

# INVESTING IN YOUNG WOMEN'S COLLECTIVE SPACES TO SHAPE KNOWLEDGE AND SERVICES AROUND SRHR

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This policy brief builds on the findings from *“Between Silence and Solidarity: A Feminist Participatory Action Research on Young Women’s SRHR Knowledge, Bodies and Relationships in North Lebanon and the Bekaa”*, a feminist participatory action research project commissioned under Oxfam Lebanon’s Power to Choose project.

Lead Researchers:

**Assil Fares and Francesca El Asmar**

Co-Researchers:

**Aseel Hamad; Baraa Al Khaled; Ghinwa Melhem; Nadia Kattoub; Ola Maatouk; Reem Daher; Rita Hanna; Zaynab Nasereldine; Suraya Al Abdallah; Yolita Malaab**



***YOUNG WOMEN'S SPACES ARE ESSENTIAL TO BUILD COLLECTIVE POWER, ARTICULATE PRIORITIES, CO-PRODUCE KNOWLEDGE AND SHAPE MORE INCLUSIVE, RIGHTS-BASED AND QUALITY SRHR SYSTEMS.***

## INTRODUCTION

Nothing about women and our bodies should be decided without us. Yet, in Lebanon, as in many countries in the region and around the world, policies, services and even individual choices are often formulated with little to no regard for women's experiences or priorities. Sexual and reproductive health and rights (SRHR) are shaped by systems of power that regulate what we are allowed to know and how we must behave, and by patriarchal institutions and norms that dictate which experiences and voices are valued, and which are made invisible or dismissed. Access to quality, non-stigmatising and inclusive SRH services and information is severely constrained within a fragmented healthcare system, weakened by the multiple crises and wars that have hit the country in recent years.

Findings from a feminist participatory action research (FPAR), commissioned under Oxfam's Power to Choose project and funded by Global Affairs Canada (GAC), reveal the different forms and layers of exclusion, violence and stigma that young women face in their everyday interactions with the health system, and in navigating the SRHR knowledge landscape. The findings also emphasise the importance of collective spaces for women, not only for dialogue, but to build

collective power, articulate priorities and co-produce knowledge. But spaces where women, and young women especially, can safely and comfortably come together remain scarce. Where they do exist, they often lack sustained resources and technical support, and are constrained by restrictive conditions and norms around women's movement and access to public spaces.

The research also shows that such spaces are essential for validating our lived experiences, generating knowledge, defining our priorities, building solidarity networks, and ultimately informing and influencing health policies, services and practices. Creating, supporting and funding these spaces is therefore a political imperative: to strengthen health system accountability, ensure policies respond to women's rights and priorities, design more impactful and relevant SRHR programmes and shape inclusive, rights-based and quality SRHR systems. **Collective spaces for women are not simply avenues for participation. They are essential infrastructure to build and share power, generate knowledge, and strengthen accountability.**

# LEARNING FROM WOMEN'S LIVED EXPERIENCES

Between September 2025 and July 2026, a team of ten young women community co-researchers, accompanied by two lead researchers, conducted a Feminist Participatory Action Research<sup>1</sup>, examining how restricted and unjust access to SRHR knowledge shapes young women's decision-making around their relationships and their bodies. Fifty-nine Lebanese, Syrian and Palestinian young women between the ages of 18 and 35, including five women with disabilities, residing in North Lebanon and the Bekaa, participated in a series of discussion, reflection and storytelling sessions.

The research brought us together to explore how we, as young women, access, understand and share SRHR knowledge, and how we experience and navigate social norms and expectations, relationships, and health services and systems that shape our lives, decisions and autonomy.

Findings were collectively analysed and validated, with participants' lived experiences and knowledge at the centre of the research process. Together, we identified common experiences, generated knowledge, and reflected on priorities and pathways for change. This research process itself also created space for collective learning, solidarity-building and experience-sharing, generating insights that inform the findings and recommendations presented in this brief.



