019 to 15 calls in 2020 (a significant 3% increase).

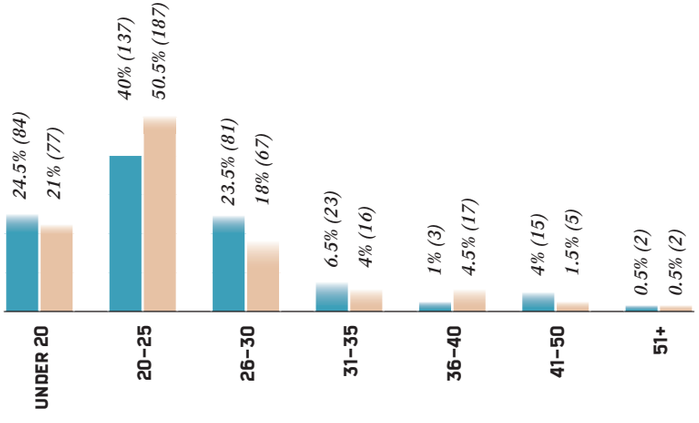
Why are alternative platforms important?

Alternative platforms challenge and pressure patriarchal institutions to change. This is not to say that alternative platforms reach their goal once oppressive structures, like medical patriarchy, make some changes to meet our demands. Rather, they function in a state of temporality keeping the big picture in mind and calling out performative non-genuine changes that barely scratch the surface of what is so deeply flawed in our society. This can be compared to the purpose of NGOs, where their existence is never to replace what people should have access to by the state, but to supplement what is missing. Alternative platforms, such as the sexuality hotline, are where we take apart and critique medical patriarchy, but also push the political discourse on sexuality and mental health that we want.

AGE OF CALLERS

345 *out of* **406** *calls recorded in 2020*
371 *out of* **441** *recorded in 2019*

More than three quarters (88%)
of hotline callers are below the age of 30.



While callers below the age of 25 continue to be the hotline's most frequent callers, it is precisely the 20-25 age bracket that has the greatest number of callers over the past two years. This year we saw a small increase (5.5%) from the year 2019 in calls made by people between the age of 26-30. The number of callers aged 36 and up remains almost the same between 2019 and 2020 with a 1% decrease in the number of calls in 2020 and a specific 3.5% decrease in calls from people aged 36 to 40.

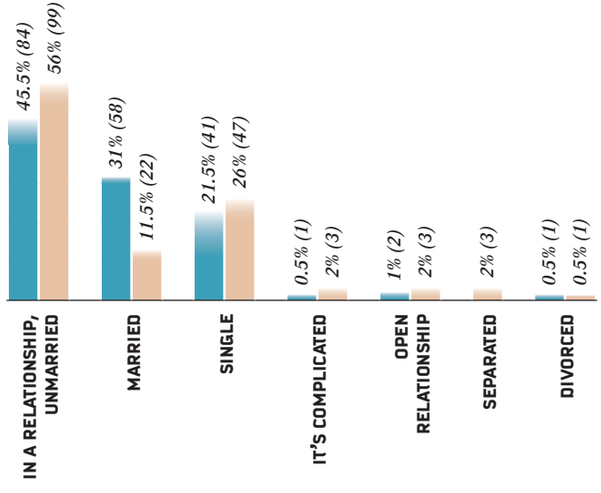
Why are young people calling the hotline?

The younger you are, the less independence, privacy, support, and confidence you have when talking about sexuality. There is a lot of shame that surrounds young people when they're first learning about sexuality or sexual health, and not enough platforms encourage young people to explore these topics without humiliation or moral judgement. As a teen, being dependent on family often means there are expectations to meet, add monitoring and surveillance and a limited and dependent income, and access to care becomes seemingly impossible. This is one of the reasons why many young people seek the hotline for information and someone to explore topics of sexuality and sexual health with.

RELATIONSHIP STATUS

107 *out of* **406** *calls recorded in 2020*
178 *out of* **441** *recorded in 2019*

Disclaimer: *Hotline counselors do not ask for the relationship status of the caller unless it is necessary or relevant to the conversation. The decision to withhold this information is at the complete discretion of the caller and does not impact the support and quality of the call.*



Of the documented relationship statuses, non-marital relationship callers contact the hotline most frequently. While this category remains in the lead for the past two years, it is important to note that it has decreased significantly from 56% in 2019 to 45.5% in 2020. This is proportionately accurate since this year the frequency of callers from those who are in marital relationships rose from 19.5% in 2019 to 31% in 2020.

Many of these callers called to discuss access and usage of contraceptives and abortion, a service that is less shameful for married couples to bring into a clinic. This suggests that the economic and overall living conditions in Lebanon have impacted married couples' decisions, access to services, and overall financial stability.

NATIONALITY

331 *out of* **406** *calls recorded in 2020*
386 *out of* **441** *recorded in 2019*

77.5% LEBANESE
83%

3.5% SYRIAN
5%

2.5% EGYPTIAN
0.5%

2% BAHRAINI
0.5%

2% ETHIOPIAN
1%

2% SAUDI
1%

2% IRAQI
2%

1% PALESTINIAN
1%

77.5% of calls made to the hotline in 2020 have been by Lebanese nationality holders and/or individuals who state being Lebanese. This means over two-thirds of the calls made to the hotline were by Lebanese people (258/356 calls total). Despite the massive number of calls made by Lebanese folks, the smaller statistics reveal the diversity of the hotline's outreach: Syrian callers (14/356), Egyptian callers (11/356), Ethiopian callers (8/356), Bahraini callers (7/356), and Saudi callers (7/356) all add substantially to the total calls made to the hotline. This year, calls were also made by Iraqis, Palestinians, Bangladeshis, Jordanians, Kuwaitis, Indians, Mexicans, Ukrainians, Italians, Sahrawis, Sri Lankans, and Syrian Kurdish.

7.5%
AMERICAN
BENGALI
JORDANIAN
BRITISH
KUWAITI
INDIAN
MEXICAN
MEXICAN-AMERICAN
UKRAINIAN
ITALIAN
SAHRAWI
SRI LANKAN
FRENCH
SYRIAN KURDISH
PREFER NOT TO SAY

6%
FILIPINA
CONGOLESE
AMERICAN
CANADIAN
SRI LANKAN
KENYAN
IRISH
CROATIAN
GERMAN
DUTCH
SIERRA-LEONEAN
IRANIAN
EMIRATI
NEW ZEALANDER
MAURITANIAN
BRITISH
TONGOLESE

Nationality plays a factor in gender prejudice in Lebanon.

Lebanese women are unable to practice the same civic and political entitlements (i.e., passing citizenship on to their children and spouses) as their male counterparts and this mere fact alone renders them second class citizens in their country.

Palestinian and Syrian refugee women and migrant women are barred from access to a variety of services and support due to racist state laws that limit their access to quality and affordable medical, sexual and social services. More often than not, refugee and migrant women must seek the support of international non-governmental medical service providers to access the care they need.

49/73 (67%) NON-LEBANESE CALLERS CALLING FROM WITHIN LEBANON:

14 Syrian

8 Ethiopian

7 Egyptian

2 Saudi, Iraqi, Palestinian, Bengali, Jordanian, American

1 Bahraini, British, Mexican, Ukrainian, Sri Lankan, Ukrainian, Italian, French

Of the 73 non-Lebanese callers that contacted the sexuality hotline this year, 49 out of 73 calls were made by non-Lebanese callers who reside in Lebanon. Issues of quality, affordable, and accessible healthcare are experienced differently by migrants and refugees who are forced to face their reproductive and sexual health concerns in the context of racist and discriminatory political circumstances. For example, factors that migrants take into consideration when deciding whether to keep a pregnancy or abort include job security and even residency security:
Will this child be considered illegal if born in this country? Will I lose my job and residency if I get pregnant and give birth here?

When migrants and refugees seek sexual and reproductive healthcare, they are often reminded that they are unwelcome, mistreated, talked down to, and are therefore left uncared for.

THESE CALLERS CONTACTED THE HOTLINE BECAUSE THEY NEEDED:

Referrals to healthcare services	27 calls
Information	27 calls
Someone to talk to	14 calls
Referral to resourcess	3 calls
Information about The A Project	1 call

TOPICS THAT WERE DISCUSSED DURING THE CALL INCLUDED:

11 Unwanted pregnancies, Abortion

6 STIs, Pleasure

5 Sexual relations

4 Contraception

3 Relationships, Wanted pregnancy, Sexual violence

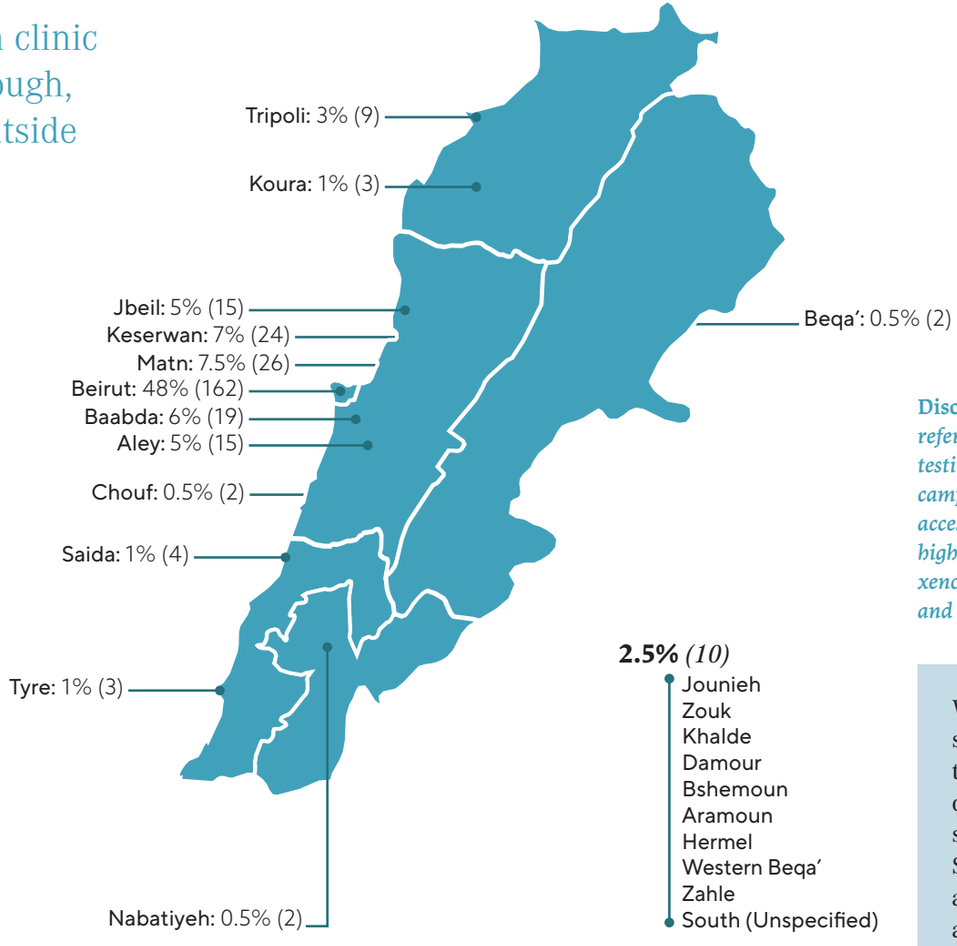
2 Trans-discrimination, Pregnancy scare, Economic support, Gender identity, General health: Stomach pain

1 Online dating, Mental health, Menstruation, "First time" sex, Hymenoplasty, Body image, Sexual orientation, General health: Tooth pain

LOCATION

339 *out of* **406** *calls recorded in 2020*

Finding a decent health clinic in Beirut is difficult enough, let alone finding one outside the capital.



