Young people's lived experiences and perceptions of sexuality in Dhaka, Bangladesh

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ABSTRACT

Background and aim: Many young people in Bangladesh have a poor understanding of their sexuality and wellbeing due, in part, to limited access to sexual and reproductive health services and reliable information. Having to navigate restrictive socio-sexual norms may also present challenges for young people. Thus, this demographic may confront negative sexual health outcomes such as sexually transmitted infections and gender-based violence.

The aim of this qualitative research is to explore meanings and perceptions of sexuality through lived experiences of young people in Dhaka, Bangladesh, and to investigate how a phenomenological lifeworld perspective can expand our understanding of sexual health and wellbeing.

Approach and methodology: Given the dearth of published research in the field of sexual health in Bangladesh, I adopted a qualitative research approach to explore lived experiences to provide a more in-depth understanding of young people's sexuality. Moreover, the 'lifeworld' – a shared and meaningful world that is embodied and experienced by us and through us every day – has the potential to provide a better understanding of young people's 'life situation' and experiences.

I collected data across Dhaka, Bangladesh over nine months (February to October 2019) through in-depth one-to-one biographical interviews with 46 young people of varying characteristics – such as sexual and gender identity, educational background, and religion etc. – to elicit experiential narrative material.

I followed a thematic approach to analysis to interpret findings by identifying and synthesising most prominent and recurring themes. I formulated meanings from significant statements by staying close to the phenomenon as experienced by participants. I clustered these meanings into common themes and developed inclusive descriptions of the phenomenon.

Findings: Findings focus on reviewing socio-sexual norms and sexual health in South Asia; lived experiences of sexual violence in Bangladesh; navigating heteronormative straightening devices; and exploring queer lifeworlds. Studies included in the systematic review suggest that young people in South Asia faced gendered societal expectations around premarital 'sexual purity' through abstinence and had limited communication around sexuality with adults. According to the interviews with 46 participants in Bangladesh, young

people's lives were punctuated by episodes of harassment and violence with adverse and long-lasting consequences on their mental and physical wellbeing. I also identified four key heteronormative straightening devices confronted by non-normative young people: marriage normativity (straightening the life course); compulsory heteronormativity in public space (performing straightness); heteronormativity within healthcare (straightening as 'care'); and consequences of failing to embody heteronormativity (unbecoming straight). Finally, queer young people in Bangladesh understood sexual intimacy to mean desiring consensual sexual and romantic relationships with sexually 'matched' partner(s) while navigating heteropatriarchal sexuality norms.

DEDICATION

For my favourite young humans: Amaya and Arissa.

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CONTENTS

ABBREVIATIONS

AFHC	Adolescent Friendly Health Corner
AIDS	Acquired immune deficiency syndrome
ASK	Ain o Salish Kendro
BSWS	Bandhu Social Welfare Society
BLAST	Bangladesh Legal Aid and Services Trust
BoB	Boys of Bangladesh
CASP	Critical Appraisal Skills Programme
CEDPA	Centre for Development and Population Activities
DOI	Digital object identifier
ESRC	Economic and Social Research Council
FGD	Focus group discussion
HIV	Human immunodeficiency virus
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
ICRW	International Center for Research on Women
IPV	Intimate partner violence
IYCF	Infant and young child feeding
LGBTQ+	Lesbian, gay, bisexual, transgender, queer, etc.
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual, etc.
LMIC	Low- and middle-income countries
LSHTM	London School of Hygiene & Tropical Medicine
MeSH	Medical Subject Headings
MSM	Men who have sex with men
NSU	North South University
PLWH	People living with HIV
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RLR	Reflective lifeworld research

SES	Socioeconomic status
SGD	Sexual and gender diverse
SGM	Sexual and gender minority
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UK	United Kingdom
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Population Fund
UNHRC	United Nations Human Rights Council
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

