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Cognitive and cultural attitudes to sex educational content on social media in Bangladesh

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ABSTRACT

This study investigated the attitudes of Bangladeshi social media users towards sex education by analysing user responses to posts on the Deutsche Welle (DW) Bangla Facebook page. Drawing from eight posts covering topics such as hymen surgery, menstruation and surrogacy, a total of 1,404 text-based comments were analysed using Reflexive Thematic Analysis. We identified seven principal themes: faith-driven resistance, moral panic, cultural resistance, sexual harassment, misogyny, conditional social support and breaking social taboos. While many users engaged positively with the social media content and expressed the desire for accurate information, others responded with resistance grounded in religious beliefs, cultural values and gender-based hostility, revealing significant barriers to inclusive public discourse. Guided by Dual-Process Theory, we found that user reactions were predominantly shaped by fast, intuitive (Type 1) processing rather than slow, reflective (Type 2) reasoning. These findings highlight how socio-cultural and cognitive factors intersect in shaping online engagement with sexual and reproductive health content and offer important insights for developing culturally responsive communication strategies in contexts like Bangladesh.

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Sex education; social media; sexual and reproductive health; Dual-Process Theory

Introduction

In recent years, social media platforms, such as Facebook, X, Reddit, Instagram and TikTok, have emerged as significant tools for promoting sexuality education and raising awareness. These platforms facilitate information dissemination and encourage discussions on sensitive topics, enabling them to reach large and diverse audiences (Rahman, Rashid, and Rahman 2025). Facebook is particularly popular in Bangladesh, with 55.6 million users, representing 74.37% of all social media users (Dixon 2024; Kemp 2024). However, despite its widespread usage, cultural and religious stigma

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creates substantial barriers to accessing sexuality education in the country on social media. Women and girls in particular encounter difficulties in acquiring accurate information due to this stigma (Zarif 2022). Additional barriers include inadequate teacher training, parental reluctance, institutional limitations and discomfort associated with mixed-sex classes in schools, all of which hinder the effective delivery of sexuality education (Kamruzzaman, Roy, and Singh 2022).

Sexuality education involves learning about sexual and reproductive health (SRH), including topics like reproduction, anatomy, contraception, consent, relationships, safe sex and sexually transmitted infections (STIs) (Döring 2009; Muller, Oosterhoff, and Chakkalackal 2017). Recognised internationally as both a fundamental human rights and an essential component of public health policy, SRH remains a much debated issue, particularly in countries where societal taboos and inadequate healthcare services limit access to accurate information (Saha et al. 2022). In many cultures, openly discussing sexuality education is still considered taboo, which contributes to widespread misinformation, confusion and unhealthy sexual practices (Vuttanont et al. 2006). Therefore, effective sexuality education is crucial in promoting healthy sexual behaviours, preventing unintended pregnancies and reducing the transmission of sexually transmitted infections (Shtarkshall, Santelli, and Hirsch 2007).

While social media holds significant potential as a platform for delivering SRH information, it is not without limitations. Algorithms often prioritise sensational or emotionally charged content over accuracy, which can amplify misinformation and polarising narratives, especially in relation to culturally sensitive topics such as sexuality education (Cinelli et al. 2021; Marwick and Lewis 2017). This environment can create echo chambers that reinforce users' existing beliefs while marginalising alternative or evidence-based perspectives (Guess, Nagler, and Tucker 2019). Therefore, analysing user responses to sexuality education content on these platforms requires sensitivity to how information is algorithmically curated and cognitively processed by diverse audiences.

However, responses to sexuality education content on social media can vary widely, influenced by individuals' personal beliefs, values and experiences (Bowen, Stevenor, and Davidson 2021). While some users view such posts as informative and beneficial, others may respond negatively due to discomfort or opposition (Ollis, Coll, and Harrison 2019). To better understand how users engage with sexuality education content on social media, this study employed Dual-Process Theory (DPT) to provide a framework for analysing cognitive processes related to decision-making, argumentation and social judgements (Gawronski and Creighton 2013). This theory differentiates between two types of cognitive processing: Type 1 (T1), which is fast, intuitive and automatic, and Type 2 (T2), which is slow, deliberate and analytical. In contexts like Bangladesh, cultural and religious norms may trigger T1 reactions of discomfort or resistance when encountering sexuality education. Conversely, T2 processing enables reflective engagement, potentially allowing users to reassess their biases and appreciate evidence-based SRH. Specifically, this research analyses the perspectives expressed by Bangladeshi users in response to sexuality education content posted on the Deutsche Welle (DW) Bangla Facebook page. By examining user comments, the study identifies common themes and patterns of reaction, with a focus on how the DPT

might explain the underlying cognitive processes. Our analysis not only illustrates on public attitudes towards SRH in Bangladesh but also highlights the social, cultural and psychological factorsm that shape online discourse around sensitive health topics. Two research questions guided the study.