The location of caller's does not imply the nationality of callers. Many expats contact the hotline from countries abroad, while many migrants or non-Lebanese people contact the hotline from within Lebanon.

89% of calls made to the hotline come from within Lebanon. Meanwhile, 11% of the hotline's calls are made from outside the country. Calls made within Lebanon are largely concentrated in Beirut, making exactly 48% of the total calls recorded. We have also seen an increase in the number of calls made throughout different areas within the country. Matn has the second highest number of calls, averaging 7.5% of total calls this year. Close behind is Keserwan with a total of 24 calls (7%). Calls made from the North and South of Lebanon remain relatively unchanged from the previous year.

Outside Lebanon

11% *(Total of 42 calls)*
UAE: 3.5% (10)
Bahrain: 1.5% (6)
Saudi Arabia: 1.5% (5)
Egypt: 1% (4)
Kuwait: 0.5% (2)
Qatar: 0.5% (2)
United States: 0.5% (2)
Jordan: 0.5% (2)
Iraq: 0.5% (2)
UK: 0.25% (1)
Palestine: 0.25% (1)
India: 0.25% (1)
Sahraa: 0.25% (1)

Prefer not to say:
0.5% *(2 calls)*

Disclaimer: *This year, The A Project launched a doctor referral campaign to collect contact information and patient testimonies of trusted healthcare providers. The aim of this campaign is to overcome the everyday harsh barriers of accessing decent sexual and reproductive healthcare (i.e., the high cost of doctors' consultations, sexism, racism, transphobia, xenophobia, etc.) and to grow our knowledge of quality sexual and reproductive healthcare providers outside Beirut.*

Women living in rural areas in Lebanon are specifically excluded from access to health clinics that cater to sexual and reproductive medical concerns. Quality maternal health and delivery services, gender affirming therapies, contraception, STI testing and treatment, among other services, are often only available in clinics located in urban areas in the country. Cis and trans women, trans men, and gender non-conforming people living outside urban spaces are not only alienated from necessary medical and social support, but their opportunity to explore their medical options or alternatives is limited to whatever information or service is available at the nearest (or only) clinic in the area – regardless of the quality.

LANGUAGE

406 *out of* **406** *calls recorded in 2020*

The hotline consists of counselors who speak in English, Arabic, and/or French. In 2020, hotline counselors took 187 calls in English. In addition to these 187 calls, 108 calls were spoken in a hybrid of English and Arabic. Adding these two statistics together reveals that a significant 72.6% of the total calls made in 2020 were, more or less, spoken in English. Calls spoken in Arabic are a total of 26% of the calls. Hybrid calls in Arabic and French make 1% of the hotline calls made, while 1 single call was spoken in a mixture of French and English.

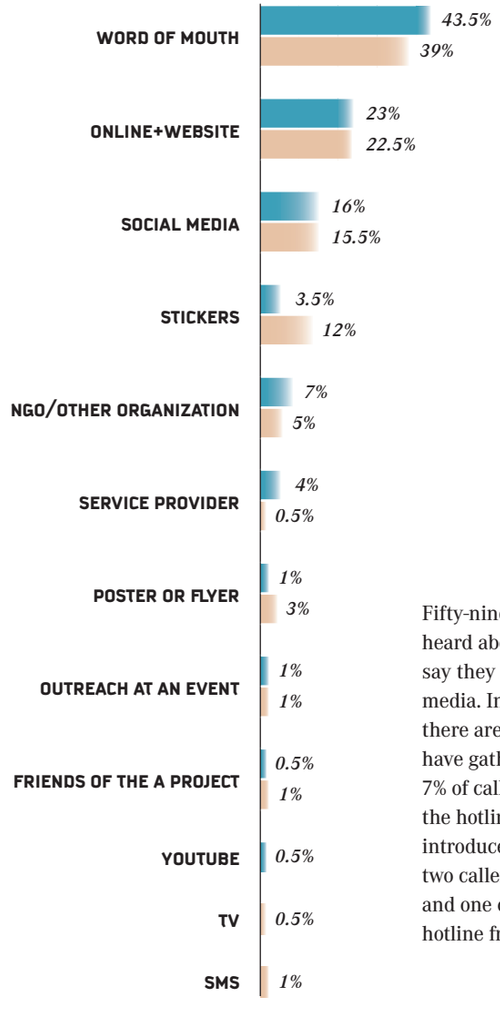
ENGLISH	**46%** *(187)*	*English & French*	**0.5%** *(1)*
English & Arabic	**26.5%** *(108)*		
ARABIC	**26%** *(106)*	*Arabic & French*	**1%** *(4)*

There are a plethora of resources on sexuality and sexual health and rights written in English. The imposition of resources published within the global north leads to the assumption that there is a lack of resources produced in the global south. We question this assumption and believe there are rich materials on sexuality and sexual and reproductive health and rights in Arabic and fertile grounds to explore them further. In fact, we draw inspiration from feminist organizers in the global south and migrant activists working in Lebanon who mobilize intentional language within their fight against oppressive structures. We recognize that by learning more about other cultures' languages on sexuality we can understand the value of those spaces' radical and progressive agenda.

HOW YOU HEARD ABOUT THE HOTLINE

254 *out of* **406** *calls recorded in 2020*
240 *out of* **441** *recorded in 2019*

This year, 43.5% of all callers say they heard about the hotline through word of mouth, making it the most popular way to learn about the hotline.

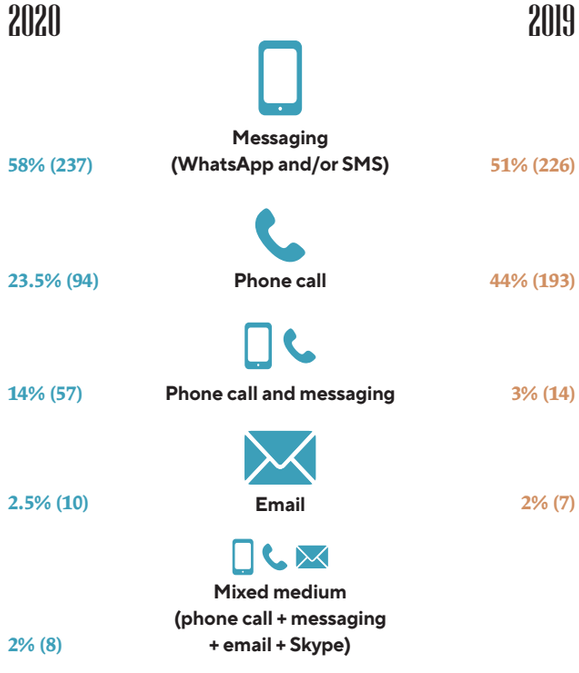


Fifty-nine people (23%) shared that they heard about it online, and 16% of callers say they heard about it through social media. In addition to virtual outreach, there are conventional methods that have gathered attraction to the hotline: 7% of callers were recommended the hotline by other NGOs, 4% were introduced to it by service providers, two callers learned about it via an event, and one caller said they heard about the hotline from a friend of The A Project.

HOW YOU CONTACTED US

406 *out of* **406** *calls recorded in 2020*
440 *out of* **441** *recorded in 2019*

Out of 406 total calls, 237 calls (58%) were made by either WhatsApp messaging or SMS. The second most popular approach to contacting the hotline is direct phone call, where 23.5% of callers utilized this medium. Although this was also the second most popular method in 2019, there has been a significant 20.5% decrease in the number of phone calls between the two years. Some callers (14%) contacted the hotline by a hybrid application of phone call + messaging.

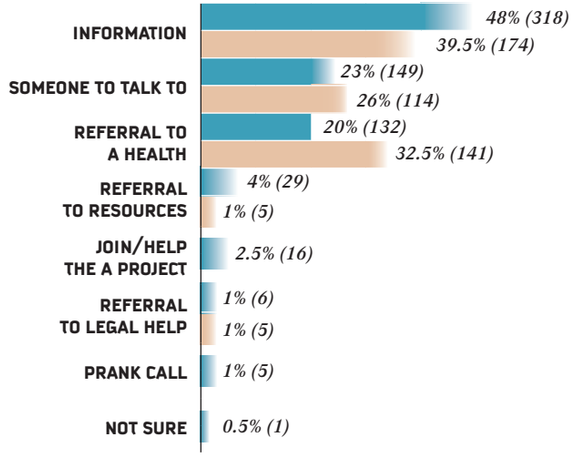


There are several ways to get in touch with our hotline counselors! You can send a message, make a call, or send an email! Callers' comfort is our priority, and any of these mediums are available for you to chat with us during hotline shifts. If you want to spare your phone credit, let us know at the beginning of a call or through text so that we call you.

WHAT WERE YOU LOOKING FOR?

406 *out of* **406** *calls recorded in 2020*
441 *out of* **441** *recorded in 2019*

There are many reasons to decide to contact the hotline. Sometimes it's for a referral to a healthcare provider, to receive a recommendation for resources, or to gain information on a topic of interest or concern. Other times, the hotline is an opportunity to have someone to talk to. This year, 318 calls (48%) were made for the purpose of gaining information about a topic or concept. The second most popular reason to contact the hotline has been to talk to someone (23%), as many callers are often just looking for a compassionate listener to explore topics that challenge normative perceptions of sexuality, gender, and/or reproductive health and rights. Seeking referrals to healthcare providers (20%/132 calls), resources (4%/29 calls), legal help (1%/6 calls) and joining The A Project (2.5%/16 calls) are other reasons callers picked up the phone this year.

