

BETWEEN SILENCE AND SOLIDARITY:

A Feminist Participatory Action
Research on Young Women's SRHR
Knowledge, Bodies and Relationships
in North Lebanon and the Bekaa

September 2026

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Canada



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OXFAM

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ABSTRACT

This report documents the findings and analyses from a Feminist Participatory Action Research (FPAR) project conducted with a collective of twelve researchers (ten community co-researchers and two lead researchers and accompaniers) between September 2025 and July 2026, commissioned by Oxfam in Lebanon under the Power to Choose project, and funded by Global Affairs Canada. Engaging 59 women from North Lebanon and the Bekaa, aged 18 to 35, through participatory group discussions, storytelling circles, and body-mapping sessions, the research explores how restricted and unjust access to sexual and reproductive health and rights (SRHR) knowledge shapes young women's relationships with their bodies, their self-perceptions, and their intimate relationships and decision-making.

Four interconnected findings emerged from the research. First, SRHR knowledge-seeking among young women is shaped by pervasive silence, stigma, and a fragmented ecosystem of sources, where women navigate structural and material barriers to construct hybrid and often precarious pathways to knowledge. Second, patriarchal control manifests as an everyday social practice, regulating women's bodies, mobility, and decisions, while normalising multiple interconnected forms of gender-based violence (GBV) across the life cycle. Third, consent, pleasure, and bodily autonomy are experienced unevenly and negotiated continuously within systems of unequal power, with many women entering intimacy without the language, knowledge, or social permission to name their needs and preferences, or recognise violations. Fourth, collective knowledge production functions as feminist resistance: through storytelling, sharing experiences, and collective reflection, women actively disrupt cycles of silence and isolation, reconstruct meaning around their bodies and relationships, and begin to reclaim epistemic authority over their lives. The report concludes with a set of recommendations and priority areas addressed to healthcare stakeholders, policymakers, community actors, educators, researchers, and donors, focused on the need for coordinated structural transformation that places women's lived experiences, bodily autonomy, and collective power at its centre.

ACRONYMS

CEFM	Child, Early and Forced Marriage
CERD	Center for Educational Research and Development
FPAR	Feminist Participatory Action Research
GAC	Global Affairs Canada
INGOS	International Non-Governmental Organisations
PCOS	Polycystic Ovary Syndrome
PMOS	Polyendocrine Metabolic Ovarian Syndrome
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations
WHO	World Health Organisation

ACKNOWLEDGEMENTS



12
RESEARCHERS



59
WOMEN ENGAGED



4
FINDINGS



**SEPTEMBER 2025
TO JULY 2026**



**NORTH LEBANON
AND THE BEKAA**

This research would not have been possible without the trust and courage of the women who shared their stories, experiences, reflections and time with us. We are deeply grateful to each participant who shared their deeply personal, and sometimes painful, experiences, and who collectively shaped this process with honesty, care and critical insight. We hope this report honours the knowledge and stories they entrusted to us and contributes, in however small a way, to advancing their demands, rights and aspirations.

We also wish to acknowledge the ten co-researchers whose commitment, care and feminist practice made this work possible. Their labour, reflexivity, facilitation and relationship-building were not merely supportive of the research process, but central to the production and interpretation of knowledge itself.

Finally, we extend our gratitude to Oxfam in Lebanon, and particularly Amany Zibar, for providing not only the resources to undertake this work, but also the trust, flexibility and space to design the process iteratively, experiment with different approaches, and remain responsive to participants and context throughout.



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EXECUTIVE SUMMARY

As women navigating a patriarchal world, our relationships with our bodies are often complex and nuanced. They are intimate and personal, but also contested and scrutinised. They are not only formed through biology and healthcare systems, but also through the social, institutional and political conditions that determine what we are allowed to know, feel and express. For some of us, this relationship can feel grounding and liberating, for others, it can be alienating and challenging, for others yet, it can seem distant or ambiguous. What is certain is that throughout our life cycles, our relationships with our bodies fluctuate. Importantly, they are shaped by systems of power that structure and regulate SRHR, including whose experiences are recognised, and whose are silenced or dismissed. In Lebanon, these dynamics are situated within a broader context of economic collapse, political instability, ongoing war and displacement, and the long-standing fragility of public healthcare and social protection systems. Within this context, access to non-stigmatising,

quality and inclusive SRH services remains uneven across intersecting axes of inequality, including gender, age, class, nationality, and disability. Questions of sexuality, consent, and bodily autonomy are also heavily stigmatised contributing to fragmented access to both services and knowledge.

In response to the urgency of those issues, we, a team of 12 researchers (10 community co-researchers and 2 lead researchers and accompaniers) embarked on a Feminist Participatory Action Research (FPAR) journey, which unfolded between September 2025 and July 2026, and the findings of which will be used in upcoming influencing actions until the Fall of 2026. This report documents the findings and analyses from over nine months of work, commissioned by Oxfam's Global Affairs Canada-funded Power to Choose Project.

RESEARCH QUESTION:

HOW DOES RESTRICTED AND UNJUST ACCESS TO SRHR KNOWLEDGE SHAPE YOUNG WOMEN'S DECISION-MAKING AROUND THEIR RELATIONSHIPS AND THEIR BODIES?



OUR FEMINIST PARTICIPATORY ACTION RESEARCH JOURNEY

Eight phases: iterative, collective and grounded in feminist methodology



ROOTED IN OUR FEMINIST METHODOLOGY



FEMINIST PAR

Power-aware, collective, action-oriented inquiry, rooted in lived experiences



POSITIONALITY

Awareness and continuous reflection of our power, privilege, assumptions and diverse experiences



REFLEXIVITY

Personal Research Journals· Structured moments for collective reflection· Informal exchanges



PARTICIPATORY ENGAGEMENT

Co-researchers shape every phase of the work· Participants engaged through participatory methods



TRANSFORMATIVE & RELATIONAL

Women and OUR lived experiences at the center· Reinforced feminist commitments for change

KEY FINDINGS



KEY FINDING 1

SRHR Information-Seeking in Contexts of Stigma, Secrecy, and Silence

- Women's access to SRHR knowledge in Lebanon is shaped by a **social production of silence** around **bodies and sexuality**, where information is rarely openly available.
- Women often seek information in moments of crisis, change, or after an "incident".
- Knowledge-seeking is discreet, shaped by fear and stigma.
- inherited myths, pervasive mis- and disinformation and gaps in formal education and public discourse.
- In the absence of structured and reliable SRHR education, women face **intersecting material, social, and institutional barriers**.
 - » *Geographical distance to services, cost of care, lack of non-stigmatising and inclusive services and repeated experiences of dismissal by healthcare providers.*
 - » *Patriarchal social norms, gendered double standards, and broader systems that regulate what women can ask, know, or express about their bodies*
- Women develop **fragmented knowledge ecosystems**, assembling information from multiple and uneven sources rather than a single reliable pathway.

*Digital/Online
Sources (privacy
over reliability)*

*Friends, peers,
family (especially
mothers)*

*Healthcare providers
(reliable but not
always trusted)*

*Lived experience
& experimentation*

- Women actively navigate and negotiate these fragmented systems, exercising **situated agency** and continuously adapting strategies.



KEY FINDING 2

Negotiating Control: Surveillance, Gendered Violence, and Resistance

- Patriarchal control operates as an **everyday social practice**, embedded in family systems, communities, intimate relationships, institutions, and social norms, systematically limiting women's autonomy across both private and public spheres.

*Reproductive roles
& expectations of
marriage & motherhood*

*Strict expectations
of 'honour'
& 'modesty'*

*Beauty standards,
body shaming &
weight stigma*

*Entrenched norms
on virginity &
sexual behaviours*

- Within this broader system, **violence appears as ordinary** and continuous across women's lives and life cycles.
- All participants reported experiencing some form of violence**, whether within families, relationships, institutions, or social spaces.

*Child, early and
forced marriage*

*Patriarchal
protectionism*

*Coercion in intimate
relationships*

Domestic violence

- Violence also extended into institutional spaces, particularly healthcare, through reports of **medical misogyny and obstetric violence**.
- The lack of SRHR knowledge** itself intensifies vulnerability to violence, coercion, and harmful decisions.
- Despite these constraints, the findings reveal **everyday forms of feminist resistance and agency**

*Collective
knowledge-sharing &
consciousness-raising*

*Bold transgressions
of norms*

*Self-care
& personal expression*

*Mothers choosing
different paths for
their daughters*



Artwork: Suraya Al Abdallah



KEY FINDING 3

Uneven Autonomy: Navigating Consent, Pleasure, and Relationships

- Consent is rarely introduced as a conscious concept linked to bodily autonomy, but instead emerges gradually through lived experience, often through discomfort that is only later reinterpreted.
- Knowledge about intimacy and sexuality is frequently delayed until marriage, leaving many women without the language to recognise boundaries, express refusal, or name discomfort → consent becomes blurred in practice.
- Pleasure is largely absent from women's sexual and relational experiences. Sexuality is most often framed through fear, morality, reproduction, or reputation, while pleasure remains silenced or treated as taboo.
- At the same time, some women described gradual shifts through access to information, peer conversations, or supportive relationships. Pleasure is deeply political, shaped by systems that regulate sexuality, knowledge, and the body from early on.
- Within this broader context, autonomy emerges as relational, uneven, and continuously negotiated.
- Intimacy often involves constant negotiation between safety, expectation, and survival.
- Control is exercised through violence, but also regulation of mobility, behaviour, appearance, and decisions
- At the same time, women describe creating space for themselves within these constraints through adaptation, reflection, and different forms of resistance.



KEY FINDING 4

Knowledge as Resistance: Building Support, Challenging Norms, and Imagining Alternatives

- Our collective research spaces became much more than sites of data collection. For many women, they represented rare spaces where speaking about the body, sexuality, relationships, and intimate experiences felt possible without shame, dismissal, or judgement.
- As stories were shared, individual experiences became moments of collective recognition, where listening to others helped women remember, reinterpret, and articulate experiences they had previously carried alone.
- Storytelling itself became a cathartic form of feminist knowledge production, legitimising embodied experiences and transforming issues long treated as taboo into socially discussable realities.
- Through conversations, awareness sessions, storytelling, and shared experiences, participants continuously revisited inherited beliefs and reconstructed knowledge about their bodies, relationships, and rights.
- Learning is not simply about acquiring information, but about collectively making sense of experiences and reclaiming language around issues surrounded by fear and stigma. In this context, knowledge production emerges as a form of resistance.

CONCLUDING REFLECTIONS AND RECOMMENDATIONS

The stories shared throughout the research reveal that navigating SRHR knowledge ecosystems is fundamentally about power: who is able to access information, who is denied it, and how these inequalities shape women's relationships with their bodies, their intimate lives, and their ability to make informed decisions. Across our discussions, knowledge emerged not simply as the simple acquisition of information, but as a collective practice of care, survival, and everyday resistance. Women continuously seek, share, question, and reinterpret knowledge despite fragmented systems, institutional silence, and restrictive social norms. These experiences highlight the urgent need to move beyond fragmented awareness efforts and isolated interventions towards more holistic and coordinated approaches that recognise the interconnected nature of knowledge, services, institutions, and social norms.

Our collective reflections, and recommendations listed in the full report, point to the importance of strengthening rights-based and non-stigmatising health services grounded in informed consent, dignity, and accountability, while rebuilding trust between women and healthcare systems. They also reaffirm the need to institutionalise comprehensive and inclusive

sexuality education and create accessible and trustworthy information systems. Equally important is the need to invest in community-based feminist spaces that support collective learning, challenge harmful norms, and strengthen solidarity and social support networks. Achieving meaningful change also requires legal and policy reforms that place bodily autonomy, consent, and protection from violence at the centre, alongside partnerships that redistribute power towards feminist and community actors and recognise lived experience as a legitimate source of expertise. Finally, this research itself reaffirmed the value of feminist participatory approaches to knowledge production. By centring lived experience and collective reflection and analysis, the process demonstrated that women are not merely 'beneficiaries' of SRHR interventions or subjects of research, but knowledge-holders, co-analysts, and agents of change. Meaningful progress in SRHR therefore requires sustained, cross-sectoral and feminist responses that address the structural conditions producing silence, exclusion, and inequality, while investing in the knowledge, care, and collective spaces through which women already navigate, resist, and reimagine their realities.

I. INTRODUCTION





I ask my body what it wants, and I talk to it. I truly sometimes feel its answers and reactions. Sometimes I feel I know what it wants, and it also knows what I want. There is a special relationship between us.

As women, navigating a patriarchal world, our relationships with our bodies are often complex and nuanced. They are intimate and personal, but also contested and scrutinised. They are not only formed through biology and healthcare systems, but also through the social, institutional and political conditions that determine what we are allowed to know, feel and express about our bodies. For some of us, this relationship can feel grounding and liberating, for others, it can be alienating and challenging, for others yet, it can seem distant or ambiguous. What is certain is that throughout our life cycles, and as our bodies change and experience different things, our relationships with them fluctuate. What is also essential to recognise, is that these relationships do not emerge in a vacuum, nor are they the product of individual experiences. They are shaped by how our understanding and knowledge about our sexual and reproductive health and rights (SRHR) are constructed, by the systems of power that regulate what we are allowed to know or ask and how we must behave, and by the institutions and norms that determine whose experiences are recognised, and whose are rendered invisible or dismissed. In Lebanon, these dynamics are situated within a broader context of economic collapse, political instability, ongoing war, and the long-standing fragility of public healthcare and social protection systems.

In 2019, Lebanon's healthcare system did not suddenly "collapse". Rooted in a clientelist political economy built on privatization and systemic defunding and neglect of public institutions (Shallal et al., 2021), it operates through structural exclusion. While COVID-19 and the economic and political crises laid bare the extent of structural breakdown within Lebanon's healthcare system (Kreichati, 2020), the country

was already contending with a longstanding system of exclusions and neglect that has been pushed to its brink.

In practice, this rendered even the already limited and fragmented services less accessible, and accelerated the exodus of healthcare workers, the collapse of subsidies, and ultimately, deepened the pre-existing inequalities in access to care, particularly SRH services, which remain among the most underfunded and stigmatised areas of care (Aoun & Tajvar, 2024). The recent Israeli war has further militarised access to healthcare by destroying infrastructure and displacing communities, and when the state did not have a sufficiently comprehensive and inclusive national emergency plan ready to respond to the high volume of violence on Lebanon, war interrupted already scarce care pathways and essential services, making existing inequalities even more acute.

Our SRHR experiences emerge within these broader conditions, yet continue to be narrowly approached through limited institutional frameworks that reduce SRHR to reproductive health, and reproductive health itself to marriage and conception for "family-making" purposes, reinforcing patriarchal control over women's bodies in service of nationalist and capitalist agendas (Hagedorn & Bucholc, 2025). Even within the already scarce reproductive health services, our access to quality, non-stigmatising and inclusive SRH services remains severe constraints, particularly on the basis of race, gender, age, disability, nationality, and other identity markers. Within this patriarchal, exclusionary and clientelist context, questions of accessibility, bodily autonomy, sexuality, consent, and gendered violence remain heavily stigmatised, silenced, or morally weaponised.

In practice, this translates into many women growing up with limited and fragmented access to SRH services, as well as to the language and knowledge necessary to understand our own bodies and experiences. Despite the urgency of these realities, our lived experiences navigating SRHR in Lebanon often remain underrepresented. If approached, they would be framed through deeply depoliticised frameworks that separate bodily experiences from the institutions and structures shaping them. The most dominant research surrounding SRHR frequently reduces our realities, as women navigating these systems, into isolated, hyper-medicalised “issues” (Potvin, 2025) with limited mainstreaming across major healthcare institutions and dominant practices, or into awareness gaps approached through decontextualised awareness sessions that fail to account for the social, relational, emotional, and political dimensions of our SRHR experiences (Gianni et al., 2021). In doing so, embodied experiences are treated as merely anecdotal in knowledge production, narrowing the horizons on interpretations of the social and political knowledge that emerges from these experiences (Peterlini et al., 2026).

In addition, dominant systems of knowledge production continue to determine whose knowledge is considered legitimate and worthy of documentation, and consequently, whose experiences become the basis upon which further research and discourse is built on, and whose knowledge gets (intentionally) dismissed within institutional and academic spheres (Medina & Harding, 2025).

Knowledge surrounding SRHR is, therefore, 1. not neutral, and 2. political. It is produced through unjust epistemic structures that privilege institutionally sanctioned forms of expertise, while marginalising the different forms of knowledge that emerge from women’s everyday navigation of the body.

In this sense, feminist knowledge production aims to challenge the very conditions through which knowledge itself is disseminated and recognised as credible in the first place. Part of our feminist commitment in this work is producing this knowledge in Arabic ([hyperlink Arabic version here](#)), not solely as a matter of accessibility, but as an intentional act of reclaiming the right to produce knowledge from within: within our social, political, and emotional realities. Knowledge in this context dictates what can be expressed, and what can be collectively understood in the first place. And as we launched this project, we faced an immense challenge to find comprehensive and political resources on SRHR in Arabic, which ultimately affected the extent to which the co-researchers could comfortably, and equally, engage with literature on the topic. Thus, writing and producing knowledge from and within Arabic allowed space for different forms of social meaning that is often flattened within dominant and academic modes of knowledge production.

II. BACKGROUND

This report emerges from a Feminist Participatory Action Research (FPAR) project conducted with a group of young women co-researchers from North Lebanon and the Bekaa between September 2025 and July 2026. The FPAR project was commissioned by Oxfam in Lebanon, under the framework of the Power to Choose project, funded by Global Affairs Canada (GAC). Rooted in feminist methodologies, the project seeks to engage young women as community co-researchers as a challenge to dominant research frameworks by “redefining the participant’s role in producing the research” and relocating knowledge production beyond the exclusive realm of academia into a collective process of sense-making and action (Hassan, 2019). Led by a research team of 12 researchers - 10 co-researchers and 2 lead researchers and accompaniers of the process, this project explores how women navigate fragmented and unequal access to SRHR knowledge, and how this lack of comprehensive SRHR knowledge reflects on our relationships with our bodies and intimate relationships. The project was collectively designed to also acknowledge participants as active knowledge producers and co-researchers whose lived experiences and embodied knowledge constitute central/pivotal forms of analysis in themselves.



Artwork: Zaynab Nasereldine

III. POSITIONALITY, REFLEXIVITY AND RESEARCH EXPERIENCE



CYCLE MENSTRUEL

Les filles ont leurs premières règles entre 9 et 16 ans, avec une moyenne autour de 12 ans selon l'endroit. Cela marque aussi le début de la puberté, cela ne veut pas dire que la personne a atteint la maturité sexuelle.

Le cycle menstruel dure généralement entre 28 et 35 jours en moyenne, cette durée est considérée comme un cycle régulier. Cependant, certaines filles et femmes ont des cycles plus courts ou plus longs, appelés cycles irréguliers. Les nombreux facteurs influencent le cycle menstruel, comme la génétique, les déséquilibres hormonaux, le stress, le syndrome des ovaires polykystiques, les fibromes, l'endométriose, etc.

Le cycle menstruel se déroule dans le système reproducteur féminin, qui est responsable de la production de différentes hormones en plus de ses autres fonctions. Il est important de noter que le cycle se produit lorsqu'il n'y a pas de grossesse en cours dans l'utérus. Une femme peut vivre son dernier cycle menstruel pendant sa quarantaine ou cinquante, 12 mois sans règles marquent son entrée dans la ménopause.



Les Règles:
La période où nos saignements

Cycle Menstruel:

- 18-35 à jours selon la personne
- Divisé en 4 phases
- Commence avec les règles



ENTRETIEN DE VOS PRODUITS MENSTRUELS

- Les tampons et serviettes jetables peuvent être utilisés jusqu'à 6 heures avant d'être jetés.
- La coupe menstruelle peut être portée jusqu'à 8h avant d'être rincée à l'eau et réinsérée.
- Les culottes menstruelles peuvent être portées jusqu'à 12 heures.
- Vous pouvez nettoyer vos produits avec de l'eau froide et du savon non parfumé. Suspendez-les pour les faire sécher après lavage.
- La durée d'utilisation dépend de l'abondance ou de la légèreté de votre flux menstruel.

SYMPTÔMES DE MENSTRUATIONS

- Saignement vaginal
- Pertes vaginales
- Crampes utérines
- Sensibilité des seins
- Douleurs dans le bas du dos
- Changements/ sautes d'humeur
- Petits saignements spotting

LES VOS AÏELES EN HIVER ET EN SITUATION DE DÉPLACEMENT

Photo: Sama

From the very beginning of our collective research and capacity-strengthening process, we engaged with the concepts of *Positionality*, *Reflexivity* and *Situated Knowledges* as foundational to feminist research praxis. We examined the ways in which claims of neutrality and objectivity in research often leave researchers' biases unchecked, reinforcing power imbalances within knowledge production and wider oppressive structures. We discussed our rejection of the illusion of a neutral, objective observer. Instead, we committed to a continuously reflexive practice: naming, unpacking and challenging our own assumptions; reflecting on our lived experiences and diverse intersecting identities, and how those influence our understandings, observations and interpretations; but also reclaiming and re-valuing our knowledge and perspectives as situated and embodied, and core to richer and more grounded research (Haraway, 1988; Alcoff, 1988).

In this section, we reflect on the diverse social locations from where we ask, listen, observe and interpret. We acknowledge that all knowledge is partial and shaped by the experiences of those producing it. Crucially, our inquiry begins from our own lived experiences: our personal and collective interactions with patriarchal norms and practices, our diverse strategies for navigating and resisting oppressive structures and their impact on our bodily autonomy and freedoms. This starting point grounds our research in Standpoint Theory (Harding, 1991), which posits that beginning research from the lives of those at the margins provides a more robust account of social reality.

As such, our FPAR methodology is an intentional choice to move beyond the acknowledgement of our positionalities, towards actively using our situated knowledges as a tool for collective action and liberation. Rather than confining our analyses to theoretical conceptualisations, our feminist reflexive praxis reinforces our action-oriented approach. It allows us to bring real-life nuance and complexity to our analyses and to center the issues which matter to us and our communities. It enables us to critically examine the strategies we deploy while navigating a complex web of social control, and to collectively imagine actions addressing the deeply embedded structures that hold it in place.



We learned how to transform women's experiences and our own personal experiences into structured knowledge that can be used to advocate for rights and create change.

- Co-researcher reflection

We use our own feminist consciousness as a primary analytical resource. Ultimately, reflexivity in our project serves as a safeguard against the co-optation of our narratives and stories, and instead transforms the research process into a collaborative inquiry with and led by those most impacted.

A. OUR VOICE AS LEAD RESEARCHERS AND ACCOMPANIER

As a team of two feminist researchers, we set out on the important and complex journey of conceptualising this collective research, action and capacity-building process, with a deep awareness of the responsibility we carry. We continuously feel accountable, not only to Oxfam, who commissioned and entrusted us with this project, but also to the 10 co-researchers who we accompanied on this process, and to the women who participated in our discussion and storytelling spaces. As a result, we continuously examined and revisited our plans, approaches, and assumptions throughout the research process.

We start from the acknowledgement of the power we hold as experienced feminist researchers, as well as the privileges and opportunities afforded to us through our higher educational backgrounds, access to opportunities and broader social positioning. We particularly recognise the power embedded in our role within this process, as lead researchers and accompaniers. Throughout the project, we continuously sought to share our power and knowledge as much as possible

within the structural and material conditions within which we operate and engage, while designing an iterative and flexible process, guided by co-researchers' priorities, interests and preferences.

Additionally, we emphasise our own personal interest and political investment in the issues explored in this action research project, namely, the SRHR of young women in Lebanon. We consider ourselves directly impacted and concerned, and deeply connected to many of the realities explored in this report. However, we do not claim to speak for all women in Lebanon, nor do we claim universality of the findings in this report. As lead researchers, we each bring distinct identities, histories, backgrounds and relationships to the issues explored, informed by our lives in different geographical regions, communities and social upbringings within Lebanon. These differences inevitably shape how we understand, interpret, and engage with the research process and findings. At the same time, we view this diversity of experiences (amongst us two, but also our broader team of co-researchers) navigating patriarchal norms surrounding SRHR in the country as a key strength of the research, enabling a more nuanced engagement with the complexities, tensions, and diversity of women's lived realities.

B. OUR VOICE AS COMMUNITY YOUTH CO-RESEARCHERS

We are a team of 10 diverse community co-researchers, coming from two large geographical areas in Lebanon: North Lebanon and the Bekaa. What joins us is a shared passion for collective action and research, and a deep interest in feminist issues and SRHR in particular. Most of us came into this process with our social justice principles and experiences with activism and community initiatives. Some of us hold experience within academic and/or medical research spaces. However, many of us had never engaged in research processes as researchers in our own right before. Most importantly, it was our first time participating - or leading on! - a feminist research project. Even if the concepts were a novelty for all of us, engaging with the ideas of positionality and reflexivity did not feel unfamiliar or distant from our own values and

practice. Each of us holds feminist beliefs in the importance of collective action and care, and in working together towards a shared purpose of social and gender justice. We are also deeply invested in our own communities, each in her own way, and interested in documenting, sharing and reflecting on our experiences. Yet, the research process itself, and the feminist approaches and tools we learned about, adopted and tested, were instrumental in deepening our consciousness of why our personal and collective experiences are such a core starting point for our feminist struggle. It helped us deconstruct knowledge production processes, and in turn, gain a better understanding of how it is always richer, more grounded and more useful, when it draws on those experiences.



This research led me to rethink the very concept of knowledge itself. I came to realise that knowledge is not acquired solely from formal sources, but is collectively produced through relationships, lived experiences, and the shared narratives between women.

- Co-researcher reflection

We each brought her own social position into this experience, with interests grounded in our lived experiences. We recognise that our personal and collective interactions with different aspects of patriarchy and social norms in our diverse communities across Lebanon significantly shapes our interests in those issues, as they directly impact our daily lives and our futures. Even if we reside in two specific governorates, we emphasise that our positionalities are very diverse, and believe this to be a rich contribution to the research findings. We each come from or reside in a different town or city within those

governorates, ranging from Akkar to Tripoli, to Minieh in the North, and from Zahle to Baalbeck in the Bekaa. Some of us live in Beirut, or between Beirut and our hometowns in those governorates. Some of us are Syrian, though the majority, Lebanese. We are all young women, between 18 and 32 years old. We have different professional and educational backgrounds: we are students, pharmacists, physical therapists, psychologists, teachers and more. At our core, we are all feminists, and we are all women negotiating our positions and power within a deeply patriarchal world, resisting oppression and claiming our space, exercising our agency in small and large ways. It is from this standpoint that we have identified our collective research questions, designed our data collection tools, and engaged with diverse women in discussion and storytelling sessions. It is also why we have felt such deep connections with the women who participated in those sessions, as many of their stories resonated with our own experiences, or those of other women around us.



One thing I learned is to listen actively, much more than before. I became someone who truly builds on active listening. I came to see that actively listening to women's experiences opens the door to knowledge, because when women feel safe, they speak, and sharing these experiences builds knowledge. Knowledge is not based only on readings, books, or research - it is not only that.

- Co-researcher reflection

C. OUR REFLEXIVE PRACTICE

As discussed, reflexivity was a cornerstone of our collective process, throughout which we protected moments for reflection and built in flexibility to pause, examine and re-examine our assumptions, emotions, and power. We practiced reflexivity at both individual and collective levels and through multiple modalities.

At the beginning of the FPAR journey, each co-researcher was given a personal research journal with guiding prompts as an individual tool for reflection. These journals were used in different ways across the group: some co-researchers engaged with them consistently throughout each phase of the process, while others used them more selectively, when they felt the need to reflect on their research experience. Overall, they served as a space to critically examine emotions, assumptions, positionalities, and relationships to the research process and participants. They enabled ongoing self-reflection and, whenever co-researchers chose to share excerpts, collective learning. They also helped us remain attentive to power dynamics, ethical tensions, moments of resistance or challenge, and the ways our lived experiences shaped the research.

In each of our in-person workshops, as well as during our weekly online meetings and sessions across analysis, validation and writing phases, we also dedicated time for facilitated and guided moments of reflection. These included exercises centred on introspection, positionality, and relational dynamics within the group, as well as our evolving experiences throughout the research process. These moments created space for us to critically engage with our research, while also strengthening trust, accountability, and collective learning within the group. In addition to these structured spaces, we maintained ongoing ad hoc check-ins and informal conversations, including bilateral phone calls and exchanges through our WhatsApp group chat, which allowed us to address emerging questions, tensions, and reflections in real time and sustain dialogue throughout the process.

Finally, as lead researchers and companions, we made sure to maintain an ongoing reflexive practice throughout the process, continuously engaging with our own positionalities, assumptions, and

emotional responses, and explicitly discussing them and unpacking them as needed. We also held responsibility for ensuring the methodological, theoretical and ethical coherence of the process, while remaining attentive to group dynamics, care needs, and power relations, and adapting facilitation accordingly to support a safe and inclusive - and also fun and enjoyable! - collective space.

D. OUR COLLECTIVE RESEARCH EXPERIENCE



The research experience was a safe space for learning and expression, where our voices and experiences were transformed into knowledge with value and impact. It was a journey of discovering both reality and ourselves at the same time.

- Co-researcher reflection

The research experience was, for all of us, a deeply relational, emotional, and transformative process that went far beyond a traditional knowledge production process. It was a collective journey in which trust, solidarity, and mutual care gradually developed among co-researchers, and with lead researchers/accompaniers, as well as with the Oxfam commissioning manager. In some cases, these relationships evolved into longer-term collaborations and friendships, beyond the scope of the project, including co-researchers meeting through the process and initiating their own collective initiatives rooted in shared feminist commitments.