RQ1: What are the dominant themes and attitudes expressed by Bangladeshi Facebook users in response to sex education content on social media?

RQ2: How do cognitive processes, influenced by cultural and religious values, shape Bangladeshi Facebook users' reactions to sexuality education content on social media?

Dual Process Theory and social cognition

DPT provides a framework of understanding human cognition across disciplines. Beginning with Kahneman and Tversky's foundational distinction between automatic and reflective thinking (Kahneman 2013), research has expanded from cognitive psychology into broader domains of social cognition (DeCoster and Smith 2000; Evans 2008) and cultural sociology (Boutyline and Soter 2021; Lizardo et al. 2016). DPT's T1 was initially defined in terms of implicit attitudes or automatic responses driven by cultural and social cues, often operating without conscious awareness (Hoffmann 2014). These attitudes are influenced by associative networks and are relatively resistant to change (Gawronski and Strack 2004). In contrast, explicit attitudes were identified as T2 by researchers and derive from conscious evaluation and reasoning. When individuals are exposed to new forms of information-rich content, for example in relation to the health benefits of sexuality education, they may engage in reflective thinking, potentially overriding initial automatic biases (Sturge-Apple et al. 2015). The application of DPT to culturally sensitive topics reveals how cognitive processing is deeply embedded in social context. In conservative settings such as Bangladesh, as in countries such as Iran (Roudsari et al. 2013), chronically accessible moral schemas likely trigger the automatic rejection of sex education content. However, this automatic resistance can be modulated through reflective engagement, as demonstrated by successful interventions in African contexts (Olamijuwon and Odimegwu 2022).

While traditionally viewed as separate systems, research suggests these processes operate along a continuum with complex interactions between T1 (automatic) and T2 (reflective). Bellini-Leite (2024) demonstrate how reflective engagement can challenge implicit biases and enhance reasoning capabilities, while Xu and Allan (2024) highlight how this cognitive flexibility proves particularly valuable in ambiguous decision contexts. Khanam et al. (2025) extend these insights to health communication, showing that strategic media exposure can activate reflective thinking to improve health behaviours.

In addition to this, cross-disciplinary integration has revealed how cultural schemas simultaneously shape automatic cognitive responses while being reshaped through reflective engagement with new cultural narratives. Recent applications of the theory have refined our understanding of the dynamic interplay between T1 and T2 processing (Frankish 2010; Gawronski and Creighton 2013). Białek and Neys (2017)

challenged the traditional view that T2 processing must override T1, showing that utilitarian reasoning can sometimes arise intuitively rather than through deliberate reflection. Similarly, Zhang and Lee's (2022) framework of Two Rivers cognitive processing offers a particularly promising integration, demonstrating how affective (T1) and cognitive (T2) pathways can be engaged simultaneously rather than sequentially. This challenges earlier DPT models and suggests that effective educational content should strategically engage both processing systems, using visually appealing elements to facilitate automatic engagement while embedding information-rich content to promote deeper cognitive processing.

This integrated understanding of DPT highlights how cultural resistance to sexuality education should not be seen solely as a barrier but as a starting point for facilitating reflective engagement while respecting cultural values. Effective strategies include framing educational content within culturally resonant narratives (Amodio and Swencionis 2018) and employing proactive control strategies (Phillips, Johnson, and Iruka 2022) that simultaneously respect automatic cultural responses while facilitating reflective consideration of health outcomes. Applying DPT in this way offers a theoretical foundation for developing culturally sensitive educational initiatives that address the interplay between automatic and reflective thinking in conservative contexts like Bangladesh, where implicit attitudes often trigger immediate discomfort or rejection of Sex and sexuality education (Yama et al. 2007).