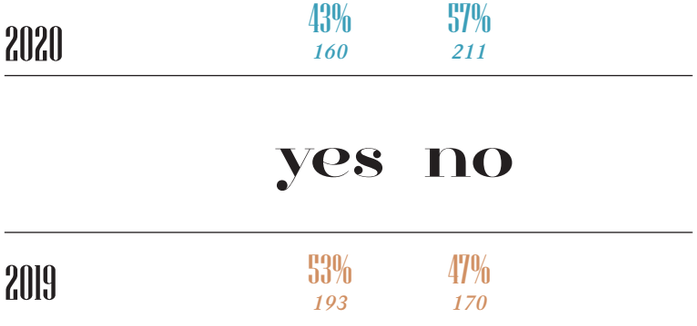


All calls to the hotline point back to the reality that there is a gap in information, resources, and lack of support in common social institutions – so much so, that we continue to seek alternatives to supplement our needs and interests.

NEW/FREQUENT CALLERS

371 *out of* **406** *calls recorded in 2020*
363 *out of* **441** *recorded in 2019*

First time caller?



Out of 371 calls recorded, 160 calls (43%) were made by first time callers. This is 10% less than the year before. 211 callers (57%) stated that they had previously called the hotline before and are calling again.

Why do callers call back?
The hotline has begun to generate a regular audience of callers who contact the hotline to explore new ideas and have conversations about all topics gender and sexuality with open minded listeners. There are 38% of all callers (81/211) who contact the hotline a second time to follow up with referrals, reconfirm information that was given in the original call, or to simply leave a comment, while 23% of calls (48/211) were made to build on previous conversations. Beyond follow-up conversations, there are people who are motivated to regularly call the hotline to discuss new topics and issues and this makes up 19.5% (41/211) of this year's total repeated calls. In all cases, callers that contact the hotline again take part in normalizing the sharing and exchange of knowledge about sexuality and the independent exploration for answers about our bodies and sexual concerns – so all the power to you <3

If you are a previous caller, are you calling about the same issue?

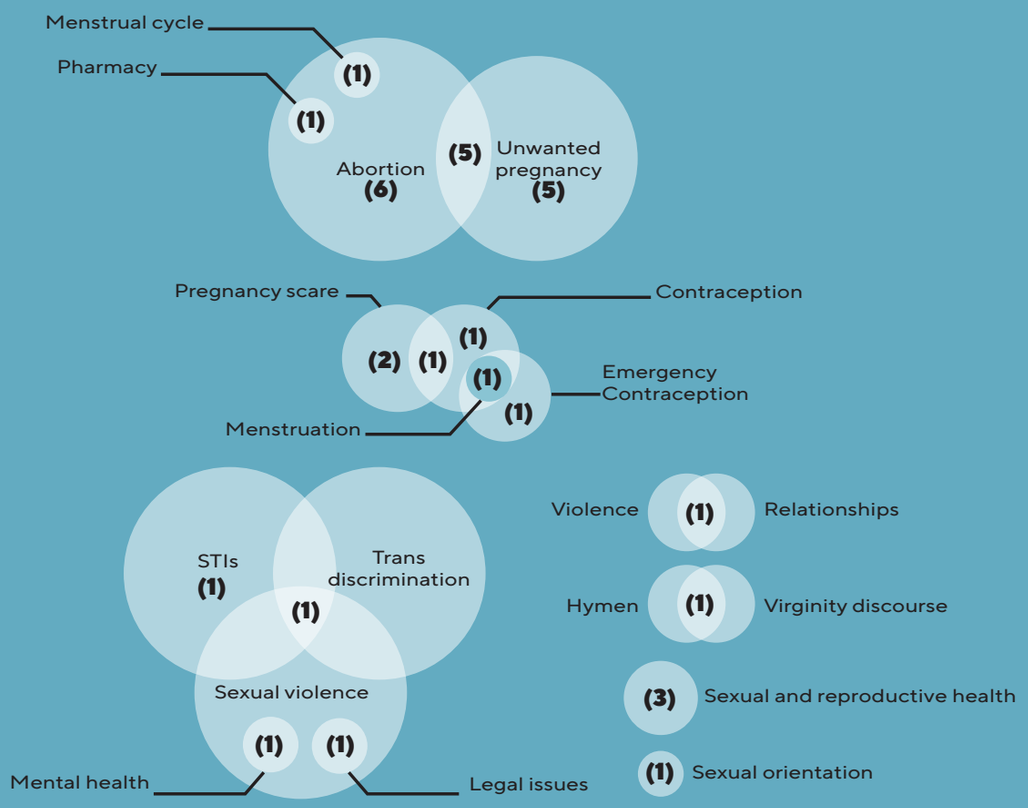
YOU CALLED ON BEHALF OF...

***402** out of **406** calls recorded in 2020*
355 calls in total were made by the callers themselves

Taking the first step to explore one's health, gender, or sexuality can be hard, and picking up the phone to contact the hotline may not be as easy for some as it is for others for various reasons. So, people may choose to have a trusted friend, family member, or partner call the hotline on their behalf, or may choose to share the call between them and their trusted someone. This year, 35 out of 402 calls (8.5%) were made on behalf of someone else – this is only 3 more calls than those made in 2019 – and 12 calls (3%) were made by both the caller and someone else. This implies that a sweeping majority of calls this year (355 out of 402 or 88.5%) were made by the caller, for the caller.

TOPICS OF CALLS ON BEHALF OF OTHERS:

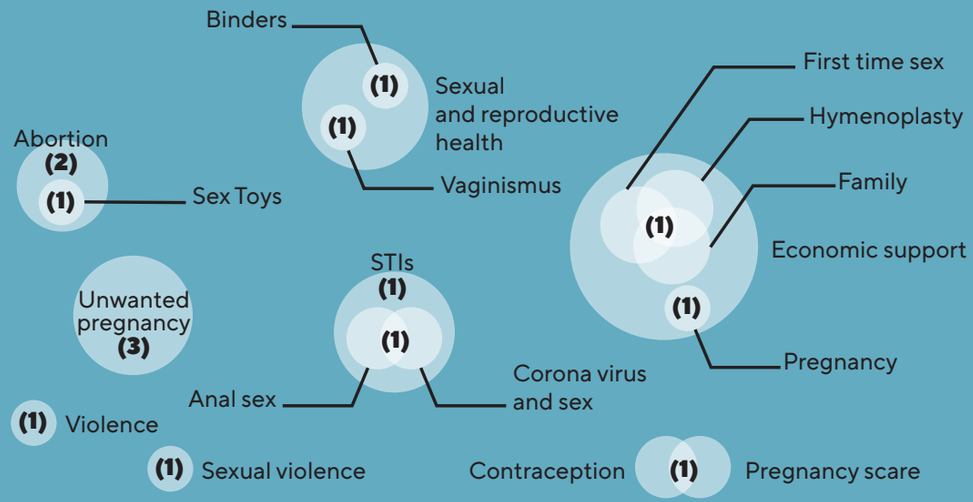
35 calls in total were made on behalf of someone else in 2020
32 calls in total were made on behalf of someone else in 2019



Call topics are not discussed in a bubble. More often than not, topics coincide and compliment other sexual and reproductive health topics

TOPICS OF CALLS MADE BY THE ORIGINAL CALLER AND SOMEONE ELSE

12 calls in total were made by both themselves and on behalf of someone else in 2020



While it isn't always clear exactly why someone is calling on behalf of another, it is always necessary to question the entitlement of the caller who is calling on behalf of someone else. Calls made by cis men on behalf of their partners, for example, allude to social dynamics and patriarchal pressures that remove agency from women seeking information and autonomy of their bodies. Health centers, common sexuality resources, and general public spaces already shut many women out by the nature of them being products of patriarchal structures. Therefore, when men take up space and resources from alternative platforms, they end up stealing our opportunity to reclaim our autonomy and exercise our freedom.

However, many callers who call on behalf of others can be doing so in solidarity with their friends and partners. In such situations, counselors simply ask that the concerned individual reach out to the hotline directly when they can.

CALL TOPICS

It's exciting to see the variety of topics explored on the hotline. However, it is sombering to realize there aren't many other places that allow for the following topics to be discussed openly and honestly. That's because topics on sexual health and sexuality continue to be considered taboo by patriarchal structures because they challenge and reject social norms that serve them. While it is delightful to know that there are alternative channels, like the hotline, that encourage sincere discussions and further exploration of regularly stigmatized topics, we must also read this extensive presentation of topics as a petition, that asks for these subjects to infiltrate public and patriarchal domains in sponsorship of reproductive justice.

TOP topics discussed in 2020

| 78 | 11.3% ABORTION
| 64 | 9.1% UNWANTED PREGNANCIES
| 60 | 8.6% STIS
| 57 | 8.2% CONTRACEPTION
| 34 | 4.7% PREGNANCY SCARE
| 31 | 4.5% PLEASURE
| 29 | 4.3% SEXUAL AND REPRODUCTIVE HEALTH
| 30 | 4.5% VIOLENCE
| 27 | 4% RELATIONSHIPS
| 27 | 4% MENTAL HEALTH
| 25 | 3.8% VAGINAL SEX
| 25 | 3.8% FOREPLAY

Conversations on the hotline concerning relationships are not always about romantic or intimate relationships (although admittedly, many are). Exploring relationships means also talking about parents, extended family, friends, employers or coworkers, and neighbors.

Not all calls made to the hotline are about sexual and reproductive health. Many callers contact the hotline to also discuss general health and accessibility issues, some of which include the availability of prescription medication in pharmacies, or referrals to doctors related to specific physical concerns (e.g. tooth pain).