**FEMINIST  
PARTICIPATORY  
ACTION RESEARCH**



**12  
RESEARCHERS**



**59  
WOMEN ENGAGED**



**4  
FINDINGS**



**SEPTEMBER 2025  
TO JULY 2026**



**NORTH LEBANON  
AND THE BEKAA**

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*1. Feminist Participatory Action Research (FPAR) is an action-oriented approach that challenges conventional research hierarchies by centering participants as active producers of knowledge. In this research, young women community co-researchers were trained and accompanied to collectively conceptualise the research, develop approaches and tools, lead data collection within their communities, collectively analyse data, co-write the report and validate findings with participants. The process also created space for collective reflection, learning and prioritisation of recommendations, with responsibilities and decision-making shared across the research team. Findings informed this policy brief, as well as several other influencing actions.*

# NAVIGATING A FRAGMENTED KNOWLEDGE ECOSYSTEM

Young women in Lebanon rarely have a clear and reliable path when seeking SRHR-related information. Instead, knowledge-seeking takes place within a restrictive context of fear, stigma and silence, with limited access to accurate and trusted information. Young women therefore construct hybrid forms of knowledge, drawing on diverse sources, including family, community, and friends; NGO-organised sessions; healthcare providers; digital sources, social media and AI; as well as personal experiences and observation.

These sources present different forms and levels of knowledge, accuracy and trust. Women often trust peers and other women because of shared lived experiences, while NGO spaces are valued for providing safe opportunities to ask questions and access reliable information. Online sources offer privacy and breadth but can also expose women to misinformation and conflicting or inaccurate advice. Healthcare providers are generally seen as sources of expertise, yet experiences of judgement, dismissal, and coercive practices undermine trust.

Knowledge gaps are therefore never simply a matter of individual awareness or behaviour.

They are produced and reinforced by structural and material barriers, including the lack of comprehensive sexuality education, the cost of and distance to health services, and their inaccessibility, unresponsiveness and sometimes judgemental attitudes. Social norms, taboos and stigma further restrict what women can openly ask, learn and discuss. As a result, women are left to continuously negotiate between what is available, what is socially acceptable, what they hear from others and what they experience themselves.



*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.*



**KNOWLEDGE GAPS AND MISINFORMATION ARE NOT ACCIDENTAL OR INDIVIDUAL; THEY ARE SYSTEMATICALLY PRODUCED AND MAINTAINED BY SYSTEMS OF POWER AND SOCIAL NORMS THAT RESTRICT WHAT WOMEN CAN ACCESS, KNOW, DISCUSS AND TRUST.**

**THE LIMITATIONS OF EXISTING SRHR SYSTEMS ARE FELT NOT ONLY THROUGH GAPS IN ACCESS, BUT THROUGH REDUCED AUTONOMY, NORMALISED VIOLENCE, EXPOSURE TO HARM, AND DIMINISHED TRUST IN THE INSTITUTIONS MEANT TO SUPPORT WOMEN'S HEALTH AND RIGHTS.**



## INSTITUTIONALISED KNOWLEDGE GAPS AND LIVED CONSEQUENCES

These gaps and restrictions in SRHR knowledge and services have direct consequences for women's autonomy, health, wellbeing and ability to make decisions about our bodies and relationships. Constraints are shaped by intersecting systems of gender, family and social control, and are felt most acutely by women facing additional forms of exclusion. Norms around marriage and sexuality restrict unmarried women's access to sexual and reproductive healthcare, while family, partner, and community expectations shape decisions around contraception, family planning, and partner choice. Bodily autonomy is therefore often conditional and negotiated within unequal power relations.