Sex and sexuality education: international and regional perspectives

Sexuality education is widely recognised as key to promoting public health and human rights (McCormack et al. 2025; Vanwesenbeeck 2020). However, discourse surrounding sex and sexuality education varies significantly across geopolitical contexts. In many high-income countries, comprehensive sexuality education (CSE) is normalised within school curricula, supported by policies that promote inclusivity, gender equality and sexual rights (Bhana et al. 2024; Kirby 2002). However, even in these contexts, debates persist around age-appropriateness, parental consent and diverse inclusion. In contrast, sexuality education in many developing countries is either absent or highly contested, being constrained by religious and cultural norms, state censorship and moral panic (De Haas and Hutter 2019; Mfeka-Nkabinde, Moletsane, and Voce 2024).

Across South Asia, and despite major cultural and religious differences, sexuality education has historically been framed as a threat to traditional values, family honour and community cohesion (Kyu et al. 2024; War and Albert 2013). For example, in India, government-led CSE programmes such as the Adolescent Education Programme (AEP) have faced backlash from religious and political groups (Jejeebhoy, Santhya, and Zavier 2014). In Nepal, adolescents and young people struggle to access sexual health information due to conservative family values and stigma surrounding premarital sex (Pandey, Seale, and Razee 2019). Similarly, in Bangladesh, sexuality education initiatives are often sporadic, heavily monitored, or removed from formal school curricula due to fears of 'moral decay' (Nazrul 2024). These contradictions highlight how CSE constitutes not just a pedagogical intervention but a cultural battleground on which global, local and religious ideologies collide.

Scholars have also questioned the idea that CSE is universally accepted, noting that Western models often ignore local knowledge systems, spiritual beliefs and non-Western views of the body and relationships (Cornwall and Jolly 2006). Others warn against the adoption of 'one-size-fits-all' approaches that fail to account for class, caste, gender identity and rural-urban divides (Boyce 2007). These debates are especially relevant for Bangladesh, where sexuality education initiatives must navigate a complex terrain shaped by cultural and social norms, gendered power structures and global development agendas.

Bangladesh: socio-cultural context and policy landscape

Understanding sexual health discourse in Bangladesh requires attention to the country's demographic and socio-political makeup. With over 169 million people the country shows persistent disparities across gender, region and education despite having a 75.2% literacy rate (UNESCO UIS 2023). While the government has introduced initiatives such as the National Adolescent Health Strategy, menstrual hygiene campaigns and HIV prevention efforts (DGHS 2017), these programmes often face challenges and are rarely integrated into school curricula as part of sexuality education.

Religious patriarchy plays a significant part in shaping socio-cultural taboos around sexuality education in Bangladesh. Religious clerics and institutions hold considerable influence over public morality and often oppose reproductive health initiatives deemed non-religious (Kamruzzaman, Roy, and Singh 2022). Topics such as menstruation, birth control, contraception, safe sex and talking about sexual violence are especially stigmatised. As a result, sexuality education content is frequently dismissed as vulgar, anti-religious, or 'Western', limiting both public discourse and institutional support for progressive reform.

This tension is further reflected in media discourse. While platforms like DW Bangla aim to normalise conversations about SRH, they often encounter backlashes, particularly on social media, where moral gatekeeping remains strong. These dynamics exemplify what Foucault (1978) described as the politics of silence and surveillance surrounding sexuality in conservative societies. Thus, any intervention in this context must not only provide knowledge but also engage with the affective and moral worlds of the audience.

Social media as a 'double edged sword'

While this paper builds on existing work demonstrating the promise of social media for CSE dissemination (Olamijuwon and Odimegwu 2022; Selkie, Benson, and Moreno 2011), it also acknowledges its limitations. Social media algorithms are not neutral; they amplify sensational content and often deepen ideological echo chambers (Cinelli et al. 2021). In the Global South, studies have shown that misinformation about sexual health can go viral more quickly than verified information due to taboos and limited digital literacy (Dasgupta 2021). Moreover, social media platforms can also reproduce patriarchal surveillance by enabling the harassment or public shaming of women who participate in discussion about sexuality (Marwick and Caplan 2018; Sobieraj 2018). While social media platforms provide accessible spaces for discussing SRH, they also

carry socio-political risks. Constructive conversations often appear alongside cyber-bullying, misinformation and moral policing. This study examines these dynamics through Bangladeshi users' responses to DW content. The paper addresses key gaps in the existing literature by applying DPT to move beyond binary interpretations of public responses, analysing how automatic (T1) and reflective (T2) thinking shape responses to sexuality education. Unlike survey-based research, it draws from real-time social media interactions to capture public attitudes.