2 –3% of this year's calls explored the following topics

| 19 | 2.7% MENSTRUATION
| 17 | 2.5% ORAL SEX
| 17 | 2.5% SEXUAL VIOLENCE
| 17 | 2.5% GENERAL HEALTH
| 15 | 2.1% SEXUAL ORIENTATION
| 15 | 2.1% EMERGENCY CONTRACEPTION
| 14 | 2.3% FAMILY
| 12 | 1.7% MENSTRUAL CYCLE
| 12 | 1.7% GENDER IDENTITY
| 9 | 1.3% ANAL SEX
| 9 | 1.3% POST-ABORTION CARE
| 9 | 1.3% TRANS HEALTH
| 9 | 1.3% FIRST TIME SEX
| 7 | 1.0% BINDERS

Callers contacting the hotline to discuss first-time sex are mainly calling to debunk or verify their expectations: *"Will it hurt?" "Should I expect to bleed?" "Will I enjoy my first time?"* and other questions of this sort are part of the conversation about sex for the first time.

up to 1% of all calls discussed these topics

| 6 | 0.8% VAGINISMUS
| 6 | 0.8% BODY IMAGE
| 6 | 0.8% MASTURBATION
| 6 | 0.8% HYMENOPLASTY
| 6 | 0.8% PREGNANCY
| 6 | 0.8% ONLINE DATING
| 5 | 0.7% DYSPHORIA
| 5 | 0.7% MARRIAGE
| 5 | 0.7% TRANS DISCRIMINATION
| 4 | 0.6% CORONA VIRUS AND SEX
| 4 | 0.6% ECONOMIC SUPPORT
| 3 | 0.5% CONSENT
| 3 | 0.5% "THE HYMEN" (VIRGINITY, DISCOURSE)
| 3 | 0.5% BODY HAIR
| 3 | 0.5% LEGAL ISSUES
| 3 | 0.5% BULLYING
| 3 | 0.5% DEAD NAMING AND MISGENDERING
| 2 | 0.3% SEX IN PUBLIC
| 2 | 0.3% SEX TOYS
| 2 | 0.3% COMMUNITY
| 2 | 0.3% CARE LABOR
| 2 | 0.3% INCEST
| 2 | 0.3% SEXUAL ATTRACTION

The COVID19 pandemic has forced many of us to seek new relationships via online social platforms. Callers sometimes call the hotline to discuss these new relationships and the nature and complications of online dating.

In the offset of the pandemic, the hotline received a few calls by people wondering if the Corona virus can be transmitted through sexual activity.

Often in the context of discussing first-time sex, callers explore expectations of "virginity" and the social function of the hymen. These conversations unpack the myth that the hymen is an indicator of a woman's sexual activity (or lack thereof) and concludes that the concept of virginity in itself is a tool to regulate the extent of women's sexual freedom.

more topics explored on the hotline in 2020:

| 15 | 1.5%

COVID19 HYGIENE ISSUES
ABUSE
A PROJECT COLLABORATION
DETAILS ABOUT THE HOTLINE
DONATION
ASYLUM
PHARMACIES
HOW TO JOIN THE A PROJECT
EMOTIONAL WELLBEING
HOUSING
IMMIGRATION
NUDES
CYBER BULLYING
PUBERTY
HPV VACCINE

WE EXTRACTED 4 CALL TOPICS AT RANDOM TO SHOW HOW MULTIPLE TOPICS COINCIDE AND COMPLIMENT EACH OTHER DURING CALLS.

violence

| 30 | 4.5%

*V*iolence +

- *R*elationships | 6
- *G*ender identity | 4
- *S*exual orientation + *R*elationships | 3
- *M*ental health | 2
- *P*leasure + *M*ental health | 2
- *S*exual orientation | 2
- *V*irginity discourse + *S*exual orientation + *S*TI
- *T*rans discrimination + *S*TI
- *M*ental health + *P*leasure + *S*exual relations
- *S*exual abuse + *C*onsent + *I*ncest + *S*exual relations
- *G*ender identity + *S*TI + *T*rans discrimination + *B*ody image
- *S*exual Cyber bullying

Violence, in very broad terms, incapsulates domestic violence, intimate partner violence, rape, abuse, harassment, bullying (cyber and in person), discrimination (whether aimed at trans people, migrants, or refugees), and family abuse. Violence can be publicly perpetuated and even encouraged from within your community, or silently committed without the knowledge of even your closest companions. Callers contacting the hotline to discuss violence heavily depend on the anonymity and confidentiality the hotline offers so they may feel free to speak comfortably about their experiences.

pleasure

| 31 | 4.5%

*P*leasure +

- *C*onsent | 3
- *S*TI + *R*elationships | 2
- *V*iolence + *M*ental health | 2
- *C*ontraception + STI
- *C*ontraception
- *F*oreplay + *M*arriage + *S*exual relations
- *S*exual violence + *M*asturbation
- *S*exual reproductive health
- *M*asturbation + *S*exual relations
- *S*exual relations + *A*buse + *V*iolence
- *S*exual orientation + *F*irst time sex + *V*iolence
- *F*irst time sex + *S*exual relations + *M*asturbation
- *R*elationships + *F*irst time sex + *S*exual relations + *M*asturbation
- *S*exual relations + *V*aginismus + *F*irst time sex + *V*irginity discourse
- *P*uberty + *S*exual relations + *F*amily + *P*ublic sex
- *S*exual violence + *M*ental health + *S*exual relations
- *S*exual violence + *F*irst time sex + *S*exual relations
- *V*iolence + *S*exual and reproductive health

Calls about pleasure challenge the limitations of normative sexual expression. Many callers want to know if it is “normal” to masturbate, “normal” to use objects or toys during sex with their partner, “normal” to want sex in public, “normal” to enjoy aggression in the bedroom, etc. Other callers want to unpack why they are not feeling pleasure during sex or how to overcome past sexual experiences that were not pleasurable to them. There are also callers who want to learn how to better pleasure their partners and selves, and where they can find further information that can guide them to a more pleasurable sex life.

Mental health

| 27 | 4%

*M*ental health +

*S*exual violence | 3
*V*iolence | 2
*V*iolence + *P*leasure | 2
*R*elationships
*A*bortion
*S*TI + *S*exual orientation
*T*rans discrimination + *D*eadnaming and misgendering
*S*TI
*D*ysphoria + *B*ody image
*L*egal issues + *R*elationships
*S*exual violence + *P*leasure + *S*exual relations
*F*amily + *R*elationships
*S*exual violence + *I*ncest
*T*rans health

Our mental wellbeing is largely connected to our everyday concerns and hardships. Mental distress may be a result of the obstacles and violence experienced when we are exploring our sexuality and gender, or seeking sexual and reproductive health support. Looking after our mental health doesn't always mean signing up for therapy or seeking the help of psychologists and psychiatrists: sometimes all we need is someone with a compassionate ear to talk to.

Family

| 14 | 2.3%

*F*amily +

*G*ender identity + *T*rans discrimination | 2
*P*ublic sex + *S*exual relations + *P*uberty + *P*leasure
*M*ental health
*P*leasure + *S*exual violence + *S*exual relations
*M*ental health + *R*elationships
*F*irst time sex + *E*conomic support + *H*ymenoplasty
*E*conomic support

Conversations on the hotline regarding family unpack the difficulties of adolescence that include embracing sexuality under the strict limitations of family and community expectations. Callers tend to discuss how to best navigate strict or conservative parents, and how to overcome family expectations to accept their identities and continue living their lives in the way they desire. These conversations include how to share their gender identity with their families (and if that's even a necessary step), how to introduce their partners to their families, and/or how to start taking the first steps in opening conversations that would be deemed controversial within their household.

WHAT DOES QUANTITATIVE DATA SAY ABOUT REPRODUCTIVE JUSTICE?

Behind every call made to the hotline is a question, comment, or concern on sexual and reproductive health.

While some callers contact the hotline for practical information, like how to _____ or where to find _____, other callers call to unpack norms or explore theories related to sexuality and sexual and reproductive health and rights. These conversations create the qualitative portion of our data, where we begin to understand in greater detail what topics are being discussed by our callers and what gaps in knowledge and resources we face. Looking at qualitative data also means the topics explored on the hotline are contextualized to specific problems i.e., living conditions and experiences in Lebanon, allowing us to make better sense of the quantitative data.

Collecting qualitative data and analysing it under a reproductive justice framework means critically unpacking the stories shared on the hotline as a method of understanding how patriarchal structures like racism, sexism, classism, and sectarianism impact day to day life for cis and trans women, trans men, and gender non-conforming people. The following sections are split into four themes that fall under a reproductive justice framework: Body, Home, Land, and Clinic. Each section shares relatable stories collected from the hotline and analyzes them under the specific themes of the framework. The Body section, for example, unpacks the negative impact of patriarchal standards and cis heteronormative values on the way we see and speak about our bodies. In Home, the conversation about our safety and what defines a "home" is explored. The following section on Land goes in detail about oppression and systemic racism towards migrants and refugees, and the final portion of the qualitative data falls under the framework of Clinic and reveals experiences of mistreatment by doctors in effort to unpack why it is nearly impossible to access quality sexual and reproductive healthcare in Lebanon. Together, Body, Home, Land and Clinic offer stories collected on the hotline and position them under a reproductive justice lens for analysis.

BODY
WE DEMAND TO BE FREE

Our bodies are ours,

yet they are ruled by patriarchal standards passed down by our families, community, school, the media, workplace, neighborhood, religion, and even our friends. Everyday calls to the hotline echo the pressures of patriarchal and social standards and reveal that mainstream expectations for cis and trans women, trans men, and gender non-confirming people have a negative impact on the wellbeing of many hotline callers. To explore this in detail, the Body section will unpack the following topics: the pressures of marriageability and (compulsory) motherhood, sex-negativity and body shaming.

Are you marriage material?

Several callers to the hotline have discussed the pressure they feel in maintaining their "virginity" to minimize any complications they may have in future relationships or when seeking to get married. Many callers requested referrals for hymenoplasty surgery or to seek advice on tips to induce or create the illusion of bleeding, aka the tearing of the hymen, during sex. Some of these callers accept the concept of virginity to be a patriarchal myth, designed to limit women's bodily autonomy and to chain them to the standards of marriageability. However, this awareness does not remove the fact that presenting as a "virgin" is a preferred reality for many women, especially when trying to navigate conservative or religious communities. It is common that women in these environments are forced to endure "virginity testing" by their doctors to "prove" they have "remained pure." One caller contacted the hotline to discuss her experience with a gynecologist who forced her into hymenoplasty after he had conducted a "virginity test" upon her parent's request to salvage her marriageability. She was forced into the procedure by both her doctor and parents under the pretense that this operation was in her best interest as a young unmarried woman, and was removed from any ability to decide for herself what was right for her body. This invoked a feeling of shame for her past sexual experiences and fear for her future if she didn't accept her "return to virginity."