Throughout the process, we experienced a wide range of emotions: from excitement to fear and frustrations, from moments of alignment to contradiction, from shared visions to diverging perspectives, as well as instances of resistance and challenge. What remained constant, and reflected both a personal commitment and deep-rooted feminist principles held by each and every

one of us, was our ability to consistently work through these challenges collectively, grounded in care, accountability, and dialogue. These moments also helped strengthen our ability to sit with difference, question assumptions, and remain committed to a shared ethical and political horizon, even when perspectives did not fully align.

More particularly, fears, uncertainties, concerns - and even resistance - were present at the beginning of the process, and emerged at different points throughout, especially during the design of research questions and data collection tools, around engaging with sensitive or taboo topics, group dynamics, navigating diverse perspectives or anticipating different forms of resistance. However, these shifted over time as trust deepened, collective grounding strengthened, and feminist facilitation practices created a sense of safety and shared ownership. As co-researchers, we were especially struck by how trusting participants were during sessions and how generous they were in sharing their stories with us. We were struck by the openness with which sensitive topics were openly discussed, and the complex mix of emotions that emerged across our sessions and interactions with women: at once inspiring, heavy, frustrating and encouraging. Overall, the process emphasised how research spaces can help surface broader social tensions, including stigma, judgement, and expectations placed on women's bodies and behaviours, which in turn shaped both personal reflections and collective analysis.



I came to understand a different kind of pain, one I had not experienced personally, but that reached me through the women's stories and affected me deeply. It changed the way I see things and made me more aware of, and sensitive to, the experiences of others.

- Co-researcher reflection

A defining feature of the research experience was the depth of intimacy that emerged within the spaces we created, both our internal spaces as researchers and the storytelling and discussion sessions with different groups of women. Many of us describe feeling directly connected to, and emotionally affected by, the stories shared by participants and fellow co-researchers. These encounters often blurred the boundary between “researcher” and “participant,” as lived experiences resonated closely with our own realities, and as we ourselves were sharing our personal stories with the other women involved.



I would describe my experience as a very profound one, unlike any other. Although I have been active with many groups, with feminist groups and in diverse collectives, this experience was definitely the deepest among them. It made me reconsider myself, my surroundings, and women's experiences, perhaps with a stronger desire for change and with a clearer sense of purpose.

- Co-researcher reflection

As such, the research sessions themselves emerged not only as spaces for generating data, but also for healing, reflection, and connection. Finally, the impact of this work extended beyond the duration of the project. For all of us, it had incredible influence over our future aspirations and work, and strengthened our feminist commitments. Overall, it was a deeply formative process of collective learning, relationship-building, and ongoing transformation, both of knowledge and of ourselves.

IV. METHODOLOGY



A. RESEARCH APPROACH: FEMINIST PARTICIPATORY ACTION RESEARCH (FPAR)

WHAT IS FPAR?

The core methodology we adopted for this research process is Feminist Participatory Action Research (FPAR), both as a research method and a process for social change. FPAR emerged from the intersections between feminist epistemologies and participatory action research practices, and is grounded in the understanding that knowledge is neither neutral nor produced in isolation from lived realities, power dynamics, and social structures (Bradbury, 2015). FPAR approaches research as a collective and relational process through which knowledge is produced collaboratively with those most impacted by the issues being studied. FPAR, thus, positions knowledge as situated, embodied, and most-importantly, co-created. It remains attentive to the unequal power dynamics that often shape research and knowledge production spaces themselves. Beyond the methodological dimension, FPAR is also rooted in a political commitment to challenging extractive forms of research and creating processes that strengthen possibilities for social transformation. While the findings emerging from this research are not presented as universal or exhaustive, they remain deeply indicative of broader lived realities and structural conditions shaping many women's experiences across Lebanon. Rather than weakening the significance of the findings, the situated and embodied nature of the knowledge produced through FPAR constitutes one of its central strengths. At its core, FPAR seeks to transform findings into collective action that can drive lasting social change. FPAR therefore understands research as a collective effort contributing to broader struggles around knowledge production and social justice.

BOX 1: WHAT IS SITUATED KNOWLEDGE? WHAT IS EMBODIED KNOWLEDGE?

The concepts of *situated* and *embodied knowledges* are deeply rooted in feminist epistemology and research methodologies. *Situated Knowledge* challenges the idea that knowledge is ever neutral or objective. Instead it emphasises that knowledge is always shaped by the social location and experiences of those producing it. Because all knowledge is partial, no one can claim a complete version of social reality. This makes dialogue with other situated perspectives an ethical and scientific necessity. *Embodied Knowledge* emerged as a challenge to the philosophical idea that the mind and the body are separate entities, arguing that our understanding of the world is intrinsically linked to how we experience it physically. In feminist theory, embodied knowledge is a political tool to dismantle the long history of male-centric universalised "truths" or knowledges. By reclaiming our bodies, and more particularly, marginalised bodies, as a legitimate and essential source of knowledge and expertise, feminist research values and validates experiences that traditional institutions have traditionally ignored.

Foundational Texts in Feminist Epistemology:

- Haraway, D. (1988). *Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective*. *Feminist Studies*, 14(3), 575–599. <https://doi.org/10.2307/3178066>
- Alcoff, L. (1988). *Cultural Feminism versus Post-Structuralism: The Identity Crisis in Feminist Theory*. *Signs*, 13(3), 405–436. <http://www.jstor.org/stable/3174166>
- Harding, S. (1992). *RETHINKING STANDPOINT EPISTEMOLOGY: WHAT IS "STRONG OBJECTIVITY?"* *The Centennial Review*, 36(3), 437–470. <http://www.jstor.org/stable/23739232>
- Hartsock, N.C. (2019). *The Feminist Standpoint: Developing the Ground for a Specifically Feminist Historical Materialism. The Feminist Standpoint Revisited and Other Essays*.
- Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). Routledge. <https://doi.org/10.4324/9780203900055>

SITUATED ADAPTATION OF FPAR

This study draws on FPAR as both a methodological and political action-oriented framework, with a particular emphasis on its participatory dimension. Rather than positioning research participants as passive subjects of inquiry, we sought to create a collective research process grounded in shared knowledge production, reflexivity, and relational accountability.

The research was designed around the engagement of community researchers from the Bekaa and North Lebanon, who conducted the research within their own communities and social contexts. This situated approach recognised community researchers as knowledge producers whose lived experiences, relationships, and political understandings fundamentally shaped the research process itself.

Participation within this project extended beyond involvement in data collection. From the outset, the research process was collectively shaped through workshops and collaborative discussions in which researchers co-developed shared understandings of key concepts related to SRHR, feminist research, ethics, care, and participation. Researchers also collectively established decision-making and accountability mechanisms that guided the project throughout its different phases. As lead researchers and accompaniers, we strived to dedicate much attention to minimising rigid hierarchies within the research structure. As such, we collectively designated focal points to coordinate each phase of the research process, including data collection, analysis and writing. This approach distributed responsibility and accountability across the collective rather than centralizing authority within a single research hierarchy, or keeping it solely with the lead researchers.

The participatory approach also informed the practical and relational dimensions of the project. To ensure accessibility and meaningful participation among researchers from different educational, linguistic, and professional backgrounds, all workshops, training materials, and discussions, and communication were facilitated bilingually in Arabic and English. We also dedicated time and effort to discuss and

unpack complex research terms and concepts, using diverse terminologies, practical activities and discussion spaces to bring them closer to our realities. We deliberately chose terms and language that reflect our feminist politics, all the while ensuring familiarity and accessibility of discussions as needed and guided by the co-researchers and participants. We also relied on a robust and solid theoretical grounding, which framed our approaches and analyses every step of the way. Finally, each co-researcher signed a clear agreement with Oxfam, outlining their expected level of effort and commitments, for which stipends were offered as compensation for their time and labour.

Throughout the project, the research process incorporated regular moments of collective reflection, dialogue, and mutual support/feedback among researchers. Reflexivity was embedded as an ongoing methodological practice throughout the project, and that shaped the relational dimension of the research process.

During the data collection and analysis phases, researchers applied feminist participatory methods and facilitation practices themselves, in their engagement with women from their communities, emphasizing dialogue, care, flexibility, and relational knowledge production. Validation sessions were conducted with participants to collectively revisit, reflect on, and discuss emerging findings and interpretations. Throughout those sessions, participants also engaged in discussion and prioritisation of the recommendations listed at the end of this report. In this sense, we made intentional design and research choices at each step of the process and all levels to ensure all of those involved meaningfully contributed to the production of knowledge: from the community researchers, to the accompaniers, to the women who shared their stories, reflections, and experiences.

Finally, from the outset, the FPAR project was designed with the intention of supporting longer-term feminist organising and community-based action. As such, the discussion and data collection sessions themselves were turned into powerful spaces for collective exchange, experience sharing, learning and sensemaking. Additionally, the next phase in the project will include capacity-strengthening and strategising

with the group of co-researchers focused on feminist influencing, including in their own future advocacy, organising and professional work, along with ongoing accompaniment aimed at designing and implementing creative and targeted feminist influencing activities that build on findings and recommendations from the present report. In this sense, rather than being a closed exercise in documentation, our FPAR process is part of a broader continuum of feminist knowledge production, capacity strengthening, and collective political engagement and action.

B. RESEARCH DESIGN AND METHODS: A PHASED AND ITERATIVE PROCESS

This study adopted a qualitative feminist research design grounded in FPAR principles and informed by feminist understandings of knowledge, embodiment, and relationality. The research sought to explore how restricted and unjust access to SRHR knowledge shapes young women's relationships to their bodies, self-perceptions, decision-making processes, and intimate relationships in North Lebanon and the Bekaa. Prioritising feminist and qualitative methodologies allowed us to capture the deeply nuanced dimensions of diverse women's lived experiences in relation to SRHR.

The research process unfolded across multiple interconnected phases that combined collective learning, participatory research practices and social change-oriented reflections. While these phases are presented separately for clarity, the research itself unfolded iteratively rather than linearly, with ongoing movement between reflection, adaptation, and collective decision-making.

PHASE 0

PREPARATORY WORK AND PROJECT FORMATION

Prior to embarking on the implementation of the research process, we, as lead researchers and accompaniers, engaged in preparatory conceptual and methodological work grounded in feminist participatory methodologies and community-based knowledge production. This phase included conceptual framing of the project and the development of preliminary training

material based on a review of the existing feminist literature. During this phase, we also developed a flexible plan for the research and capacity-strengthening process, which would later be adapted, refined and redesigned in response to co-researchers' preferences and support needs, and in response to wider contextual factors.

Simultaneously, together with the Oxfam team who commissioned this work, we initiated the outreach, application, and selection process for the community co-researchers from North Lebanon and the Bekaa. The selection process sought to engage women already connected to their communities through forms of feminist, social, educational, or community work, and who could both take our findings forward in their own actions in the future, all the while remaining attentive to diversity in experiences, backgrounds, locations, and forms of engagement with SRHR issues. Rather than treating researchers as neutral facilitators external to the communities involved, the project intentionally sought to build a research collective composed of women whose lived experiences, relationships, and social locations shaped their understandings of the issues being explored.

Following a thorough review of the 29 applications we received, we identified our cohort of 10 diverse young women co-researchers, aged between 18 and 32. Co-researchers were invited to a short onboarding process, during which they confirmed their interest and received in-depth clarifications around the different elements of the process, including participation and accessibility facilitations and compensation.

PHASE 1

TRAINING AND CAPACITY STRENGTHENING

Following the formation of the research collective, the project moved into a training and capacity-strengthening phase, through a three-day workshop focused on feminist research and methodologies. Crucially, these sessions also focused on building a strong foundation of trust between the team members. Throughout the workshop, lead researchers and accompaniers facilitated a blend of theory and practice-based activities, focused on agreeing on common definitions of key feminist and SRHR-

related concepts, exploring feminist research methodologies, tools and ethics, and collective accountability. The workshops also created space for researchers to collectively reflect on their own relationships to SRHR knowledge, recognising that feminist participatory work cannot be separated from the positionalities and lived experiences of those conducting the research itself. Throughout this phase, emphasis was placed on building relationships of trust, collective reflection, and mutual support among researchers. Reflexivity was introduced as an ongoing practice accompanying the research process rather than a detached exercise conducted after data collection.

To ensure accessibility and meaningful participation among researchers from different educational, linguistic, and professional backgrounds, all workshops, discussions, materials, and communication processes were facilitated bilingually in Arabic and English. This formed part of a broader feminist commitment to accessibility and reducing barriers to participation within knowledge production spaces. We also dedicated time and effort to discuss and unpack complex research terms and concepts, using diverse terminologies, practical activities and discussion spaces to bring them closer to our realities. We deliberately chose terms and language that reflect our feminist politics, all the while ensuring familiarity and accessibility of discussions as needed and guided by the co-researchers and participants. We also relied on a robust and solid theoretical

grounding, which framed our approaches and analyses every step of the way.

PHASE 2

COLLECTIVE RESEARCH DESIGN AND CONCEPTUALISATION

The research design was intentionally flexible, open-ended, and adaptive. The project treated methodology itself as a collective and evolving process, as opposed to fixed tools applied uniformly across contexts. While the overall theme of SRHR for young women in Lebanon was clearly identified from the beginning, the research questions and areas of focus were conceptualised collectively, in a long - and at times frustrating! - process of co-creation. During this process, co-researchers engaged in literature reviews around their areas of interest linked to SRHR, and lead researchers facilitated discussions and exercises to identify priority areas of inquiry, gaps in knowledge, and to formulate research questions. This process was undoubtedly the most challenging, yet the most important, of the entire project. It involved negotiations amongst each other about priority areas of interest, and surfaced diverse fears, concerns and resistance around engaging externally, beyond the safety of our small research group, around issues that are often quite sensitive. Ultimately, we identified research questions that resonated with the group as a whole and made sure to pause and reflect on how best to approach diverse topics and support each other throughout the data collection phase.

RESEARCH QUESTION:

HOW DOES RESTRICTED AND UNJUST ACCESS TO SRHR KNOWLEDGE SHAPE YOUNG WOMEN'S (AGED 18-35, IN NORTH LEBANON AND THE BEKAA) INFORMED DECISION-MAKING AROUND THEIR RELATIONSHIPS AND THEIR BODIES?

SUB-QUESTIONS:

1. What does young women's access to SRHR knowledge and information look like?
 - a. *What type of knowledge do they look for?*
 - b. *What are their trusted sources of information?*
 - c. *What are the main barriers they face in accessing them?*
2. How does restricted and unjust access to SRHR knowledge shape women's relationships with their own bodies, self-perceptions and daily practices?
3. How does restricted access to SRHR knowledge and women's relationships with their bodies shape their intimate relationships?

While lead researchers introduced co-researchers to a range of feminist qualitative approaches, the final design of the data collection process, including the selection and adaptation of methods and activities, emerged collectively through multiple discussions, reflections, and exchanges among the community researchers, through a series of three research design and conceptualisation workshops.

Through these discussions, we identified participatory and thematic group discussions, storytelling, and body-mapping exercises as the primary methods to be used. The methodology was grounded in feminist understandings of co-produced knowledge, while also remaining attentive to the practical and emotional realities of conducting research on highly sensitive and socially regulated topics related to SRHR.

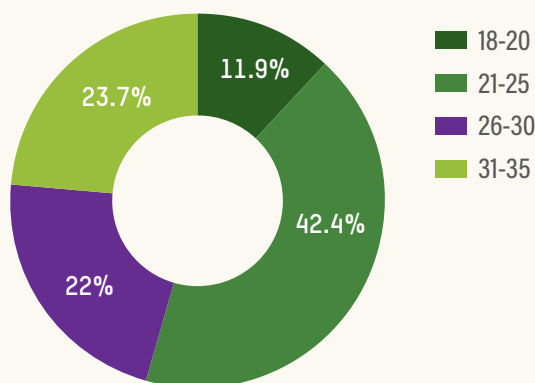
We also collectively explored diverse facilitation practices, and discussed ethical considerations, accountability mechanisms, and approaches to participation and care within the sessions.

PHASE 3

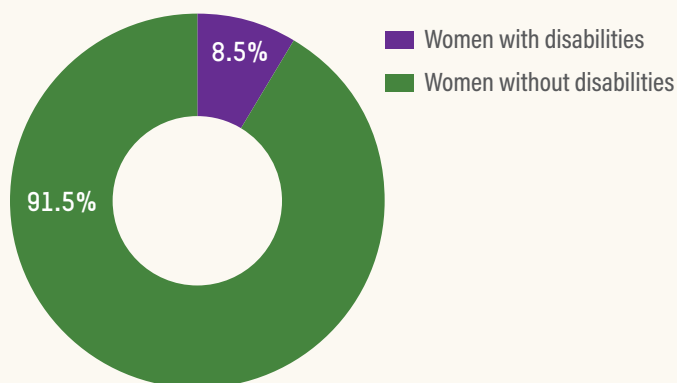
OUTREACH AND DATA COLLECTION

The study engaged a total of 59 women between the ages of 18 and 35 across North Lebanon and the Bekaa through a series of small-group participatory sessions, facilitated by the community co-researchers. Participants included Lebanese, Palestinian, and Syrian women with diverse lived experiences, including women living with disabilities, unmarried, divorced and married women and mothers (see graphs below).

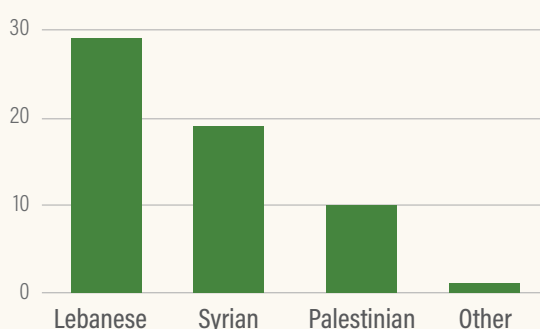
Graph 1: Participants by Age Group



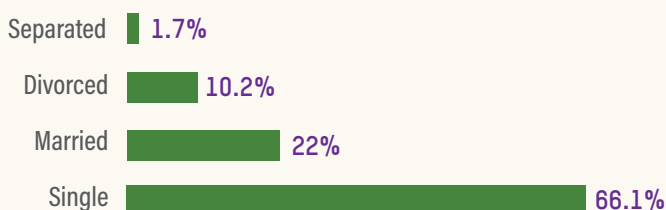
Graph 2: Participants by Disability



Graph 3: Participants by Nationality



Graph 4: Participants by Social Status



Participants were approached primarily through existing community networks, relationships of trust, and snowballing. These networks are rooted in the co-researchers' embeddedness in their communities as women already active in local development initiatives and/or feminist organising. They brought with them (into this research) those pre-existing relationships with women in their areas, as peers and/or participants in their initiatives. In some cases, co-researchers also invited women already involved in their initiatives to express their interest, either verbally, through WhatsApp, or through a brief online form.

We decided to organise participants into 10 smaller groups of 6, grounded in feminist emphasis on trust-building, and creating intimate and comfortable spaces in which women could speak openly about experiences often shaped by stigma, silence, and social regulation. The data collection process unfolded through three collective sessions with each group, as per the table below, including four groups in the Bekaa and six groups in North Lebanon. All sessions were conducted in Arabic.

Table 1: Data Collection Session Plans

SESSION	OBJECTIVES	ACTIVITIES
Session 1: INTRODUCTORY SESSION	• Get to know each other • Share information about the research process • Build trust • Confirm interest and commitment • Start the conversation on SRHR	• Introductions • Overview of our principles • Overview of the research process • Activity: How do you define your relationship to yourself and your body? • Activity: SRHR Myths vs. Facts
Session 2: ACCESS TO INFORMATION AND RELATIONSHIP WITH OUR BODIES	• Unpack questions related to our relationships with our bodies and our self-perceptions • Unpack questions related to access to information • Share instructions for the storytelling activity	• Facilitated Discussion: Access to SRHR information • Activity: Body Mapping • Facilitated Discussion: Relationship to our bodies, self-perceptions, and daily practices
Session 3: OUR INTIMATE RELATIONSHIPS	• Collect and reflect on stories and experiences about our intimate relationships • Make linkages and connections between access to information, our relationship to our bodies, and our intimate relationships	• Activity: Storytelling Circle • Facilitated Discussion: Patterns, similarities, differences • Facilitated Discussion: Linking access to information, our relationship to our bodies, and our intimate relationships

Discussions employed guided activities, storytelling practices and body-mapping exercises, allowing conversations, reflections, and emotional processes to build cumulatively across sessions¹. The first session focused primarily on building trust, collectively establishing principles of confidentiality and participation, and initiating conversations around women's relationships with their bodies and SRHR knowledge. The second session centered on body mapping, access to information, self-perception, and the embodied impacts of fragmented or restricted SRHR knowledge. The third session focused on storytelling and collective reflection around intimate relationships, embodiment, self-perception, and women's relationships to knowledge and care.

Sessions were facilitated using semi-structured guides that included thematic open-ended and probing questions, while allowing significant flexibility for conversations to evolve organically according to participants' priorities, emotions, and lived realities. Community researchers frequently adapted questions, pacing, activities, and facilitation approaches according to the dynamics emerging within each group. Discussions often moved beyond direct responses to research questions and became spaces where women collectively reflected on shared experiences, challenged normalised assumptions, and identified common patterns shaping their relationships with their bodies and access to knowledge.

Storytelling was incorporated as a feminist methodological practice that recognises lived experience and personal narrative as forms of collective and political knowledge. Participants were invited to share stories rooted in personal experiences, memories, observations, and reflections related to SRHR knowledge, embodiment, and intimate relationships. Women were encouraged to choose the forms through which they wished to express these stories, including speaking, writing, drawing, or other creative forms of expression.

Body mapping functioned as an embodied and participatory method through which participants could explore and reflect on their relationships with their bodies beyond purely verbal articulation. Through reflective prompts and visual representation, participants engaged with themes related to safety, shame, bodily autonomy, vulnerability, comfort, strength, and the impacts of restricted or fragmented access to SRHR knowledge.

Across all methods, women were approached as active co-producers of knowledge whose reflections shaped both the direction and meaning of the research process itself.

PHASE 4

COLLECTIVE DATA ANALYSIS

The data analysis process unfolded collectively and iteratively rather than through a strictly linear process. Rather than treating women's stories as isolated experiences to be coded and extracted, the analysis sought to understand how meaning was collectively produced through women's relationships to their bodies, communities, intimate lives, and conditions of access to information, as well as how the research spaces themselves contributed to collective sensemaking and experience sharing.

In the first stages of the analysis, lead researchers prepared a thematic codebook based on session transcripts, which was validated by co-researchers. The latter then conducted a thorough thematic coding and preliminary analysis of the transcripts for their respective groups.

A series of collective analysis sessions were then conducted with the research team throughout this phase, including one half-day online workshop and several shorter online sessions. Thematic analysis allowed researchers to identify recurring patterns across discussions and stories, while narrative analysis created space for understanding how women constructed meaning around experiences related to shame, fear, intimacy, bodily autonomy, silence, and self-perception over time. Co-researchers were also encouraged to frame their interpretations using feminist and systems-thinking analytical

¹ See Annex I and Annex II for the data collection and validation sessions' guides, respectively.

approaches, which informed the process of tracing the ways structural inequalities, social norms, nationality, class, disability, age, marital status, and gendered expectations shaped women's experiences.

The analysis process acknowledged that many reflections emerging during interpretation were informed not only by participants' experiences, but also by lead and co-researchers' own lived experiences navigating stigma, misinformation, shame, fear, and restricted access to SRHR knowledge. Reflexive discussions therefore accompanied the analysis process continuously to examine assumptions, positionalities, emotional responses, and interpretive biases shaping the reading of the data.

PHASE 5

COLLECTIVE WRITING AND KNOWLEDGE PRODUCTION

The writing process followed the same feminist principle of co-produced knowledge. The co-researchers, along with the lead researchers and accompaniers, held weekly discussions around emerging themes, as well as representing women while protecting their integrity and privacy, and the framing of the findings that emerged from the data. Much time was dedicated to exchanges around how women's experiences could be represented ethically, while remaining attentive to the nuances of every experience and avoiding simplification.

This phase, being held by twelve different writers, required continuous negotiation across different levels. Coming from diverse backgrounds and levels of expertise, we all had different writing styles, levels of research experience, preferred writing language, and forms of engagement with feminist knowledge production. However, this diversity was embraced throughout the writing; rather than seeking complete uniformity, the report attempts to reflect multiple voices, forms of reflection and interpretation while maintaining coherence within the broader research framework. As such, it is also important to note that different sections in the report were originally written in either English or Arabic, and lead researchers played the additional role of editors to ensure consistency and flow. Lead researchers edited and translated all sections

into English, while a translator edited and translated all sections in Arabic.

PHASE 6

VALIDATION AND COLLECTIVE REFLECTION

Following the preliminary analysis phase, a series of 5 validation sessions with 46 participants were conducted with the goal of collectively revisiting and reflecting on the findings emerging from the research. Participants were invited to respond to the findings and interpretations, as well as to clarify meanings, challenge representations they did not identify with, highlight missing dimensions, or expand on ideas requiring further nuance or contextualisation. The sessions adopted participatory approaches (see Annex II) and also included prioritisation of recommendations. They formed an important component of the feminist participatory approach guiding the research, particularly in relation to accountability, collective reflection, and resisting extractive forms of knowledge production in which participants are excluded from interpretation processes once data collection is completed.

Overall, most participants deeply related to the findings of the research and expressed a strong sense of recognition and ownership. The groups confirmed that the analysis reflected both their own experiences and those of women in their surroundings, often noting that the findings "spoke in their name" or captured realities they had previously struggled to articulate. Rather than challenging the content, participants largely validated and enriched it, adding further nuance, examples and contextual details. They also highlighted the value of returning to the findings collectively, something they had never experienced before, in any research or knowledge production processes or projects. They described the sessions as spaces where they could better understand shared experiences across different groups, including differences among divorced women, women with disabilities, and women from different areas.

The process was experienced, in addition to a validation of findings, as a transformative space fostering dialogue, solidarity, and the articulation of clearer rights-based demands. Finally, many participants expressed that the

findings strengthened their sense of urgency and motivation to speak more openly about these issues, recognising the importance of breaking silence and continuing collective discussion and action.

PHASE 7

TOWARDS ACTION

As mentioned, we approach research as part of a broader continuum of feminist organising and advocacy to create possibilities of change through what comes after the documentation. In the upcoming phase of our project, co-researchers will participate in a two-day feminist influencing and advocacy workshop aimed at collectively reflecting on how the findings, relationships, and experiences emerging from the research could inform future community-based initiatives and feminist interventions beyond the formal duration of the project. The workshops will also serve as spaces to strategise and plan for concrete feminist influencing actions that will be implemented in the coming months.

C. LIMITATIONS AND CONSTRAINTS

As with any research process, ours unfolded within a series of structural, political, logistical, and interpersonal constraints that shaped both the possibilities and limitations of the project. These limitations actively informed the research process itself, including the pace of the work, the forms of participation that became possible, the emotional dynamics within the groups, and the scope of the research outcomes.

One of the primary constraints shaping this research was **time**. For a participatory intervention with a group of 12 young women, each with her own professional, personal and care-related responsibilities and commitments, time was a limited and valuable resource. As per any research and collective action project, time was required for collective engagement, trust-building and iterative reflection. At the same time, meaningful participation also required building in enough time for every researcher to engage and contribute as well as to learn and reflect personally and collectively. As such, while we intentionally worked to create spaces rooted in care, the timeframe and realities of project-based

funding structures and institutional timelines inevitably shaped the extent to which certain discussions, relationships, and forms of action could fully develop. Still, anchored in the flexible and adaptive design of the process, Oxfam's project manager, and the lead researchers and companions, made several adjustments along the way to ensure enough time and space were dedicated for a meaningful process. As a result, our original timeline for the project of 4 months was extended twice, extending into a full year (9 months for the research process to be finalised, and 3 extra months for additional activities emerging from the findings of this research), making room for more time for co-researchers to engage with and process new material and tools, to roll-out activities at a pace that worked best for them and for participants, and to deeply and meaningfully interpret and make sense of findings.

At the same time, the research took place within, and not merely alongside, an ongoing **context of war and displacement, political and economic collapse, and the acute precarity shaping daily life** in Lebanon. These realities were part of the very fabric of our research process. For the participants and researchers alike, the war presented a lived condition that shaped our capacity to think, process, feel, and just be present within collective spaces. Staying truthful to our feminist ethics, we could not separate the emotional and psychological weight that the researchers and participants carried into and out of every session, from an FPAR project conducted under active war and structural violence. In collective analysis sessions, co-researchers reflected how this reality shaped both participation and interpretation across sessions, even when not always directly foregrounded in every discussion. Participants shared experiences of heightened violence, fear, and precarity during the war and displacement, including increased restrictions on women's mobility and decision-making, intensified insecurity for women with disabilities, and direct exposure to bombing and threats to housing, all of which were often compared to pre-war conditions. For some, the sessions themselves became spaces of emotional release and temporary relief, allowing participants to process fear and trauma collectively, while for researchers the context underscored how

inseparable the production of knowledge was from the lived realities of crisis, survival, and ongoing instability.



One participant shared her experience before and during the war, about violence against women and how it increased, and [the increase in restrictions] particularly in relation to women's decision-making and mobility; coincidentally, she is originally from the South, but was displaced to Akkar, where her mother is from.