Methods

We conducted a qualitative reflexive thematic analysis (RTA), in line with the approach suggested by Braun and Clarke (2022). Data were collected from Facebook, the most widely used social media platform in Bangladesh. Although specialised health platforms like Maya exist in Bangladesh, we deliberately selected DW Bangla, a mainstream news outlet, to examine how sexuality education is presented through journalistic media and how audiences engage with such content outside specialised health communities. DW is an international public broadcaster funded by the German federal tax system and promotes intercultural dialogue through content tailored to specific regions (DW 2024; Richter 2009). We acknowledge the limitations of studying a German-funded platform in the Bangladeshi context. However, DW Bangla's localisation of global health information through Bangla dubbing provided valuable insights into cross-cultural health communication. This aligns with Hermeking's (2005) findings that culturally adapted communication styles increase audience trust and receptivity, particularly in conservative societies such as Bangladesh (Rabbani et al. 2024).

After selecting the platform, we collected data between 1 August and 13 September 2022. During this period, we identified eight posts related to sexuality education from the series titled 'Sex and the Body'. These eight posts, published between 30 May and 11 December 2021, represented the full set of content released under this series. The topics addressed included hymen surgery, vaginal and leukorrhoea concerns, clitoral sexual satisfaction, nocturnal emissions, hormones and concupiscence, semen and masturbation, menstruation and surrogacy. All the posts took the form of videos and were narrated by a female voice speaking in Bangla. After finalising the posts, the researchers manually collected comments from the selected eight posts. A total of 5,996 comments were shown on these posts, including replies to the original comments. As Rashid and Al-Zaman (2023) did in their analysis, we extracted only the direct comments (2,042 in total). Comments from each post were stored in Microsoft Word files for final analysis. To protect user privacy, all identifiable information, including usernames and personal references, was removed.

Comments originally in Bangla were then translated into English, and quotations were paraphrased in the findings to prevent user identification through search engines (Townsend and Wallace 2017). We then excluded comments that contained emojis ($n = 638$). Finally, a total of 1,404 text-based comments were retained for the analysis to explore cognitive and cultural attitudes. In analysing the comments, we followed six steps of the RTA, which are: familiarisation with the data, coding, initial theme generation, reviewing themes, writing the theme and defining it (Byrne 2022). Later, two coders initially analysed 14% of the dataset ($n = 200$ comments) independently.

They came up with themes, such as teachable, acknowledging sources, appreciating the presenter, cyberbullying and socio-cultural norms-based disagreements. To develop a final coding framework, we discussed and merged similar themes into a single theme or split them in the following way. For example, teachable, acknowledging sources and appreciating the presenter were merged, and we came up with conditional social support and breaking social taboos. We modified cyberbullying to address two themes: sexual harassment and misogyny. We split faith-driven resistance from socio-cultural norms-based disagreements on the basis of the use of religious text identifiers, and those that did not mention any religious identifiers, so as to identify two themes: (1) cultural resistance and (2) moral panic.

We resolved all initial coding disagreements through discussion, reaching consensus through negotiated agreement to enhance reliability by addressing disagreements and clarifying ambiguities (Campbell et al. 2013; Garrison, von Ellenrieder, and Louton 2006). In this way, iterative discussion improved intercoder agreement and added to reliability (Hruschka et al. 2004; MacQueen et al. 1998). After resolving discrepancies and finalising the seven themes, we proceeded with final coding.

Results and discussion

We identified seven key themes that characterised public discourse on this topic: faith driven resistance, moral panic, cultural resistance, sexual harassment, misogyny, conditional social support and breaking social taboos. These themes revealed both significant oppositions to sexuality education content based on cultural and religious beliefs and instances of openness.

Faith driven resistance

Faith-driven resistance was primarily rooted in religious teaching, which served as a dominant framework for rejecting sex and sexuality education content. Users often labelled practices such as surrogacy, masturbation and hymen surgery as prohibited, relying on religious authority to evaluate these topics. A key feature of this resistance was the frequent citation of religious texts, to support their views. For instance, one commenter quoted, 'Have you no fear of God? What we need is proper religious education'. Another added, 'Fear the God, not death. May God guide people like you [the presenter]'. Another stated, 'Efforts must be made to prevent what is forbidden in religion from gaining legitimacy in our country. As far as I know, surrogacy is not religious. Clear statements from experts on this matter are necessary'.