Nevertheless, there are some women who have an interest in getting a hymenoplasty of their own will because it is what they need to feel comfortable within their bodies. A caller interested in hymenoplasty surgery shared that despite being in love with her sexual partner, she feels that she "should've waited until they were married because [she] feels like something is missing [in her] and [she] is '*na2ssa*'. This caller is not alone in expressing the feeling of something "missing" or feeling '*na2ssa*' after having sex for the first time. Despite deciding on her own to pursue a hymenoplasty, the feeling that "something is missing" is in reference to the expected consequences that come with not having an intact hymen, which may lead to feelings of guilt and remorse when we have sex before marriage, even when the sex is consensual and enjoyable. Even people who consent to sex before marriage and/or understand virginity as a social construct may choose to pursue hymenoplasty surgeries because they don't want to deal with the repercussions of being seen as a "non-virgin."

Women are conditioned to believe that sex for the first time is the act of giving (in the case of marital sex) or losing (in the case of premarital sex) an integral part of themselves. After all, having sex for the first time is literally and almost always referred to as "losing virginity" which immediately references the notion that our bodies are for the taking. The truth is, women's sexual services may be valued above her and her wants, so much so that it can be considered transactional. Our bodies may be used in the same way as money: depending on when we have sex, the value of our sexual service increases or decreases, making the currency, i.e., our bodies, hold less worth. Patriarchal norms wish to enforce the idea that we are "overspending" or not receiving the value of our "money" when we engage in premarital sex because we are "giving ourselves up for cheap." However, sex within marriage is also a transaction because the way sex is perceived as an expectation in marriage implies that women are valued for their bodies and the only way to retain our "full value" is by remaining abstinent until marriage. In both cases of premarital and marital sex, the use of money as a synonym for our bodies not only shows us how our sexual services can be transactional but reveals how their worth is dictated by patriarchal standards dependant on when it is "of value" to engage in sexual acts.

Are you mother material?

The standards that dictate whether or not women are fit for marriage do not simply end when we have found (or been assigned) a spouse. Even during marriage, women are expected to uphold principles that define the ideal mother and wife, and when these principles aren't upheld, they are faced with harsh criticism, blame, and even punishment. In marriage, a woman's initial duty becomes looking after her family – her husband, her house, her children. Her personal interests and passions are often placed second to her domestic role, leaving her with little to no space for any self-fulfillment and care. Many women contact the hotline in acknowledgment of this reality and seek to discuss the often-romanticized experiences that come with being a mother. For one caller, this meant talking about her feeling of guilt for taking contraceptive pills without her husband's knowledge. After only being married for 9 months, her friends and family are enthusiastically looking forward to, and have already begun hassling her, to become pregnant. The caller explained that she feels socially pressured to conceive children, but she is not ready to become a mother as she says she is not ready to give up herself in the process.

Compulsory motherhood (i.e., expecting and requiring women to birth and raise children) belittles or ignores the physical difficulties that come with motherhood. It assumes that motherhood begins when the baby is born and rejects women's complaints regarding the difficulties of pregnancy under the argument that it is a woman's bodily duty and primary function to give birth (ergo, "part of the job" to deal with any difficulties attached to this labor). Before giving birth, there are 9 months of difficult physical work and bodily changes that are not talked about enough. Following that are endless nights of little sleep and breastfeeding, among other very serious physical changes also rarely addressed in conversations about motherhood. For some women, these physical changes and the fear of potential health complications are reason enough to cancel the thought of motherhood altogether. Callers who contact the hotline to share their anxieties about the ambiguous 9 months of pregnancy often continue to talk about the expected post-pregnancy physical and emotional changes. For some callers, having access to this information helps them decide whether keeping a pregnancy is the right decision for them, and in all cases, gives callers the opportunity to understand what potential physical labor they may experience. Nevertheless, deciding on whether to have a baby or not is never just about the pregnancy. There are various reasons that guide women to decide whether they should conceive – loss of personal freedom and time, as well as physical, economic, environmental, and family concerns. The one thing these reasons have in common is the added pressure and influence that comes from society's unnecessary opinion on how to handle these various concerns.

Racist double standards towards motherhood

While some women's bodies are decidedly useful primarily for their reproductive ability, other women are completely shamed for having children and are deemed negligent or downright criminal if ever they do get pregnant. Whether they are married or not, racist culture in Lebanon frowns upon refugee women birthing what they (the state and all racists) consider new generations of refugees. Children born to a refugee family in Lebanon are not naturalized as Lebanese, and their status, alongside their economic class, access to resources, and endured racial discrimination and profiling, takes after their parents'. On the other hand, migrant women in Lebanon are legally restricted by the Kafala system from giving birth, and they are threatened with the loss of their income and residency status if they are to break this regulation. However, seeking abortion can be a complication of its own. Doctors are often less willing to help migrants and refugees, and those that do "help" tend to charge exorbitant amounts of money for them. This year, the hotline received 42 calls by non-Lebanese people living in Lebanon and of those 42 calls, the topics of abortion and unwanted pregnancies were the most discussed by far. Due to this country's practicing laws, many refugees and migrants are unfortunately pressured to terminate their pregnancies to appease social and legal restrictions, making their control of their bodies limited to the racist demands of this country.

Are you lovable material?

It is nearly impossible to avoid the power behind social expectations. Whether consciously or not, cis-heteronormative expectations often take precedent over our own wants and desires, leading us to a mindset of sex negativity. Sex negativity isn't just about having a negative attitude towards sex. It is about allowing cis-heteronormative trends to dictate what feels normal or right to our bodies. Every year, callers repeatedly contact the hotline asking if their sexual desires and experiences are "normal" or if there is something "wrong" with them for feeling the way they do. Often, a list of questions following the sentence trend, "**is it normal if I _____?**" are asked by callers. Some of these questions include: "is it normal if I masturbate with a shower head?", "Is it normal that I wiggle when I'm having penetrative sex?", and "Is it normal to enjoy rough sex?". After asking such questions, one specific caller asked if her sexual experiences and desires make her a "*sharmouta*." The answer to that is unfortunately yes, any sexual activity outside cis-heteronormative values will have us labeled as *shrameet*. But following normative guidelines doesn't shield us from being labelled *shrameet* either. We can check off all the values and expectations of cis-heteronormativity and be a feminine presenting cis-woman, virgin until married, stay-at-home mom, etc., but the moment we stand up for ourselves while being catcalled on the street by saying something as small as "*3ayb*," we become a *sharmouta*. The reality is even when abiding to patriarchy's standards, we are considered sluts in both public and private spaces for resisting harassment and violence, or for affirming how we wish to be treated or what we want.

Unpacking sex negativity and bodily autonomy requires us to reflect on how often we focus on how we see *ourselves* instead of how we are *seen*. This approach to "body image" is not the definition often used but is one that better relates to our own expectations of what we look like or want to look like. For example, making our body lovable or desirable is often understood in the setting of beauty standards that are often unattainable or unrealistic. More often than not, having a "lovable body" has less to do with standards of beauty and more to do with whether or not our body image matches who we are. One person called the hotline to discuss body image and dysphoria, attributing that looking and sounding like a girl is what causes his friends and family to misgender him. In the attempt to erase feminine features, he bound his chest so tight that he required urgent medical attention. Many others callers express frustration in hearing their voices sounding too high-pitched, seeing their facial structure as too round/feminine, and feeling as though they don't measure up in the width of their shoulders, arms, hands, and in fact measure too much in their hips and thighs - seeing curviness or shorter stature to be "female" attributes. Such complaints are not about general standards of beauty. Rather, they are complaints about the caller's own specific image of themselves and their desire to have their image match who they are. Another caller contacted the hotline for advice on how to bind his chest because he just "want[s] to feel nice." In both cases, having a lovable body doesn't mean feeling beautiful, but instead is about feeling nice and feeling like we belong in the bodies we have.

The social pressure to "love yourself" or "love the skin you're in" and all other versions of similar jargon is a reductive approach to discussing body image because it limits our understanding of what it means to be content with our self-image to social expectations of beauty. The social demand to love your body can sometimes be toxic because it extends past physical beauty standards and suggests "beauty" as an umbrella term that equates able-bodied, healthy, active, and productive. Redefining loving ourselves should be solely based on what makes us feel comfortable and connected to our bodies. ■

How are issues relating to body linked to the reproductive justice framework?

Patriarchal standards and normative expectations should have no say in how we see, treat, and care for our bodies. We must question what we are told is pretty, what criteria we must meet to be considered "marriageable," what sexual desires, preferences, and behaviors are acceptable and why some are deemed wrong. Within a reproductive justice framework, the topic of beauty shifts from being a conversation about marriageability and is instead acknowledged for what it is: a measure of value and worth that gives legitimacy to those who meet society's gender expectations. Moreover, any decisions we make about birth, abortion, and parenting must be grounded in our bodily autonomy and not in normative expectations. Patriarchal standards and traditions regularly limit us from being the parents we want to be and instead force us to be parents that reinforce patriarchal traditions to our children (ever wonder why mom is stricter than dad? You got your answer). It is the woman of the house's job to instill patriarchal values and norms onto her children, in a twisted hope that by doing so her children will be better fit to exist in society. Reproductive justice in the context of motherhood is not only the acknowledgement that we can and should decide for ourselves when and if we want to be mothers, but it is also the recognition that we can choose to parent in the way we want. Regardless of whether we are young, old, unmarried, married, interested in having children, mothers, completely uninterested in being a parent, wishing to change our bodies, to use our bodies in a specific way, etc., our bodies are our own and any decisions impacting our bodies should be made in service of our own interests.

HOME
WE DEMAND SAFETY

Our sense of wellbeing and physical safety is often too easily compromised.

To explore the various ways our security is often threatened, the Home section shares stories from hotline callers that highlight the role of the state in legitimatizing violence against cis and trans women, trans men, and gender non-conforming people, as well as daily cases of bullying and discrimination, cases of intimate partner violence, and family conflicts. This section also looks at "home" as a space for healing and explores stories that ask us to reassess what kind of homes we want to have or want to make.

there is no home in the Lebanese justice system

The Lebanese justice system plays a leading role in the normalization of violence against cis and trans women, trans men, and gender non-conforming people. A few callers explained that one of the reasons they are reluctant to seek help from the police is because they expect they cannot be supported without a wasta. Lebanon's clientelist nature has left many of us believing that little (or nothing) can be accomplished without someone on the inside to nudge forward our requests/cases. One caller contacted the hotline to say that she had filed two complaints after being raped twice by a man in her village, only to be met with sarcasm and tease by the police who suggested she should marry the rapist. They also made fun of her by blaming her for wearing "revealing" clothes or suggesting she was drunk. Moreover, because the rapist was the son of an important person (and so had a wasta of his own), the complaints filed against him offered her no justice at all and she was left without so much as a follow up. In such an example, it is obvious that the justice system is serving he who supports patriarchy, abandoning those whose retribution undermine it. Demanding evidence to prove we've been assaulted is a large reason why our justice system fails us, especially because more often than not, testifying that we've been raped or assaulted is not enough "proof" to condemn a rapist.