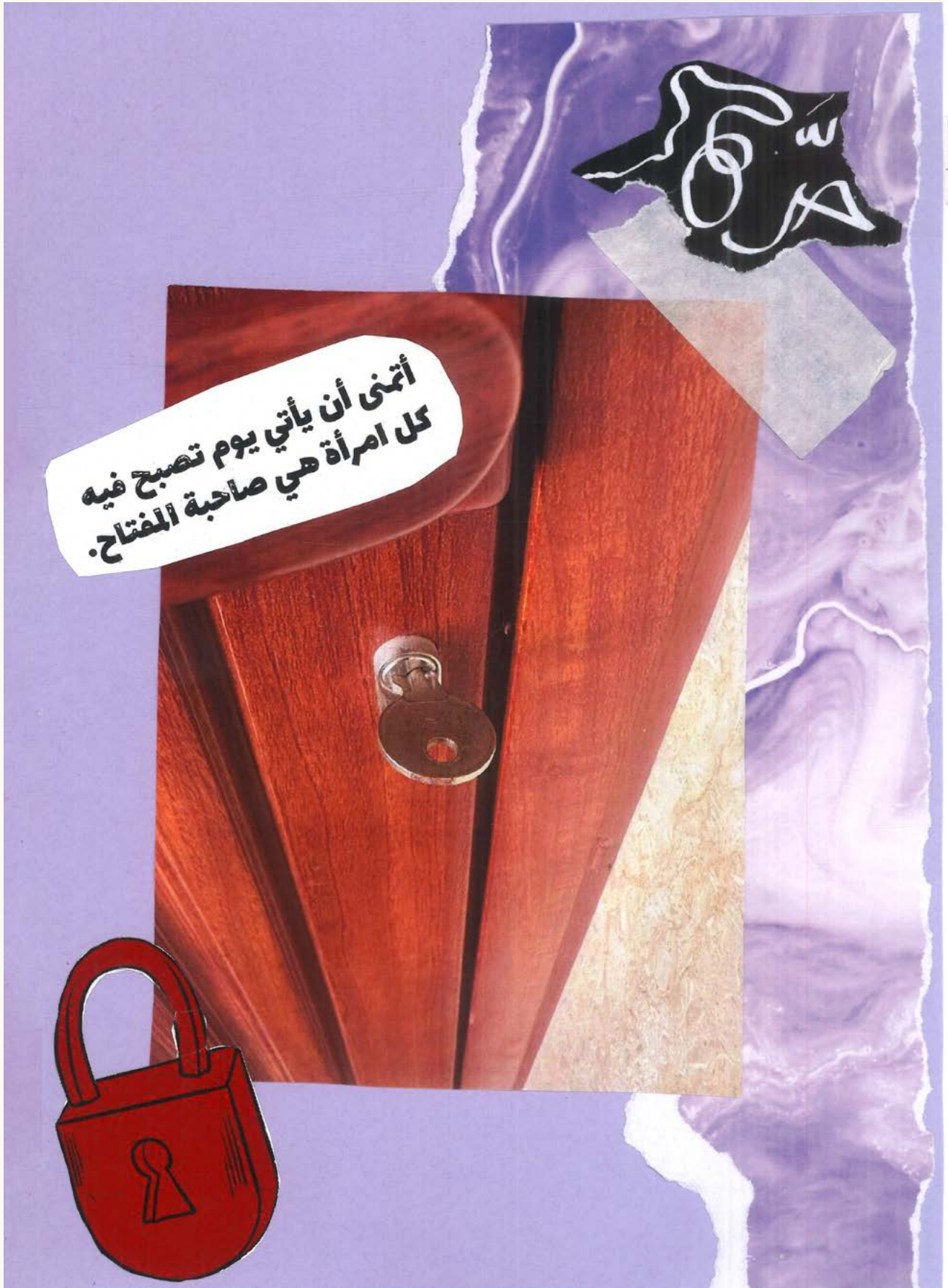
In addition, in several instances during the data collection phase, many of us had to navigate competing priorities rooted in survival: caregiving responsibilities, sometimes intensified by displacement and loss, work, transportation barriers, broader concerns related to safety, and the emotional labour of processing collective grief and fear while simultaneously holding space for each other's most intimate experiences. These conditions impacted momentum and continuity at different points of the process. Nevertheless, our shared interest and commitment to this work allowed us to sustain and rebuild momentum whenever it slowed down. Feminist participatory work cannot be detached from the conditions under which people are attempting to live, survive, and sustain themselves, particularly within contexts of ongoing instability.

The collective nature of the research process also introduced important **methodological and interpersonal complexities**. The team of co-researchers came from different social locations, professional backgrounds, levels of research experience, facilitation styles, and relationships to feminist and SRHR work. This diversity did indeed enrich the process and expand the forms of knowledge and perspectives present within the research, but it also required continuous negotiation, adaptation, and collective reflection.

Researchers moved through different learning curves requiring ongoing accompaniment from the trainers, adjustments, collective problem-solving, and flexibility, to respond to varying support needs, capacities, and ways of working.

Relatedly, the research process was not free from tensions, hesitations, or fears, which at times posed challenges, but ultimately reflected genuine, deeply grounded relationships, and with time, strengthened the trust within our group. Given the sensitivity surrounding sexuality, reproductive health, and bodily autonomy within many communities, the research team initially encountered varying forms of resistance, caution, and uncertainty. Some co-researchers expressed hesitation regarding participation due to fears related to fear of exposure or community stigma. Others were unfamiliar with the idea of speaking openly about their bodies, relationships, or SRHR experiences within collective settings. The participatory and relational nature of the research raises these questions regarding positionality and potential bias. The researchers were not detached observers external to the realities being discussed, but women and feminist researchers who themselves navigate many of the social, political, and gendered conditions shaping the research topic. Building trust therefore required careful outreach processes grounded in ongoing consent and care practices. Even within the sessions themselves, participants engaged differently with disclosure, vulnerability, and participation, and the research remained attentive to respecting these differences without forcing uniform forms of engagement.

Many of the limitations encountered throughout the process also became part of the **learning and methodological reflections** emerging from the research itself. The need for flexibility, emotional accompaniment, and collective negotiation continuously reaffirmed that feminist participatory research cannot operate through rigid or extractive frameworks. Rather, it requires responsiveness to people's realities, changing capacities, emotional needs, and political conditions as they unfold. In this sense, the constraints shaping the project were not external interruptions to an otherwise stable research process, but part of the very conditions within which feminist knowledge production takes place.



"I hope the day comes when every woman holds the key."

Artwork: Zaynab Nasereldine & Francesca El Asmar

V. FINDINGS



1. SRHR INFORMATION-SEEKING IN CONTEXTS OF STIGMA, SECRECY, AND SILENCE

Throughout our conversations with diverse young women from North Lebanon and the Bekaa, we collectively unpacked our experiences navigating restrictions and seeking SRHR information. We found that knowledge-seeking behaviours differ based on diverse social, material and identity factors, as well as on personal experience and social support networks. Access to information is significantly shaped by social norms and restrictions, as well as women's sense of trust or mistrust towards certain sources. In this section, we first highlight the types of information young women often seek and in which circumstances, as well as pervasive knowledge gaps, misinformation and myths. Then, we discuss the interconnected, structural and material barriers that shape knowledge and access to information and later delve into how this ecosystem leads to various information-seeking behaviors and influences (mis)trust and reliance on different information sources.

1.1 THE SOCIAL PRODUCTION OF SILENCE AROUND BODIES AND SEXUALITIES

For young women in Lebanon, there is rarely a clear and reliable path when searching for SRHR-related information. Often, the search occurs secretly, within a restrictive context characterised by fear, stigma, silence, and a lack of readily available and accurate resources (El Kak et al., 2025). In understanding knowledge-seeking behaviours and conditions, we first sought to identify the key areas of SRHR information that young women report being most interested in or in need of, and critically, the ones where they seem to have the least access to information about, or around which misinformation and myths remain pervasive.

Through our discussions, but also based on the questions participants asked us during and after our sessions, we found that **women most often seek knowledge during or after an incident occurs to them or someone around them, or during moments of change in their lives.** This includes experiencing sexual or reproductive health conditions, feeling pain or discomfort, experiencing unexpected changes in their

bodies, and in relation to puberty, first periods and sexual experiences, pregnancy, marriage and so on.



If I had accurate information about pregnancy, childbirth and the breastfeeding period, I would have prepared myself psychologically and physically before each stage, and I would have dealt with any problem in an easier way.

Many participants also indicated a lack of preparation or explanation before pivotal moments in their lives made their experiences confusing or frightening.



I used to think that menstrual blood was just blood from the body, not that there was a uterus and an ovum involved. [...] I even got married without knowing how a woman gives birth. I didn't even understand what intercourse was. When I used to ask what marriage was, they would just say, 'it's like a bee sting.' I suffered a lot because of this lack of reproductive and sexual knowledge.

The information received or accessed by women in those moments is often shaped by a socially constructed system of inherited myths, silence and misinformation. Primarily, these are passed down through families and communities, presented as immutable facts heavily intertwined with norms around honor and shame, and leading to a distorted understanding of the body (Naji et al., 2025). For example, contraception is often linked to infertility, and pregnancy and childbirth are portrayed as constant dangers, creating deep-seated fear that influences women's decisions.

Many pervasive misinformation and myths were revealed through stories shared by participants.



Because of past experiences with contraception causing infertility, I'm afraid to use it and become infertile myself... and also, experiences of childbirth where the mother might die during delivery made me even more afraid to get pregnant.

For example, in many cases, physical changes are interpreted through inaccurate beliefs, such as the association between marriage and a reduction in menstrual pain, or between infertility and contraception. This reflects how fundamental knowledge is obscured and replaced by superficial or socially accepted notions that do not reflect physical or health realities or are unfounded medically. The latter reinforces the confusion between normal bodily changes and functions, and socially constructed assumptions or norms.



Before marriage, my menstrual pain was severe, but after marriage, the pain lessened.

Mothers, older women and other female relatives also tend to be a central source of information. While this offers important insights into social support and collective knowledge-building (explored below), it often also perpetuates silence and myths, because these women themselves would often have been denied access to accurate knowledge, and navigate the same systems of social regulation and stigma that shape their daughters' experiences. The information that mothers and other women pass on is thus shaped by what they were allowed to know, what they were shamed into silence about, and what survival within patriarchal structures required them to accept as truths. In this sense, the transmission of misinformation and myths is a reflection of how systems of epistemic exclusion reproduce themselves through the very relationships that are meant to offer care and guidance. Some participants shared that they

might only be able to turn to their mothers when in need of support, despite being aware that very often, they themselves do not have the answers they need. Some might be too embarrassed to discuss sensitive or taboo topics, and others might pass on misinformation. For example, one participant, a mother herself, reflected on her own difficulties in educating her daughter about her body, reflecting how both gaps in information and the absence of dialogue are passed down from generation to generation.



I don't know how to talk to my daughter about menstruation when she reaches puberty.

Still, mothers and other female relatives are sometimes the only trusted and available source of support and knowledge, heavily relying on their own personal experiences, and often offering greater comfort and reassurance than doctors or peers. This illustrates how individual experiences can sometimes become a source of collective fear and inaccurate knowledge, highlighting knowledge gaps and misinformation as a systemic issue, rather than an individual one.

All participants expressed a high interest to fill their knowledge gaps and seek more information. Through our different sessions, several issues of interest and concern emerged, the most prominent being:

- Menstruation, including first periods, menstrual pain, sexual intercourse during menstruation and hormonal changes.
- Sexuality, including first sexual experiences, pain during sex, women's pleasure and masturbation.
- Pregnancy, childbirth, miscarriages and fertility.
- Contraception and abortion.
- Sexual and Reproductive Health, including Sexually Transmitted Infections (STIs), Polyendocrine Metabolic Ovarian Syndrome (PMOS, formerly, Polycystic Ovary Syndrome (PCOS) (essi, 2026), and other conditions.

- Sexual education in general, including anatomy and bodily functions and changes throughout the life cycle.
- SRH services, and Obstetricians and Gynecologists' role and support offered.
- Virginity and the hymen.

While areas of interest were mostly common amongst participants, some emphasised certain types of information based on their own lived experiences. For example, unmarried women were keen on having better access to information about sexuality and pregnancy before getting married, as they feared social judgement and stigma if they ever sought it out.



It wasn't until I got married when I was 14 years old [that I started receiving some information about my body], I thought marriage was just a white dress.

Women with disabilities especially highlighted information related to accessible and inclusive services, based on their experiences of control and restricted agency at the hands of doctors and healthcare providers. Women who experienced different types of health incidents or who had chronic reproductive health conditions were most interested in information about sexual and reproductive health.



"When I had PCOS, no one took me to the doctor. My family did not know. I used to feel like there was something wrong with me. No one asked me about it. I did not even know that there was such a thing as a gynecologist. [...] Then I got married and moved to a different city, and that also affected me. My husband was the one who realised and noticed that I needed

treatment because I was not getting my period. The family of a friend were the ones who took me to the doctor, not my own family."

Additionally, many participants highlighted their lack of knowledge and information about anatomy and basic bodily functions. Some shared stories about not knowing whether certain bodily changes or secretions were normal or indicators of illness, and many explained that the only words they know for sexual organs were vulgar and derogatory.



Sex education is almost non-existent for us, especially the names of sexual organs. We know the colloquial words for them, while scientific names are never spoken of.

In addition to a gap in information, what is evident is a **fundamental absence of anatomical terms and a familiar or comfortable "language" to describe different bodily functions or organs.** This gap represents much more than simply missing knowledge, but rather a gatekeeping of agency and a denial of the fundamental right to access and freely use language that describes one's own lived and embodied experience. Women described the use of symbols or metaphors to replace direct explanations (such as comparing marriage to a bee sting - see Box 2). This highlights a form of control that permeates into cognitive and linguistic dimensions, effectively alienating women from their own bodies and constraining their autonomy. Ultimately, the absence of language is not accidental, but a systematic barrier, denying women the vocabulary for their anatomy, silencing those who do have it, and limiting our ability to ask questions, communicate distress or concerns, build self-understanding or even seek care. In fact, it is only by naming our body and its functions, as well as the different changes or conditions that might happen to us, that we can begin to understand it and take better care of it.



"كنت ففكرة إذا ببوس الزلمة بحمل..."
- فتاة في عمر المراهقة

“

I used to believe that if a man kissed me, I would immediately get pregnant!

“

I had fears about the first night of marriage and the first sexual relationship, and if I had had enough information, I would have enjoyed my wedding more instead of constantly thinking about what was going to happen.

BOX 2: NOURA'S STORY

"Before my marriage, I had no awareness of sexual health. I remember that all I was ever told was that marriage was like a wasp sting. They would say, 'Don't be afraid, you will only feel a little pain.' Beyond that, I knew nothing. They also said that the 'sign' or 'mark' (blood to prove 'virginity') would have to be shown to my mother and mother-in-law, but I did not even know what that meant. I told myself I would ask my husband.

I believed that in intimate relationships, pain and fear were the natural state that a woman simply had to endure in silence. I lacked information about how my body worked, or even about my right to feel comfortable and safe in my body. At that time, my dominant feeling was alienation from my own body. I felt guilty because I did not enjoy it (sexual intimacy), and I felt afraid because I did not understand what was happening. This lack of awareness around intimacy became a heavy duty that I tried to escape from internally. It affected my behavior and the communication between us, because I did not express myself or understand my own needs at the time.

Eighteen years ago, if I had had accurate and reliable information about sexual and reproductive health, my experience would have been completely different. I would have realised that there are many ways to reach pleasure and orgasm. I would have understood that open communication with my husband about my body is the foundation of a physical relationship. I would have made decisions based on psychological and physical comfort rather than on social expectations and misinformation.

The biggest lesson I have learned is that our relationship with our bodies is the mirror that reflects the quality of our relationships with others. When we respect and understand our bodies, we set healthy boundaries and build bridges of trust with our partners. So do not let silence or distorted information build a wall between you and yourselves."

Finally, these systemic gaps in information so central to our lives reflect the wider social regulation of women's behaviours and bodies. In fact, socially preserved misinformation, fears and stigma around sexuality, (in)fertility, pregnancy, but also purity and honor, function as tools for control, maintaining ignorance and determining when, how, and to whom a woman can ask questions or act. This also restricts the type of information that diverse groups of women are socially allowed to seek or hold.



Is it true that a girl must marry someone from her community, or she may die during sexual intercourse?

The sustained gaps and denial of information and persistent social stigma around SRHR, force women to construct their own knowledge through precarious and uncertain paths. It often leaves us feeling powerless, confused and afraid, and significantly shapes decision-making and bodily autonomy.

1.2 ACCESS UNDER CONSTRAINT: THE MATERIAL AND SOCIAL CONDITIONS OF RESTRICTED ACCESS

Women's experiences, and more specifically, their SRHR information-seeking behaviours, are heavily shaped by a complex web of interconnected barriers. Those barriers are present within several aspects of our lives, including personal and individual-level barriers, family and community-level barriers, as well as national, institutional and structural barriers.

Almost all participants reflected on the **material and physical barriers** they face when seeking SRHR-related care, services or knowledge. Many women reported struggling to afford the cost of medical consultations or tests, which are not only critical for healthcare, but also a key resource to understanding one's body and making informed decisions.



In this town, there are no clinics, primary care centers, or medical centers to provide these services to women, so they are forced to go to areas that are far to obtain services, and this constitutes a geographical and economic obstacle due to the payment of transportation allowance, so they are often forced to postpone or cancel the examination.



If the situation is very urgent and sensitive, you would have to take away from your food expenses to be able to go [to the doctor].

Even where financial resources might be available, many women, especially those residing in rural areas, describe geographical distance as a challenge to reach health centers, further compounded by the lack of safety and reliability of transportation options (i.e. public transportation and taxis). Many participants shared stories of harassment or stalking while using public transportation and would prefer avoiding the consultation all together to protect themselves. For women with disabilities, material barriers are exacerbated as both transportation and centers themselves are often inaccessible or fail to account for diverse types of disabilities. Refugee women with irregular legal status might also face challenges related to commuting and accessing healthcare.



I would like there to be specialised sources and centres for these issues that girls, and anyone who needs this kind of support, can turn to. I have never seen a centre in the Bekaa that specialises specifically in sexual and reproductive health and rights, and we really need such centres. It should not always be necessary to ask family or friends, because there is no guarantee that their information is correct; in fact, much of it is not. We were raised with inaccurate information and have carried it with us throughout our lives. So we definitely need centres like these. Geographic distance from such centres is itself a barrier to accessing information.

Even more so than material ones, **structural and systemic barriers** emerged as the largest, and most difficult to overcome. Those barriers often manifest themselves in different forms and spaces, are multi-layered and deeply embedded in our social structures, institutions and norms.

First, the lack of any form of age-appropriate, inclusive and non-stigmatising education around sexuality and reproductive health and rights, especially concerning topics like puberty, menstruation, contraception, sex and pleasure, creates an overarching feeling of confusion and fear. This gap is very much institutionalised, as attempts to reform the formal school curricula and integrate some form of sexuality and reproductive health education have always been met with resistance. In fact, in 1998, Lebanon introduced sexual education to its official curriculum, based on recommendations from the World Health Organisation (WHO) and efforts by the Centre for Educational Research and Development (CERD). However, this was met with severe resistance from social, political and religious actors, and was therefore fully or partially repealed, depending on the class/grade (Yamine, Khalil & Clement, 2012). Subsequent attempts to reform the sexual education curriculum followed, generally through collaborations and recommendations

with UN agencies and non-governmental actors. However, they were consistently met with resistance, manufactured moral panics and opposition, and the curriculum remains severely lacking (Mansour, 2021; Bechara, 2023). This reflects wider forms of social control over our bodies and sexuality, producing a system that reinforces silence, myths and stigma, while regulating access to knowledge through dominant social norms, moral anxieties, and patriarchal expectations. As a result, many of us grow up without learning the correct terms for our own anatomy, except through dedicated and personal efforts of searching, reading and asking.

In many cases, barriers to accessing knowledge foster severe fears and concerns related to our bodies, sexualities and health. Rather than a mere psychological response to missing information, this is a clear manifestation of social systems regulating women's behaviours. As such, those barriers function as a tool for control, determining when, how, and to whom a woman can ask questions or act. This also makes it harder to explain health problems to doctors, who, in many cases, might already be dismissive or lack empathy. Moreover, systemic barriers are also pervasive in the **health sector**. Many participants shared stories in which doctors and healthcare providers did not take their pains or concerns seriously or were dismissive of their questions and requests for clarifications. This reflects the long history of medical patriarchy and misogyny, which has often dismissed women for being "hysterical" and continues to belittle their pain, significantly compromising our sexual and reproductive health outcomes. As such, many conditions impacting women's bodies are significantly under researched and under- or misdiagnosed (Covan, 2022). Many participants also shared experiences of obstetric and other forms of violence faced at the hands of healthcare professionals and institutions, which are further explored in section 2 below.

Additionally, **patriarchal social norms and practices** significantly restrict women's ability to access SRHR knowledge and care and make autonomous decisions. They often materialise in the form of strict social rules and control over women's bodies, movement and access to services, as well as in the form of social taboos,

judgement, shame and stigma. For example, patriarchal norms around marital and intimate relationships tend to place control over women's movements, decisions and lives within the hands of their male partners. Women are often socialised into carrying the entire weight of unpaid labour and limited to reproductive and caregiving roles. In many cases, women are also commodified or objectified within these patriarchal marital dynamics. Furthermore, social norms related to virginity, shame and marriage prevent unmarried women from accessing healthcare, with severe consequences on health and wellbeing. Some participants also explained that healthcare providers sometimes contribute to these barriers, by refusing to see or treat unmarried women. Because simply visiting a sexual and reproductive health clinic is perceived by communities as an indication of sexual activity, this also creates fears of judgement and stigma amongst young and unmarried women.



When a woman is single or divorced and wants to go to a gynaecologist, they ask her why she wants to go if she is not married.

Nevertheless, a few participants mentioned that norms are slowly shifting, and that it is now easier for unmarried and younger women to visit gynaecologists than it used to be in the past, though this remains uneven and shaped by material and social constraints.



"If I told my mom 'take me to a gynaecologist,' they would drag me through the mud and shame me. In our family, it's considered shameful for an unmarried girl to go to a gynaecologist. I still remember when something happened to my sister, they took her secretly, and I panicked and told my mother it seems like it's something serious.

My mother didn't have a problem with it, but it's the family that would shame us. If there was nothing wrong with her, she wouldn't have gone to a gynaecologist. Now it has become normal for unmarried girls to go even before married women."

The fear of being shamed by one's own family or community often forces women to stay silent, seek information in total secrecy or avoid the medical system entirely. For unmarried women, asking questions about sex, marriage or virginity is often linked with interest or engagement in sexual activity and therefore prohibited. This phenomenon does not end after marriage, as most married women explained that they wouldn't discuss sexuality, pleasure or other similar topics with their husbands, to avoid being perceived as having had prior sexual relationships.



"If you truly love your body and yourself, there should be nothing wrong with a woman speaking openly and telling her husband, for example, 'Today I feel like being close to you.' But unfortunately, in our society we still feel ashamed and afraid. People might think she has had previous relationships or say things like 'God knows what she has experienced,' or assume someone must have talked to her about these things before."

A clear double standard was also identified during our sessions, whereby boys and men are judged less harshly, and in some cases, encouraged, to seek out SRHR-related information.



Our parents explained things to the boys, but not to the girls. My mom talked to my brothers, but she left me to get married [without knowing anything], as if I was just supposed to figure it out, or that my husband would know.



"I went with my teddy bear, thinking it was just a little outing" – A woman who experienced early marriage

These barriers are not only social or interpersonal, but are also deeply embedded within broader institutional environments, including education, health systems, and public services, which collectively shape what kinds of SRHR knowledge are made available, legitimised, or silenced. This creates an environment where women avoid asking questions directly and instead rely on listening and overhearing stories shared by peers, neighbours or relatives, severely limiting the kind of knowledge they hold, and restricting it to their own and others' personal experiences. Women end up searching privately, often on the internet, for information they cannot ask about explicitly, or relying on peers to avoid being judged by their community.

1.3 A FRAGMENTED KNOWLEDGE ECOSYSTEM

Women's navigation of SRHR knowledge systems reflects not only gaps in information, but deeper structural inequalities that shape who can access knowledge, under what conditions, and with what level of autonomy. Through our discussions with participants, but also in our reflections on our own experiences seeking SRHR-related knowledge, we found that our access to SRHR knowledge and information-seeking efforts are heavily shaped by a fragmented ecosystem of information sources - formal and informal, online and offline, trusted and mistrusted. In the absence of comprehensive, accessible, and non-stigmatising information or education, women actively construct their own knowledge pathways by navigating between multiple sources that vary in credibility, accessibility, and safety.

In this context, women do not rely on a single source of information but rather construct hybrid knowledge that draws on the internet, healthcare providers, family, friends, and personal experiences. This behaviour reflects a pragmatic and realistic attempt to adapt to an environment lacking accurate and safe information, where the need for privacy becomes a crucial factor in which information sources to turn to. Accordingly, women tend to avoid formal and/or visible sources and instead turn to discreet channels.



I researched alone on my phone because I was too shy to ask anyone. I had no one to ask, except the internet.

Most often, participants reported looking for answers to their questions online, especially for topics considered sensitive or difficult to discuss openly - through search engines, social media platforms, and AI tools. These platforms are perceived as safer, offering faster information, and greater privacy.



I used AI because it is considered shameful in our society to know about contraception or marital relations as long as you are not married.

Still, participants emphasised the potential dangers of limiting their information to online searches and highlighted the risks of being exposed to both misinformation and disinformation. Some expressed difficulty discerning between correct and incorrect information. A few mentioned privacy concerns with AI tools but generally felt more comfortable and protected by the perceived or actual anonymity of online searches. Several participants expressed prioritising privacy over accuracy, highlighting the trade-offs and compromises women have to navigate to protect themselves and feel comfortable.



When I first got my period, I had no information about it. I kept saying to myself, I don't know what this is, and I thought it might be something dangerous. I did not tell anyone for three days. [...] I learned about it from YouTube. I watched a video where "Noor Stars" said this video is for girls only, so I thought I'm a girl, let me watch it. And when she explained it, I understood that this is called a period - menstruation.

Digital platforms and social media indeed emerged as important and accessible sources of information, enabling women and girls to seek knowledge privately and without fear of judgement, and at times to feel better prepared when interacting with healthcare providers; however, participants also recognised that such sources vary in credibility and cannot replace trusted spaces for discussion, potentially contributing to misinformation, isolation, and fragmented understandings.

Beyond digital sources, women rely heavily on informal and experience-based knowledge systems, including peers, friends, and other women within their social networks. Storytelling, shared experiences, and collective memory emerge as key mechanisms for learning, offering validation and reducing isolation. These exchanges function as informal support systems and can foster a sense of solidarity. Yet, they are also embedded within the same socio-cultural context that perpetuates myths, silence, and partial knowledge, leading to the reproduction of inaccurate or incomplete information. Stories shared reflect a pattern of listening, as opposed to actively seeking or asking, particularly when it comes to highly sensitive issues. Women listen to what others choose to share, to communal gossip, to advice from friends and family to comments on television - to whatever is presented to them. Participants also reported that the family is a traditional source of information, but is often limited or insufficient due to embarrassment or a lack of knowledge. One participant stated, "[my mother] didn't even tell me about my period," while another indicated that she "only asks her mother in very urgent situations."

Conversely, healthcare providers are sometimes viewed as a more "reliable" source, but seeking their help is often delayed due to cost, embarrassment, lack of knowledge, societal judgment, family expectations, or negative past experiences, reflecting an uneasy relationship with the healthcare system. In many cases where women or those around them have had negative or even harmful experiences, a high level of mistrust was noted with regards to doctors and healthcare providers. Some women compare medical opinions, or advocate for their rights within healthcare settings. Others prefer to seek alternative sources of knowledge, fearing misdiagnosis, medical errors or mismanagement, or inappropriate treatment. The healthcare sector thus appears simultaneously as a space of potential harm and a space for knowledge.



I like to ask my mother and be comfortable with her, even if her information is limited, because I am not comfortable with the doctor because he has no empathy, and I feel that doctors set limits for single women. For example, when I accompany my sister when visiting the gynaecologist, they always ask me to wait outside.

At the same time, participants' experiences reveal forms of self-knowledge building. In the absence of trusted guidance, women often engage in **personal experimentation and observation** to understand their bodies. This process reflects both agency and constraint: while it allows women to reclaim some control over their health and lives, it also places the burden of interpretation and risk management on individuals, sometimes resulting in delayed care or harmful practices. This also demonstrates that knowledge is not static but dynamic and evolves over time and throughout one's life.



Before marriage, it never occurred to me to ask about these topics because they did not pique my curiosity, but when I started experiencing different things, I was shocked and started looking on my own.



My personal experience changed my convictions. I used to think that contraception led to big problems, but when I used it, under medical supervision, nothing of what they used to tell me happened

Friends and other women, sometimes - but not always - mothers (see section 1.1), appear to play a pivotal role in knowledge transfer and learning through sharing experiences and narratives. We all deeply relate to feeling supported and less lonely whenever we share or hear stories of our friends and sisters, realising that our experiences are similar and our struggles, collective. Those interactions significantly contribute to knowledge transfer, but also to its collective reinterpretation and a deeper understanding of bodies and experiences.

Another trusted source of information repeatedly highlighted by participants are **awareness and discussion sessions organised by NGOs and local initiatives**, which they describe as alternative and safe spaces, offering reliable information, and encouraging them to break the silence around these issues. For many, those spaces opened the door into insights and *"information our families don't know about"*. These spaces not only contribute to knowledge transfer but also foster a sense of confidence and solidarity, helping women reframe their experiences outside the confines of shame and fear. Our research discussion and storytelling sessions themselves emerged as powerful spaces for experience sharing, solidarity and collective reflection. Beyond awareness raising, participants consistently emphasised an urgent need for activities and sessions where they could collectively learn, but also share, make sense of their experiences, and openly and safely discuss topics that cannot otherwise be broached. Participants also reported that whenever they had access to accurate and useful information, this has always led them to greater curiosity, more active seeking, and better knowledge about where to find needed information, resulting in better decisions and practices and healthier relationships. As such, knowledge gaps create a continuous cycle of dis- and misinformation, whereas the opposite fosters greater bodily autonomy, confidence and wellbeing.