*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.*

These dynamics extend into women's experiences of intimacy, consent, and violence. Gendered power imbalances and restricted access to SRHR knowledge normalise coercion and intimate partner violence, while stigma and shame around sexuality limit women's ability to recognise, communicate, and exercise consent. Social norms also normalise child, early, and forced marriage and further position reproduction and motherhood as central to

women's identities, often prioritising these roles over health, wellbeing, and personal aspirations. For women with disabilities, intersecting harmful norms around gender and disability further restrict knowledge, privacy, mobility and decision-making, and their infantilisation increases reliance on caregivers and erodes privacy and agency. These forms of control and exclusion also extend into healthcare settings: judgement, dismissal, coercive practices and obstetric violence compound the harm created by stigma and restricted access to information, further undermining trust in healthcare providers and services.



*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.*

# COLLECTIVE SPACES TO SHAPE HEALTH SYSTEMS

Yet, women do not engage with information sources and constraints passively or individually. Across informal and organised spaces, conversations with friends, family, other women, and NGO-facilitated sessions, opportunities to share experiences, compare knowledge, ask questions, and challenge assumptions about bodies, relationships, sexuality, and rights are crucial and can provide forms of knowledge and support that are otherwise difficult to access. However, spaces where women can speak openly about SRHR, without judgement or shame, remain limited and are particularly important where other avenues for information, support, and dialogue are restricted.

Collective spaces can shift how women understand and respond to their own experiences. Through speaking, listening, and collective reflection, women recognise experiences of coercion, violence, or unequal treatment, name what is harmful, and identify possibilities for action. The research spaces themselves demonstrated this potential: creating opportunities to speak openly about SRHR and reflect with others, enabling women to reinterpret experiences and to identify collective priorities. The research process itself also generated demand for more such spaces.



*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?*

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***WHEN WOMEN IDENTIFY SHARED EXPERIENCES, BARRIERS AND NEEDS, THEY GENERATE KNOWLEDGE ABOUT WHAT NEEDS TO CHANGE AND TURN LIVED EXPERIENCE INTO COLLECTIVE PRIORITIES. THIS KNOWLEDGE CAN INFORM MORE RESPONSIVE SRHR POLICIES, SERVICES, STRATEGIES AND PROGRAMMES. COLLECTIVE SPACES ARE THEREFORE NOT SIMPLY VALUABLE FOR DIALOGUE OR PARTICIPATION: THEY BUILD COLLECTIVE POWER AND STRENGTHEN WOMEN'S ABILITY TO HOLD SRHR AND BROADER HEALTHCARE SYSTEMS ACCOUNTABLE.***



*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.*

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## **INVESTING IN COLLECTIVE SPACES FOR YOUNG WOMEN TO SHAPE RESPONSIVE, INCLUSIVE AND RIGHTS-BASED HEALTH SYSTEMS**

Building stronger, more accountable SRHR - and healthcare - systems requires comprehensive and holistic investments and actions, led by diverse actors in this ecosystem playing complementary and mutually reinforcing roles. Donors, International and national non-governmental organisations (INGOs and NNGOs), women's rights and feminist organisations and initiatives, and allies in the health sector each have a distinct role to play in creating, resourcing, sustaining, and responding to women's collective spaces and voices. Investing in women's collective spaces in no way deprioritises services; it is what makes investment in services accountable, relevant and useful. Without women's collective knowledge shaping them, SRHR services continue to be designed around assumptions about our needs rather than our stated priorities. The recommendations below set out pathways through which these actors can jointly reinforce one another to ensure that women's knowledge and priorities inform SRHR policies, services, and strategies, and that our experiences and needs are central to decision-making.