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CHAPTER 1. INTRODUCTION

Illustration 1.1 Introduction artwork

1.1 Introduction

Many young people – aged 15-24 years – in South Asia often have a poor understanding of sexuality and wellbeing, partly because of limited access to sexual and reproductive health services and reliable information (Barkat & Majid, 2003; Bhuiya et al., 2004; Cash et al., 2001; Nahar et al., 1999; Pandey et al., 2019; UN, 2019; UNFPA et al., 2015). The situation is exacerbated by taboos relating to gender and sexuality – centring on premarital abstinence and monogamous procreative heterosexual marriage – which limit sexual and reproductive health (SRH) communication between young people and adults (Barkat & Majid, 2003; Bhuiya et al., 2004; Cash et al., 2001; Ismail et al., 2015; Nahar et al., 1999; van Reeuwijk & Nahar, 2013). For example, young people say they feel embarrassed discussing sexual health with parents, elders, health professionals, and even friends and sexual partners (Brahme et al., 2020; Farid-ul-Hasnain et al., 2013; Hamid et al., 2010; Khan & Raby, 2020; Regmi et al., 2010). Approaching adulthood with misconceptions and insecurities because of incomplete and incorrect information on sexuality further perpetuates inequitable gender and sexuality norms (van Reeuwijk & Nahar, 2013).

As a consequence of these, and other, factors, many young people in South Asia may face negative sexual health outcomes such as sexually transmitted infections (STIs), unwanted pregnancies, gender-based violence and risks associated with early marriage, and these may affect them more than the adult population (Barkat & Majid, 2003; Cash et al., 2001; Kabir et al., 2015; Muna, 2005; Nahar et al., 2013; Nahar et al., 1999; UNFPA et al., 2015). Despite growing evidence around such negative health outcomes, there is a lack of in-depth qualitative research on everyday experiences of sexuality in the region (see systematic review in Chapter 2). My doctoral research aims to address this gap through a

phenomenological exploration of young people's lived experiences of sexuality in Bangladesh.

Having such up-to-date information on qualitative research around young people's experiences is important to consolidate our current understandings of sexuality across developing landscapes. Given the huge size of the population of young people – as well as their diverse health needs – it is crucial to understand young people's sexuality to inform services and ensure the best outcomes for this large and expanding group.

Lived experiences of sexuality are embedded within a broader sociocultural context which influences young people's vulnerability or resilience to adverse sexual health outcomes (Collumbien et al., 2014; Mmari & Astone, 2014). For instance, young people – in South Asia as well as globally – who are seen to be deviating from socio-sexual norms of gender binaries and heterosexuality may face victimisation and bullying as well as negative attitudes from their peers and family (Earnshaw et al., 2016; Laiti et al., 2019; Lancet, 2011; UNFPA, 2014; Wandrekar & Nigudkar, 2020). Consensual same-sex sexual behaviour may have different consequences depending on varying social structures, such as prevailing norms and laws around compulsory heterosexuality (Collumbien et al., 2014). In Bangladesh, for example, discrimination against sexual and gender diverse (SGD) young people is pervasive and ongoing (Hossain, 2020; Rashid et al., 2011). A lack of recognition of sexual diversity continues to contribute to a scarcity in research around the experiences of sexual and gender diverse young people (Khan & Raby, 2020; Rashid et al., 2011).

Research in the field of sexuality in Bangladesh has predominantly focused on the health of men who have sex with men governed by a global interest in HIV/AIDS and disease prevention (Gagnon, 2006; Hossain, 2017, 2020; Siddiqi, 2011). Such studies emphasise measuring transmission and responses to interventions, rather than the role of sexuality within young people's lives (Gagnon, 2006). This preoccupation with 'decontextualised goals and superficial measures of quality' risks dehumanising research and practice and often neglects the 'lifeworld' – a shared and meaningful world of emotions and memories that is textured, embodied and experienced by us and through us every day (Hemingway, 2011; Hemingway et al., 2015). As such, we need more attention to a contextualised people-centred approach to understanding wellbeing rather than only the causes and treatment of ill health.

1.2 Socio-historical context

Bangladesh is a relatively young nation, having gained independence from Pakistan in 1971 after a nine-month liberation war. Prior to partition in 1947, it was part of the Indian subcontinent and, therefore, part of the British colony. During this time, the subcontinent has gone through several temporal and legal shifts regarding sexuality and gender (see Table 1.1). In order to capture sociostructural and cultural nuances of lived experiences, it is important to acknowledge how these temporal shifts may have shaped contemporary notions of sexuality in Bangladesh. Here I briefly describe the transitions in sexuality from ancient India to present day Bangladesh.