Trust in diverse sources of information therefore remains a fluid and negotiated process rather than a fixed attribute of specifically defined actors. Women continuously assess and reassess the credibility of information based on personal experience, accessibility and topic sensitivity.

This reflects that knowledge is not acquired solely based on availability but also within the social and cultural context that dictates what can be said or asked. Formal medical knowledge may be perceived as authoritative but inaccessible or judgmental, while informal sources are perceived as accessible and empathetic but not always accurate. This dynamic reflects a broader absence of comprehensive, trusted, and inclusive SRHR information systems. Women's SRHR information-seeking behaviour can be described as pragmatic, context driven, and shaped by stigma, as we navigate a knowledge ecosystem that is fragmented, hybrid and restricted.

Importantly, these navigation strategies are shaped by *intersecting structural barriers*, related to age, marital status, geographic location, socio-economic conditions, and disability, as participants' stories reveal disparities in access to knowledge amongst diverse women. For example, younger and unmarried women or those with less access to education and services face greater gaps related to structural and material barriers.

The very limited availability of accessible information severely constrains women with disabilities' access to knowledge, and even more so specialised information about their distinct experiences. Inaccessibility of healthcare facilities, lack of adapted communication formats, and limited inclusive programming also restrict their engagement with formal knowledge systems. Additionally, social stigma and ableist norms and practices constrain women with disabilities' interactions with their peers and access to networks for social support and experience sharing. Prevailing social attitudes often desexualize or infantilize them, reinforcing the assumption that they do not require SRHR knowledge. In many cases, the mediation of information through caregivers or family members limits not only access, but also women's control over what they are allowed to know about their own bodies. As a result, women with disabilities often rely more heavily on informal or second-hand sources, frequently without the possibility of seeking information privately or independently.

This fragmented and unequal access to knowledge has direct implications for women's health outcomes, wellbeing, decision-making, and ability to exercise their bodily autonomy safely and confidently. Nevertheless, it is crucial to emphasise women's adaptive and situated agency within this fragmented and heavily restricted knowledge ecosystem.

Overall, our findings suggest that SRHR knowledge is constructed within a complex network of relationships and experiences, structural and material barriers, stigma and misinformation, where it is collectively produced and constantly reshaped. The absence of a reliable and safe source also highlights that women move between multiple sources, making knowledge a continuous negotiation between what is available, what is socially acceptable, and what is personally experienced. In the absence of inclusive education, a weak and sometimes inaccessible healthcare system, and persistent social stigma, women are forced to take responsibility for constructing their own knowledge. Therefore, knowledge gaps and the spread of misinformation cannot be understood in isolation from these structures, but rather as a direct consequence of them. This underscores the need for comprehensive interventions that address not only the gaps of information, but also the deeply rooted systems that produce and reinforce them.



"Are our bodies ours?"

2. NEGOTIATING CONTROL: SURVEILLANCE, GENDERED VIOLENCE, AND RESISTANCE

For women navigating SRHR knowledge and decision-making, patriarchal social norms and expectations have direct implications on day-to-day practices and behaviours, and foster a web of control and surveillance that consistently police our bodies and lives. Throughout our discussions, participants shared experiences of social surveillance and judgement, restricted autonomy and decision-making, as well as normalised violence and institutional harm. They also reflected on various forms of resistance, both subtle and bold, within a system and society that seeks to regulate our bodies, limit our power and constrain our independence. In this section, we start by unpacking the gendered social norms and expectations that shape our lives, before reflecting on the normalised forms of violence women face across the life cycle. Finally, we explore strategies for resistance and solidarity women have shared, in the face of control, policing, and harm.

2.1 PATRIARCHAL CONTROL AS AN EVERYDAY SOCIAL PRACTICE

Gendered social norms and expectations operate as deeply embedded systems of power that regulate women's bodies, behaviours, and access to knowledge, shaping not only what women can do, but also what they are allowed to know, express, and decide. Stories and experiences shared by participants strongly illustrate how these norms function as pervasive mechanisms of control, embedded within family structures, community practices, intimate relationships, institutions and broader social discourse. They shape everyday interactions and reinforce unequal gendered power relations, limiting women's autonomy across both private and public spheres.

Prevailing social expectations often **constrain women to reproductive roles and pressured them to marry and bear children** - often young. We are expected to prioritise motherhood and reproduction, sometimes at the expense of our health, wellbeing or personal aspirations.

For example, many participants shared stories centred on their constant fears of being infertile. They also linked this to the fears of their partners leaving them should they not be able to bear children. This has direct implications on their own health and on the decisions, they take with regards to their bodies.



I thought the pill caused infertility and I was wrong. After I stopped the pills, I got pregnant. However, this hurt me because I was not ready for pregnancy and I was affected by psychological pressure. It affected me physically too.



I know someone who got married, and she used to hear that it is shameful for her to go to a gynaecologist. After a year, she and her husband decided to have a child. It is only they weren't able to that they turned to a doctor, and they discovered that she had some type of infertility. If she had discovered this at the beginning of her marriage, maybe she could have found a solution or a treatment, but the treatment takes a lot of time. In the meantime, her husband could divorce her or take a second wife, and she consistently hears tough words from her community.

This pressure is reinforced by narratives that **normalize early or child marriage** and frame reproduction as a central aspect of womanhood and femininity, reducing women's entire identities and lives to a reproductive role. Women are also faced with rigid expectations around **acceptable behaviours and gender expressions** linked to socially defined concepts of "femininity", and daily lives are characterised by consistent

surveillance and restriction. Families and communities often monitor a woman's clothing, where she goes, and how she speaks to ensure she follows standards of "modesty" or "honour". This environment means women are judged much more harshly than men, which limits their power to make independent decisions about their own bodies.



They used to comment on my clothes and say that I dress loosely. They would tell me not to wear tight clothes or cut my hair because it affects my femininity.



It is definitely different, society focuses more on a woman's body and evaluates her on her shape and appearance, while men are less pressured on their body shape, society is more interested in women's clothes, height, weight and hair shape, while men are often held accountable for this shape in the same way.

Social regulation and gendered pressures around "femininity" also extend into **beauty standards** and often take the form of body shaming and weight stigma. Women's bodies are subjected to constant scrutiny and regulation, with participants describing ongoing comments, judgment, and pressures related to appearance, modesty, and conformity to socially constructed beauty standards. Instances of bullying and social pressures to lose weight or change one's appearance were commonly noted, with severe impacts on mental and physical health, and overall wellbeing and confidence.



"I wish I could be as free as a bird."



Women are treated like a commodity. My grandmother used to put bags in my chest to make them look bigger and tell me, 'Cow, stop eating!'. There is a saying that goes 'men cannot be faulted for anything.' This means if a man has a belly, it is something normal or even something good, but not women. Women are often blamed and told 'take care of yourself and change your appearance or hair so he doesn't cheat on you'. I discovered my body in high school, and at one point I was thinking about getting Botox and fillers, but now it doesn't matter to me anymore.



I am bullied because of my weight, with verbal insults and a sense of discomfort and forcing me to lose weight to get a perfect body. Although my image of herself is good, it still has a negative impact.



[Norms] are definitely different for men and women. Society focuses more on a woman's body and evaluates her based on her shape and appearance, while men face less pressure around their body shape. Society is more interested in women's clothes, height, weight and hair, while men are rarely evaluated in the same way.

This logic of valuing women through appearance rather than competence also extends into the **workplace**. Participants described how women's skills and qualifications are often secondary to their physical appearance and conformity to expected gender norms, including during recruitment. In some cases, women reported being evaluated on how they look or speak rather than on their expertise or professional backgrounds, reflecting broader patterns in which women are reduced to their bodies even within professional contexts. These dynamics are further reinforced through workplace sexual harassment and persistent gender pay gaps, where women continue to face unequal treatment and limited recognition despite equivalent qualifications and experience.

These dynamics are sustained by broader institutional dynamics across education, healthcare, and legal systems, which regulate sexuality and reproduction through uneven access to information, services, and rights-based frameworks. These institutional aspects appeared in several moments in the stories shared by participants, and they form part of the structural environment within which gendered norms are produced and reproduced.

This continuous surveillance transforms the body into a site of public evaluation, where deviation from expected norms can result in stigma, shame, or social exclusion. In this context, our bodies become socially regulated spaces, continuously monitored and disciplined.

As one participant reflected, *"people are always watching what we wear and how we look,"* highlighting how constant scrutiny shapes everyday behaviour and self-perception.

During the body mapping exercises, many participants highlighted specific parts of their bodies that brought them shame, anxiety or unwanted attention and (hyper)sexualisation. Often, those were focused on breasts, legs or buttocks. Sometimes, women pointed to their mouths, explaining that they hesitate or feel uncomfortable speaking freely in front of men, and especially around issues related to SRHR.



My breasts are a source of fear and anxiety. I always cover it. I feel the pressure of hiding it. I used to wear a wide sweater until I was seen, even here at home it is forbidden to wear short clothes.

At the same time, norms and expectations surrounding virginity, honour, and sexual behaviour impose strict and rigid boundaries on women's bodily autonomy and sexuality. While this slightly differs between certain communities, or even between families, women's "purity" and "virginity" are very often associated with her value and extending to her family or community's "honour". This pushes many women to fear intimate relationships, feel shame or mistrust towards their own bodies, and establish a general sense of discomfort and taboo when discussing anything related to sex, intimacy or relationships. The infamous "hymen" becomes a social obsession and tool for control over women's bodies. This appears in practices of family and communal monitoring of women's "virginity" after the first night of marriage, whereby women are expected to prove their virginity and intactness of their hymens by showing drops of blood on their bedsheets. While for some, this practice may seem outdated, many participants told us of their own personal experience with it, as well as the fears, stress and concerns they felt during and after those first sexual experiences.



I am afraid of the idea of marriage... I am afraid of ending up married to someone who's intolerant or conservative, and who doesn't understand the [true] idea of the hymen. I'm afraid to choose someone and to later find out he is someone else.

Some were surprised to hear about the elasticity and diverse shapes and forms of hymens, while others expressed that even if they did hold this knowledge, it did not reduce their fears due to wider social expectations.



My mother always told me that when I get married, as soon as I see blood, it is enough and we should stop. It is forbidden for him to use his hands. We are raised based on all these ideas. It is forbidden to have sexual relations before marriage, and honour is always tied to the hymen.

A few women shared stories of supportive partners or mothers, while others described extreme measures, such as making a cut in their arms or legs, to secure the "blood drops" on their white sheets.



It happened to my friend on her wedding night. There was no bleeding. But her mother said it was completely normal, and even her husband didn't comment on it.



There's such a thing as an elastic hymen. But our society rejects that idea. When my uncle got married a long time ago, people didn't know about this. There was no bleeding, and the whole family panicked. They went to the doctor, who explained that it was an elastic hymen.

Women's behaviours are also closely scrutinised and policed before marriage, limiting mobility, restricting interactions and silencing questions or conversations around sexuality. Participants expressed frustrations at the gendered double standards by which men are judged less harshly - or sometimes not at all - with regards to their relationships and sexual practices, while women are consistently shamed, judged and stigmatised.



Society places more burdens on women than they can bear. It puts women into a very rigid and difficult mold where mistakes are not allowed, while men are allowed to make mistakes. If a woman makes a mistake, everyone attacks and judges her, whereas a man does not face the same treatment.

Furthermore, family and social control over women's lives directly impact their healthcare, autonomy and wellbeing. For example, norms related to marriage and perceptions around sexuality prevent unmarried women from seeking sexual and reproductive healthcare. Family, partner and communal influence also often dictate decisions related to contraception, family planning, marriage and partner choice, systematically restricting bodily autonomy. In this context, the right to make independent choices about one's body becomes conditional, negotiated, and often constrained by power relations within family and community structures.



Once, I wanted to go and get a necessary medical check-up before I got pregnant. But my parents prohibited me from doing so and told me that I should not decide on my own. At that time, I felt that my rights were restricted, and no one would listen to me unless they agreed with what I wanted.

Participants especially shared stories of **partners controlling their decisions and behaviours**, and while intimate partner violence is explored in more details below, this reflects yet another example of the ways in which patriarchy extends into women's intimate relationships and restricts their decision-making and lives.



I was in love with someone who controlled me. If I wanted to go out, I had to take his permission. He made me quit my studies and the technical institution, after I registered and was already attending [classes]. Even if I wanted to go out with my mother, it was forbidden. If I wanted to go out with my friends, it was forbidden. There was pressure on me. I left him and preferred to be on my own, and I went back to doing everything that made me comfortable, and I went back to studying.



"I want her to be a 'blind cat' " – A macho man.

Intersecting norms around gender and disability further intensify constraints on decision-making for women with disabilities. Their experiences are often characterised by heightened control, restricted movement and social interactions, and exclusion from SRHR-related conversations, even when they concern their own bodies and lives. Infantilisation and desexualisation further foster those dynamics, and reliance on caregivers or family members limits privacy and autonomy and increases surveillance.

Participants' stories also shed light on how women sometimes internalise harmful norms, directly impacting their self-perceptions, behaviours, and perceptions of others. Feelings of shame, hesitation, and fear of judgment lead many women to self-censor, avoid seeking information, or remain silent about their needs. In this way, social control operates not only externally through surveillance and restriction, but also internally through the regulation of thoughts, desires, and expressions. These dynamics directly shape SRHR outcomes, including access to services, understanding of our bodies, and ability to make safe and informed decisions.

Finally, the data highlights that gendered norms are not static, but actively reproduced and negotiated through everyday interactions, and women carry the burden of having to navigate, resist and challenge them. Gendered social norms and expectations are therefore powerful structural factors that limit women's autonomy, restrict access to knowledge and services, and perpetuates inequalities. Addressing these norms requires not only increasing access to information, but also transforming the underlying systems of power, social expectations, and institutional practices that sustain gender inequality and restrict women's bodily autonomy.

2.2 VIOLENCE AS ORDINARY: NORMALISATION ACROSS WOMEN'S LIFE CYCLES



The following section includes references to gender-based violence (GBV), sexual violence, and other forms of harm and abuse. It also contains participants lived experiences and testimonies that may be sensitive or distressing to read. Reader discretion is advised.

For most survivors, gender-based violence does not appear as a sudden or exceptional incident. Rather, it is a familiar and recurring reality, embedded in the details of everyday life, emerging across the life cycle in different forms. All participants described having faced some sort of violence in their lives. These incidents are not always recognised as violence and sometimes assumed to be an aspect of reality one has to get used to or adapt to. They often begin inside the home and within the family, continue in intimate partner relationships, and extend outside the private sphere into public spaces, permeating into digital spaces too. Multiple forms of violence were described by participants, all highly interconnected and deeply embedded in patriarchal social norms and gendered power imbalances. They are also highly linked to SRHR, with direct implications on our overall health, and an emphasis on controlling our bodies and decisions.

Some stories might at first appear to be slightly benign, such as monitoring of girls and women's clothes or movement to ensure their own safety. This, however, reflects pervasive **patriarchal protectionism**, whereby control and surveillance at the hands of male relatives are framed as care and protection, and where women and girls' safety is conditional upon their subordination and obedience (Young, 2003). Within this dynamic, embedded in gendered power imbalances affording men and boys control and decision-making, gender-based violence emerges as a disciplinary measure, particularly when women and girls assert autonomy and independence.

In that sense, whenever women and girls transgress this dynamic or any social expectations related to their gender, their male relatives and intimate partners, who are meant to be their “protectors”, not only withhold their protection, but sometimes become the source of threat and violence themselves.



Our families are afraid for us, but they protect us in the wrong way. Why don't they explain things to us properly? They should teach us so that if something like this happens, we would recognise it as harassment. Many girls experience harassment and don't even know that it is harassment.

Some participants recounted instances where mothers and other women in their families and communities reinforced and normalised restrictive norms. This reflects the ways in which patriarchal systems and norms are heavily internalised, and as a result, collectively maintained and transmitted across generations, including by women whose own lives have been shaped by the same structures and constraints.



"I felt like the ring on my finger was suffocating me" — A woman forced into marriage

Child, early and forced marriage (CEFM) were prominent in women's stories, some speaking to their own experiences, and others, reflecting on those of relatives and friends. Stories highlighted the ways in which patriarchal structures and systemic denial in knowledge foster a lack of awareness around marriage and the absence of decision-making. Many spoke about the intense psychological and physical pressures placed on them to reproduce, shortly after marriage, often regardless of age, readiness and wellbeing.



My cousin got married at a young age, when her body was not yet fully developed and not ready for pregnancy and childbirth. After getting married, she became pregnant immediately and went through a very difficult and exhausting period. She suffered greatly during childbirth, and even after giving birth her body did not change at all. She had to breastfeed with formula because her breasts were not fully developed. Her husband would bully her and criticise her body, saying that it had not fully developed even after childbirth. When I saw her, I felt very sorry for her. This woman regretted her early marriage.

Most accounts also reflected the trauma, fear and shame associated with having to “prove” one's virginity, usually with limited to no prior understanding of sexuality or reproductive health. Some participants mentioned marriages with significantly older partners, and almost always, highly controlling ones, fostering dependency and restrictions on their autonomy. Despite the prevalence and normalisation of this form of violence, many participants were outraged at those stories and offered important reflections of how harmful these practices are for young women and girls, and society as a whole.

BOX 3: REEM'S STORY

"A girl I know got married as a minor, and from the first night she was subjected to accusations regarding "honour", due to the absence of vaginal bleeding after her first night of marriage. This is an unscientific indicator of virginity according to modern medical literature. She was taken to a gynaecologist without her parents, and forced to undergo a virginity test, even though this type of examination is medically inaccurate and violates bodily rights.

Later, she suffered from recurrent gynaecologic infections, cysts on her ovaries, and chronic pain. After a year without pregnancy, she was blamed exclusively. She was stigmatised in society, and her husband married another woman on the basis of her presumed infertility. Medical tests proved her fertility, and it was later found that it was her husband who had fertility issues. Instead of seeking treatment, he turned to physical and psychological violence against her, which escalated severely and led to internal bleeding and medical intervention.

After they separated, her health deteriorated due to chronic infections, and she underwent surgical intervention due to aggravating cysts. During a subsequent pregnancy, she faced serious complications that almost killed her, with infections that required intensive care, and she ended up having a part of her ovaries removed to save her life.

This shows how early marriage and stigma associated with misconceptions about virginity and fertility, as well as gender-based violence interact and lead to a series of complex physical and psychological health complications. This also emphasizes the importance of evidence-based sex education, involving men in the assessment and treatment of infertility, promoting safe access to reproductive health services, and protecting girls from forced and early marriage."

Even for women who married as adults, systemic gaps in SRHR knowledge, alongside constrained freedoms and entrenched gendered power imbalances, severely impacted their first and subsequent sexual experiences, and enabled coercion, pressure and harm at the hands of their partners. Some women described the difficulty distinguishing between desire and obligation, particularly in an environment where violence is normalised and marital sex is framed as duty. Many explained not understanding consent at the time (or at all), or only developing that understanding later in life, often retrospectively recognising their experiences as non-consensual (see section 3.1). Some stories also emphasise coerced sexual intercourse during menstruation, despite the pain and discomfort involved.

As a result, intimate partner violence is normalised within marriage, including sexual coercion and marital rape, often interpreted as a husband's 'right' and a conjugal duty.

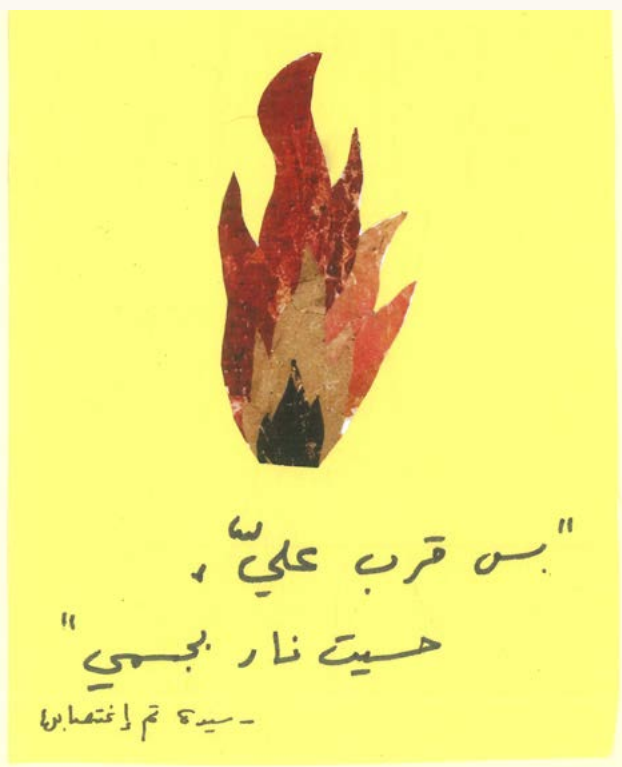
This normalisation is reinforced by silence around sexuality, limited access to SRHR information, and entrenched norms that prioritise men's entitlement and women's compliance.



When I got married, I didn't know anything about the sexual relationship and how it should be, and I thought that I had to endure anything because no one explained my right to understand and ask.



We always hear that it is the husband's right to have sex whenever he wants, even if the woman is not ready.



"When he came close to me, I felt a fire burning through my body" — A woman who was raped

In this context, women's ability to refuse, negotiate, or express discomfort is significantly constrained, and many only came to reframe these experiences through personal experience or later exposure to concepts of consent and bodily autonomy in conversations with peers or in facilitated awareness and discussion sessions around SRHR and GBV.



I never knew about sexual violence, or about rape in a marital relationship. I thought it was my husband's right, and I didn't know that I could refuse.

These dynamics sometimes directly translate into episodes of physical and psychological violence within marriage. In several accounts, women described that attempts to refuse sex, express discomfort, or delay sexual activity were met with anger, threats, or harm. This reflects a pattern in which violence functions as a mechanism to enforce sexual access and compliance within the relationship.



I cannot refuse or he will hit me.

Sometimes my husband asked me to have sex while I was tired and I refused. He did not accept this and got angry and didn't talk to me for a whole day. This affected my physical and psychological comfort.

In a few cases that particularly marked some of us in the group, some women described forms of **exploitation, harassment and manipulation** within the framework of other types of intimate relationships.



There's a woman I know who, during her engagement, her partner made her touch his genitals and told her, 'Look, what happens to me when I see you.' She was shocked, and ever since she is shaky and terrified when she sees him.

In those accounts, fiancés or boyfriends used relationships as a socially sanctioned space for sexual access, forcing or coercing sexual relationships under the assumption or promise of future marriage. Some later withdrew their commitment, leaving women to carry the social and reputational consequences, while others used the prior sexual relationship as a form of long-term leverage and control. Women also shared highly relatable experiences of **violence in public spaces**, describing sexual harassment, unwanted stares and comments on their bodies as common daily occurrences.



I never feel safe when I use a van or public transportation.

In our sessions, we collectively reflected on how those experiences are not exceptional ones, but rather common features of our everyday mobility which systematically shape how we navigate streets, transportation, workplaces and public life. Participants spoke of the different self-protective strategies they adopt and develop, including, reduced visibility, heightened vigilance, and continuous reassessment of clothing, routes, timing and behaviour in public spaces.

Another space in which participants reported experiences of violence is the healthcare sector. **Medical misogyny and obstetric violence** were mentioned across several discussions. Beyond dismissive attitudes and inadequate attention to women's pain or concerns, participants shared stories of invasive examinations without informed consent, failures to explain procedures, unnecessary exposure of women's bodies, rough or coercive handling during physical examinations, and the absence of privacy or dignity during care. These experiences reflect how patriarchal control extends into

institutional and professional spaces, where medical authority can override women's consent, privacy, and bodily autonomy under the guise of clinical practice.



After a surgery, my doctor had travelled, and he referred me to another doctor. I brought all my reports and scans with me. He did not do an external ultrasound; instead, he performed a transvaginal ultrasound without telling me. He inserted it forcefully, and I screamed. On top of that, he exposed my chest and began pressing on it, saying this was part of the examination to check whether there was any milk. I was in pain and completely shocked and embarrassed. I wanted to cover myself. I will never forget that day. I left crying, in pain and deeply distressed.



Artwork: Zaynab Nasereldine

"I am the butcher doctor, and I certify that the body being examined will be at our disposal and under our control, and its owner will have no say in choosing or deciding anything concerning it."



During my last delivery, part of my placenta remained inside and my uterus had closed. The doctor was not present, and a nurse kept on going in and out of the room. They were inserting their hands and removing parts manually, and a trainee nurse effectively was doing her internship practice on me. [...] My family even blamed me for pushing the nurse away, saying I was overreacting.

These experiences are especially acute for women facing distinct forms of marginalisation due to disability, nationality and legal status, and other intersecting social factors. For women with disabilities specifically, healthcare encounters are often shaped by infantilising and ableist assumptions about their ability to understand, question or consent to medical procedures, which can result in decisions being made over their bodies with minimal explanation or without their agreement. For refugees and those with irregular legal status, experiences are sometimes characterised by lack of social support, discrimination and mistreatment, as well as limited access to care.



When my mother was giving birth, neither her husband nor any of her relatives were with her because she is Syrian. She woke up the morning after giving birth to find herself uncovered, with a male cleaner in the room. He saw her while she was not wearing her hijab. She felt ashamed and quickly put on her headscarf. Her privacy was not respected, and this incident remains deeply imprinted in her memory to this day, and she still speaks about it.

In many cases, participants also shared stories of violence and coercion that might have been prevented if they held much needed accurate information. As such, the systemic denial of

SRHR knowledge actively contributes to the normalisation and persistence of violence across different stages of women's lives.

These experiences demonstrate that violence is neither isolated nor exceptional, but rather a systemic and embedded continuum of norms and practices that operate across social, institutional and intimate spheres, to regulate women's bodies, autonomy and decisions. This violence is sustained through entrenched power relations that normalise control and entitlement over our lives and bodies. In parallel, pervasive victim-blaming narratives further exacerbate these dynamics, by shifting responsibility onto women themselves and reinforcing impunity for perpetrators.

2.3 EVERYDAY FEMINIST RESISTANCE WITHIN SYSTEMS OF CONTROL



When I understood my body and knew my rights, I was able to say no to what suited me, and to protect my health and avoid any psychological or physical harm.

Despite these structural constraints and the many forms of control and violence women face throughout their lives, the stories we shared with each other also revealed diverse strategies to navigate, resist, and reclaim agency. Resistance does not always manifest through direct, overt or public acts - although it sometimes does - but often takes the shape of small, everyday actions, with deep personal and collective impacts.

One of the most prominent ways in which women navigate patriarchal norms, expectations and restrictions, was collective, through the sharing and exchange of experiences, knowledge and advice with one another. Participants spoke about the importance of having trusted friendships and informal support networks, and about the feelings of safety, comfort and validation that emerge from being able to openly discuss experiences, fears and questions.

They emphasised how meaningful it is to any space where these issues - which are so often framed as shameful, sensitive or prohibited - can be discussed openly and without judgement or fear thereof. These spaces, which remain so rare and inaccessible for many of us, were often described as having the potential to be deeply transformative, for they allow us to begin naming our experiences differently, build confidence in our feelings and decisions, and realise we are not alone in what we might be going through. For many women, simply listening to others' stories creates possibilities for self-recognition and the gradual development of confidence and negotiating power within everyday lives and relationships.



After I went and asked [to get some information], my ex-husband started saying 'see why I don't want you to mix with those people? They will open your mind to things and ruin you.'



When I had my first pregnancy, I didn't know anything about breastfeeding or how the body works after giving birth. I needed someone to explain to me what is normal and what is not normal. I had to ask my friend who had experience, and then I felt that I had more confidence in my body and was able to deal with changes without fear.

Even within our research sessions themselves, participants were already sharing strategies and information, asking each other for advice, and reflecting jointly on potential solutions or ideas to navigate different circumstances. As such, these processes of **collective consciousness-raising** play a crucial role in disrupting cycles of silence, isolation and control, making information sharing and storytelling deeply political processes.

In another example, those amongst the group who are mothers talked about how important it was for them to carve a different path for their daughters, one enlightened with accurate, age-appropriate information, trust-based and healthy relationships, and autonomous decision-making.



I suffered a lot, and it took me a very long time to even learn that sexual health existed. Now, I try to pass knowledge on according to my daughter's age. For example, when my daughter is sitting with her grandmother or with her cousin, who is only a year older than her, and these topics come up, my sister-in-law looks at me with surprise because of the way I speak: for example, when I explained to my daughter how menstruation happens. I myself got married without understanding how menstruation happens or what causes it. I thought it was like the blood they draw from my arm for medical tests. I do not want my daughter to go through the same path or suffer in order to access information the way I did.



My daughter sometimes asks me about love, and I explain it to her in a simple and age-appropriate way. I also taught her that her body is a special area and no one has the right to touch it. Nowadays children can watch things on TV, so I prefer to make them aware early in the right way.

For some, resistance also consists of being bold and taking risks in the face of injustice and constraints, and transgressing norms and expectations around dress, behaviour or acceptable forms of femininity and respectability. In these cases, agency is expressed through visible acts of non-conformity, even when these come at a social cost. For others who could not afford this cost, resistance took more imagined, symbolic and internal forms. For example, even when it was not possible to look or act differently in daily life, some described allowing themselves to mentally explore alternatives. This emerged clearly during our body mapping exercise, where some participants used drawing as a way to express desires or identities that could not be publicly expressed otherwise.



I drew myself with short hair, because I wish my hair were short.

Through that same exercise, participants were invited to reflect on parts of their bodies that brought them comfort or felt like sources of strength, highlighting how revaluing and reclaiming our bodies is an important and necessary practice in contexts where bodily autonomy is constrained.



Everything in my body feels a source of strength because I have confidence in myself: My face, because I feel comfort when I stand in front of a mirror and look at it. My chest, because it gives me a nice appearance. My neck, because it is long and soft. My hair, I love my hair and it makes me feel feminine.