## **RECOMMENDATIONS FOR INTERNATIONAL AND NATIONAL ORGANISATIONS:**

### **Building bridges between women's collective spaces, donors and health sector allies**

- **RECOGNISE AND PRIORITISE INVESTMENT IN COMMUNITY AND WOMEN-ONLY SPACES**, responding to women's own stated demand, especially from women who attended awareness sessions, research spaces, dialogue sessions and trainings, for more spaces where they can speak openly about their experiences and exist without judgement or shame, and where that openness can translate into collective knowledge, solidarity, and shared priorities for change.
- **INVEST TECHNICAL, FINANCIAL AND HUMAN RESOURCES** in strengthening and sustaining existing collective spaces for and led by women, particularly young women, including through dedicated budgets in SRHR programmes covering facilitation, venue, transport, childcare, interpretation and accessibility, and through multi-year sub-grants of at least three years that include core, unrestricted and flexible funding and remain accessible to informal and unregistered groups.
- **RECOGNISE AND COMPENSATE WOMEN AND THEIR GROUPS FOR THEIR KNOWLEDGE, TIME AND LABOUR**, applying a standard honorarium, alongside transport, childcare, and other participation-related costs for every consultation, validation and advisory role, and including these in programme budgets from proposal stages. This should include the additional costs that women with disabilities may incur to participate, such as personal assistance, accessible transport, interpretation or other reasonable accommodations, with these costs included in programme budgets from the proposal stage.
- **ESTABLISH AND MAINTAIN FORMAL AND INFORMAL COMMUNICATION AND ACCOUNTABILITY CHANNELS** between women's collective spaces and health sector actors, creating clear pathways such as creating regular liaison meetings, feedback loops through NGO focal points, establishing channels for women's groups to meet and engage with relevant primary healthcare and/or Ministry of Public Health departments or focal points or community-based healthcare workers and clinics, or facilitating representation in agenda-setting and decision-making spaces, through which women's priorities and demands can reach decision-makers, receive a response and influence policies, services and strategies. This can also include playing an active role in capturing and relaying key demands and asks generated within women's spaces in formal policy meetings, briefs and other processes involving engagement between INGOs, NNGOs and health sector actors.
- **DESIGN AND ADAPT PROGRAMMES INFORMED BY THE PRIORITIES AND KNOWLEDGE GENERATED THROUGH WOMEN'S COLLECTIVE SPACES**, documenting which priorities shaped programme objectives and returning to those spaces with what has changed, what has not and why, while sharing funding, advocacy and reputational risks where women and their collectives and groups are challenging discriminatory norms and practices or institutional barriers.