Although there is not much we know of everyday experiences of sexuality by way of historical data, sexually explicit prehistoric cave and temple carvings as well as poetry 'drenched in desire and same-sex mysticism' were not unusual in ancient and medieval India (Menon, 2018). In Islamic traditions, for instance, Mughal rulers had commissioned sensual paintings of women bathing in the harem and emperors having sex with their mistresses (Menon, 2018). Queer narratives can also be found in ancient Sanskrit texts and epics. In the Mahabharata, for example, transgender warrior Shikhandi is venerated for defeating Bhishma – the most powerful warrior of the time. Shikhandi has seen life from the perspective of both woman and man 'which gives them a power rarely accorded to mere mortals' (Menon, 2018, p. 19). This is the same power associated with hijras – comprising a publicly institutionalised subculture of male-bodied feminine-identified people – which is why historically in the subcontinent their blessings are sought during auspicious occasions (Hossain, 2017; Menon, 2018).

At the same time, more sexually explicit texts – such as the Kamasutra – existed alongside other texts that took a more sexually repressive approach – such as Manusmriti (Menon, 2018; Menon, 2007). Although historical lines between an era of precolonial permissiveness and an era of colonial repression cannot be drawn so neatly, the British Empire tilted the balance away from permissiveness and towards repression by policing the sexual lives of 'natives' and enforcing rigid gender binaries (Menon, 2018). The British introduced a legal code against sexual proclivities – including criminalising homosexuality and gender nonconforming groups such as hijras – that 'did not conduce to the reproduction of the missionary position' (Menon, 2018, p. 13).

In the 19th century, two opposing forces – British colonial interventions and the emergence of new nations – came together to create the effect of 'erasing homoeroticism and naturalising heterosexuality' (Menon, 2007, p. 8). However, the subcontinent is 'deeply

homophilic even as it is often superficially homophobic' (Menon, 2018, p. 8). In Bangladesh, for example, sexual taboos are not so much about sexuality as about bringing into the public domain matters that should remain private (Siddiqi, 2011b). As such, even though Bangladesh has not repealed Penal Code Section 377 – the 'anti-sodomy' clause inherited from the British in 1861 – the clause has rarely been enforced in the country as certain sexual practices are tolerated when hidden from view (Hossain, 2020; Siddiqi, 2011b).

> "Procreative heterosexual marriage is central to the regulation and experience of sexuality across the board. [This reflects] the centrality of marriage to the social construction of sexuality and identity in Bangladeshi society."
>
> - Siddiqi (2011b, p. 4)

As the above quote illustrates, procreative heterosexual marriage provides a dominant reference for sexual morality across postcolonial South Asian nations. Heteronormativity – framed under strict gender binaries, compulsory heterosexuality and marriage normativity – has become inscribed into postcolonial nations' legal frameworks and gradually established as universal; ultimately negating the subcontinent's own history of sexual diversity (Karim, 2012; Menon, 2018; Menon, 2007).

The process of postcolonial modernity in the region of Bengal – incorporating both present-day Bangladesh and the Indian state of Bengal – created a dominant urban middle class constructed as progressive and educated '*bhodrolok*' and '*bhodromohila*' (gentlemen and women) (Camellia et al., 2021; Karim, 2010; Menon, 2007; Mookherjee, 2013; Siddiqi, 2011b). The growth of an urban middle class also coincided with more rigid ideals of masculinity and femininity as well as patriarchal marriage as norm (Camellia et al., 2021; Karim, 2010; Muna, 2005). For example, middle class respectability required young people to focus on displaying 'good virtue' by not mixing with the opposite sex (Camellia et al., 2021; Khan & Raby, 2020). At the same time, urban middle classness also provided multiple sexual expressions 'sanctioned or tolerated or ignored, as long as such activities remain hidden from the public gaze' and do not disrupt the ideal of procreative heterosexual marriage (Siddiqi, 2011b, p. 4).