For me, breasts are a source of giving, so I drew them as a flower, because they nourish the child and give it life. I drew the uterus as a flower as well because it is the safe place where the child lives throughout pregnancy. I feel that my body contains me, protects me, and gives me a sense of safety and love.

Many participants also spoke about practices of resistance and navigation rooted in self-care, embodiment and personal expression. These included grooming, exercising, dancing, going for walks and other forms of bodily care and movement - within the confines of what is safely possible for different women - which allowed them to reconnect with themselves and reclaim a sense of comfort and ownership over their bodies. These practices reflect situated forms of agency that may appear simple at the surface, but which constitute important ways of negotiating constraint, sustaining wellbeing and reclaiming one's body, in contexts where autonomy is restricted.

In other stories, women described how the practice of actively seeking knowledge constitutes in itself an important and transformative action, whether it is done overtly or privately. Access to information, through personal searches, experience-sharing, awareness sessions, or otherwise, was recurrently referred to as essential to navigate constraints and achieve greater well-being and make better and more informed decisions. In some cases, this also contributed to shifts within intimate partner relationships, whereby increased knowledge enabled more open communication, and for some, improvements in relationship dynamics.

Some women spoke of attempts to set boundaries within relationships or to express their needs more clearly, even if this was gradual or intermittent. It is important to emphasise that resistance within relationships is often gradual and negotiated, rather than immediate or linear, and is often shaped by unequal power dynamics, fears of partner reactions, emotional dependency and broader social constraints. Therefore, resistance appears as an ongoing negotiation process, not a final, fixed decision.



After marriage, I discovered that I did not know my legal rights as a wife, especially with regard to my consent or personal decisions in my body. I thought I had to agree to everything, but after I attended an awareness session, I understood that it was my right to refuse or choose, and this gave me a sense of power and choice.



Respecting my body and understanding my rights could reduce fear and psychological pressure, and help me deal with my body in a healthy way and make decisions based on my needs rather than social judgments. When I gained more information about my body and my rights, I felt more confident and more able to protect myself and make conscious choices.

Women also developed various strategies to maintain privacy and make their decisions discreetly. This secrecy was not a sign of weakness, but rather a way to cope with complex and real constraints. Here, making a personal decision, seeking information, or asking for help becomes an act of resistance in itself.

These findings show that women not only experience patriarchal forms of control, constraint and violence, but also actively navigate them through diverse strategies of caution, adaptation, and persistence. While these forms of agency do not erase structural constraints, they challenge any notion of passivity and instead reveal how women continuously negotiate, reinterpret, and push against restrictive norms in everyday life. They reveal women's ability to create small spaces of control within a restrictive reality and shed light on potential entry points for solidarity-building and social norms change.

3. UNEVEN AUTONOMY: NAVIGATING CONSENT, PLEASURE, AND RELATIONSHIPS

Throughout our discussions, women reflected on how experiences of intimacy, consent, pleasure, and bodily autonomy are shaped by far more than individual relationships alone. Rather, women's experiences revealed how sexuality and intimate life are deeply influenced by broader systems of control and male hegemony. Across different age groups and social positions, participants described entering intimate relationships with little preparation, limited language to understand their experiences, and significant fear surrounding sexuality and bodily change. At the same time, women's narratives also revealed the unequal ways intimacy, pleasure, and autonomy are experienced. In this section, we first explore how understanding of consent often emerges through lived experience rather than formal understanding, shaped by unequal power relations within intimate relationships. We then examine how women's experiences of pleasure and intimacy are profoundly shaped by inequality, fear, shame, and restricted access to knowledge around bodies and sexuality. Finally, we reflect on how women continuously negotiate autonomy within intimate and social relationships, highlighting both the structural limitations constraining women's choices and the everyday forms of resistance, and relational negotiation through which women attempt to reclaim space for themselves and their bodies.

3.1 UNDERSTANDING CONSENT THROUGH EXPERIENCE



The following section discusses consent and includes references to sexual violence, including experiences shared by participants. The content may be sensitive or distressing. Reader discretion is advised.

Women's experiences show that consent was rarely introduced to them in a discussable or

conscious way. Rather than being understood as a right connected to bodily autonomy, comfort, desire, or even just mutual agreement, understanding of consent often emerges gradually through lived experience, often through moments of discomfort that women only later began to interpret differently. As explored above, across many conversations, women described entering intimate relationships with very limited knowledge about their bodies, sexuality, or their right to communicate their needs and desires. For many, intimacy was not approached but through silence and fear. One participant shared how she was constantly told that *"when you get married, you'll understand"*, reflecting a profound absence of consent and communication as an understood and practiced right. Several participants who are or had been married described how **knowledge about intimacy and sexual relationships was deliberately postponed or withheld until marriage**, implying that the need to understand one's body and sexuality was inappropriate, even forbidden, outside socially accepted relational frameworks (Alomair et al., 2025). In practice, this silence translates to women entering marriage and intimacy without language to understand their experiences, or articulate boundaries, or just to recognise discomfort. Participants repeatedly reflected on how they were socially prepared for marriage as a social role or life milestone, while remaining emotionally and physically unprepared for intimacy itself.



I was 14 years old. All I knew about marriage was the white dress... and when sex happened, I was shocked.

Within this context, many women describe experiences where silence became normalised inside their intimate relationships and thus consent blurred. Rather than openly expressing discomfort or refusal, women often spoke about suppressing their feelings or prioritising the comfort and expectations of their partners over their own emotional or bodily needs.

In several narratives, the inability to say “no” did not necessarily stem from explicit physical force alone, but from broader gendered expectations that positioned women as responsible for accommodating relationships, avoiding conflict, or fulfilling relational and marital obligations (Mojahed et al., 2020).



I feel like, for example, if she says no to him, he would go look for another woman... he wants her to be only his, I mean... she has no freedom, no say...

BOX 4: MAYSAA'S STORY

"I got engaged and married at a very young age. At the time, I had my first disagreement with my fiancé before the engagement contract had been officially written, and I told my mother that I no longer wanted him. She asked me why I wanted to leave him, and I told her it was because he shouted at me when my friend just greeted me. He got jealous and started yelling, and I would be frightened by him and cry. My mother told me to "be reasonable" and said it would pass, reminding me that we were still only engaged. [...]

After we reconciled and signed the engagement contract, he said we would get married two months later. The first time we saw each other, we were alone and he forced himself on me. I did not understand what was happening. I saw blood and started crying. I asked him why he did that to me. The pain was not normal. He told me not to ever think of leaving him. At that time, I could not speak to anyone, and this is the first time I am telling this story. I did not even understand that I had then become a woman.

He brought me water and tried to calm me down, as if nothing had happened. When we were about to leave, he told me not to talk about it and not to worry, because in a month we would have the official wedding. When I arrived home, I was in so much pain that I could not walk. [...] He would tell me, "I am your husband, it is lawful for me, there is nothing wrong." At the wedding, I asked him, "Now what do you want to do? What are you going to tell people?" He started shouting at me. I cut myself and wiped the blood on a piece of cloth. The next day, when my family called, I told them everything was fine.

I stayed married for several years, and whenever he came close to me, I would become tense. I never experienced a loving marital relationship; it was always conflict, and he always treated me as if I were a child who did not understand anything. No matter how much I begged and cried, saying I did not want this, he would not listen. [...]

The person who helped me the most was my neighbour. She heard me screaming several times and would speak to me through the intercom because he used to lock the door before leaving. Even though she was not much older than me (she was 17 and I was 16) she came to check on me. When I told him the neighbour had invited me to her house, he reacted angrily and said I was not allowed to go anywhere. He then increasingly restricted my movement and locked me in the house.

Later, with her help, I managed to open the door, and she supported me in telling my family what was happening, which was very different from the life they believed I was living. He would usually force me to speak to my family in front of him. During this time, he alternated between controlling and isolating me, and periods of gifts and apologies where he begged me not to leave. Eventually, I told my family everything and decided not to give him another chance after years of violence and psychological abuse. I filed a case and divorced him. I always say I had a life before, and a life after.

Maysaa's story (box 4) forces us to pause not only at the violence itself, but at the conditions surrounding it. What emerges here is an entire social structure organised around women's silence; her fear does not begin with the act itself. It appears earlier in not understanding what was happening to her body, to the pressure surrounding virginity and "proof", the inability to speak to her family, and the repeated insistence that what happened was legitimate because he was her husband. The body here becomes something women are expected to surrender before they are even given the language to inhabit it themselves.

The fact that she tells us, *"this is the first time I am telling this story"* also remained with us. The violence of these experiences often extends beyond the moment itself into the years of silence that follow it; and what women carry is not only pain, but also the burden of not being allowed to narrate it. Consent therefore appeared not simply as the presence or absence of a verbal agreement, but as something deeply shaped by unequal power relations along with social conditioning of women to learn endurance (Hussain, 2026).

Women's experiences also reflect how shame and stigma surrounding sexuality limited their ability to develop the language necessary to understand or communicate consent. Discussions around bodies, desire, pleasure, or boundaries are frequently treated as a taboo, leaving many women unable to ask questions openly or seek guidance without fear of judgment; *"there are things that are shameful to ask about"*, one woman shares. In this environment, silence functions as a social mechanism that restricts women's ability to interpret and negotiate their own experiences.

At the same time, participants' narratives reveal understandings of consent that are not entirely fixed within these dynamics. For some women, awareness developed gradually through personal experiences, exposure to new information, conversations with others, or entering relationships where communication and trust became possible.



After attending the sessions and listening to other women speak, I began to realise that there were things I had always thought were normal, but weren't. For the first time, I felt that I have the right to say no.

Women described beginning to reflect differently on their needs and boundaries, sometimes for the first time. One participant described this transformation by saying, *"I started saying what I want and don't want... and thinking about what suits my body"*, demonstrating how awareness around consent can evolve over time through knowledge.

However, these shifts were rarely linear or complete. Women's ability to communicate boundaries remains shaped by broader structural conditions, including unequal gender norms, social expectations surrounding marriage and femininity, fear of judgment, power imbalances in relationships, and limited access to comprehensive and affirming SRHR knowledge. What emerges from these experiences is that consent cannot be understood solely as an individual choice or isolated moment of agreement. Rather, it is shaped through broader social and political conditions that determine whether women are given the knowledge, language, safety, and legitimacy necessary to fully inhabit and express their own boundaries.

3.2 THE POLITICS OF PLEASURE

Across the discussions we had, pleasure rarely emerged as something women were encouraged to understand or even prioritise within their lives and relationships. Instead, women's experiences reflect how **sexuality is often approached through a system that shames women** and instils fear in them regarding their own bodies, shaping not only access to knowledge, but also women's emotional and embodied relationships to intimacy itself. For many participants, conversations around sex focused almost

entirely on danger, morality, reproduction, or reputation, while pleasure remained absent, and treated as an inappropriate subject to discuss openly, in both private and public spaces that we navigate in life.

At the same time, our experiences of intimacy and pleasure are not uniform. Feminist and intersectional scholarship has long demonstrated that **sexuality is unevenly shaped through intersecting structures of gender, disability, age, class, marital status, and broader social positioning.** Feminist disability scholarship further complicates dominant understandings of sexuality by demonstrating how women with disabilities are frequently positioned outside normative constructions of sexual subjectivity. Disabled women's bodies are often simultaneously desexualised and hyperregulated: treated as bodies requiring supervision, protection, or control, rather than as subjects capable of desire, pleasure, and agency. What these dynamics reveal beyond this is how dominant social understandings of sexuality remain deeply shaped by ableist, heteronormative, and patriarchal assumptions about which bodies are considered desirable and sexually legitimate, or worthy of autonomy in the first place.

Many women reflected on growing up without language to understand desire and sexual needs outside frameworks of fear and shame. Intimacy is often introduced through anxiety rather than curiosity, connection, or self-understanding. Some participants described entering marriage or sexual relationships with very little understanding of their own bodies or what intimacy could feel like beyond obligation or pain.



I was afraid of the first night of marriage and of having sex for the first time. If I had had enough information, I would have enjoyed my wedding more instead of constantly thinking about what was going to happen.



Before I got married, I had no sexual awareness at all. All they ever told us was that marriage is like a wasp sting. They would say, 'Don't be afraid, it hurts a little and then it's over.' Other than that, I knew nothing. And even the issue of the 'proof' [of virginity] and how it had to be shown to my mother and mother-in-law... I didn't even understand what that meant.

In these accounts, sexuality is not experienced as a natural experience that women could gradually explore or understand on their own terms, but rather as something obscure surrounded by pressure and uncertainty. Marriage itself becomes associated less with mutual emotional connection than with enduring discomfort and proving bodily "purity." Women's narratives repeatedly return to the overwhelming anxiety surrounding virginity and bleeding during first sexual experiences, revealing how patriarchal regulation enters even the most intimate moments of women's lives and bodies.



When I first got married, he was supposed to host me for three days, but on the second day he no longer wanted to wait and had sex with me in a way that was psychologically and physically distressing (her eyes filled with tears). It hurt me a lot; pieces of blood came out of me and... the towel was soaked. And until now this still affects me very much (she sighs). At that time I didn't know what would happen or how the relationship would be... I was shy and knew nothing and I froze. I still think it was the worst moment and I cannot forget it...

The participant's account still lingers with us, through what happened, but also through how she tells it, and the intensity of returning to this moment, years later. The pauses, tears, and reactions accompanying the story reflect how deeply embodied these experiences remain. As women, we are often taught to carry fear into intimacy itself. Before the relationship even begins, the body is already tense, anticipating pain, shame, and the need to endure.

Misinformation and myths surrounding sexuality and reproduction also significantly shape women's experiences of intimacy and pleasure. Several participants reflected on fears they carried for years due to the absence of accessible and accurate SRHR information.



I used to think that if a man kissed me, I would immediately get pregnant.

Others described fears surrounding contraception, infertility, virginity, or bodily changes, illustrating how misinformation becomes emotionally embodied through anxiety or shame or avoidance, and transforming the body into an alien site that we don't even know how to deal with. In this sense, the absence of knowledge does not simply create informational gaps, but actively shapes how women experience their bodies and intimate relationships on a daily basis.

Participants also reflected on how **broader social expectations around femininity and respectability shaped women's ability to express desire, communicate needs, or even recognise pleasure as something they are entitled to experience.** In many discussions, women describe learning that "respectable" women should remain silent around sexuality, avoid speaking openly about desire, and prioritise men's comfort and satisfaction over their own experiences. Pleasure becomes difficult to articulate even with partners in marriage because women have been often socially discouraged from imagining themselves as deserving of pleasure in the first place. Sexuality itself therefore becomes structured

around accommodation and endurance rather than mutuality, communication, or bodily comfort.



I can't tell him 'I don't want to anymore' or that I'm not enjoying it. I force myself just to get through it. I can't say no, because the moment I show or say I don't want to, he would get upset and sulk, and then we would end up fighting.



We grow up believing that the man has rights, and the woman has to endure and stay silent... no one asks whether she is comfortable or happy.

Several women described never imagining that their own comfort, desire, or satisfaction could be central to intimacy in the first place. Instead, many entered relationships carrying the understanding that sexuality primarily revolved around men's needs and expectations.



I used to think that marital sex was an obligation for me, not something where I also needed to be comfortable or enjoy it.

Several women also connected their experiences of intimacy to insecurities surrounding their bodies and appearance. Fear of judgment shaped how some women navigated relationships and sexuality, particularly in contexts where women's value is heavily tied to beauty standards, attractiveness, and maintaining relationships. One participant shared in this regard that, *"When we don't have confidence in our bodies, we become dependent on the other person and fear they will leave us."* Hers, as many of our experiences as women, show how women's relationship to pleasure is not a private matter,

as it cannot be separated from broader structures that continuously evaluate, shame, and regulate women's bodies.

At the same time, and as described earlier in this report through women's practices of navigating and resisting control and violence, participants' narratives also reflected moments of transformation and growing self-awareness. For many women, access to information, collective discussions such as the ones we held together throughout this research, and supportive relationships gradually shifted how they understood intimacy, pleasure, and their own bodies.

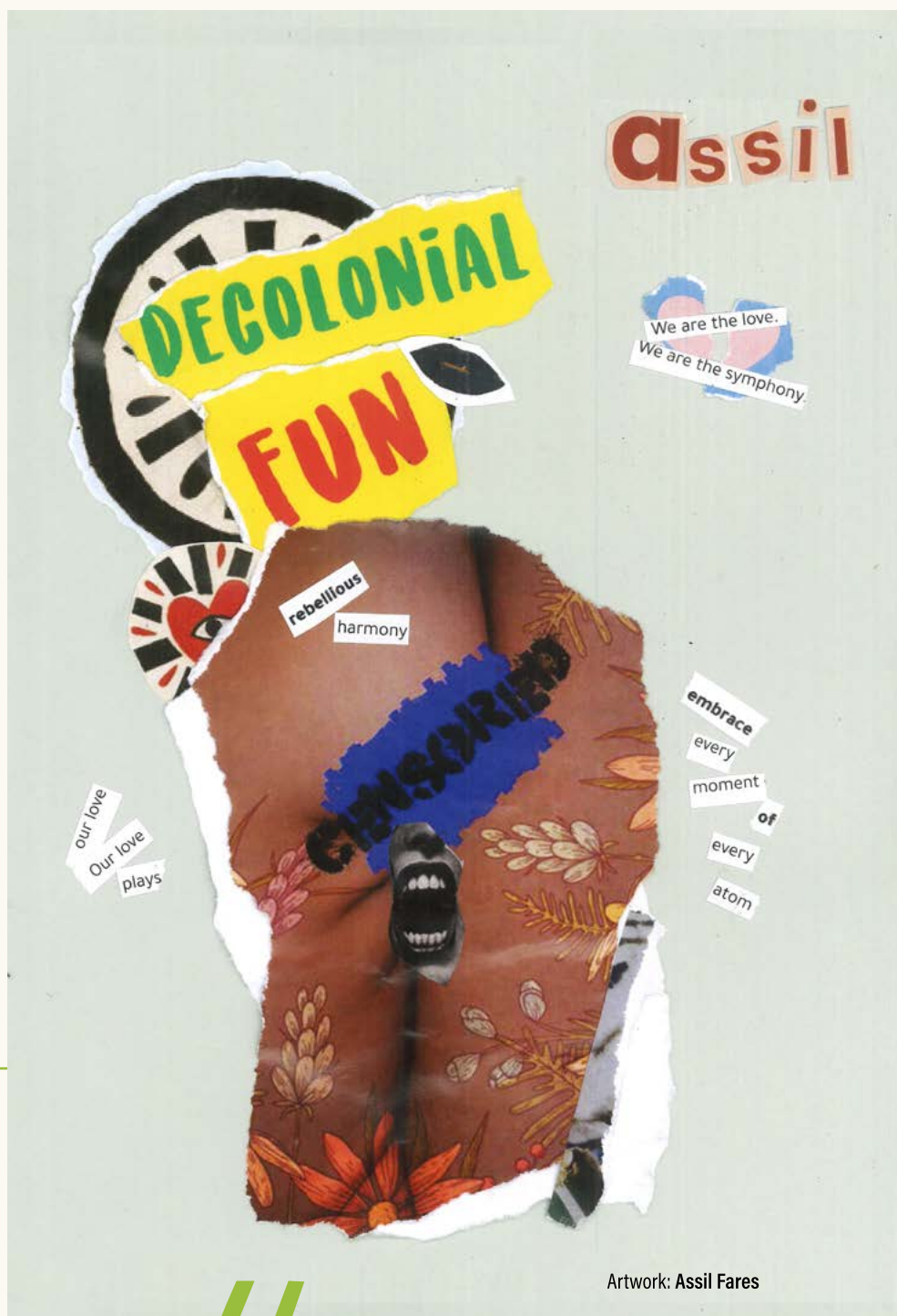


When I started attending awareness sessions and understanding my body more, I gained more confidence and my fear of bodily changes decreased.

Others described beginning, often for the first time, to articulate desire and bodily needs more openly.



It is my right to have the option to have sexual relations with my partner, to refuse and to initiate, because just as it is his right to enjoy this relationship, it is also my right to enjoy it.



Artwork: Assil Fares



I started saying what I want and don't want, and I started thinking about what is suitable for my own body and my mental well-being, not just for the other person.

The significance of these moments extends beyond individual confidence alone. Within contexts where women are systematically discouraged from naming desire explicitly, hearing women openly speak about pleasure, refusal, comfort, and bodily entitlement carries an important emotional and political weight. Several women reflected on how liberating it felt simply to hear other women speak openly about these experiences without shame.

At the same time, some women's experiences revealed how women's desires themselves continue to be heavily stigmatised outside socially accepted frameworks.



When I first got married, he was supposed to host me for three days, but on the second day he no longer wanted to wait and had sex with me in a way that was psychologically and physically distressing (her eyes filled with tears). It hurt me a lot; pieces of blood came out of me and... I was also curious to know if there are pills to reduce sexual desire. After I got divorced, I sometimes felt like I wanted a sexual relationship, and I didn't want to harm my body in any way. So I went to a pharmacist and asked her if there was such medication, and she started shouting at me saying: 'You have no manners! I'm going to report you to your family! Shame on you!' And I was only asking so that I wouldn't reach a point where I might harm myself. the towel was soaked. And until now this still affects me very much (she sighs). At that time I didn't know what would happen or how the relationship would be... I was shy and knew nothing and I froze. I still think it was the worst moment and I cannot forget it...

Rather than receiving support and trusted information, women are often met with humiliation and moral policing for expressing even basic

questions about sexuality and desire. In this sense, the regulation of women's sexuality extends beyond controlling sexual behaviour itself toward controlling women's ability to even seek care safely.

Shifts remain uneven and shaped by broader structural realities. Women's ability to experience intimacy safely and comfortably continues to be affected by unequal gender norms, economic dependence, or limited access to comprehensive and affirming SRHR knowledge. These experiences shared in the report, along with many stories that stay behind closed doors, demonstrate that women's experiences of pleasure are profoundly political and social. They are shaped not only by intimate relationships themselves, but by broader systems and power dynamics that regulate women's bodies, sexuality, confidence, mobility, and access to knowledge from an early age.

3.3 AUTONOMY AS RELATIONAL AND UNEVENLY NEGOTIATED

The many stories we have shared together in these sessions, and the different ways we navigated daily situations, reflect that autonomy within intimate relationships is rarely experienced as unconditional. Rather than describing freedom or control as fixed states, many women spoke about continuously negotiating their needs, boundaries, decisions, and daily survival within relationships. Women's experiences highlight the complexity of navigating intimacy and partnership in a context where maintaining safety often requires compromise and careful negotiation. Safety looks different to each one of us, depending on the context. For example, safety was described as emotional or financial stability for some, and family cohesion for others. Yet at the same time, women's stories also reveal ongoing efforts to reclaim space for themselves, protect their boundaries, and redefine what they want relationships to look and feel like.

For many of the women we sat with, marriage itself was closely tied to social legitimacy and security. Several participants reflected on entering relationships while carrying pressures to maintain the family, or in a more general term, fulfil the expectations associated with being a

“good” wife or woman. Within these dynamics, autonomy was not necessarily absent, but often shaped through constant calculations around how to move around these expectations: when to speak, when to stay silent, what can be refused safely, and what consequences certain choices might carry. Several participants described fears around entering relationships where control and authority become normalised. One woman reflected on this directly when speaking about the possibility of marriage:



What can affect... If I meet someone who wants to impose his authority on me. Why do you want to impose your authority on me? It ends up being him wanting things his way, and she has to go his way. Whenever she wants to go out, she has to justify what she's wearing and what she's doing.

Her reflection captures how **control within relationships** is not always experienced through direct violence alone, as explored in section 2, but often through everyday attempts to regulate women's movement and clothing and other daily choices surrounding mobility, representation, and the body. Similarly, several women reflected on how women are socially expected to prioritise maintaining the relationship over their own comfort or desires.

Participants also repeatedly connected these dynamics to the ways women and men are socialised differently from a young age. Several participants reflected critically on the **normalisation of male entitlement** and double standards within their communities. These translated into everyday encounters with the subject of male hegemony, which is not limited to or contained in the male partner, but extends to also emerge from the family and other social groups in society (Savigny & Scullion, 2019). Women repeatedly connected intimate dynamics to broader forms of socialisation that teach men entitlement and authority, while teaching women accommodation, patience, and self-monitoring.



By the way, we see this a lot: the man is never blamed for anything. He does whatever he wants, but for her it's shameful, sinful, and forbidden... it's haram for a woman to do this... it's always allowed for the man but forbidden for the woman.



Oh my God, what love does to a person! I even gained weight after we broke up, and during the relationship I gained a lot of weight too. Then I met someone else who told me: if you lose weight you'll become more beautiful. So I left him and went to eat a shawarma sandwich.



Why did they place honour only on the woman and not on the man? ... If she does something, she brings shame to us? Why? If he does something, doesn't he bring shame to you too? They say it's just 'youthful mistakes'.

At the same time, participants' stories reveal that women are not simply passive within these unequal dynamics. Across discussions, we reflected on the different ways **women continuously find to negotiate space for themselves**, even within restrictive conditions. These ways were shaped by conditions that depend on access to support, knowledge, and economic or emotional independence. One woman spoke openly about how hormonal conditions and excess hair growth affected her relationship with her body and confidence:



For example, not being confident about the hair on my body makes me... feel ashamed. I have a bit of health issues, related to hormonal hair growth and things like that. He would tell me, 'My wife, just stop thinking about this topic.' Thank God my husband is aware of these things.

She then added:



Sometimes it is the partner who gives you that confidence in your body.

Rather than framing confidence as something purely internal or individual, these reflections show how experiences of autonomy and bodily comfort are deeply relational, shaped by whether relationships reproduce shame and control or instead create space for safety and affirmation.

At the same time, many women spoke about actively resisting the idea that they must reshape themselves entirely around men's expectations or social judgement. Across the discussions, participants repeatedly returned to the importance of remaining connected to their sense of self.



I don't do anything to make him comfortable; I do things so that I am comfortable... if I have to pretend, I won't feel comfortable.



I love myself as I am... whoever wants to accept me, accepts me, and whoever doesn't shouldn't be close to me... this is me.

These moments are important because they show women articulating forms of agency that do not necessarily appear through visible acts of resistance alone. Instead, they appear through everyday refusals. For some women, autonomy appeared through setting boundaries and questioning social expectations.

Women's experiences therefore complicate simplistic understandings of autonomy as either fully present or entirely absent. Instead, autonomy emerged as something negotiated unevenly across relationships, families, institutions, and social expectations. It was shaped by fear and constraint, but also by adaptation, reflection, resistance, and the continuous work women undertake to carve out space for themselves within unequal conditions. Autonomy cannot be separated from the broader realities shaping our lives. Rather than existing as a purely individual freedom, autonomy is experienced as relational, conditional, and deeply connected to women's access to knowledge, safety, economic resources, emotional support, and collective spaces where alternative possibilities can begin to emerge.

4. COLLECTIVE KNOWLEDGE AS RESISTANCE: BUILDING SUPPORT, CHALLENGING NORMS, AND IMAGINING ALTERNATIVES

This theme explores how, in resistance to the lack of knowledge related to SRHR, women seek knowledge that is collectively produced through interactions with one another and within shared spaces of reflection. Moving beyond understandings of knowledge as fragmented or externally provided, the findings show how women actively co-produce meaning through the exchange of lived experience. Ultimately, Theme 4 argues that knowledge production in this context is deeply political, requiring us to remain attentive to who gets to know things, and what kinds of knowledge are treated as valid or trustworthy, and who holds the very authority to decide. In Lebanon's SRHR landscape, women have been systematically excluded from all three, as dominant institutions (whether medical, education, religious, etc.) have long determined what women are allowed to know about their



Photo:Yolita Malaab

own bodies and rights, very often dismissing or silencing the knowledge that emerges from their lived experiences. In this context, when women come together to question inherent beliefs and collectively make sense of their bodies and relationships, they are actively creating alternative epistemic spaces that challenge dominant norms, and ultimately, imagine more supportive and just ways of knowing and expressing their sexual and reproductive life.

4.1 COLLECTIVE SPACES AS COUNTER-SPACES AGAINST MARGINALISATION

Collective research spaces were not merely sites for data collection, but became, for many women, rare spaces where speaking about the body felt possible without immediate dismissal or shame. In contexts where conversations around the body, menstruation, sexual and reproductive health, and intimate relationships are often approached cautiously, if at all, the existence of a space where women could speak openly without immediate policing was itself significant. Many of us arrived carrying stories that we have learned to minimise, or laugh off, or remain entirely silent about.

For some participants, this was the first time they had been asked to reflect on their relationships with their bodies or experiences in ways that did not already carry assumptions, and beyond medical need or social expectation. For many, this was the first time they had been invited to reflect on their bodies at all. As a result,

speaking initially felt unfamiliar and vulnerable, yet gradually opened space for articulating experiences that had remained unspoken for years.



It's the first time in my life that I talk about this topic... even with the people closest to me, I don't talk about such things. This is an opportunity... that someone is listening, and that we can make a difference together. I want there to be a difference in any woman's life, even a small one, so that no one goes through the same experience and no one else has to relive these feelings.

What deeply stayed with many of us as co-researchers was not only the stories themselves, but how quickly the atmosphere in the room shifted once women sensed they would not be mocked or blamed. Several of the co-researchers later reflected on how unexpectedly it felt that women would speak with such openness about experiences they had never previously shared, particularly within a relatively short period of collective discussion. We had not fully anticipated the extent to which women would open up once a collectively held and non-judgmental space became available, especially that we did not know how these women might

even react to the topics we were reflecting on together, and the extent to which they would share. One story often carried another behind it. A memory someone hesitated to mention suddenly became familiar to another woman across the room. Some participants cried while speaking. Others laughed midway through painful experiences. Several women returned later in the discussion to complete stories they had initially stopped themselves from telling. These moments illuminated the transformative potential of collective feminist spaces in interrupting this isolation, even temporarily, by legitimising our experiences as worthy of discussion, reflection, and collective listening.