Knowing that our complaints are not taken seriously by the justice system is a large reason why we feel we have nowhere to report sexual violence. A caller contacted the hotline to share her story about online harassment and why she made the decision to refrain from contacting the police about her case. For weeks, she had been receiving threatening messages on Instagram by an anonymous account who was repeatedly calling her a slut, asking for nudes, and demanding proof that she's a virgin. Even after blocking him, he would continue to stalk her via different fake accounts. While the caller said she was aware that the police have an internal department that deals specifically with cyber monitoring and bullying, she did not trust them to take her complaint seriously enough to use those resources to convict

her harasser. Knowing that there is no legal reproach to violence means that all forms of violence, whether it be intimate partner abuse, online bullying, sexual harassment, stalking, rape, etc., are normalized and institutionally sanctioned by the Lebanese justice system. Being underhandedly told by the justice system "we don't care about you and your safety" is an indication of how other state institutions perceive our concerns for our safety and wellbeing.

Is there really such a thing as a "safe space"?

Even when we are at our friend's house, our favorite cafes, at home or any location we consider to be "like home," we are not free from potential harassment. Spaces that are created with the promise of being welcoming or "friendly" to marginalized people cannot ensure that their "friendliness" is equivalent to being %100 harassment-free. Sure, such spots do suggest tolerance to marginalized peoples, however in no way can it guarantee safety or accountability when harm is committed. The mere fact is that we regularly anticipate harassment wherever we are, despite acknowledging and fighting for our right to feel safe.

There is no home in this relationship

A total of 47 calls (7% of all calls made in 2020) discuss the topic of violence and sexual violence, many of which were specifically made by people wishing to talk about the abuse they face by their partners. Intimate partner violence encompasses physical abuse, sexual abuse, verbal abuse, psychological abuse, economic abuse, and stalking by romantic partners. When calling to discuss intimate partner violence, not everyone is at the stage of seeking to leave their abusive partner. In fact, most callers are often aware of their situation and choose to contact the hotline mainly to have someone to talk to or to seek information and resources on how to cope with the conditions they are in. One caller contacted the hotline to ask if getting hit or punched in the stomach during her period would affect her fertility. She disclosed that her partner is physically abusive and being hit on the stomach made her worry for her future ability to have children. Dealing with violence in relationships becomes even more complicated for queer couples, couples where one partner is a citizen and the other isn't, or in situations of unmarried cohabitation because these relationships are not considered legitimate in Lebanon and therefore fall out of the lines of protection.

The lack of consequence for intimate partner violence and domestic abuse allows different levels of manipulation, blackmail, gaslighting, and abusive power dynamics to play a role in the relationship, especially within relationships considered non-legitimate by society. The fact that queer relationships and dating in queer circles must be kept quiet creates opportunities for perpetrators of abuse to get away with mistreatment, mockery, and abuse. In other words, we can't file a complaint saying: "the guy I met on Grindr is harassing me" because, let's face it, the first question we would be asked is: "Well, why are you on Grindr?" When discussing intimate partner abuse, we must acknowledge the impact of the taboos associated with being in non-normative relationships on a person's support system and available resources in finding safety and seeking justice.

Overt sexual harassment and violence are not the only aspect of a relationship that threaten our safety, as expectations of reproductive labor can impact how comfortable and safe we feel in our space and with our partners. One hotline caller shared that she is asexual yet participates in acts of intimacy with her partner just to please him. She articulated that she understands that she shouldn't feel pressured to do anything she doesn't want to, but she fears losing her partner over something that would be entirely her "fault." Reproductive labor in relationships is more than just who carries the responsibilities of domestic and care work. Rather, it is the idea that we must provide something in a relationship that speaks to our duty as a partner, otherwise our partner will leave us. This dynamic is rarely considered violence in the common use of the term. However, the elements of forced labor, coercion, and expectations that make up reproductive labor are in fact characteristics of normalized violence. These expectations do not solely exist in monogamous relationships but also in open relationships where there is the assumption that "anything goes." For example, a caller shared that her partner, who she is in an open relationship with, forced her into a threesome with her ex. Being coerced into sex is violence, and the expectation that sex is a given characteristic

of relationships is incorrect. Gender roles and expectations can often times make us feel like there are conditions to the love we receive in our relationships, that without meeting those conditions we are unworthy of affection. This obviously should not be the case because we deserve to be in loving and supportive relationships built on mutual trust and respect, without any conditions and free of coercion.

there is no home in this house

The Covid-19 pandemic exacerbated our relationships with the people we live with; and being under lockdown for almost the entire year meant we were forced to spend more time with and speak to our families at home. Several calls to the hotline made by gender non-conforming and trans people reveal fearing or regretting conversations with their family members during lockdown. One of the most common comments made during calls was the fear of being judged for "coming out" and questioning how that judgement will alter their participation in their homes and in public spaces. One caller specifically called to unpack her confusion regarding "coming out," saying that she is "torn between risking being abandoned" by her family and "hiding who she really is from everyone." Being trapped at home played a role in us feeling pressured to have conversations we didn't particularly want to or didn't find necessary before lockdown. We also reassessed the general assumption that parents are supportive, kind, and unconditional with their love. One caller contacted the hotline to express his confusion about his parents' support during his transition, saying that although they say they support him (and he does believe they do) they continue to misgender and deadname him, which in return confuses him about their support. Assuming parents are consistent people is part of the reason we expect them to be unconditional with their love; however, like any other person, parents can contradict their intentions with their own personal reservations. Regardless of that, being trapped in situations where we don't feel we can be ourselves, or where we are not seen and acknowledged for who we are puts us in a situation where we are constantly feeling hurt, uncomfortable, sad, betrayed, and frustrated.

Even before the pandemic, many of us may have already experienced feeling trapped by our families. This sense of being trapped was shared by one caller who contacts the hotline frequently to speak about her conservative and religious upbringing, and how her parents "lock [her] at home." She shares that she does not have any social life because her parents do not let her leave the house. Even when she manages to sneak out, she can barely enjoy herself because her parents do not give her any spending money, and they do not allow her to work. Such cases show that for some of us, home was a prison far before the Covid-19 lockdown began and the desire to be surrounded by like-minded people was heightened by spending so much time with people who think and act differently from us. In fact, the hotline received calls this year from people looking to find new homes with others who share the same values, interests, and communities as them. One caller in specific asked for help finding a flat in Beirut because she "wants to live with people from the queer community." However, there were other calls that unpacked how living in an environment with likeminded people does not necessarily make it easier to be themselves or to feel safe. One caller shared her story of how she came to Lebanon about a year and a half ago, thinking that she would be better accepted as a trans person in Beirut as opposed to in her country of origin. However, what she found instead of safety was assault similar to what she experienced in her country, toxicity within queer circles in Beirut, and bullying between friends – which she also added was more painful to endure than bullying and discrimination by individuals outside her community. ■

How are issues relating to home linked to the reproductive justice framework?

We are constantly told that we are not safe in public places, on the streets, and around people we do not know well, so we are advised to find "safety" in our home. But when we enter our home, we find that we aren't safe there either because we are coerced into conditions that leave us unseen for who we are and undervalued for the work we do. More than that, the assumption that our predators are lurking solely in public spaces undermines the various levels of violence (i.e., bullying, harassment, stalking, sexual abuse, and rape, etc.) that can unravel between intimate partners, family members, and good friends in private. Being restricted to a private space in the name of safety is a prison sentence and not an opportunity for security. While we can't change patriarchal expectations and understandings of private/public dichotomies, we can reimagine the concept of home as a space that offers us the safety and comfort we deserve. In this reimagining, a home is a place where we don't need to meet reproductive labor expectations to feel that we deserve love. It is a place where we can cohabitate with friends and intimate partners without feeling that we are in non-legitimate living arrangements. It is about challenging normative expectations and medical patriarchy by encouraging the possibility of home births or abortions and acknowledging the care and support that flourish in the home during such times. Reimagining an accessible, safe, and home-y space requires us to own up to the truth that we are certainly deserving of a space that doesn't disown us for being who we are.

LAND
WE DEMAND SECURITY

Patriarchal institutions do not serve anyone and are especially oppressive towards migrants and refugees living in Lebanon.

Systemic racism embedded in state institutions makes it a challenge to access essential resources and care through various measures. This section on Land will unpack variations of systemic racism through the stories shared by non-citizens on topics of mobility, legal statuses, financial hardships, and access to medical care and family support.

Financial security and legal status

Access to sexual and reproductive healthcare is especially challenging for migrants and refugees who want to build a family and is discouraged by institutions and social expectations that control the bodily autonomy of these women. In fact, the understanding that migrant and refugee women are entitled to intimacy and the decision of when or if they have children is a concept completely disregarded by medical institutions and society in Lebanon. Moreover, the financial conditions of refugee women are often weaponized against them to further justify why they shouldn't have children. Nasty statements like: "if you can't afford a kid, you shouldn't have one" are preached by right wing, conservative Christian political parties or other like-minded institutions who see the reproductive ability of refugee women and migrant women as a threat to their politics. Despite this, there are many who decide to have children in Lebanon.

One Bangladeshi caller, calling on behalf of his pregnant Bangladeshi wife (who speaks neither English nor Arabic), contacted the hotline for a referral to a doctor who can provide regular checkups and support during the delivery. They shared that they had already seen three doctors but were unable to afford them because of extreme economic hardship. In addition to a doctor referral, the caller and his partner were looking for financial support or a referral for a food program that could help them access daily meals. A second caller, an Ethiopian woman who was seven months pregnant, also called in search of financial support. Already a mother of two, she was calling to ask for help in finding her Sudanese husband a job. She said she is looking forward to having her third child but is concerned as she is three months behind on rent, can't afford healthcare, and hasn't been able to afford registering her daughter in school. In both examples, each migrant family is deciding to have a baby while mitigating financial complications. Refugee and migrant women are regularly made to feel that they must

justify their desire to have children, especially when their living situations are not "family friendly" i.e., lacking financial security, a two-parent household, a home in a stable and friendly neighborhood, etc., and when they do decide to have kids, they are shamed for raising a family in "poor" living conditions.

security in movement

The lockdown that was enforced during the onset of the Covid19 pandemic introduced the loss of freedom of mobility to those who have never been faced with this privation before. At some point during this period, almost everyone in the country was required to ask for permission to leave the house, were told what hours they could go out, and what time they needed to be back home. These restrictions weren't new to refugees and migrants who have always been barred from moving freely in this country either because of unlawful curfew restrictions set within municipalities (in the case of refugees) or by employers who monopolize the movement of domestic workers employed under their care.