The rise of non-governmental organisations (NGOs) and development-sector organisations in 1990s working on health and sexual rights ruptured Bangladesh's culture of silence around sexuality, if somewhat unevenly (Hossain, 2017; Siddiqi, 2011a). The emergence of HIV/AIDS as a global epidemic, as well as associated fears of 'uncontrolled' or 'deviant' sexual practices, shifted the parameters of public discourse on sexuality by targeting

populations deemed to be at high risk of HIV infection (Siddiqi, 2011a, 2011b). Non-normative sexualities were constructed through a medicalised lens by focusing on minimising harm from disease (Siddiqi, 2011a, 2011b). For example, the epidemiological category of 'men who have sex with men' (MSM) was established as legitimate framework in public health and policy circles concerned with HIV/AIDS in Bangladesh (Hossain, 2017). From 2005 onwards, there was a gradual shift away from risk and disease towards a rights-based framework among NGOs working primarily with MSM, partly due to the emergence of gay groups in Dhaka and their criticism of the narrow focus on sexual health (Hossain, 2017, 2020).

One of the most prominent legal shifts came in 2013 when the Government of Bangladesh officially recognised 'hijra' – popularly considered in Bangladesh as neither men nor women – as a third gender on legal documents (Hossain, 2017). This recognition was hailed as major achievement by civil society and the international community, creating impetus for more organisations to work with the hijra (Hossain, 2017). However, conventional occupations of hijra continued to be targeted as criminal as new initiatives grew to 'transform the hijra into citizens worthy of rights and recognition' (Hossain, 2017, p. 1426). What is more, the Government of Bangladesh continued to delegitimise hijras based on genitalia and through the use of stigmatising conceptualisation and language (e.g. '*jouno o lingo protibondhi*' – literally 'sexually and genitally handicapped') (Hossain, 2017).

In 2016, lesbian, gay, bisexual and transgender (LGBT) activists Xulhaz Mannan and Mahbub Rabbi Tonoy were brutally murdered by a local Islamist organisation with links to al-Qaeda (BBC News, 2016). Until these murders, there was no reported precedent of attacks of such a magnitude on marginal gender and sexual communities (Hossain, 2020). Since the incident, many prominent LGBT activists have gone underground or left the country.

Table 1.1 presents a summary of relevant socio-legal changes and events related to sexual and gender diversity in Bangladesh.

Table 1.1 Timeline of socio-legal shifts related to sexual and gender diversity in Bangladesh

Time period	Date	Shifts	Dimension	Description/social consequences
British colonial India	1861	Penal Code Section 377 (anti-sodomy clause) introduced by British.	Legal	- Modelled after Buggery Act of 1533 criminalising all sexual acts 'against the order of nature', including consensual homosexual sex.
	1871	Criminal Tribes Act enacted by British.	Legal	- Communities (e.g. gender nonconforming groups such as hijras) criminalised and defined as immoral and corrupt.
Bangladesh (1971-present)	1996	Bandhu Social Welfare Society (BSWS), largest non-governmental organisation (NGO) in field of male-to-male sexuality, set up.	Advocacy – health intervention	- Epidemiological category of 'men who have sex with men' (MSM) established as legitimate framework in public health and policy circles concerned with AIDS in Bangladesh given rise of global epidemic.
	1997	Publication of '*Somoprem o AIDS*' ('same sex affect and AIDS').	Research	- First attempts to generate awareness beyond public health and policy circle about male sexual health and HIV/AIDS, and necessity to repeal Section 377.
	2001	Badhon Hijra Shangha, MSM-focused organisation, established by local hijra sex workers and Care International Bangladesh.	Advocacy – health intervention	- Realisation that hijra formed distinct group with specific sexual health needs that require separate NGOs.
	2002	Boys of Bangladesh (BoB), one of the earliest gay groups, starts as online platform.	Advocacy	- BoB initiates community events to provide a safe space for likeminded people to come together.
	2005	BoB sends letter to popular English newspaper The Daily Star to mark International Day Against Homophobia.	Advocacy – rights	- Letter sparks sustained debates as BoB begins expanding outside of community social events towards advocating for LGBT rights.
	2005	BoB initiates safe sex campaign for gay men, offering HIV testing services at icddr,b in Dhaka.	Advocacy – health intervention	- Public health interventions focus on 'high risk' male sexual health and disease prevention.
	2007	'Shawprova' women's same-sex support group starts.	Advocacy	- Now-dissolved group first to focus on women's sexualities with meetings restricted to members.
	2007	James P Grant School of Public Health, BRAC University holds first public workshop on sexuality rights.	Advocacy – rights	- Attended by many organisations with aim of building platform of awareness and advocacy, sharing resources, and collaborating for training, research, and advocacy activities.