## RECOMMENDATIONS FOR DONORS:

### Fostering the financial and political conditions for women's collective spaces and power

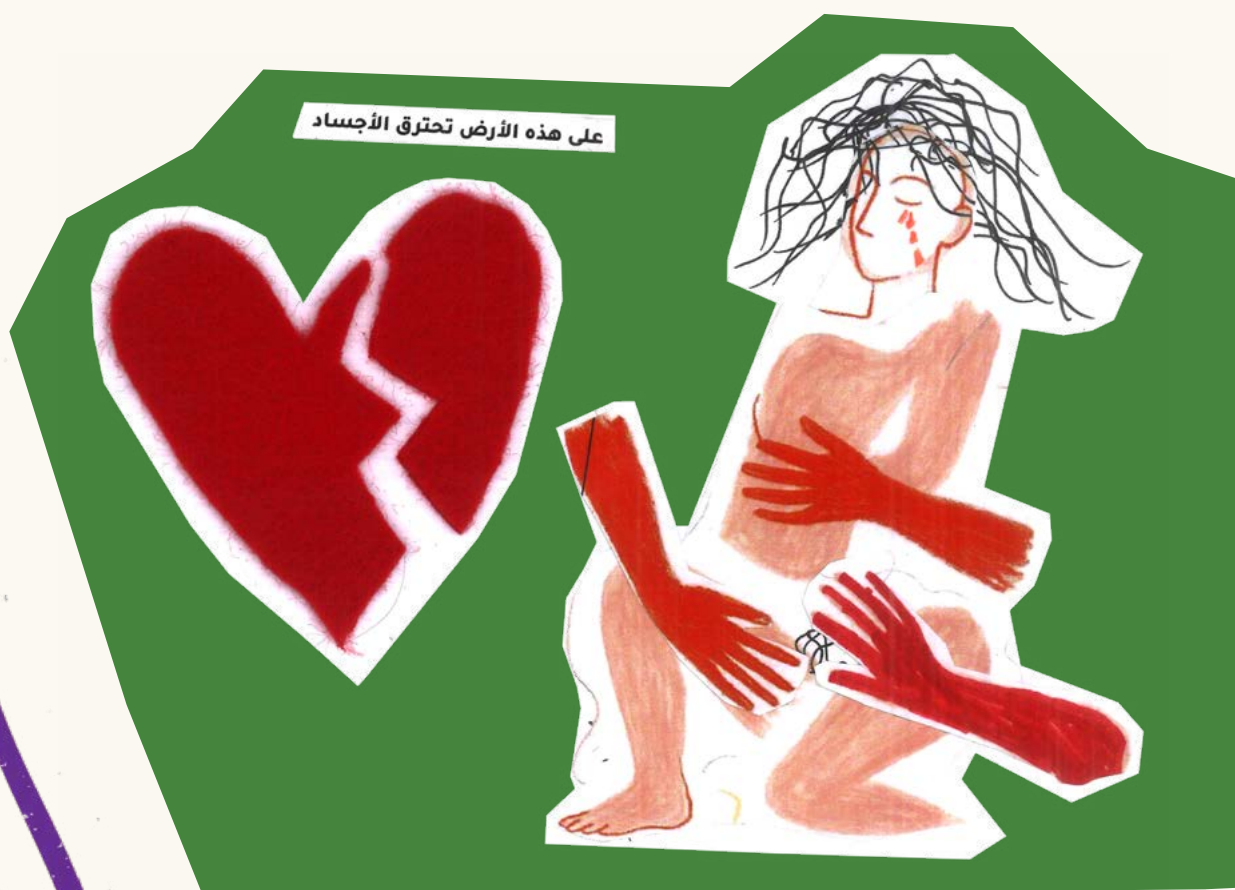
- **RECOGNISE WOMEN'S COLLECTIVE SPACES AND ORGANISING AS ESSENTIAL INFRASTRUCTURE FOR ACCOUNTABLE SRHR SYSTEMS**, rather than as optional participation or short-term project activity, and create dedicated funding streams for women-led collectives, particularly those led by young women and women facing intersecting forms of exclusion, that remain open to informal and unregistered groups.
- **PROVIDE LONG-TERM, FLEXIBLE AND PREDICTABLE FUNDING TO WOMEN'S RIGHTS, FEMINIST AND SRHR ORGANISATIONS AND INITIATIVES**, including core and institutional funding that enables organisations to sustain spaces (e.g. grants of 3 to 5 years) and retain staff, alongside rapid and accessible emergency mechanisms that disburse within weeks when crises, conflict or sudden funding disruptions threaten the continuity of women's spaces, networks and support.
- **SHIFT FUNDING MODELS AWAY FROM SHORT-TERM, OUTPUT-DRIVEN APPROACHES** that limit organising, solidarity and movement-building and knowledge generation, replacing indicators of reach and activity with measures of influence and learning (such as most-significant-change stories, learning spaces and reflections, participatory reflection sessions, or tracked shifts in service/policy responsiveness) that trace how change actually happens, how priorities generated in collective spaces shape programme design and health sector decisions, and that recognise trust-building, solidarity and women-led knowledge production as results in their own right.
- **REQUIRE MEANINGFUL PARTICIPATION AND ACCOUNTABILITY IN FUNDED PROGRAMMES**, ensuring that diverse women's priorities shape design, implementation and evaluation, that organisations demonstrate how women's knowledge influenced decisions, and that honoraria, transport, childcare and accessibility costs are treated as eligible expenditures.