At the same time, the “collective” itself does not always emerge as a neutral or universally equal space. Collectivities themselves remain structured through unequal relations of power that shape whose voices become audible, whose experiences are recognised as legitimate, and whose knowledge is treated as credible or authoritative (Joseph, 2002). These dynamics were also present within our discussions. Women entered the space carrying profoundly unequal relationships to knowledge, speech, confidence, and legitimacy, shaped by age, marital status, education, disability, motherhood, class position, and prior exposure to feminist or awareness-based language surrounding rights and bodily autonomy. While some participants spoke relatively comfortably about SRHR-related topics, others struggled to name bodily experiences they had never previously discussed aloud.

Silence revealed itself differently in these moments as something we had learned to organise ourselves around for years; and this silence was not static, as it moved between generations quietly. Even within the family, often imagined socially as a site of care and intergenerational support, women described profound forms of epistemic rupture and silence surrounding the body.



During menstruation, we did not have enough information; there was a significant lack of awareness. At school, we were given very basic information, and even at home there was no clear information, and I was the eldest sister. When I got my first period, I did not understand what was happening, and I did not even know what it was. I was afraid to ask and did not know who to turn to, so sometimes we would go to the school nurse, and she might give us inaccurate information.

There was always a sense that this topic was shameful at school, at home, and in society, so it was difficult to ask about it. There was constant fear, as if speaking about it was not allowed, and if we did, it had to be in front of specific people only.

As participants began sharing stories, the discussions became more than exchanges of individual experiences; they became **moments of collective recognition**. One woman’s story often opened the space for another woman to remember, reinterpret, or finally articulate something she had previously carried alone.



Is it possible that we all went through these things and no one talked about it? So each one of us thought she was alone?

This collective sharing shifted the meaning women attached to their experiences, as it produced new conditions for interpretation. Feelings of fear, confusion, shame, or uncertainty were no longer understood solely as personal weakness or individual failure, but increasingly connected to broader systems of silence, stigma, and exclusively restricted access to knowledge. They began to form connections between the systems that allow for such experiences to be

normalised. As women listened to one another, feelings of isolation often began to lessen, and forms of quiet **solidarity** emerged between participants. This solidarity did not necessarily rely on formal language or explicit political framing, but was built through listening, and the experience of feeling understood by others who had lived through similar realities. (Stevens & Xaba, 2024).



I discovered more things about myself, and I did not expect that these words would come out of me or that I would connect between these experiences. I felt a great sense of relief.



I felt that there were practices I used to engage in before, and I felt relieved when we started sharing them together now.



I felt that I released negative energy that was inside me.

Storytelling itself also became a form of epistemic production of situated knowledge grounded in embodied experience. Topics that had long been treated as “taboo” were finally and safely enough to discuss within a space that approached women’s experiences with seriousness rather than judgment. This shift is important because silence does not protect women; rather, it isolates them further and intensifies fear, confusion, and self-blame. (Lorde, 1977). When experiences are spoken aloud and collectively reflected upon, it becomes possible to reinterpret them differently as forms of lived knowledge emerging from the body, from everyday life, from fear, pain, confusion, and unanswered questions. In this sense, **storytelling was a cathartic experience**

for these women, but also an epistemic one; a way of collectively producing and legitimising knowledge grounded in our lived realities rather than external authority or socially dictated norms. (hooks, 1989).

At the same time, the possibility of participation remained unevenly distributed. Feelings of safety alongside the ability to disclose experiences remained shaped by age, marital status, family dynamics, motherhood, divorce, illness, disability, and exposure to social judgment or surveillance. These differences influenced how the women spoke, what they felt able to disclose, and how they related to discussions around the body and sexuality. As such, the collective space illuminated unequal social positions and the additional burdens carried by some women because of their social and material conditions. All of this is to show that collective feminist spaces cannot be romanticised as inherently liberatory or universally accessible. They remain shaped by the same unequal social relations we are attempting to navigate and resist outside the room itself. This is not to discredit the spaces we aim to create for ourselves, but rather to acknowledge and reflect on what we carry with us as we step inside, and how it shapes the dynamics, but also on how we show up, and how we can be attentive and intentional in shifting our practices and power, and holding spaces for genuine listening, solidarity and exchange (hooks, 2000).

Despite these contradictions, the sessions repeatedly demonstrated the **importance of collective feminist spaces** in contexts where women are systematically denied socially legitimate opportunities to speak openly about their bodies and intimate lives. Through speaking, listening, questioning, remembering, and collectively reflecting, women gradually transformed silence from an individual burden into a socially recognisable condition shaped by broader systems of gendered control, epistemic exclusion, and bodily regulation. In doing so, these spaces functioned as counter-spaces to dominant structures that isolate women within shame and fragmentation, opening possibilities for alternative forms of solidarity, interpretation, and collective feminist knowledge production grounded in lived experience rather than institutional authority alone.

4.2 COLLECTIVE RECONSTRUCTION OF KNOWLEDGE

As discussed in Section 1, women's relationships to SRHR knowledge were shaped by fragmented access to information, institutional silence, and the absence of socially safe spaces for asking questions openly. Yet women did not simply remain passive within these conditions of exclusion. Rather, participants repeatedly described engaging in **ongoing processes of interpretation and collective verification** through which knowledge was gradually reconstructed across different stages of their lives.

Many of us in these sessions reflected on how understanding our bodies often emerged belatedly, after years of harmful experiences had already taken place. Learning through experience did not always emerge as empowerment. In many cases, knowledge arrived late, after emotional distress, bodily harm, or practices that negatively affected physical and psychological wellbeing had already occurred.



The lack of information led to bad practices that negatively affected my health.



I didn't know anything about my body... I started searching on my own and reading little by little because there was no one to explain to me.

Awareness and discussion sessions played an important role in this process. Women described these spaces not only as sources of information, but as spaces that enabled them to rethink previous assumptions about their bodies, sexuality, relationships, and rights. Several participants reflected on how learning accurate information shifted their relationships with themselves, increased confidence, or helped reduce fear surrounding bodily changes and sexual health. In this light, one woman expressed how "through awareness sessions...

I feel more confident", while another explained that she previously "did not have a source she could rely on", but now she does. These shifts did not emerge through the simple transmission of "correct" information, but through the possibility of collectively interpreting experiences that had previously been isolated.

At the same time, women did not engage with these sources passively. Women repeatedly described reinterpreting earlier assumptions in light of new **conversations and experiences**.



There were many things I thought only I had experienced... but when we started talking, I understood that these are shared among all women.

Even as women reconstructed knowledge collectively, certainty itself often remained unstable. We have discussed in Section 1 the alternative knowledge sources that women seek information from, but it is important to reiterate ongoing negotiation with ambiguity as women move between contradictory medical advice, social expectations, online information, and embodied experience without always arriving at clear or complete answers.

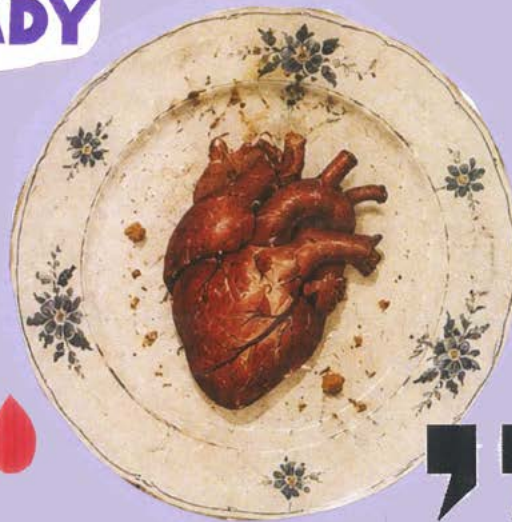
Importantly, the findings demonstrate that knowledge production itself can function as a form of resistance. In contexts where women are systematically denied comprehensive, accessible, and non-judgmental SRHR education, the act of seeking information, sharing experiences, questioning inherited beliefs, and collectively interpreting bodily experiences becomes politically significant. Women are not simply passive recipients of information, but active participants in constructing meaning around our bodies, relationships, and wellbeing despite ongoing barriers and contradictions. Knowledge therefore emerges not only as information, but as an ongoing social process through which women negotiate fear, reclaim language around their experiences, and gradually expand possibilities for bodily autonomy, self-understanding, and collective support.

VI. CONCLUSION AND RECOMMENDATIONS



Photo: Yolita Malaab

WOMEN ALREADY HAVE VOICES



رکائ قلبی وجبة غدا،
یتناولها لیل شباع رغبة.



Our research emerged from a shared urgency to make sense of, name, and document our experiences as young women navigating fragmented SRHR knowledge landscapes and deeply restrictive, stigmatising social environments in Lebanon. What began as a research process quickly became a deeply emotional and transformative collective journey, shaped by vulnerability, recognition, and care. Across discussions and storytelling sessions, an unexpected depth of trust and intimacy unfolded, not only between us and the women who participated, but also among ourselves as researchers, as silenced experiences, fears, and questions were spoken aloud, often for the very first time. Taken together, these conversations reveal how access to SRHR knowledge is not simply about information availability, but about power: who can access it, who is denied it, and how these inequalities shape women's relationships with their bodies, their sense of self, and their intimate relationships and decision-making.

As women collectively shared stories, and as we reflected on our experiences, questioned inherited beliefs, and navigated different sources of information, knowledge emerged as something far broader than the simple acquisition of "correct" information. Across our discussions, it appeared as a form of

emotional survival, collective care, and everyday resistance within contexts where women are routinely denied accessible, trustworthy, and non-judgmental support regarding our bodies, sexualities, relationships, and reproductive health. These processes of meaning making do not take place within supportive institutional or communal structures, but rather within environments shaped by silence, stigma, fragmented information, and unequal access to care and education. Silence is not accidental but socially produced and sustained through systems of control and gendered norms that regulate what women are allowed to know, ask, or express about our bodies. Participants' narratives vividly illustrate how women are often expected to carry the burden of navigating risk and uncertainty individually, in the absence of accessible and reliable SRHR information and support systems.

Knowledge, therefore, emerges as a collective and political practice of survival, care, and resistance. Through seeking, sharing, questioning, and collectively producing knowledge, women challenge systems that normalise silence, isolate bodily experiences, and restrict bodily autonomy. At the same time, these stories point to the urgent need for sustained, accessible, and non-judgmental spaces where women can openly discuss our



bodies, relationships, fears, and desires. Spaces that move beyond fragmented awareness efforts toward more collective, feminist, and structurally grounded approaches to SRHR.

The findings of this research highlight the need to rethink how SRHR knowledge is framed and supported in practice. They point to the importance of addressing the structural conditions that shape access, including the availability, safety, and legitimacy of spaces where women can seek and share knowledge. In our collective reflections as lead and co-researchers, we identified a set of key recommendations, that are directly grounded in these findings and experiences and addressed to stakeholders who hold power and influence over SRHR knowledge, access, and services. These were discussed, refined, and prioritised together with participants through validation sessions, ensuring that they remain grounded in women's experiences, needs, priorities and continuous negotiations of safety, autonomy, and care. As such, the recommendations proposed in the following section respond directly to these lived realities and seek to address not only gaps in information, but the broader systems that produce and sustain those gaps.

Recommendations focus on strengthening accessible, rights-based, and non-judgemental

SRHR ecosystems that respond to women's everyday realities. They are organised thematically and highlight key stakeholders, with the purpose of emphasising potential collaborations across key areas of influence. Critically, these categories are not intended to be read or implemented in isolation. Rather, they reflect interconnected dimensions of the same system, where services, knowledge, norms, and policy continuously shape one another. As such, the recommendations should be understood and acted upon as a holistic framework for change, requiring coordinated and cross-sectoral responses.

Our feminist methodological approach grounded in collective reflection, lived experience, and participatory knowledge production, allowed for a deeper and more holistic understanding of the structural conditions shaping SRHR in Lebanon. This approach is not only analytical but also political, as it challenges fragmented and technocratic readings of SRHR issues and instead situates them within broader relations of power, gender, and inequality. In this sense, the recommendations reflect our approach's core insight: that meaningful change in SRHR cannot be achieved through isolated sectoral reforms, but requires coordinated, systemic transformation across interconnected domains.

RECOMMENDATIONS FOR SERVICES



RELEVANT STAKEHOLDERS

Ministry of Public Health; hospitals and clinics; primary healthcare centres; healthcare providers; Orders of Physicians and Nurses; Lebanese Order of Midwives; civil society organizations; donors.



FOCUS

Healthcare systems and services must shift from hierarchical, paternalistic and coercive models of SRHR care, towards patient-centred, rights-based and non-stigmatising services, grounded in informed consent, confidentiality, dignity and bodily autonomy.



PRIORITY AREAS

- **From narrow clinical SRHR provision to a diverse, needs-responsive ecosystem of services:** SRHR services in Lebanon remain concentrated in hospital-based, biomedical, and urban settings, which limits accessibility and responsiveness to diverse women's everyday realities. A structural shift is needed toward a more diverse ecosystem of services that includes community-based, mobile, low-cost, and non-hospital entry points for SRHR care, alongside the mainstreaming of SRHR services and priorities within major healthcare institutions and dominant medical practices to ensure rights-based, non-stigmatising and consent-based care across all levels of the health system.
- **From fragmented access pathways to community-identified networks of trusted providers:** Women often rely on informal networks to identify safe and respectful providers due to mistrust of formal systems. These community-generated pathways should be recognised and strengthened through supported networks of trusted providers identified by women themselves, including midwives, doctors, and counsellors known for respectful, trauma-informed, inclusive and non-stigmatising care, across geographical areas.
- **From formal consent procedures to enforceable, practiced consent in clinical encounters:** SRHR care often relies on assumed consent shaped by authority, urgency, or silence rather than active, ongoing agreement. The priority is to shift consent within healthcare service delivery from a documented procedure to an active and continuous rights, and an enforceable practice embedded in provider behaviour, patient interaction, and institutional monitoring.
- **From centralised and hospital-based care to decentralised and trusted SRHR entry points:** Access to SRHR services remains uneven across geography, class, age, ability, legal status and other factors, with heavy concentration in urban areas. Expanding decentralised, community-based, and midwife-supported models is essential to reduce exclusion and over-medicalisation.

- **Building accountability for respectful and dignified care:** Obstetric and medical violence persist in contexts where complaint systems are internal, inaccessible, or socially discouraged. A structural shift is needed toward independent, survivor-centred accountability mechanisms with investigative and sanctioning authority beyond professional syndicates and hospital systems. Also, existing systems often fail to address everyday disrespect, coercion, and emotional harm in healthcare settings. Accountability mechanisms must address not only extreme violations but also routine forms of disrespect, neglect, and stigma in SRHR care delivery.
- **Investing in mandatory training on non-stigmatising, inclusive and accessible SRHR care:** Moving beyond technical competence only, ensure continuing education and licensing focus on interpersonal practice and non-stigmatising inclusive care. A structural shift is needed toward mandatory, continuous training that addresses non-stigmatising communication, inclusion, disability-sensitive care, tailored practices for diverse women, and respectful engagement with young women and unmarried patients.
- **Transforming provider attitudes and clinical authority:** Violence and exclusion are frequently reproduced through attitudes of judgement, moralisation, and paternalism in clinical encounters. Addressing SRHR gaps requires transforming how providers understand and exercise authority, including challenging stigma around sexuality, unmarried women, contraception, and reproductive autonomy.
- **From fragmented services to rebuilding trust between health systems and communities:** A core barrier to SRHR access is the erosion of trust in healthcare institutions, shaped by stigma, coercion, and repeated violations of dignity and autonomy. Rebuilding trust requires consistent respectful care, institutional accountability for harm, and sustained responsiveness to women's lived experiences. Investing and expanding the role of already trusted community-based healthcare providers is also essential in this process.
- **Ensuring accessible, multilingual, and trustworthy SRHR information-sharing within healthcare settings:** In practice, healthcare providers often act as the primary gatekeepers of SRHR knowledge, yet information-sharing is frequently inconsistent, overly technical, or filtered through stigma and dismissive attitudes. A structural shift is needed to ensure that healthcare providers systematically deliver accurate, accessible, and culturally appropriate SRHR information in ways that support informed decision-making and bodily autonomy, and challenge pervasive silence and misinformation.

RECOMMENDATIONS FOR ADVOCACY AND POLICY REFORM



RELEVANT STAKEHOLDERS

Members of Parliament; Ministry of Public Health; Ministry of Social Affairs; Ministry of Education and Higher Education; civil society organisations; UN agencies.



FOCUS

SRHR in Lebanon must shift from fragmented legal recognition and partial enforcement into a coherent, enforceable rights framework that addresses bodily autonomy, consent, and structural gender inequality across institutions.



PRIORITY AREAS

- **From fragmented education to institutionalised CSE:** The educational system currently reproduces silence, misinformation, and gendered stigma around sexuality, relationships, and bodies. A structural reform is needed to integrate mandatory, age-appropriate, and rights-based Comprehensive Sexuality Education across schools and universities. This must go beyond biological content and anatomy to include consent, bodily autonomy, relationships, contraception, pleasure, GBV, and digital safety, and must be institutionally embedded within the national curriculum.
- **From fragmented legal protections to a consent-based legal framework on violence in intimate relationships:** Current legal frameworks on domestic violence remain limited in scope and enforcement and fail to adequately address coercion and control within intimate relationships. A key priority is reforming domestic violence legislation to adopt a clear consent-based approach, explicitly recognising psychological, sexual, and coercive forms of violence within and outside marriage.
- **From legal silence to explicit criminalisation of marital rape:** The absence of explicit recognition of marital rape within Lebanese law reflects and reinforces the normalisation of sexual coercion within marriage. Legal reform must explicitly criminalise marital rape, recognising bodily autonomy within marriage as non-negotiable and legally protected.
- **Moving towards a national SRHR information system grounded in rights and accessibility:** Access to SRHR knowledge remains fragmented, inconsistent, and heavily shaped by stigma, geography, and social gatekeeping. Policy reform is needed to establish accessible, standardised, and publicly available SRHR information systems in several languages, ensuring that accurate information on bodies, sexuality, contraception, and services is not dependent on informal networks or social permission. This includes integrating SRHR information into public institutions, digital platforms, and health and education systems in ways that protect privacy and reduce stigma.



- **Strengthening the legal framework on sexual harassment:** Reform and strengthen existing sexual harassment legislation¹ by expanding its definitions to fully cover verbal, non-verbal, physical, digital, and institutional forms of harassment across all public and private spaces. Ensure effective enforcement through accessible, confidential reporting mechanisms, independent investigation procedures, protections against retaliation and survivor-centred protections that reduce the burden of reporting and address the structural barriers that currently limit the law's implementation and impact.

1. *Sexual harassment legislation in Lebanon (Law 205 passed in December 2020) provides a basic legal definition and protection framework, primarily focusing on workplace harassment and certain public-space contexts. However, feminist and women and human rights actors have criticised the law for being too narrow and incomplete in scope, with gaps in coverage of digital forms, broader public/private spaces, and structural or institutional harassment, and is also constrained by weak implementation and reporting barriers. It fails to include key protections such as prevention measures, workplace obligations, enforcement mechanisms, and accessible civil remedies for survivors (Human Rights Watch, 2021).*

RECOMMENDATIONS FOR COMMUNITY-BASED INTERVENTIONS



RELEVANT STAKEHOLDERS

International NGOs, Feminist organisations; CSOs; local NGOs; youth networks; media actors; donors.



FOCUS

Shift community-level SRHR work from awareness-raising towards feminist consciousness-raising, collective knowledge production and solidarity-building, focus on social norms and behavioural change strategies, and support women's navigation of violence, relationships, and bodily autonomy.



PRIORITY AREAS

- **From awareness-raising to collective feminist knowledge infrastructures:** SRHR interventions must move beyond one-directional awareness-raising toward sustained spaces where women share stories and collectively interpret their experiences, build shared understanding of bodies, relationships, and violence, and develop practical strategies for navigating everyday realities. Support for these spaces should also focus on sustaining social support networks, reducing isolation and enabling women to rely on trusted peer connections for emotional support, information exchange, and guidance in decision-making around SRHR, relationships, and care-seeking.
- **From stigma management to structural transformation of gendered norms and relationships:** Interventions must move beyond managing stigma and risk at the individual level toward addressing the structural norms that regulate sexuality, marriage, bodily autonomy, and women's roles in intimate relationships. This includes challenging honour/shame frameworks, addressing coercion and control in relationships, and engaging critically with how gendered expectations shape women's ability to make informed decisions about their bodies and lives. Feminist social and behavioural change approaches and social norms change interventions should be centered, such as community dialogue spaces that centre women's lived experiences of relationships and bodily autonomy, participatory storytelling and theatre-based interventions that surface norms around consent and control, and intergenerational discussion spaces that allow for critical reflection on inherited beliefs around sexuality and marriage. It also includes peer-led group work that supports reflection on consent, boundaries, and power within intimate relationships in ways that are grounded in everyday realities. These processes must be led by women themselves as knowledge-holders and agents of change within their communities. Engagement with power-holders and potential allies, such as community leaders, religious leaders, and men and boys, should be guided by clear feminist standards of accountability, identified by women themselves, and defined by concrete shifts in behaviour, attitudes, and power relations, rather than symbolic or performative notions of "allyship."
- **From token participation to feminist participatory methodologies:** Community interventions should be grounded in participatory feminist methods that centre lived experience as knowledge. Approaches such as storytelling, body mapping, and collective reflection should be recognised as tools for both knowledge production and social transformation, not only engagement.

RECOMMENDATIONS FOR EDUCATION AND KNOWLEDGE SYSTEMS



RELEVANT STAKEHOLDERS

Ministry of Education and Higher Education; schools; universities; teacher training institutions; curriculum developers; CERD; school counsellors; NGOs; feminist educators.



FOCUS

Transform sexuality education and knowledge systems as institutionalised, rights-based infrastructures that shape women's and young people's capacity for informed decision-making, bodily autonomy, better care, and safer intimate relationships.



PRIORITY AREAS

- **Design and institutionalise a mandatory comprehensive sexuality education integrated in official school curricula:** SRHR education must be institutionalised and standardised across formal education systems, rather than dependent on NGOs or discretionary implementation. CSE must be aligned with international standards and ensure a focus on trauma-informed, non-stigmatising and inclusive information. Education must include consent, relationships, contraception, pleasure, bodily autonomy, digital safety, and violence within intimate relationships. Curricula must explicitly address gendered power relations, coercion in relationships, and how norms shape women's understanding of intimacy and consent.
- **From silence to safe disclosure and support systems in educational spaces:** Schools and universities must provide confidential, non-punitive and non-judgemental pathways for support and referral, recognising their role in protecting children and youth, and shaping early decision-making and safety.
- **Invest and sustain feminist co-production of knowledge and popular education:** Feminist organisations and community actors should be recognised as co-producers of SRHR knowledge within education systems, rather than external add-ons to formal curricula or service delivery. This requires supporting and sustaining non-formal, grassroots feminist education spaces as central sites of learning and meaning-making. Community-led workshops, peer education groups, and feminist consciousness-raising spaces already play a key role in how many women access information and interpret their experiences. These should be supported as core components of SRHR education ecosystems, with sustainable resourcing and institutional recognition. This approach implies a shift toward co-production as a redistribution of epistemic authority, where lived experience and feminist pedagogy are treated as essential to shaping how SRHR knowledge is produced, shared, and applied.

RECOMMENDATIONS FOR PARTNERSHIPS AND COLLABORATIONS



RELEVANT STAKEHOLDERS

INGOs; UN agencies; feminist organisations; grassroots groups; ministries; research centres; donors.



FOCUS

Ensure partnerships redistribute power and center feminist and community actors' leadership in shaping priorities, knowledge, and implementation rather than serving as delivery mechanisms.



PRIORITY AREAS

- **From extractive partnerships to redistribution of power and decision-making:** Current partnership models often position local organisations as implementers rather than decision-makers. A structural shift is needed toward co-governance models where feminist and community-based organisations hold meaningful authority over programme design, priorities, and resource allocation, rather than being consulted retrospectively.
- **From short-term project cycles to sustained investment in strategic feminist partnerships and structures:** SRHR work in Lebanon is heavily dependent on short-term, fragmented funding cycles that undermine continuity and trust-building. Partnerships must prioritise long-term investment in strategic feminist partnerships and structures, including grassroots organisations, community networks, peer education systems, and SRHR knowledge spaces that require sustained engagement rather than time-bound interventions.
- **From symbolic participation to feminist epistemic justice in partnerships:** Feminist and community actors must be recognised as producers of analysis, strategy, and evidence, not only beneficiaries or implementers. Partnerships should explicitly redistribute epistemic authority by ensuring that lived experience and feminist knowledge shape programming priorities, monitoring frameworks, and evaluation criteria.
- **From coordination gaps to integrated cross-sectoral collaboration and feminist, locally led SRHR ecosystems:** SRHR responses must reflect the interconnected nature of health, education, justice, and social systems, and partnership structures should move beyond technical coordination between institutions, or top-down implementation agreements, toward feminist ecosystems where women's organisations and grassroots actors are positioned as central responders and decision-shapers. This requires recognising that local feminist actors are not service extensions, but key infrastructural actors sustaining SRHR knowledge, care, and protection in contexts of crisis and state withdrawal.

RECOMMENDATIONS FOR RESEARCH AND KNOWLEDGE PRODUCTION



RELEVANT STAKEHOLDERS

Universities; research centres; INGOs; donors; researchers; media platforms; community organisations.



FOCUS

Shift SRHR research from extractive documentation toward feminist, participatory knowledge production that centres women's priorities and lived experience, structural analysis, and policy relevance.



PRIORITY AREAS

- **From extractive research to feminist co-production of knowledge:** SRHR research must move beyond extractive methodologies where communities are treated as data sources. Instead, women and community actors should be recognised as co-researchers and co-analysts, shaping not only data collection but also interpretation, framing, and dissemination of findings. This requires shifting power away from external researchers and toward shared ownership of knowledge production processes. This research process itself reaffirmed the value of participatory and inclusive approaches to knowledge production, as co-researchers and participants consistently highlighted how meaningful it was to engage not only in sharing experiences, but also in collectively interpreting findings, validating interpretations, and shaping recommendations. This iterative engagement strengthened the relevance, depth, and grounding of the findings, while also reinforcing feminist commitments to shared ownership of knowledge and accountability to participants.
- **Systemic analysis of SRHR experiences, oppressive systems and power:** SRHR research should move away from framing women's experiences as isolated "knowledge gaps" or individual information deficits or experiences, and instead treat them as part of a systemic and interconnected web of power relations. This requires analysing how access to SRHR knowledge, experiences of the body, and intimate decision-making are structurally shaped by institutions, social norms, legal frameworks, and healthcare systems. Research must therefore explicitly examine how these systems interact to shape women's ability to understand their bodies, recognise violence, navigate relationships, and make informed decisions about sexuality, reproduction, and care.
- **Invest in accessible feminist knowledge ecosystems:** Research outputs must be produced in accessible formats for persons with diverse disabilities, as well as Arabic and in formats that are meaningful beyond academic or donor audiences. This includes ensuring clarity, cultural relevance, and usability for communities themselves, and recognising that language, accessibility, and tone are central to whether knowledge can actually inform women's choices and everyday decision-making. This also requires actively building on and amplifying existing community-produced and feminist resources. Materials such as the present research piece and the 2025 Oxfam published *Youth Guide to SRHR* (El Asmar & Spencer, 2025), and other locally grounded SRHR tools should be treated as part of a growing feminist knowledge ecosystem. Strengthening dissemination, adaptation, and collective use of such resources is essential to ensuring that SRHR knowledge remains continuous, situated, and accessible.

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VIII. ANNEXES



ملحق ١: دليل جمع البيانات - العربية

الجلسة ١: جلسة تمهيدية

دليل الجلسة

الترحيب (٥ دقائق)

المقدمة (١٥ دقيقة)

- تقديم الفريق.
- اشكري الجميع على انضمامهم. اشرحي مدة الجلسة، وشاركي أي معلومات لوجستية أخرى.
- اشرحي أهداف الجلسة:
 - « مشاركة معلومات حول عملية البحث
 - « التعارف وبناء الثقة
 - « تأكيد الاهتمام والالتزام
 - « بدء المحادثة
 - « اشرحي السرية.
 - « اشرحي أنه لا توجد إجابات صحيحة أو خاطئة، وأنا مهتمة بمعرفة المزيد عن قصصهن. اشرحي أنه قد تكون هناك أوجه تشابه واختلاف في تجاربنا، وأن جميع تجاربنا صالحة، ومهمة، ولها قيمة.
 - « اشرحي أن وجودنا هنا ليس للحكم على تجارب بعضنا البعض، بل للتعلم منها والتفكير بما يجب تحسينه أو تغييره
 - « كي نشعر براحة وأمان أكبر في حياتنا وعلاقاتنا وأجسادنا.
 - « خذي موافقتهم على بدء الجلسة، وتدوين الملاحظات، و/أو التسجيل.

التعارف: نشاط لكسر الجمود (٢٠ دقيقة)

سيتم اختيار نشاط كسر الجليد بما يتماشى مع تفضيلات المستفيدات، طبيعة المجموعة، ومستوى الراحة والتفاعل. وبما يضمن خلق مساحة آمنة، محترمة، وشاملة للجميع

١. نشاط: «اسمي واسم اللي قبلي»

- نبدأ النشاط بدائرة.
- كل مشاركة تعرّف عن نفسها بالترتيب وتشارك:
- الاسم أو الاسم الذي تفضل أن تنادي به
 - اسم المشاركة التي سبقتها
 - وبعدين اسمها (ثم اسم المشاركة مرة أخرى)
 - كل مشاركة تكرر الأسماء السابقة وتضيف اسمها.