Not having the freedom to move from place to place whenever we please means that we are limited to resources, activities, and services that are in our immediate vicinity. Sexual and reproductive healthcare, which is already difficult to access, becomes inaccessible for migrants and refugees who need to travel long distances to access the medical support they need. A large concern for migrant workers calling the hotline is how they plan to get out of their "homes" for their doctor appointments and if they will be able to afford the travel expenses to and from the clinic. These conditions create an environment where abuse, violence, and sexual harassment occur without consequences. This was the experience of a domestic worker who called the hotline to voice that she was thrown out of the house she worked and lived in after having been raped by her employer. After being brought to safety, she learned that she was pregnant and was in immediate need to terminate the pregnancy. It is possible that this woman would have remained trapped in her employer/rapist's home had he not thrown her out. Nonetheless, being out on the streets made her vulnerable to other dangers, especially with no legal support or security, no network, and no money. Thus, the value of mobility goes beyond choosing when we go out and where; it is a requisite for us to be able to safely and immediately remove ourselves from harm›s way and seek shelter.

security in friendships

Leaving loved ones behind is a component of fleeing or migrating to a new place. Being separated from our partners, children, parents, etc., leaves us lacking the support systems we've relied on and needed in the absence of systemic support. This is why the value of friendship is twofold when we are far away from our families – because these relationships do not only serve as friendships but are in themselves equivalent to family. Many callers articulated relying on their friends for advice on topics like relationships or living conditions and depending on their friend's company during/after doctor appointments. Women undergoing medical abortions have regularly shared that they are being looked after by their friends who assist them through the physical and emotional labor of the process. Oftentimes, these friends are in similar situations where they have left their families behind too, and therefore share the need for solidarity and support between each other.

However, not all callers are open to sharing details about their support system in Lebanon. This is because some people may not be able to tell their friends here about their sexual experiences or about being violated for fear that news would reach home and they will be shamed when they return to their countries. Answering the question of whether one has a support system or not can be a very difficult question to answer, especially for people who are estranged from their families, limited to how often they can speak to them, or denied permission by their employers to contact their family abroad. Being purposefully disconnected from family impacts the new connections we make but also influences the level of gratitude we feel towards common gestures of kindness. The support received on the hotline – whether it be the information or resources received or just the sense that there is someone to talk to – is provided with the consideration that callers are disconnected from family and friends. During these

Is it caller solidarity or a language barrier?

Calls made by people on behalf of their friends are interesting to unpack. The authenticity of the caller's intentions is always assessed with questions like: *why didn't the concerned individual make the call themselves? Is the caller speaking with the consent of their friend/partner/family member? How possible is it that this caller is making decisions on behalf of the person concerned?* These questions do not change when calls are made on behalf of migrants and refugees, however it is taken into consideration that sometimes language barriers play a role in the reason why non-Lebanese people do not contact the hotline themselves.

Earlier in this section, we had reviewed a story of a Bangladeshi couple dealing with a wanted pregnancy and financial concerns. The caller's partner could not speak English or Arabic and so depended on her partner to make the call and represent her interests. On the one hand, deep solidarity and trust are exhibited when a friend or family member calls on behalf of their loved one. On the other hand, this makes the conversation a little tricky because, until we have a translator with us, we are forced to rely on the person making the call and trust they are in solidarity with the person they are calling on behalf of and not just taking advantage of the situation to enforce their agenda. Not having a translator available makes it necessary for the concerned individual to depend on the help of a trusted friend or family member to access the information or resources they need. For people who lack a trusted support system, the option to have a friend call on one's behalf is simply not an option at all.

calls, people are often overly grateful for the conversations they have on the hotline by repeating words of thanks and emphasizing the impact the call has had on them. While it is great to receive thanks and to reaffirm the hotline is serving its purpose, such expressions of gratitude speak on the value of solidarity in the absence of it and how the lack of family or friends impacts how deserving we feel of common gestures of kindness. If these callers had access to the support system of their choice, their appreciation for the hotline, or any other helpful resource for that matter, would be complementary to the care and assistance they receive at home.

securing my health

Sexual and reproductive healthcare, and general healthcare for that matter, are often offered to migrants and refugees via NGOs who specifically tailor their services for people excluded from the support of Lebanese institutions. Nonetheless, such care offered to migrants and refugees fails to meet many of their needs as the programs are subject to the NGOs' funding, objectives, and personal interests. This situation applies to one specific caller who contacted the hotline looking for a referral for a clinic that could provide her with a general check-up. The caller, who is a 50-year-old Sri Lankan woman, articulated feeling pain when urinating and other general issues that she wanted to have checked by a medical practitioner. The age of this woman is important to reassert the point that NGOs working in sexual and reproductive health cater to servicing women of reproductive age and even then, mostly advocate for/offer contraception with the intention of limiting pregnancies. Although this caller is a migrant in need of medical support, her age renders her a non-priority for many NGOs working in sexual and reproductive healthcare. Medical patriarchy is evident in the priorities of humanitarian aid and the services they offer; women above the age of reproductivity lose their value, and their pains and complaints are belittled and ignored (as is the case of medicine for all women). ■

How are issues relating to Land linked to the reproductive justice framework?

Non-citizens living in Lebanon suffer from invasive and intentional disconnect from resources, security, and support. Reproductive justice in the context of Land means being critical of how we are connected to the country we are in, and how our well-being, access, and opportunities are shaped by that environment. This not only means measuring our sense of belonging via citizenship, freedom of mobility, or access to healthcare but also reflecting on how we live in harmony with nature and our surroundings. Often it is low-income people, migrants, and refugees who are forced to live in overpopulated urban spaces and refugee camps that have polluted water, are littered with garbage issues, and are usually located near incinerators or landfills. Care for such areas is often ignored, and blame on the deteriorating living conditions is placed on the people living there rather than the systemic violence and purposeful neglect that impoverishes these communities. Policies that ignore the rise of pollution or fail to address poor infrastructure and crowded living conditions threaten both our mental and physical well-being as well as the sustainability of the land we live on. Under a reproductive justice lens, living in an environment that is spacious, clean, and safe is directly linked to our health, comfort, and our ability to bear children if we choose to and raise them in a healthy environment.

CLINIC
WE WANT ACCESS

Is it too much to ask for some quality sexual and reproductive healthcare?

No, it's not.

But then again, it is a challenge to access the sexual and reproductive healthcare and support needed to feel well cared for in Lebanon. To unpack this reality, this section draws on stories shared by hotline callers that reveal experiences of mistreatment during clinic visits.

Dr. "Types"

We've all had our share of unique experiences at the doctor's office – some we wish never happened, some so brief we barely remember being there, and some, dare I say, surprisingly pleasant. A patient's level of comfort during clinical visits is often an immediate result of the doctor's ability to make their patients feel heard, calm, safe, and informed. Unfortunately, hotline discussions regarding clinic visits show that doctors fail to make their patients feel at ease and often approach their patients with an attitude of unquestionable authority that leaves them regretting booking the appointment in the first place. On the other hand, some doctors this year have taken the initiative to call the hotline themselves in search of resources and further information on topics they lack knowledge in, hoping that they can be better prepared to support their concerned patients with relevant information. Based on callers' descriptions, we have identified four types of doctors notorious for bad patient care:

The daddy Dr.

This doctor uses patronizing language and gaslighting to reaffirm their position of power over you as a patient - interrupting you when sharing the details of your health concern(s) because they believe their knowledge precedes your worry, condescendingly dismissing your unease as an overreaction or non-issue, or even limiting your care options as they believe they know what's best for you. One specific caller revealed her doctor's insensitivity when she contacted him to follow up on prescribed medication. As she told him of her extreme reaction to the side effects of the medication, he interrupted her saying she was overreacting and there were no alternative options. Unfortunately, such doctors have a talent for silencing their patients, cornering them away from feelings of agency during their appointment. Daddy Doctors can also be patronizing by shaming you out of talking about

topics considered taboo. Callers have shared that discussions with their doctors about contraception and STIs are regularly brushed off, emphasizing abstinence as the solution. In reality, these callers are looking to learn about what contraception options are available to them, what side effects to expect, or how STIs are contracted, tested, and treated. Patients are often left feeling embarrassed, ashamed, and frustrated when the answer to their many questions is reduced to abstinence.

> "She was very inquisitive and shocked as to why doctors would purposely give wrong information, and we had a light and sarcastic conversation about that."
> - *Counselor's feedback*

The Lollar-Dollar Dr.

This doctor prioritizes making money and often abuses their patient's trust and lack of medical knowledge to exploit them. Many callers contact the hotline in hopes of finding affordable clinics that come vetted and highly recommended while others ask about available financial support to help them pay for medical services and prescriptions they need. These requests are often coupled with stories about doctors who have overcharged them for services such as IUD insertions and hymenoplasty surgeries, or doctors who, for their own financial benefit, prescribed patients unnecessary and costly treatments. One caller shared that she was compelled by her doctor to take an expensive shot that would allegedly protect her future pregnancies, despite repeatedly telling him that she had no interest in ever conceiving children. There are also callers who contact their doctors in hopes of getting medical abortions (which require a doctor's prescription) but instead get intimidated into a likely unnecessary and more financially profitable surgical abortion. Then, there are other doctors that request payments before treatment even begins – completely dehumanizing the experience of visiting the doctor before it has even started. Realistically, when doctors place the value of an appointment on the dollar above the patient, they are making it very clear where their interests lie. Unfortunately, it isn't always immediately clear to the patient that the Lollar-Dollar Doctor is just money hungry.

> It is every patient's right to refuse treatment, even if it is allegedly beneficial to them, and it cannot be assumed that considerations taken for the future are more important than current financial considerations.

The Orthodox Dr.

Orthodox doctors often give recommendations based on what serves social norms rather than what best attends to their patient. Topics of sexuality that challenge normative values (e.g., homosexuality, premarital sex, non-procreative sex, self-pleasure, sex with more than one person, etc.) continue to be stigmatized topics at an Orthodox Doctor's office – and when they are discussed, they are discussed to the moral satisfaction of the doctor. For example, callers have shared stories of doctors discouraging them from seeking abortions by arguing for the "soul" of the fetus and overtly stating that abortion is a crime. On a related note, one caller expressed her specific discomfort and complete lack of trust for doctors after having received an unwanted surgery that the doctor claimed would make her a "virgin, again." Orthodox doctors tend to run their clinic in service of patriarchal standards of sexual and reproductive health. This often means enforcing conservative opinions disguised as medical advice that shape the course of their patients' future sexual and medical experiences.