## RECOMMENDATIONS FOR WOMEN'S RIGHTS, FEMINIST AND SRHR ORGANISATIONS:

### Movement-building, solidarity and organising

- **CREATE, SUSTAIN AND EXPAND DIVERSE COLLECTIVE SPACES FOR WOMEN**, particularly young women and women facing intersecting forms of exclusion, where they can safely share experiences, access information, build solidarity and organise around shared priorities. Design their timing, location and format around mobility restrictions, care responsibilities and disability, and convene close to where women live, recognising that the conditions determining who can attend also determine whose priorities are heard.
- **SUPPORT WOMEN TO MOVE FROM SHARED EXPERIENCES TO COLLECTIVE ANALYSIS AND ACTION**, creating opportunities through structured reflection sessions or participatory analysis workshops or processes, to identify patterns, challenge harmful norms and practices, generate knowledge and develop shared demands. Generate regular and ad hoc sets of priorities that can travel to donors, INGOs, NNGOs and health sector actors.
- **FORTIFY WOMEN'S LEADERSHIP, SELF-ORGANISATION, SOLIDARITY AND COLLECTIVE ADVOCACY**, including through cross-organisational networks, peer exchange visits and knowledge-sharing spaces, and joint advocacy coalitions..
- **DOCUMENT AND COMMUNICATE COLLECTIVE KNOWLEDGE AND PRIORITIES** in ways that can influence policy and practice, while protecting women's privacy, safety and ownership of their knowledge and stories.



## RECOMMENDATIONS FOR ALLIES IN THE HEALTH SECTOR:

### Building responsive health systems

- **CREATE SUSTAINED AND MEANINGFUL CHANNELS FOR WOMEN'S COLLECTIVE SPACES TO INFLUENCE HEALTH SECTOR DECISION-MAKING**, including policy development, service design, programme planning, strategic action plan setting, monitoring and evaluation. This could include facilitating representation of women's collectives on relevant planning and advisory committees, and in strategy development and action planning consultations. It can also include the identification of focal points in key institutions or departments for outreach, consultation and engagement, regularly interacting with women's collectives and feeding back into decision-making or prioritisation.
- **RESPOND TO WOMEN'S STATED PRIORITIES, DEMANDS AND LIVED EXPERIENCES IN A TIMELY AND CONCRETE MANNER** such as putting in place a regularly reviewed standard operating procedure for tracking and responding to input, and communicating how this input has influenced decisions, where they haven't, and why, so that accountability to women's collective spaces is demonstrable and trackable rather than consultative.
- **CHALLENGE INSTITUTIONAL PRACTICES, NORMS AND BEHAVIOURS** that reproduce stigma, discrimination, coercion or exclusion, addressing judgemental treatment, dismissal, coercive practices and obstetric violence through provider training and supervision, and establishing safe, effective and confidential complaints routes that diverse women can use without risking retaliation or stigma.
- **USE WOMEN'S COLLECTIVE PRIORITIES AND LIVED EXPERIENCES** in service design, provider training curricula and resource-allocation decisions to identify and address gaps in the accessibility, quality, inclusiveness and rights-based delivery of SRHR services, and advocate within institutions and with donors for sustained investment in women's collective spaces.



*WHEN WOMEN HAVE SPACES TO COME TOGETHER, SHARE AND VALIDATE KNOWLEDGE, IDENTIFY SHARED PRIORITIES AND BUILD COLLECTIVE POWER, THEY ARE BETTER POSITIONED TO SHAPE THE SYSTEMS THAT AFFECT THEIR LIVES. INVESTING IN THESE SPACES IS THEREFORE A NECESSARY IMPERATIVE FOR MORE RESPONSIVE, INCLUSIVE AND RIGHTS-BASED HEALTH SYSTEMS. ALL ACTORS IN THE SRHR ECOSYSTEM MUST ACT TO RESOURCE, SUSTAIN AND RESPOND TO WOMEN'S COLLECTIVE SPACES AND VOICES SO THAT WOMEN'S KNOWLEDGE, PRIORITIES AND EXPERIENCES SHAPE DECISIONS, SERVICES AND SYSTEMS.*



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