ملاحظة مهمة :

يمكنك اختيار الاسم الذي تفضل استخدامه خلال الجلسات، على أن يعتمد الاسم نفسه في جميع اللقاءات، تقديراً لاختيارك ولكي تتمكن من التواصل وتذكر بعضنا بسهولة.



التعارف: نشاط لكسر الجمود (٢٠ دقيقة)

٢. لعبة بنغو الجسد Body Bingo

حُضري ورقة Bingo (٣×٣) أو (٤×٤) تحتوي أسماء أعضاء الجسم (واحد بكل مربع).

أمثلة على الأعضاء

الجلد	الكلبي	المعدة	القلب
الرحم	العظام	الأمعاء	الرئتان
الخصيتان	العضلات	الكبد	الدماغ

طريقة اللعب

الميسرة تنادي اسم العضو ← المشاركات يعلّمن عليه.

٣. جمل وآراء حول مواضيع متنوعة

تتحرك فيها المشاركات بأجسادهن أو بأيديهن يميناً أو يساراً للتعبير عن مواقفهن.

لمحة عن مسار البحث ومبادئنا (١٠ دقائق)

معلومات أساسية عن البحث



هذا البحث هو جزء من مبادرة تقودها باحثات وناشطات نسويات ومجتمعيات، وتنطلق من فكرة أساسية وهي أن قصصنا وتجاربنا ليست مجرد «حكايات شخصية»، بل هي معرفة بحد ذاتها.

معظم ما نمر به ونشعر به في حياتنا اليومية لا يُكتب في البحوث الرسمية ولا يصل إلى الإعلام، رغم ما يحمله من فهم عميق للواقع وللظلم ولما يجب أن يتغير. نحن في هذا المشروع لا نهدف لدراساتٍ أو جمع معلوماتٍ منكن، ولا نفصل بين «باحثات» و«مشاركات»، فنحن نعمل معاً لنصنع المعرفة سوياً، بالاعتماد على تجاربنا وأسئلتنا وتحليلاتنا.

هذه المساحة هي مخصصة لكنّ، لكي نتحدثن وتساءلن وتعرضن وتضفن ما نشعرن أنه يعكس واقعكن بصدق.

كل ما سنعمل عليه:

- سنشاركه معكنّ
- وسنعود إليكنّ بالنتائج من خلال جلسة المصادقة لنسمع رأيكنّ وتؤكد من أن ما كُتب يمثّل أصواتكنّ حقاً.

الغاية النهائية هي تحويل تجاربنا ومعارفنا لخطوات عملية:

- تشمل مطالبنا وبالتالي تحسّن السياسات
- تطوّر الخدمات
- وتدعم حقوقنا وتلبي حاجاتنا

لمحة عن مسار البحث ومبادئنا (١٠ دقائق)

منهجية البحث: نسوية وتشاركية



- البحث قائم على منهجية نسوية وتشاركية، مما يعني:
- لكل واحدة منكن صوتٌ يجب أن يُسمع
- ولكل تجربة قيمة حقيقية.
- العمل الجماعي هو ما يصنع التغيير لأننا نحن جميعاً أساس هذا العمل.
- هذا البحث لا يُجرى عليك، بل يُبنى معكن.

دوركن في البحث



- أنتن شريكات بالبحث، ولستن "مواضيع" للدراسة.
- مشاركتكن تساهم بشكل مباشر بصياغة:
- النتائج
- التوصيات
- والخطوات الجاية
- كل كلمة، كل قصة، وكل مشاركة هي جزء من عملية تغيير أوسع بالمجتمع.

المشاركة والموافقة المستنيرة



المشاركة اختيارية ١٠٠٪

- قبل البدء، سوف يتم شرح:
- هدف البحث
- الأنشطة بكل جلسة
- مدة المشاركة
- الفوائد المتوقعة
- (مثل: مساحة آمنة للحوار، الاعتراف بالتجارب، وتحسين السياسات والخدمات)
- المخاطر المحتملة
- (مثل: الشعور بعدم الراحة عند مشاركة مواضيع شخصية)

لكل مشاركة الحق بـ:

- القبول أو الرفض بأي مرحلة من المراحل
- المشاركة أو تخطي أي سؤال
- الانسحاب بأي وقت، بدون أي ضغط أو عواقب

وسيتم سؤالكن بوضوح إذا كنتن موافقات على:

- المشاركة
- تدوين الملاحظات
- بخصوص التسجيل الصوتي للمجموعة، فإذا كانت بيننا مشاركة واحدة فقط غير مرتاحة للفكرة، فهذا كافٍ للامتناع عن التسجيل، والقرار متروك لكن بالكامل.

الخصوصية وحماية البيانات



- لن يتم استخدام أسمائكن الحقيقية في أي تقرير أو عرض.
- أي معلومة شخصية ممكن ان تميّزكن سوف يتم حذفها أو تغييرها عند تحليل البيانات والعودة لكن فيها.

الملاحظات والتسجيلات (في حال تمت الموافقة عليها):

- تُحفظ بمكان آمن وتحذف بعد انتهاء مرحلة الكتابة
- يُطلع عليها فقط فريق البحث
- لا يتم مشاركتها مع العائلة، المجتمع، أو أي جهة ثانية بدون موافقتكن

عند نشر النتائج:

- تُعرض بشكل جماعي
- بدون قصص أو تفاصيل ممكن تعرّف بشخص معيّن

راحتكن وحدودكن أولاً.

إذا شعرت في أي لحظة أن هناك سؤالاً أو مشاركة غير مريحة:

- فإمكانك طلب التوقف
 - أو عدم تدوين هيدا الجزء
 - أو عدم استخدامه بالبحث
- وقراركن سوف يُحترم بالكامل، بدون أي نقاش أو ضغط.

النشاط ١

كيف تعرّفين علاقتك بنفسك وبجسدك؟
لعبة «جسدي وحكايتي» (٢٥-٣٠ دقيقة)

الأدوات

- أوراق صغيرة أو بطاقات اختيارية
- أقلام
- مساحة للجلوس في دائرة



الهدف



- استكشاف شعور كل مشاركة تجاه جسدها
- وصورتها الذاتية بطريقة كلامية وتفاعلية.
- فهم كيف تؤثر المعرفة أو نقصها عن الصحة الجنسية والإنجابية على العلاقة بالجسد.
- صنع مساحة آمنة للتعبير والمشاركة بحرية.

تعليمات اللعبة:

التمهيد:

١. رّحبي بالمشاركات:

مرحباً! اليوم رح نعمل نشاط اسمه جسدي وحكايتي. هيدا النشاط دعوة لنشارك، بالقدر اللي منرتاح فيه، أفكار أو مشاعر عن علاقتنا بأجسادنا، ضمن مساحة آمنة ومحترمة لبعضنا.



٢. اشرحي الفكرة:

بهالنشاط، منعبر إنّه تجاربنا مع أجسادنا هي معرفة بحد ذاتها. كل وحدة رح تحكي عن تجربة أو شعور عندها مع جسدها، ونشارك أفكارنا بطريقة اختيارية وبراحتنا لبنني معرفة أقرب لواقعنا.



خطوات اللعبة:

١. اجلسن في دائرة.
٢. ورّعي أوراق وأقلام
٣. اعطي كل مشاركة وقت ١-٢ دقيقة للتحدث عن نفسها:
 - شيء في أجسادكنّ تشعرن أنه مصدر قوة أو راحة.
 - موقف أو تجربة جعلتكنّ تغيّرن نظرتكنّ لأجسادكنّ، سواء كان ذلك سلباً أو إيجاباً.
 - تجربة جعلتكنّ تشعرن أن المعلومات حول الصحة الجنسية والإنجابية كانت ناقصة أو مربكة.
 - العوامل أو الأشخاص الذين يؤثرون على علاقتكنّ مع جسديكنّ؟
٤. «وأنتن عم تحكوا، ممكن تمر ببالكنّ أسئلة مثل: كيف بتتغير علاقتنا بحسمننا حسب المرحلة اللي عم نمر فيها؟ أو كيف منتعامل مع حسمننا مقارنة مع شخص منحه؟ متى فكرت بحسمنك بطريقة إيجابية أو سلبية؟ وشو كان السبب؟ مش ضروري تحابوا على هالأسئلة فوراً، بس خلوها حاضرة ببالكن.»
٥. قبل أن نبدأ، نودّ تذكيركنّ بأن:
 - المشاركة اختيارية، ولكنّ كامل الحرية في تجاوز الدور أو التحدث بالقدر الذي يريحكنّ.
 - ما يُقال هنا، يبقى هنا.
 - لا توجد إجابات صحيحة أو خاطئة، كما لا يوجد تعليق أو إطلاق أحكام على تجارب غيرنا

بعد كل مشاركة، اسألي المجموعة أسئلة تحفيزية للنقاش:

- ما هو أكثر شيء تشعرن أن المجتمع يركز عليه في أجساد النساء؟ وكيف يؤثر ذلك علينا؟
- من خلال نقاشاتنا، ما هي الأشياء المشتركة التي لاحظتُنّها بين قصصنا ونظرتنا لأجسادنا؟ وماذا يخبرنا ذلك عن كيفية بناء علاقتنا مع أجسادنا كنساء؟



ملاحظة: المشاركة بالكلام اختيارية، ولكل واحدة منكنّ حرية التحدث أو الاكتفاء بالكتابة.

التوثيق:

- إحدى الميسّرات توثق الأفكار والنقاشات بشكل يحافظ على السرية.
- ركزي على الربط بين الوصول للمعلومات والعلاقة بالجسد والثقة بالنفس.

الإغلاق:



قبل أن تنتقل للنشاط التالي، نود أن نتوقف لحظة مع أنفسنا. إن ما قيل هنا اليوم ليس سهلاً، ومشاركة قصصنا عن علاقتنا بأجسادنا تتطلب شجاعة وثقة كبيرة.

نود تذكيركنّ بأنه لا توجد طريقة «صحيحة» أو «خاطئة» للشعور تجاه أجسادنا، وبأن كل تجربة سمعناها لها قيمتها ومعناها. إذا أثّر بداخلكنّ أي شعور، يمكنكنّ الاحتفاظ به، أو التحدث عنه بعد الجلسة إذا رغبتنّ في ذلك. لنأخذ نفساً عميقاً، ونحاول العودة للتركيز على وجودنا هنا والآن.

في النشاط القادم، سننتقل من مشاركة التجارب والمشاعر إلى الحديث عن المعلومات نفسها: ما تعلمناه عن أجسادنا، وما قيل لنا، وما كان ناقصاً أو مغلوطاً.

سنفكك معاً بعض الخرافات ونضعها مقابل الحقائق، ليس بهدف اللوم أو التصحيح القسري، بل لفهم كيف تصلنا المعلومات، ومن هو مصدرها، ولماذا تكون أحياناً مربكة أو يصعب الوصول إليها.

النشاط ٢

شو منسمع؟ وشو بتقول المصادر الطبية/الحقوقية؟ معلومات منتشرة مقابل معلومات أدق (٢٠-٢٥ دقيقة)



- تصحيح المعلومات المغلوطة حول الصحة والحقوق الجنسية والإنجابية.
- فهم نوع المعلومات التي تبحث عنها النساء، مصادرها، والعوائق التي تواجهها في شمال لبنان والبقاع.
- تحفيز النقاش والمشاركة الفعّالة بين المشاركات.

التعليمات للميسّرات:

تهيئة الجو:

- ذكّري المشاركات بأن الهدف هو التعلم وتبادل المعلومات وليس الحكم على أي شخص.
- شجّعيهن على النقاش بحرية ومشاركة خبراتهن وتجاربهن الشخصية.

آلية النشاط:

- وزّعي بطاقات "خرافة/حقيقة" على المجموعات الصغيرة (٣ مشاركات).
- كل مجموعة تقرأ العبارة وتناقش ما إذا كانت خرافة أم حقيقة، مع ذكر السبب.
- بعد النقاش، إسألي قبل المشاركة:
 - « ماذا تتوقعن أن يكون الأقرب للواقع؟ ولماذا؟
 - « هل هناك مصادر أو تجارب تدعم هذا الأمر أو تشكك فيه؟
 - « بعد أخذ مداخلتين أو ثلاثة حسب الوقت، شاركي الإجابة الصحيحة مع الشرح الموجز.

ربط النشاط بالسؤال الفرعي:

- بعد نهاية النشاط اسألي المشاركات:
 - هل كانت هذه المعلومة مألوفة لك؟
 - من أين كنت ستحصلين عادةً على هذه المعلومة؟

التوثيق:

- ميسّرة مخصصة لتدوين الملاحظات حول:
 - نوع المعرفة التي تبحث عنها النساء
 - المصادر الموثوقة لديهنّ
 - أبرز العوائق للوصول إلى المعلومات

الخرافة ❌	الحقيقة العلمية ✅	الشرح والتوضيح (معلومات إضافية)
وسائل منع الحمل تسبب العقم الدائم	وسائل منع الحمل لا تسبب العقم الدائم	معظم وسائل منع الحمل (الحبوب، اللولب، الحقن، الواقي) تأثيرها مؤقت، وتعود الخصوبة بعد إيقافها. قد يتأخر الحمل قليلاً بعد بعض الوسائل مثل الإبر، لكن هذا لا يعني عقماً. العقم له أسباب طبية أخرى مثل التهابات غير معالجة، مشاكل هرمونية، أو أمراض تناسلية.
العلاقة الجنسية تسبب الألم الطبيعي دائماً	العلاقة الجنسية لا يجب أن تكون مؤلمة	الألم ليس طبيعياً، وقد يكون بسبب الخوف، التوتر، قلة الترتيب، عدم الجاهزية النفسية، أو وجود مشكلة صحية مثل التهابات أو تشنج مهبلية. العلاقة الصحية تقوم على الراحة، التواصل، والرضا المتبادل. استمرار الألم يحتاج استشارة طبية.
أول علاقة جنسية يجب نزول دم	نزول الدم غير ضروري ولا يحدث دائماً	الغشاء المهبلي له أشكال متعددة، وقد يكون مطاطياً أو لا ينزف. النزيف قد يحدث بسبب التوتر أو الاحتكاك، وليس دليلاً على "الشرف". عدم نزول دم لا يعني أن الفتاة ليست عذراء. هذه الخرافة سببت أذى نفسي واجتماعي كبير للفتيات.
الحمل لا يمكن أن يحدث أثناء الرضاعة الطبيعية	يمكن حدوث الحمل أثناء الرضاعة	الرضاعة الطبيعية تقلل احتمال الحمل فقط بشروط محددة (رضاعة حصرية، دون انقطاع، خلال أول 6 أشهر، وعدم عودة الدورة). عند غياب أي شرط، يمكن حدوث حمل حتى بدون نزول الدورة الشهرية.
التحدث عن الجنس والصحة الجنسية والإنجابية يزيد الفضول السيئ لدى الشباب والشباب	التوعية الصحيحة تحمي ولا تفسد	الدراسات تظهر أن التثقيف الجنسي يؤخر العلاقات الخطرة، ويزيد الوعي، ويقلل الأمراض والحمل غير المرغوب. الصمت يترك الشباب يتعلمون من مصادر خاطئة مثل الإنترنت أو الأصدقاء.
ألم الدورة الشهرية دائماً أمر طبيعي	الألم الخفيف مقبول، لكن الألم الشديد قد يتطلب تدخلاً طبياً	الألم الذي يعيق الدراسة أو العمل، أو يترافق مع قيء، نزيف شديد، أو إغماء قد يدل على مشاكل مثل الانتباز البطاني الرحمي أو تكيس المبايض. تجاهل الألم الشديد قد يؤخر التشخيص والعلاج.

طريقة النقاش بعد كل عبارة:

- أسألي المشاركات عن معرفتهن السابقة بالمعلومة.
- اكتشفي نوع المعرفة التي يبحثن عنها.
- سجلي مصادر المعلومات الموثوقة التي يعتمدن عليها (إنترنت، أطباء، أصدقاء، منظمات، عائلة...).
- أسألي عن العوائق التي واجهنها للوصول إلى المعرفة (ثقافية، اجتماعية، اقتصادية، نقص مصادر موثوقة...).

الإغلاق:



ما استخلصناه اليوم يوضح أن نقص المعلومات ليس مسؤولية فردية، بل هو نتيجة أنظمة ومحظورات ومصادر محدودة. الأسئلة التي طُرحت اليوم لا يُشترط أن نجيب عنها فوراً؛ بل على العكس، هي جزء أساسي من هذا البحث ومن المسار الذي نمشي به سوياً.

الإختتام (١٠ دقائق)

في نهاية هذه الجلسة، سنتوقف قليلاً معاً لنستشعر كل القصص والمشاعر التي وثقنا في مشاركتها اليوم. بدايةً، إذا كانت لديك أي أسئلة أخيرة أو نقاط تودّين استيضاحها، فهذا الوقت مخصص لكنّ، ونحن نرحب بأي مشاركة أو تعليق. نودّ تذكيرك بأن وجودك ومشاركتك في هذا المسار قيمة أساسية، فأصواتك هي التي تمنح هذا البحث معناه، وفي الوقت نفسه، تظل مشاركتك دائماً مبنية على راحتك وظروفك. إذا شعرت أنك قادرات على إكمال الطريق معنا في الجلسات القادمة، فإن وجودك سيكون إضافة هامة، وسيساعدنا للوصول إلى نتائج تمثل تجاربنا بصدق أكبر. (اطلبي من المشاركات تأكيد مشاركتهم في الجلسات القادمة).

كما نود تذكيرك بمواعيد الجلسات القادمة، وسنعيد مشاركتها معك بوضوح لتكون الجميع على اطلاع بها. وقبل أن نختم، نود سؤالك: كيف تفضلن أن نتواصل معك في الفترة القادمة؟ سواء عبر واتساب، أو اتصال هاتفي، أو رسالة صوتية، أو مجموعات، أو أي وسيلة تريحكن؛ فرائكن مهم لنتمكن من التواصل بطريقة تناسبكن وتحترم وقتكن وحدودكن.

وأخيراً، شكراً من القلب على وقتكن وحضوركن وثقتكن. وجودك معنا ليس مجرد مشاركة، بل هو شراكة حقيقية في هذا المسار.

الجلسة ٢: الوصول إلى المعلومات والعلاقة مع أجسادنا

دليل الجلسة

الترحيب (٥ دقائق)

المقدمة (١٥ دقيقة)

- التذكير بشكل سريع بالجلسة الأولى والمواضيع التي تمت مناقشتها.
- اشكري الجميع على انضمامهم. اشرحي مدة الجلسة، وشاركي أي معلومات لوجستية أخرى.
- اشرحي أهداف الجلسة:
 - « مناقشة الأسئلة المتعلقة بالوصول إلى المعلومات
 - « مناقشة الأسئلة المرتبطة بعلاقتنا بأجسادنا وصورتنا الذاتية
 - « مشاركة التعليمات الخاصة بنشاط سرد القصص
- اشرحي السرية.
- اشرحي أنه لا توجد إجابات صحيحة أو خاطئة، وأنها مهمات بمعرفة المزيد عن قصصهن. اشرحي أنه قد تكون هناك أوجه تشابه واختلاف في تجاربنا، وأن جميع تجاربنا صالحة، ومهمة، ولها قيمة.
- اشرحي أن وجودنا هنا ليس للحكم على تجارب بعضنا البعض، بل للتعلم منها والتفكير بما يجب تحسينه أو تغييره
- كي نشعر براحة وأمان أكبر في حياتنا، وعلاقتنا، وأجسادنا.
- خذي موافقتهم على بدء الجلسة، وتدوين الملاحظات، و/أو التسجيل.
- أخذ في عين الاعتبار في حال تم إغفال أي موضوع أو عدم التطرق إليه بشكل كافٍ.

النشاط ١

نقاش حول الوصول إلى المعلومات

(٣٠ دقيقة: ١٠ دقائق لكل محور)

المحور ١

نوع معلومات الصحة والحقوق الجنسية والإنجابية المطلوبة

السؤال الرئيسي (١):

ما هي أكثر المعلومات أو المعارف التي تشعرين أنك بحاجة إليها أو تبحثين عنها في مجال الصحة والحقوق الجنسية والإنجابية؟



هدف السؤال



تحديد أنواع المعرفة المطلوبة كما تراها النساء أنفسهن، وليس كما تُعرّفها البرامج أو الجهات المقدمة للخدمات.



أسئلة المتابعة (Probing Questions)

يمكن اختيار سؤال أو أكثر حسب دينامية النقاش:

١. هل يمكنك ذكر أمثلة محددة على هذه المعلومات؟
(مثل: الدورة الشهرية، وسائل منع الحمل، الحمل والولادة، الصحة الجنسية، العلاقات الزوجية، الموافقة، العنف الجنسي، الحقوق القانونية، الوصول إلى خدمات صحية).
٢. في أي مرحلة من حياتك شعرت بالحاجة الأكبر لهذه المعرفة؟ ولماذا؟
(المراهقة، قبل الزواج، بعد الزواج، أثناء الحمل، بعد الإنجاب، أو في مواقف صحية طارئة).
٣. هل هذه المعرفة أقرب إلى معلومات طبية/صحية، أم حقوقية وقانونية، أم إرشادات عملية يومية؟
سؤال تعميقي: ما الذي يجعل هذا النوع من المعرفة مهمًا بالنسبة لك؟
٤. عندما تفكرين بالمعلومات التي تحتاجينها، هل تشعرين أنها متوفرة وكافية، أم ناقصة أو غير واضحة؟
هذا السؤال يساعد على الربط غير المباشر مع محوري المصادر والعوائق.
ما الذي تشعرين أنه غير متوفر أو غير مشروح بشكل كافٍ؟

المحور ٢

نوع معلومات الصحة والحقوق الجنسية والإنجابية المطلوبة



السؤال الرئيسي (١):

عندما تحتاجين إلى معلومات حول الصحة أو الحقوق الجنسية والإنجابية، إلى أين تتوجهين عادة للحصول عليها؟

هدف السؤال



فهم قنوات الوصول الفعلية للمعلومات، وليس فقط القنوات "المفترضة" أو الرسمية.



أسئلة المتابعة (Probing Questions)

١. أي من هذه المصادر تعتبرينها الأكثر ثقة؟ ولماذا؟
(طبيب/ة، قابلة قانونية، صيدلي/ة، مراكز صحية، الإنترنت، وسائل التواصل الاجتماعي، العائلة، الصديقات، الجمعيات، رجال/نساء دين).
٢. هل تختلف المصادر التي تلجئين إليها حسب نوع السؤال أو حساسيته؟
سؤال تعميقي: متى تختارين مصدرًا "رسميًا"، ومتى تفضلين مصدرًا "قريبًا أو غير مباشر"؟
٣. هل واجهت معلومات متضاربة من قبل؟ كيف تعاملت معها؟
هل بحثت عن رأي ثانٍ؟ هل تجاهلت المعلومة؟
٤. هل هناك مصادر تتمنين الاعتماد عليها أكثر لكن لا تستطيعين؟ ولماذا؟
(تكلفة، بُعد جغرافي، خوف من الأحكام، عدم الخصوصية).

المحور ٣

العوائق التي تواجه النساء للوصول إلى المعلومات والمعرفة

السؤال الرئيسي (١):

ما هي أبرز الصعوبات والعوائق التي تواجهينها عند محاولتك الحصول على معلومات حول الصحة والحقوق الجنسية والإنجابية؟



شرح شفهي من الميسرة: «بإمكانكن التفكير في العوائق من أي زاوية تشعرن أنها قريبة منكن: سواء كانت اجتماعية، أو مادية، أو لغوية، أو غيرها».



هدف السؤال

تحديد العوائق البنيوية، الاجتماعية، الفردية، والرقمية من وجهة نظر النساء.



أسئلة المتابعة (Probing Questions)



١. ما هي أنواع العوائق؟
(مثلاً: (١) عوائق اجتماعية أو ثقافية (٢) عوائق مادية أو لوجستية (٣) اللغة أو طريقة شرح المعلومات)
٢. هل مررت بوقت شعرت فيه بصعوبة السؤال أو البحث عن معلومة معينة؟ ما الذي كان يجعلك تترددتين؟
سؤال تعميقي: ما هي المخاوف أو الاعتبارات التي كانت حاضرة في بالك وقتها؟
٣. برأيكن، كيف تختلف هذه العوائق بين النساء حسب العمر، أو الحالة الاجتماعية، أو الجنسية، أو الإعاقة، أو مكان السكن، أو غيرها من العوامل؟

النشاط ٢

رسم خريطة الجسد (Body Mapping)
(٣٠ دقيقة)

الأدوات

- ورق كبير أو بطاقات
- أقلام ألوان
- ملصقات صغيرة ملونة



الهدف

- استكشاف شعور كل مشاركة تجاه جسدها وصورتها الذاتية.
- فهم كيف تؤثر المعرفة أو نقصها عن الصحة الجنسية والإنجابية على العلاقة بالجسد.
- صنع مساحة آمنة للتعبير والمشاركة بدون أحكام.



تعليمات للميسرات:

التمهيد:

١. رحّبي بالمشاركات بطريقة ودية:

مرحباً بكنّ جميعاً، سنقوم اليوم بنشاط يسمى «رسم خريطة الجسد». سيساعدنا هذا النشاط على فهم كيف تشعر كل واحدة منكنّ تجاه جسدها وعلاقتها بنفسها.



٢. اشرحي الهدف:

ليس من المهم أن يكون الرسم متقناً، فالمهم هو التعبير عن مشاعرك وأفكارك. هذه الرسمة مخصصة لكنّ، وأنتنّ من تقرررنّ إذا كنتنّ ترغبين في مشاركتها مع المجموعة أم لا. سيكون هناك نقاش جماعي، وبإمكانكنّ اختيار مشاركة أفكاركنّ وتأملاتكنّ فقط، أو اطلعنا على الرسمة أيضاً.



للميسرات:

إذا كانت مجموعتكنّ تضم مشاركات ذوات إعاقات بصرية، تأكذنّ من إحضار الصلصال (pâte à modeler) أو أدوات أخرى تسمح لهنّ بالمشاركة الكاملة.



خطوات النشاط:

١. كل مشاركة تأخذ ورقة كبيرة وأقلام ألوان.
٢. ارسمنّ شكلاً يمثل جسم إنسان على الورقة (لا يشترط أن يكون الرسم متقناً، وبإمكان الميسرة عرض مثال توضيحي).
٣. بعد الرسم، تتأمل كل واحدة منكنّ وتكتب أو تضع ملصقات للإجابة على الأسئلة التالية:
٤. نبدأ بتأمل فردي أولاً، ثم نعود لمناقشة الأسئلة معاً:
 - ما هو الشيء في جسديّ أو في علاقتك معه الذي تشعرين أنه مصدر قوة أو راحة؟
 - ما هو الجانب الأكثر صعوبة في علاقتك بجسديّ أحياناً؟ (مشاركة هذه النقطة اختيارية).
 - كيف تصفين شعورك تجاه جسديّ في هذه الفترة؟ (قوية، متعبة، مرتاحة، متوترة، متقلبة، أو أي كلمة تعبر عن إحساسك).
 - ما هي الأشياء التي تمنحني الشعور بالأمان والثقة بجسديّ؟

أسئلة نقاش تحفيزية (يمكن مشاركتها بعد رسم الخريطة):

- هل هناك جزء من الجسد تجاهلته أو لم تشعر به برغبة في رسمه؟ كيف تفسرين ذلك؟
- الأمان والانتماء بالجسد: ما هو الشيء الذي يجعلك تشعرين أن جسمك مكان آمن لك؟

التوثيق:

- إحدى الميسرات تتأكد إنها توثق كل الأفكار، المشاعر، والنقاشات بشكل يحافظ على خصوصية المشاركات.
- التوثيق يساعد على فهم العلاقة بين الوصول للمعلومات وتجربة الجسد ويدعم النقاشات المستقبلية.

النشاط ٣

نقاش حول الوصول إلى المعلومات
(٢٠ دقيقة: ١٥ دقيقة للمحور الأول و ٥ دقائق للمحور الثاني)



الهدف

- فهم شعور المشاركات تجاه أجسادهن وصورتهم الذاتية.
- استكشاف تأثير محدودية المعلومات أو المعلومات المغلوطة على ممارساتهن اليومية.
- صنع مساحة آمنة للتعبير والمشاركة بحرية.



التوثيق

- إحدى الميسرات تتأكد من توثيق كل الأفكار والملاحظات بطريقة تحافظ على خصوصية المشاركات
- ركّزي على ربط النقاش بما ظهر في نشاط خريطة الجسد.

المحور ١

كيف نشعر في أجسادنا + صورتنا الذاتية



السؤال الرئيسي (١):

بناءً على تجاربنا الشخصية كيف نكون صورتنا عن أجسادنا؟ ما هي العوامل التي تؤثر على صورتنا الذاتية؟

أسئلة فرعية (Probing questions):

- متى بدأنا بتكوين فكرة عن شكل أجسادنا؟
- ما العوامل التي أثرت على هذه الصورة (الأسرة، المدرسة، المجتمع، الإعلام، المعايير الاجتماعية)؟
- هل تتغير صورتنا الذاتية مع الوقت؟ كيف؟
- ما "الصورة المثالية للجسد" المنتشرة في المجتمع وكيف تؤثر علينا؟
- هل تختلف هذه المعايير بين النساء والرجال؟
- كيف يمكن تعزيز علاقة إيجابية مع الجسد؟ (مثل: ممارسات شخصية، دعم من الأصدقاء أو الأسرة أو المجتمع، التوعية، الدعم النفسي...)