These responses demonstrate how users often dismissed considerations in favour of religious doctrine. Our findings support existing research on religious resistance to health education in conservative societies, where religious values strongly influence views about SRH (Kamruzzaman, Roy, and Singh 2022). This reliance on religious texts and principles highlights the role of religious authority in legitimising opposition, a pattern observed in similar contexts such as Pakistan, Iran and Nigeria, where religious beliefs are prioritised over scientific perspectives (Boyce 2007).

This evidence of immediate rejection of sexual health practices connects with DPT's explanation that T1 processing, automatic, religiously induced reactions. Morgan (2016)

further explains that religious beliefs, rooted in T1 processing, are often resistant to reflective, T2 thinking, making them difficult to challenge through rational argument.

Moral panic

Moral panic emerged as another dominant response to sexual health discourse. Many commenters positioned themselves as protectors of societal values, warning of harmful consequences to traditional structures. They often linked sexual health topics to broader anxieties about social decline and instability. For example, one user wrote, 'this initiative is an expression of society's decay', in response to a post on hymen surgery. Another commented, 'due to open discussion of sex-related issues, divorce and extramarital affairs are increasing in our country'.

Several users expressed concern that open discussion could destabilise social institutions. As one stated, 'breaking social chains will lead to the degeneration of humanity'. Others worried about younger audiences, with remarks like, 'this will encourage young people to engage in immoral activities'. Practices such as surrogacy, masturbation and even discussion of menstruation were framed as signs of moral decline. These patterns reflect broader concerns found in the literature regarding the perceived erosion of traditional values through sexual health discourse.

People resist discussions that challenge their traditional sexual norms and are viewed as contributing to moral erosion (Dasgupta 2021). This response mirrors broader societal fears around children's exposure to sexual health information. Lipari (2018) suggests that social norms significantly influence how individuals make decisions and process information, with users making comments like 'everything should not be promoted everywhere… keeping some things secret is good'. These reactions align with the moral intuitions described by Baumard and Boyer (2013), where existing beliefs formed by societal norms and values shape fast, automatic responses that instinctively reject ideas perceived as morally wrong and broader anxieties about the erosion of traditional values (Lipari 2018).

The overall tone of moral panic related comments suggests reliance on automatic moral evaluations, which hinder constructive engagement with the content (Khanam et al. 2025). This connects with DPT's T1 processing, where culturally conditioned judgements contribute to immediate moral condemnation and fears of societal harm.

Cultural resistance

We found cultural resistance to be another dominant theme. Social media users showed concern about cultural integrity and anxiety with fear of foreign influences on local culture, which contributed to the rejection of the SRH online content. Some users also questioned information dissemination using experts from another country, such as Germany. Several comments described the content as a 'Western system' or 'Jewish-Christian practice' which illustrates resistance to foreign influence on local values (Pandey, Seale, and Razee 2019). For example, one user mentioned, 'DW Bangla, is your purpose to rot this country like America's corrupted social system?' Another user mentioned,

> Surrogacy! They talk about morality, but they are actually against it. They bring up such baseless issues that only confuse people. Basically, they ridicule civilisation and immerse people in Western mentality. In reality, they are the epitome of shamelessness and degeneracy. This auntie [the presenter] is talking more about these issues; perhaps she wants to indoctrinate Bangladeshis with this culture.

Several commenters perceived SRH content as a breach of cultural norms, expressing discomfort with its public visibility. One remarked, 'Not everything needs to be advertised everywhere', reflecting the belief that such topics should remain private. This discomfort ties into wider anxieties about globalisation, in which foreign ideas are seen as threats to local moral boundaries (Boyce 2007). In conservative settings like Bangladesh, such responses reflect cultural resistance to SRH discourse. As Liu, Tsang, and Shi (2025) note, in contexts with strong cultural or religious beliefs, people often rely on superstitious heuristics, and quick and intuitive decisions that maintain conformity and reduce uncertainty.