The Missing-in-Action Dr.

Following up with a previous appointment is literally impossible when the doctor is nowhere to be found. Even with all the contact information available online or directly given to us before/after an appointment, it can still be impossible to get in touch with our doctors. No matter what approach we try, we may still find that doctors are unresponsive to emails, WhatsApp messages, and/or phone calls. MIA Doctors are an issue for patients at any stage of their doctors' visit – whether it's when trying to set an appointment, or when trying to receive their examination results or to book a follow-up appointment. MIA doctors are especially problematic for patients who are depending on their doctors for treatment(s) or for those who need to be monitored regularly. One caller explained that she had been trying to reach her doctor after she was originally prescribed an antibiotic that was intended to treat her ureaplasma infection. Instead of doing its prescribed job, the antibiotic altered her symptoms, leaving her in a constant state of physical discomfort and in dire need of a follow-up with her doctor who was impossible to reach. Cases like this demonstrate how a doctor's job and responsibility towards us does not simply end when we leave the clinic with a prescription.

The COVID19 pandemic has complicated the availability of STI tests and contraception in Lebanon. STI testing became unavailable during various periods of the lockdown, leaving people waiting with their symptoms and anxieties until the reopening of clinics. Contraception, on the other hand, became unavailable due to a decrease in imports within the year, as well as a steady increase in their price due to the economic collapse in the country. Callers mention the dysfunctionality of the country as a key reason for the unavailability of these services and resources noting that it is not the pandemic's fault for these privations, but rather, the government and medical sector's inability to operate under duress that has caused these shortages. In reality, access to STI testing and contraception has always been limited even prior to the pandemic and economic crisis (you can find detailed accounts of issues of access documented in The A Project's previous reports). What makes the issue an even larger problem now is that amid all the other crises facing Lebanon, securing sexual and reproductive health provisions falls last on patriarchy's list of things to care about.

How are issues relating to the clinic linked to the reproductive justice framework?

The Clinic is a layered place that acts as a checkpoint for patriarchal standards of normativity. This is one of the (many) places that support the state's role in excluding/demonizing/punishing unmarried sexually active people, unmarried pregnant women, trans and gender nonconforming people, migrants, and refugees. Reproductive justice in the context of the Clinic is not only about access to quality and affordable reproductive and sexual health care and support; rather, it is about the political undertones and power dynamics that exist within the creation and implementation of the Clinic. All doctors who – intentionally or not – remove us from deciding how to care for our bodies are only endorsing practices of medical patriarchy, which ultimately offers us no quality service at all.

Callers' stories have made it clear that clinics, hospitals, pharmacies, and all other medical institutions serve medical patriarchy. Medical patriarchy is tangibly represented and protected by doctors, who are also charged with being the eyes and ears of the state. This means that their willingness to care for us is dependent on how well that care aligns with patriarchal values; since many of us require care that conflicts with these normative standards, we find ourselves lacking the medical support we need. For example, this reality is of immediate concern to women seeking abortions. Regardless of marital status, abortions are deemed legally restricted in Lebanon unless keeping the pregnancy threatens the pregnant person's life. Being unmarried with an unwanted pregnancy further complicates a person's ability to secure safe and affordable abortions. Such a law makes a woman's health, security, and choices secondary to state interests. To escape the legal consequences of terminating pregnancies, women are forced to navigate various obstacles to secure the closest version of wellbeing they can reach. Most callers with unwanted pregnancies identify their largest obstacle to be anonymity and secrecy, articulating that their biggest fear is being found out by their families, communities, and doctors.

On abortion:
contextualizing inherited colonial laws

There are details within Lebanese law that criminalize anyone who assists a woman in aborting. This level of detail is not an invention of Lebanese lawmakers but rather a characteristic of outdated French laws that have not been updated since the colonial era. While France itself has advanced and amended their laws on abortion, making them free and legal on demand for up to 12 weeks after conception, Lebanon remains stuck with archaic French laws.

Callers in pursuit of medical abortions share they find small relief in knowing that the symptoms and remnants of a medical abortion are the same as a miscarriage, allowing them to escape any unnecessary conversations with their doctors. Criminalizing abortion and placing barriers on women's access to medical support impedes on their bodily autonomy, limits their ability to safe choices, and forces them into fear and insecurity during a situation that is already difficult enough without the added strain of state-imposed restrictions. We are drawing on the case of abortion as an example, but this isn't the only case where our medical needs and concerns are disregarded and left unaddressed, nor is it the only case where medical patriarchy imposes on our bodily autonomy. The stories collected on the hotline this year have offered us a peek at doctors and clinics notorious for bad patient care, and while we have gathered enough stories to create a prototype list of doctor-types to be wary of, it must be said that there are plenty more versions of shitty doctors out there.

REFLECTIONS

Reflecting on hotline calls is an integral part to learning how to improve this service for future and returning callers. Callers are given the opportunity to evaluate their experience with the hotline via an online survey form that asks them to reflect on the pace of the conversation, if there were any connectivity issues, if their main concern was tackled, whether they found the counselor to be knowledgeable and comfortable to speak to, and if they received a referral that was useful or not useful to them. This information helps us understand how effective we've been in supporting callers and if there is something more that we need to do or that is lacking in our current approach.

Hotline counselors are also required to leave their feedback and self-evaluate their counseling method so that we can understand from all angles how and where we need to improve. The process of self-reflection is vital to allowing us to serve callers while making sure counselors are also being supported in their role.

Feedback from callers
The data on the next page has been collected from the online evaluation form. In 2020, a total of 134 evaluation forms were filled and submitted.

Was your main concern tackled in the conversation?

103	7	0	24
yes	kind of	no	did not respond to the question

Were you satisfied with the conversation?

86	24	2
very satisfied	satisfied	neutral

1	21
dissatisfied	did not respond to the question

Did you feel the counselor was knowledgeable about the topic?

102	1	10	21
yes	kind of	no	did not respondto the question

Did the counselor ask any questions, or make any statements that made you feel uncomfortable?

4	92	38
yes	no	did not respond to the question

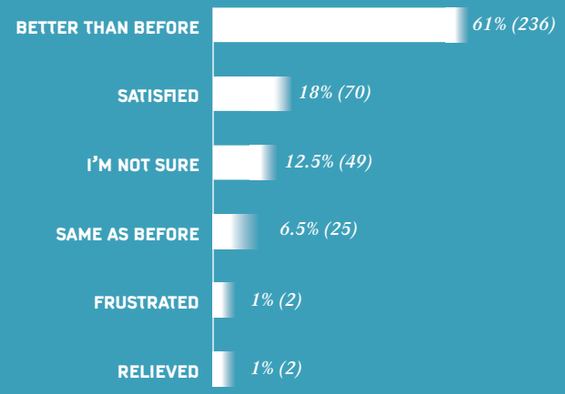
How would you rate the hotline after all?

67	30	8
excellent	very good	good

2	27
fair	did not respond to the question

How do you think the caller felt after talking to you?

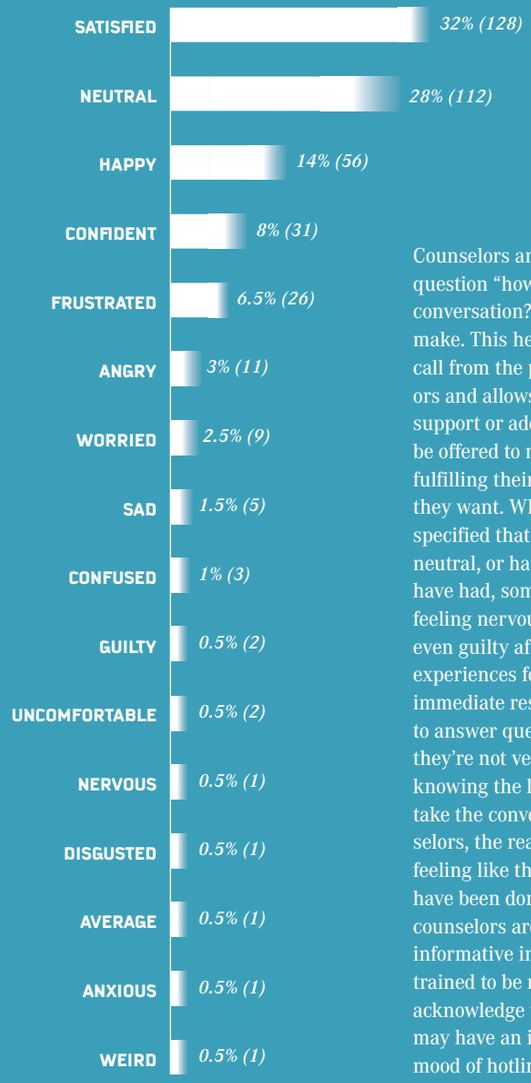
On the flip side, counselors are asked to share their opinions on how they think the caller felt after reaching out to the hotline. These opinions are solely based on the counselor's intuition and perception of how well the call went overall. A total of 384 responses from counselors reflect on how they think callers felt after their conversation:



If you have contacted the hotline and not yet filled an evaluation, here is your chance! Go to https://theaproject.org/sexuality-hotline/evaluation and let us know how we did!

COUNSELOR'S POST-CALL FEELINGS

***390** out of **406** responses recorded hotline counselors' feelings after conversations with callers*



Counselors are asked to respond to the question "how did you feel after the conversation?" after every call they make. This helps clarify the mood of the call from the perspective of the counselors and allows us to see if there is any support or additional training that can be offered to make sure counselors are fulfilling their role and having the impact they want. While most counselors (74%) specified that they feel either satisfied, neutral, or happy with the calls they have had, some counselors (1.5%) report feeling nervous, uncomfortable, and even guilty after hotline calls. Negative experiences for counselors are often an immediate result of feeling unprepared to answer questions on certain topics they're not very familiar with or not knowing the limits of how far they can take the conversation. For some counselors, the reaction of guilt comes with feeling like there was more that could have been done or said. While hotline counselors are trained to be practical and informative in their support, they are not trained to be robotic or unfeeling, and we acknowledge that the mood of the call may have an immediate impact on the mood of hotline counselors too.

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.

OUR WORK AND COMMUNITY ENGAGEMENT

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.

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

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

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 •

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!

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 judgment.

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.

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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THE A PROJECT
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