السؤال الرئيسي (٢):

كيف يؤثر الوصول إلى أو نقص المعلومات عن الصحة الجنسية والإنجابية على علاقتنا بجسودنا وصورتنا الذاتية؟ ما دور المعرفة والمعلومات في علاقتنا بأجسادنا؟

أسئلة فرعية (Probing questions):

- هل يمكننا التحدث عن تجربة شخصية أو موقف شعرنا فيه أن المعلومات التي تملكها ساعدتكم على التعامل مع أجسادكم بطريقة أفضل؟
- كيف يمكن للحصول على معلومات دقيقة وشاملة عن الصحة الجنسية والإنجابية أن يغير نظرتكم لأجسادكم أو يعزز ثقتكم بأنفسكم؟

السؤال الرئيسي (٣):
كيف يرتبط الشعور بالجسد بالحقوق والاختيار؟



أسئلة فرعية (Probing questions):

- هل نشعر بأن لنا الحق في اتخاذ قرارات تخص أجسادنا؟
- متى نشعر بأن هذا الحق مُقيّد؟
- كيف يساهم احترام الجسد في تعزيز الصحة والحقوق الجنسية والإنجابية؟

المحور ٢

أثر محدودية المعلومات على ممارساتنا اليومية

سؤال رئيسي مفتوح:
كيف يؤثر نقص المعلومات أو المعلومات المغلوطة عن الصحة الجنسية والإنجابية على حياتك اليومية أو على العادات التي تتبعينها؟



أسئلة متابعة مفتوحة:

- هل شعرت يوماً أنك لم تتمكني من العناية بجسدك أو صحتك بسبب نقص المعلومات؟ شاركينا ما حدث معك.
- هل هناك سلوكيات أو عادات يومية تتبعينها أو تتجنبينها بناءً على معلومات غير مكتملة أو مغلوطة؟
- كيف كانت حياتك اليومية ستختلف لو توفرت لديك معلومات دقيقة وكافية؟
- ما هي سبل الدعم أو المصادر التي تعتقدين أنها قد تساعدك لتكوني أكثر راحة وثقة بجسدك؟

هدف الأسئلة:

ربط محدودية المعلومات أو المعلومات المغلوطة بالممارسات اليومية، والعادات الصحية، والثقة بالنفس.

خطوات تنفيذ النقاش:

١. ابدئي بالسؤال الرئيسي لكل محور، واتركي للمشاركات مساحة للتحدث بكل حرية.
٢. استخدمي الأسئلة المفتوحة لتشجيع النقاش إذا طال الصمت، أو عندما ترغبين في التعمق بالإجابات.
٣. شجعي المشاركات على ربط نقاشهن بما ظهر في «خريطة الجسد».
٤. وثقي كل الأفكار، المشاعر، والملاحظات لتغذية التحليل والاستنتاجات لاحقاً.

تعليمات للجلسة الجاية

تعليمات نشاط سرد القصص (١٥ دقيقة)

قدّم الشكر للمشاركات على مساهمتهم في جلسة اليوم، وعلى مشاركة تجاربهم وأفكارهم وقصصهم القيمة. وضح للمشاركات أن الجلسة القادمة تتطلب بعض التحضير، وسنشارك التعليمات الآن.



الأدوات



- مساحة للجلوس في دائرة
- أوراق أو بطاقات اختيارية
- أقلام أو ألوان
- اختياري: رسم، أو أي أداة إبداعية تساعد المشاركات على سرد قصصهن

الهدف



- تشجيع المشاركات على التعبير عن تجاربهن الشخصية أو تخيلاتهن بطريقة حرة وآمنة.
- استكشاف تأثير المعرفة أو نقصها على الممارسات اليومية والقرارات المتعلقة بالصحة الجنسية والإنجابية.
- تطوير مهارات التعبير والتواصل داخل المجموعة.

التعليمات للميسّرات:

التمهيد:

١. رَحِّبِي بالمشاركات بطريقة ودية:

سنقوم الآن بنشاط سرد القصص. ستحكي كل واحدة منكنّ قصة قصيرة، قد تكون تجربة حقيقية، أو موقفاً شخصياً، أو حتى قصة خيالية تعبر عن مشاعرها وأفكارها.



٢. اشرحي الغرض:

يساعدنا هذا النشاط على فهم أعمق لكيفية تأثير توفر المعلومات أو نقصها حول الصحة الجنسية والإنجابية على قراراتنا وعلاقاتنا وحياتنا اليومية.



ستحضر كل واحدة منا قصة، سواء من تجاربها الشخصية، أو تجربة صديقة، أو أحد أفراد العائلة، أو شخص من مجتمعها. يجب ألا تتجاوز القصة خمس دقائق عند سردها، وبإمكانكنّ استخدام أدوات إبداعية إذا رغبتنّ في ذلك.



من المهم أن تركز القصة على أثر الوصول إلى المعلومات حول الصحة الجنسية والإنجابية، أو نقص هذا الوصول، وعلاقتنا بأجسادنا وتصوراتنا عن ذواتنا، وتأثير كل ذلك على علاقاتنا الحميمة. سنشارك معكنّ مجموعة من الأسئلة التي قد تساعدكنّ في التفكير.

قد تكون العلاقات الحميمة رومانسية أو جنسية، كما يمكن أن تتعلق بال صداقة أو العلاقات العائلية أو غيرها، لكن الأساس هو أن تركز القصة على معلومات الصحة الجنسية والإنجابية وعلاقتنا بأجسادنا.

خطوات النشاط:

١. اختاري وسيلة التعبير الإبداعي:

«بإمكان كل واحدة منكنّ اختيار طريقة حكي قصتها، سواء بالكلام، أو الرسم، أو باستخدام صورة.»

٢. «فكري في علاقة معينة في حياتك، قد تكون عاطفية أو غير عاطفية. الآن تذكري موقفاً أو لحظة أو تجربة مرتبطة بالصحة الجنسية والإنجابية أو بعلاقتك بجسدك، وكيف أثرت هذه التجربة على تلك العلاقة؟ كيف أثر توفر المعلومات أو غيابها في ذلك الوقت؟ وكيف تأثر تصورك لنفسك؟»

هذه بعض الأسئلة الإضافية التي يمكن أن تساعدك في التفكير: أسألي المشاركات لتوجيههن نحو التحضير:

- ما هي القصة التي تحكي شعورك أو موقفًا أثر فيك في علاقتك بصحتك أو بحسدك؟
- هل هناك موقف شعرت فيه أن معلومات عن الصحة الجنسية أو الإنجابية ساعدتك أو حرمتك من اتخاذ قرار؟
- كيف أثر هذا الموقف على حياتك اليومية أو تصرفاتك؟ وكيف أثر على هذه العلاقة الحميمة؟
- ماذا كان شعورك وقتها، وكيف تعاملت مع الموقف؟
- نتذكر أن علاقتنا بأحسادنا تؤثر على علاقاتنا الحميمة. (التركيز على الوعي الذاتي بالحسد/فهم كيف أن احترام حسدنا واحتياجاتنا يؤثر على تواصلنا وعلاقاتنا الحميمة والصحية مع الآخرين خاصة مع الزوج.
- إذا لم يتم ذكر العلاقات الحميمة يحب لفت النظر لها والتشجيع على التحدث عنها



التعليمات للمشاركات للتحضير في البيت:

١. خصصي وقت هادئ (حوالي ٣٠-٤٥ دقيقة) لتفكري بالقصة التي سوف تشاركها في الجلسة.
٢. اختاري شكل السرد الذي تحبيه:
 - سرد القصة بالكلام أو كتابتها على ورقة.
 - الرسم أو استخدام خريطة توضيحية.
 - اختيار أغنية أو عبارة قصيرة تعبر عن القصة.
٣. ركزي على النقاط التالية أثناء التحضير:
 - موقف أو تجربة شعرت فيها أن نقص المعلومات أو المعلومات المغلوطة عن الصحة الجنسية والإنجابية أثر على علاقتك بجسدك أو على علاقاتك الحميمة.
 - شعورك في ذلك الوقت وكيف أثر على تصرفاتك أو خياراتك.
 - ما الذي كان من الممكن أن يختلف لو توفرت لديك معلومات دقيقة أو كافية؟
 - أي درس تعلمته أو نصيحة تحبين مشاركتها مع المجموعة.
 - نوضح أن هناك أنواعًا مختلفة من العلاقات: بيننا وبين الأصدقاء، أو ضمن الأسرة أو في سياق جنسي.
 - نشرح ما يعنيه كل نوع
 - نؤكد أننا لا نصدر أحكامًا بل نتعلم من تجارب بعضنا.

نصائح:

- اكتبي أفكارك أو ارسميها بطريقة مريحة لك.
- لا تقلقي بشأن الشكل أو التفاصيل، فالمهم هو التعبير عن المشاعر والفكرة الأساسية.
- يمكنك تحضير أكثر من قصة قصيرة إذا رغبت، لكن ركزي على القصة التي تشعرين أنها الأهم أو الأقوى.

الإختتام (٥ دقائق)

- افسحن المجال أسئلة أخيرة.
- أعدن مشاركة موعد الجلسة المقبلة.
- اشكرن المشاركات على وقتهن.

الجلسة ٣: علاقاتنا الحميمة

دليل الجلسة

الترحيب (٥ دقائق)

المقدمة (١٥ دقيقة)

- تقديم الفريق.
- اشكري الجميع على انضمامهم. اشرحي مدة الجلسة، وشاركي أي معلومات لوجستية أخرى.
- اشرحي أهداف الجلسة:
 - « مشاركة قصصنا وتجاربنا حول علاقاتنا والتأمل فيها.
 - « نقاش حول العلاقة بين الوصول إلى المعلومات، وعلاقاتنا بأجسادنا، وعلاقاتنا الحميمة.
- اشرحي السرية.
- اشرحي أنه لا توجد إجابات صحيحة أو خاطئة، وأنها مهتمات بمعرفة المزيد عن قصصهن. اشرحي أنه قد تكون هناك أوجه تشابه واختلاف في تجاربنا، وأن جميع تجاربنا صالحة، ومهمّة، ولها قيمة.
- اشرحي أن وجودنا هنا ليس للحكم على تجارب بعضنا البعض، بل للتعلم منها والتفكير بما يجب تحسينه أو تغييره كي نشعر براحة وأمان أكبر في حياتنا، وعلاقاتنا، وأجسادنا.
- خذي موافقتهم على بدء الجلسة، وتدوين الملاحظات، و/أو التسجيل.

النشاط ١

سرد القصص (٤٥ دقيقة)



- الهدف: تحضير المشاركات لسرد قصصهن حول تأثير الوصول المحدود للمعلومات الجنسية والإنجابية على علاقاتهن الحميمة.
- التفكير مسبقاً بالمواقف، المشاعر، والدروس المستفادة قبل الجلسة.

خطوات النشاط:

التمهيد (٥ دقائق):

١. رحّبي بالمشاركات:

الآن يا صديقتي، سنشارك القصص التي حضرناها في البيت. هدفنا هو فهم كيف يمكن للوصول المحدود للمعلومات أو المفاهيم المغلوطة عن الصحة الجنسية والإنجابية، وعلاقاتنا بأجسادنا، أن تؤثر على حياتنا وعلاقاتنا الحميمة.



٢. ذكري المشاركات بالتعليمات، يمكنك السؤال عن تجربة التحضير لهذا النشاط.

٣. ذكري المشاركات بأن المشاركة اختيارية وأن كل تجربة مهمة.

سرد القصص (٣٠ دقيقة):

- بما أن عدد المشاركات ٦ نساء، خصصي لكل مشاركة حوالي ٥ دقائق:
- مشاركة القصة عبر الحديث، أو الرسم، أو أي وسيلة قمتن بتحضيرها.
- شجعي المشاركات على التفاعل الإيجابي فقط، دون إطلاق أحكام أو إجراء مقارنات

النقاش الجماعي (١٠ دقائق):

- بعد مشاركة جميع القصص، افتحي باباً لنقاش جماعي شامل:
- ما هي النقاط المشتركة بين تجاربكن؟
- كيف يمكن للمعلومات الدقيقة أو الدعم المناسب أن يغيّر التجربة؟
- ما هي الخطوات العملية التي يمكننا القيام بها لتحسين علاقتنا بأجسادنا وعلاقتنا الحميمة؟

التوثيق:

- إحدى الميسّرات تدوّن كل قصة، ثم النقاط الرئيسية للنقاشات، مع الحفاظ على السرية.
- ركّزي على تأثير المعرفة أو نقصها على العلاقات الحميمة والثقة بالجسد.

الإختتام (٥ دقائق):

- اشكري المشاركات على الشجاعة والمشاركة.
- ذكّرين أن كل تجربة لها قيمة وأن الهدف هو التعلم من تجارب بعضنا البعض.
- أكدي أن النقاشات والقصص ستبقى سرية ومحفوظة بأمان. (مساحة آمنة دون أي أحكام)
- ركّز على التجربة أكثر من النشاط نفسه
- نحصر على أن يحصل كل مشارك على الوقت والمساحة التي يحتاجها، مع تجنّب أي نقاشات جانبية.
- وإذا كان الحوار والنقاش يتدفقان بشكل جيد حول موضوع البحث، يمكننا الاستغناء عن النشاط.
- احترام وقت كل مشاركة دون المقاطعة!!!

النشاط ٢

النقاش (٤٥ دقيقة)

الموضوع ١

علاقتنا الحميمة + الأنماط والتشابهات في قصصنا

سؤال رئيسي مفتوح:

بعد أن استمعنا لقصص بعضنا البعض، ما الذي تلاحظونه بشأن أنماط العلاقات الحميمة للنساء في مجتمعاتنا؟



أسئلة استقصاء:

- ما هي العوامل الأساسية التي تؤثر على الطريقة التي تتعامل بها مع شركائنا أو مع علاقتنا الحميمة كنساء في مجتمعاتنا؟
- وهل لاحظنا تشابهاً بين شعورنا تجاه أجسادنا وكيفية تأثير ذلك على علاقتنا؟

الهدف :

رصد التشابهات والأنماط المشتركة بين التجارب، وربطها بالعلاقة بالجسد والمعلومات المتوفرة.

الموضوع ٢

تأثير علاقتنا بأجسادنا على علاقاتنا الحميمة



سؤال رئيسي مفتوح:

كيف تؤثر علاقتنا بأجسادنا على علاقاتنا الحميمة؟

أسئلة استقصاء:

- كيف يؤثر شعورنا بالثقة أو عدم الثقة بأجسادنا على خياراتنا في العلاقة؟
- كيف يمكن لأجسادنا أو لمعرفتنا بها أن تمنحنا طاقة إيجابية أو سلبية خلال العلاقة؟
- كيف يمكن لشعورنا تجاه أجسادنا أن يغير سلوكنا أو تواصلنا مع الشريك؟

الهدف :

فهم العلاقة بين الصورة الذاتية، الثقة بالجسد، والممارسات أو القرارات في العلاقات الحميمة.

الموضوع ٣

تأثير محدودية المعلومات على علاقاتنا الحميمة



سؤال رئيسي مفتوح:

كيف يؤثر نقص المعلومات أو المعلومات المغلوطة عن الصحة الجنسية والإنجابية على علاقاتنا الحميمة؟

أسئلة استقصاء:

- كيف يمكن للمعلومات الناقصة أو الخاطئة أن تدفعنا لتجنب أمر ما، أو اتخاذ قرار قد يكون مناسباً أو غير مناسب؟
- كيف يمكن أن تختلف تجاربنا لو توفرت لدينا معلومات وافية ودقيقة؟
- ما الذي يمكننا فعله لنساعد أنفسنا أو غيرنا في الحصول على المعلومات الصحيحة؟

الهدف :

ربط محدودية المعرفة بالممارسات اليومية، الثقة بالنفس، والعلاقات الحميمة.

الربط بين الأسئلة الثلاثة:

- **الموضوع ١:** يحدد الأنماط المشتركة في التحارب، ويتيح التعرف على التشابهات والاختلافات بين النساء.
 - **الموضوع ٢:** يركز على تأثير علاقة النساء المتنوعات بأحسادهما على العلاقة الحميمة، وهو مرتبط مباشرة بما ظهر في قصصها وفي الموضوع الأول.
 - **الموضوع ٣:** يوضح كيف الوصول المحدود للمعلومات الصحية والإنجابية ينعكس على العلاقات، مكمل لفهم العلاقة بين الحسم والثقة بالنفس والقرارات في الموضوع ٢.
- بهذه الطريقة، يكمل كل موضوع الآخر ليرسم صورة شاملة عن الترابط بين المعرفة والجسد والعلاقات الحميمة.

خطوات تنفيذ النقاش:

١. ابدئي بطرح السؤال الأساسي لكل محور، واتركي للمشاركات مساحة كافية للتحدث بكل حرية.
٢. استخدمي أسئلة التعمق لتحفيز الحوار أو لتوضيح النقاط الهامة التي تبرز خلال الجلسة.
٣. شجعي المشاركات على ربط النقاش بما ظهر في نشاط سرد القصص.
٤. وثقي كافة الأفكار والملاحظات لتكون مرجعاً لعملية التحليل والاستنتاجات لاحقاً.

الإختتام (٥ دقائق)

قبل أن نختم، نود أن نفتح المجال لفرصة أخيرة لطرح أي سؤال أو طلب أي توضيح، فليس هناك أسئلة صغيرة أو غير مهمة.

أود تذكركنّ بأن قصصكنّ وتجاربكنّ وتأملاتكنّ لا تقدر بثمن بالنسبة لهذا البحث، وكل كلمة شاركتنّها تشكل أساساً حقيقياً لما نبنيه سوياً.

المرحلة القادمة هي مرحلة التحليل، وبعدها سنتواصل معكنّ قريباً لندعوكنّ إلى جلسة المصادقة من النتائج، لنتأكد من أن ما توصلنا إليه يمثل أصواتكنّ وتجاربكنّ بالفعل.

وفي الوقت نفسه، أود التأكيد على أن كل ما شاركتنّه سيبقى سرياً بالكامل، ولن يُستخدم إلا في هذا البحث، وبطريقة تحميكنّ وتحترم خصوصيتكنّ. ثقتكنّ بنا مسؤولية كبيرة ونقدرها جداً.

وأخيراً، شكراً من القلب على ثقتكنّ ووقتكنّ ومشاركاتكنّ الصادقة. وجودكنّ معنا هو جوهر هذا البحث.

ملحق ٢: دليل جلسات المصادقة - العربية والإنجليزية

خطة جلسة المصادقة

مدة الجلسة: ساعتان و ٣٠ دقيقة

المقدمة (٥ دقائق)

شكرًا لكنّ جميعًا على انضمامكم إلينا اليوم! نحن متحمسات جدًا لرؤيتكم جميعًا. بعضكم يعرف بعضه البعض من الجلسات التي عقدناها معًا سابقًا، بينما قد لا تعرف أخريات بعضهن البعض لأننا نجتمع اليوم بين مجموعتين. وكما وعدناكم سابقًا، نحن هنا اليوم لنشارككم التحليل الذي قمنا به والتقدم الذي أحرزناه في البحث.

كما أوضحنا سابقًا، جميع المساهمات مجهولة الهوية، وقد جمعنا جميع التجارب معًا لإعداد تحليلنا. الهدف من جلسة اليوم هو أن نشارك معكم النتائج الأساسية التي توصلنا إليها، وأن نستمع إلى آرائكم حول مدى ارتباطها بتجاربكم وأولوياتكم، ومدى فائدتها وانعكاسها لما شاركتننا به.

تختلف هذه الجلسة عن الجلسات السابقة، إذ إن الهدف منها ليس إنتاج أفكار جديدة أو مشاركة قصص جديدة. بل سنقوم اليوم بعرض عملنا عليكم، وطرح بعض الأسئلة التي تساعدكم على التفكير في النتائج وتقديم ملاحظاتكم وتأملاتكم حولها.

نظرة عامة على البحث (٥ دقائق)

نود أولاً أن نبدأ بتذكيركم بأسئلة البحث ومنهجيتنا. يهدف بحثنا إلى استكشاف الأسئلة العامة التالية:

سؤال البحث:

كيف يؤثر الوصول المقيّد وغير العادل إلى المعرفة المتعلقة بالصحة والحقوق الجنسية والإنجابية على اتخاذ النساء الشابات (بممر ١٨-٣٥ سنة في شمال لبنان والبقاع) قرارات مستنيرة بشأن علاقاتهنّ وأجسادهنّ؟



الأسئلة الفرعية:

١. كيف يبدو وصول النساء الشابات إلى المعرفة والمعلومات المتعلقة بالصحة والحقوق الجنسية والإنجابية؟
 - a. ما نوع المعرفة التي يبحثن عنها؟
 - b. ما هي المصادر التي يثقن بها للحصول على المعلومات؟
 - c. ما هي أبرز العوائق التي يواجهنها في الوصول إلى هذه المعلومات؟
٢. كيف يؤثر الوصول المقيّد وغير العادل إلى المعرفة المتعلقة بالصحة والحقوق الجنسية والإنجابية على علاقة النساء بأجسادهنّ، وتصوراتهنّ عن أنفسهنّ، وممارساتهنّ اليومية؟
٣. كيف يؤثر الوصول المقيّد إلى المعرفة المتعلقة بالصحة والحقوق الجنسية والإنجابية، وعلاقة النساء بأجسادهنّ، على علاقاتهنّ الحميمة؟

لإيجاد إجابات لهذه الأسئلة، نظمنا جلسات معكّن ومع العديد من النساء الأخريات في البقاع وشمال لبنان. عقدنا ثلاث جلسات مع كل مجموعة. في الجلسة الأولى، تعرّفنا إلى بعضنا البعض، واستكشفنا بعض الخرافات المرتبطة بالصحة والحقوق الجنسية والإنجابية، وشاركنا بعض التأمّلات حول تصوراتنا لأنفسنا. في الجلسة الثانية، قمنا بنشاط رسم خريطة الجسد، وأجرينا نقاشات حول وصولنا إلى المعلومات، والمعلومات المضلّة والتحديات التي نواجهها، بالإضافة إلى تأثير ذلك على ممارساتنا اليومية وعلاقاتنا بأجسادنا. أما لقاءنا الثالث فكان جلسة لسرد القصص، شاركنا خلالها قصصًا عميقة وشخصية حول علاقاتنا الحميمة، وأجسادنا، وتأثير محدودية المعلومات على حياتنا.

جمعنا جميع التجارب التي تمت مشاركتها خلال هذه الجلسات، وتأمّلنا أيضًا في تجاربنا الشخصية، بهدف تحليل القضايا التي نواجهها والخروج بنتائج واضحة يمكننا الانطلاق منها للتفكير في إجراءات وتوصيات عملية.

سنشاركك هذه النتائج، ونود أن نستمع إلى آرائك حول مدى أهميتها وارتباطها بواقعك، وما إذا كنّ ترين أن هناك أمورًا مفقودة، أو أي أفكار إضافية ترغبين في تضمينها.

بعض المبادئ التي يجب أخذها بعين الاعتبار

- تذكّر أن العديد من تجاربنا متشابهة حدًا، لكن العديد منها مختلف أيضًا وقد يكون متناقضًا أحيانًا. لذلك، قد تحدين نفسك في بعض الأجزاء أو تشعرين بأنها تشبه تجربتك، بينما قد تلاحظين اختلافات كبيرة بينها وبين حياتك في أجزاء أخرى.
- هدفنا ليس الوصول إلى «حقيقة واحدة» بل إلى التعبير بشكل أفضل عن غنى التحارب وتعقيدها وتنوعها.
- حافظن على ذهن منفتح واستمعن بفضول، حتى عندما يبدو شيء ما غير مألوف أو مختلفًا عن تجربتك الشخصية.
- احترمن أن تحارب الأخريات صالحة ومهمة حتى عندما تختلف عن تحاربك.
- تذكّر أن هدفنا اليوم هو تعزيز المحتوى وتطويره، وليس النقاش بهدف إثبات وجهة نظر أو «الفوز» بالحجج.
- وكما في كل مرة، يرحى مراعاة الوقت لإتاحة المجال للجميع للمشاركة، واحترام السرية (ليست هناك حاجة للحديث عن أشخاص محددين أو مشاركات أخريات عند الإشارة إلى تجربة معينة).
- قدّمن ملاحظاتكنّ بطريقة واضحة ومحددة (مثل توضيح ما الذي تشعرن أنه مفقود، أو غير واضح، أو يحتاج إلى تعزيز).

وأخيرًا، تذكّر أن هذه عملية جماعية لصنع المعنى. تأملاتكنّ ليست مرتبطة بكونها «صحيحة أو خاطئة»، بل تساعدنا على التأكد من أن التحليل يعكس فعلاً اتساع التجارب التي تمت مشاركتها وتعقيدها ودقتها.

النشاط ١

التحقق من المحتوى

(ساعة و ٣٠ دقيقة)

- استخدم من عرض جلسة المصادقة من النتائج، وتأكد من تحضير المحتوى مسبقاً.
- قسّم المشاركين إلى ثلاث مجموعات (مختلطة من حيث الأعمار والجنسيات). تجلس كل مجموعة معاً ويتم إعطاؤها أوراق ملاحظات لاصقة.
- حضّر ثلاث أوراق ورقية كبيرة (Flipcharts) في أنحاء الغرفة. يجب أن يتضمن الأول السؤال التالي: «هل تعكس هذه النتائج تجربتك أو تجارب نساء أخريات تعرفينهن؟ ما الذي يبدو مشابهاً أو مختلفاً؟» أما الثاني: «ما الذي ينقص هذه النتائج أو لم يتم التقاطه بشكل كامل؟» أما الثالث: «ما هو الأمر الأكثر أهمية أو الأكثر إلحاحاً الذي يجب أن نسلط الضوء عليه؟»
- تبدأ الميسّرات بعرض النتائج الأساسية للقسم الأول من التقرير. بعد ذلك تتم مشاركة أسئلة التأمل (كما هي مكتوبة على أوراق الـ Flipcharts الثلاثة).
- تأخذ المجموعات ٥ دقائق لمناقشة النتائج فيما بينها استناداً إلى الأسئلة الثلاثة، وتكتب إجاباتها على الأوراق اللاصقة وتضعها على الورقة المناسبة.
- خلال ذلك الوقت، تقوم الميسّرات بقراءة الإجابات وتجميع المتشابه منها معاً. وبعد انتهاء الدقائق الخمس، تلخص الميسّرات أبرز التأمّلات وتساأل المجموعة: «هل ترغبين بإضافة أي شيء؟»
- يتم تكرار العملية نفسها مع الأقسام الأربعة كافة من التقرير. يجب ألا يتجاوز عرض كل قسم ٥ دقائق.
- في نهاية النشاط، تأكد من التقاط صورة لجميع الإجابات أو تدوينها بوضوح.

النشاط ٢

التحقق من التوصيات

(٤٠ دقيقة)

الجزء الأول : تخيل مستقبلنا الجماعي (٢٠ دقيقة)

- ادعين المشاركات إلى إغلاق أعينهنّ، واقرأن لهنّ التعليمات التالية لتخيّل مستقبل أفضل وأكثر عدالة بشكل جماعي. شجّع المشاركات على الحلم والطموح في المستقبل الذي يتخيّلنه.
- « لتتخيّل مستقبلاً، ربما بعد عدة سنوات من الآن، تكون فيه حياتنا وحياة الشابات الأخريات في مجتمعنا أفضل وأكثر أماناً وأسهل. حياة يمكننا فيها اتخاذ قرارات مستنيرة بشأن أجسادنا وعلاقاتنا الحميمة.
- « كيف تبدو الحياة؟ كيف تشعرين؟ كيف تشعر النساء الأخريات من حولك؟
- « كيف تبدو علاقاتنا بأجسادنا؟ وماذا عن علاقاتنا الحميمة؟
- « ما الذي يختلف؟ ما الذي تحسّن؟ ما الذي يبدو أكثر أماناً أو عدالة أو دعماً؟
- « ماذا يفعل أو يفكر أفراد المجتمع، وقادة المجتمع، والجهات الفاعلة الأخرى من حولنا؟
- بعد أن يفتحن أعينهنّ، اطلبن منهنّ كتابة أهم ثلاث خصائص لهذا المستقبل.
- افتحن نقاشاً، وتأكدن من توثيق الإجابات باستخدام الأسئلة التالية:
- « ما هي أهم ثلاث خصائص لهذا المستقبل؟
- « ما الذي يجب أن يتغيّر في حياتنا، وعائلاتنا، ومجتمعاتنا، وبلدنا، حتى نتمكن من تحقيق هذا المستقبل؟

الجزء الثاني - ترتيب أولويات إجراءات التغيير (٢٠ دقيقة)

- تلخص الميسّرات الأفكار المتعلقة بالتغيير التي شاركتها المشاركات، وتوضحن أننا حاولنا أيضًا تخيّل بعض إجراءات التغيير بأنفسنا.
- اعرضن التوصيات المبسطة (استنادًا إلى عرض جلسة المصادقة من النتائج)، وادعين المشاركات إلى ترتيب الأولويات بناءً على السؤال التالي:
ما هي أهم ٣ إجراءات من بين جميع هذه الإجراءات؟
- أجرين نقاشًا قصيرًا وقمن بتدوين الملاحظات استنادًا إلى الأسئلة التالية (جولتان: الأولى حول الإجراءات التي اقترحتها المشاركات، والثانية حول توصياتنا):
« لماذا اعتبرت هذه الإجراءات هي الأكثر أهمية لتحقيق التغيير؟
« ما الذي يجب أن يحدث عمليًا حتى تنجح هذه الإجراءات فعليًا في حياتنا؟
« هل هناك شيء يربط بين جميع هذه الإجراءات؟

الإختتام (٥ دقائق)

اشكرن المشاركات على وقتهنّ، واشرحن لهنّ أننا سنستخدم جميع الأفكار والملاحظات التي شاركنها اليوم، إلى جانب تلك التي سنجمعها من مشاركات أخريات في جلسات مشابهة، من أجل تطوير تحليلنا وتوصياتنا وصياغتهما بشكل نهائي ضمن التقرير. سيتم استخدام النتائج للمساهمة في توجيه أنشطة ومشاريع أخرى في المستقبل.



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