According to DPT's T1 processing, cultural schemas can lead to the immediate rejection of content seen as conflicting with local values or originating from out-groups. While less common, some users appeared to engage in more reflective processing, questioning the cultural implications of the content. This was evident in concerns about cultural sovereignty, such as in the comment, 'We don't need this kind of Western system in Bangladesh'.

Sexual harassment

Another theme identified was sexual harassment. Within it, SRH educational content was viewed as feeding harassment, with commenters objectified the presenter and reducing the discussion to sexually explicit remarks. This theme provides us with a sense of the challenges of discussing sensitive health issues in environments shaped by strong sexual taboos. For example, one user commented, 'I'll learn, if *you* [the presenter, who was a female] give me a practical demonstration'. Another user added, 'If I could do it with *you* [the presenter], I would learn what sex is'. These findings align with previous research on online harassment in educational contexts, particularly when women engage with topics related to sexuality (Sobieraj 2018). These comments reflected a broader pattern of objectification and harassment, subverting educational content to sexualise the individuals involved (Dasgupta, 2021).

Harassment was also used to discredit the presenter's authority *via* comments such as, 'I think the presenter also does the same things; that's why she's talking about this topic'. Another user added, 'The presenter's face seems distorted; she must be masturbating'. Another user, responding to the presenter's discussion of sex education topics, commented, 'Be careful with your [the presenter's] clitoris', with this sexualisation being used to undermine the presenter's credibility and professional role (Amodio and Swencionis 2018). Other comments extended harassment to the presenter's family, normalising abuse for women who discussed taboo subjects (Foucault 1978). For example, we found a Bangla comment that translated into English as, 'Do you openly discuss sex and masturbation with your family members such as parents, sons and daughters, or only online? I would appreciate your reply'. This negativity not only discourages open dialogue but also creates a hostile environment that

hinders efforts to enhance a more inclusive space for discussing sex and sexuality education (Kaneko et al. 2021; Marwick and Caplan 2018).

Overall, DPT T1 processing appeared dominant within this context, with immediate reactions being shaped by objectification and gendered cultural norms. Reflective T2 processing was less evident, as most comments displayed impulsive judgements that sought to undermine the educational message.

Misogyny

The theme of misogyny revealed that many people still have strong negative attitudes towards women, especially when they talk openly about SRH. These attitudes were demonstrated in comments that questioned the morality and right of women to speak out openly about sex and sexuality. In such instances, comments attacked the presenter's character, suggested she was mentally ill and implied women should not speak publicly about such topics. Some comments suggested the presenter must be sexually promiscuous in order to know about issues pertaining to sexual health. Other comments such as, 'this woman's mental health problems should be treated first [instead of providing sexual education]' highlight the judgement women faced when speaking out openly about sexual and reproductive choices, while men's actions went largely unchallenged.

The data showed that many people held fixed ideas about what it means to be a woman, with comments such as 'a woman's fulfilment comes through motherhood', seeking to delegitimise reproductive options such surrogacy, thereby reinforcing restrictive gender roles (Cornwall and Jolly 2006). Misogynistic attitudes were also evident in the questioning of women's appropriateness and authority in discussion of sexual health, with comments like, 'Couldn't this video be narrated by a man?' and 'Overly smart, low, uneducated women [targeted to the presenter] can talk about those subjects. It's disrespectful. Stop it'.

Here, DPT T1 processing explains how deeply ingrained gender schemas can lead to objectification, negative moral judgement and the pathologisation of women.

Conditional social support

Some users expressed conditional support for both surrogacy and sexuality education but made their approval conditional upon regulation and alignment with cultural and religious values. For instance, support for surrogacy was sometimes framed in terms of its potential to assist childless couples. As one commenter noted, 'In my opinion, surrogacy should be legalised. [so that] many childless couples can have children'. Similarly, expressions of support for sexuality education were sometimes made conditional on context, with one user suggesting, 'We need sexuality education alongside other subjects, but [need to] ensure it's not applied in the wrong place'.

A key aspect of conditional support was the incorporation of religious perspectives. Some commenters connected religious principles to their support for sexuality education, stating, for example, 'sexuality education is necessary, and Islam provides instructions for sexuality education in a decent and disciplined way'. This suggests that religious views were not necessarily in opposition to sexuality education so long

as its content and delivery took place in culturally appropriate ways. Woolford and Horner (2024), drawing on 30 semi-structured interviews with individuals from six different faith communities, found that individuals can experience both alignment and tension between their religious beliefs and medical science, leading them to seek a balance between faith and health-related needs.

DPT T2 processing, which involves reflective thinking, was dominant when users engage thoughtfully with these topics, weighing up the benefits and considering how best to align them with cultural values. Moreover, T2 processing wass also present in reflective calls for religious reinterpretation, in which commenters sought expert guidance to navigate modern medical practices. The absence of T1 processing here indicates a more deliberate form of evaluation that goes beyond immediate rejection based on cultural discomfort. Importantly, the existence of conditional support offers promising ways of developing acceptable approaches to sexuality education.

Breaking social taboos

The theme breaking social taboos reveals that many people in Bangladesh are surprisingly open to discussing SRH on social media, despite discussion about these issues being taboo in everyday life. Many users actively sought out accurate information and expressed the desire to learn about sex and sexuality, particularly in situations where formal instruction had been limited by cultural and religious norms. Such findings challenge the assumption that conservative societies uniformly reject open conversation about SRH.

User comments illustrate these tendencies. For example, one commenter stated, 'this [sex education] is a very important topic; everyone should know', while another noted, 'Sex education is severely lacking in this country', pointing to a significant educational gap. Such expressions of support reflected a willingness to engage with SRH content when it is presented in a respectful and informative manner. Notably, culturally grounded acceptance was also present in response to a post related to menstruation, when one social media user remarked, 'There is also some evidence of Islam here. *Alhamdulillah* [praise be to God]', suggesting that religious frameworks can enhance receptivity when aligned with health messages.

These findings are consistent with research showing that social media can serve as a relatively safe space for discussing sensitive issues, especially in contexts where community norms restrict such conversation. In particular, social media allows users to navigate the tension between traditional norms and the need for better health knowledge. In this study, some responses were informed by intuitive thinking, while others showed deeper forms of reflection. From a DPT perspective, automatic reactions shaped by cultural or religious values may cause hesitation, but well-framed content can encourage reflection and trigger attitude change. The mix of resistance and openness seen in user comments reflects this process.

Limitations

There are several limitations to this study. First, it draws on comments from DW Bangla, an international media platform, which may not reflect the views of the wider

Bangladeshi population, including those who do not use social media, do not have access to Facebook and/or do not follow DW Bangla. The audience whose responses were focused upon is likely more digitally engaged or internationally exposed, which limits generalisability. Second, the analysis excludes content produced by local actors such as government agencies, NGOs, local doctors and social media influencers, whose material may prompt different forms of engagement. Third, while social media may offer valuable insights into public discourse, it may lack reliability and validity, as users are often anonymous and may express strongly polarised views. And lastly, lack of demographic data further limits understanding of group-specific responses, and it must be recognised that the qualitative dataset was relatively small.

Conclusion

Our analysis revealed something of the complex socio-cultural and psychological factors shaping online discourse on sensitive health topics in Bangladesh. In this study, several key factors were identified as influencing T1 type processing, including religious schemas (Lau 1989) that label certain practices as forbidden; culturally ingrained perceptions of Western sex and sexuality education as a threat to local culture; and gender biases that led to the objectification of female presenters. In this study, each of these factors was seen as triggering an immediate rejection and moral condemnation, preventing more reflective consideration of the scientific, medical and personal value of the information provided. Importantly, there was also of more reflective T2 processing in online comments that discussed the benefits of sex and sexuality education in challenging cultural taboos. Some individuals actively sought out information about SRH to satisfy their intellectual curiosity, suggesting that online media provided a relatively safe space for such discussion. T2 engagement increased when SRH content addressed community concerns such as childlessness, misinformation and low health literacy.

The findings from this study offer practical suggestions for improving sex and sexuality education in conservative settings. Integrating religious perspectives into sex education content and communication strategies, rather than questioning them, may reduce resistance and enhance acceptance. Featuring both male and female presenters and emphasising men's role in SRH can also be used to challenge misogynistic attitudes. Additionally, positive online discussions that break taboos can serve as social proof to show that open engagement with SRH is accepted and valued by others, thereby encouraging more open dialogue and improved health outcomes. Further research is needed to explore how religious frameworks, longstanding cultural norms and digital platforms shape SRH discourse in similar cultural contexts. This might include examining the influence of influencers, religious leaders and repeated exposure to reflective content in shifting cognitive biases.

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