Bangladesh (1971-present)	2009	Report of Bangladesh's LGBT situation submitted to UNHRC's Universal Periodic Review.	Advocacy – rights	- Report provides recommendations on socio-political rights of sexual and gender minority communities of Bangladesh (e.g. gay, lesbian, bisexual, transgender and hijra). - Government side-lines or rejects concerns in report.
	2009	Gradual shift from risk and disease to rights framework among MSM-based NGOs in Bangladesh.	Advocacy – rights	- Shift partly due to emergence of gay groups in Dhaka and their criticism of MSM-based NGOs' narrow focus on sexual health.
	2013	Government of Bangladesh officially recognises hijra, popularly considered in Bangladesh as neither men nor women, as a third gender on legal documents such as passports.	Legal	- Recognition hailed as major achievement by civil society and international community, creating impetus for organisations – beyond specialised NGOs – to work with the hijra. - Conventional occupations of hijra still targeted as criminal as new initiatives grow to recognise them as citizens with rights.
	2014	Publication of first Bangla-language LGBT-focused magazine, Roopbaan.	Advocacy	- Magazine reaching wider audience by moving beyond English discourse of everyday issues around sexuality.
	2014	First 'Rainbow Rally' pride event organised by Roopbaan during Bangla new year.	Advocacy – rights	- 100 attendees dressed in colourful costumes to promote diversity and friendship. Do not use any LGBT slogans or banners.
	2014	First annual 'hijra pride' event by BSWS with support from international donors and Ministry of Social Welfare to mark day of recognition.	Advocacy – rights	- Event attracts international attention with presence of foreigners associated with embassies and donor organisations. Remains culturally unintelligible to majority of people in Bangladesh.
	2015	BoB launches 'Dhee', first Bangla-language comic featuring lesbian protagonist.	Advocacy – rights	- Flashcards used as advocacy material in workshops to start dialogue around gender and sexuality.
	2015	Ministry of Social Welfare to recruit hijra as low-ranking clerks. Initial selection undergoes medical examination concluding candidates are male as they have penis and scrotum. Appointments terminated as candidates seen to be male-bodied people impersonating hijra.	-	- 'Delegitimisation' of hijras based on their male sexual organ, essentialising gender identity to sexual organ a person is born with. - Use of stigmatising conceptualisation and language continues (e.g. '*jouno o lingo protibondhi*' – literally 'sexually and genitally handicapped' – to describe hijra community).
	2016	LGBT activists Xulhaz Mannan and Mahbub Rabbi Tonoy brutally murdered by local Islamist organisation with links to al-Qaeda.	-	- No reported precedent of attack of similar magnitude on marginal gender and sexual communities until these murders. Many prominent LGBT activists go underground or leave the country.
	2017	Rapid Action Battalion – elite security force in Bangladesh – raid community centre outside Dhaka in what media billed as 'gay party'. Rumours circulate those 27 men arrested would be charged under Section 377 for 'being gay'.	Legal	- First time Section 377 explicitly invoked as reason for such a raid, although law enforcement agency refrains from using it in the end. - Clause rarely enforced in Bangladeshi context as certain sexual practices tolerated when hidden from view.

1.3 Review of sexual and reproductive health in Bangladesh

Prior to starting my PhD, I carried out a systematic review of qualitative and mixed-methods research conducted in Bangladesh. I screened a total of 2255 English-language articles which I identified by searching five electronic databases: Ovid Global Health, Ovid MEDLINE, POPLINE, PubMed, and Scopus. A combination of search terms relating to three categories was used to retrieve potential articles: sexual and reproductive health-related issues, young people as the population of interest and Bangladesh as the geographic area of interest. I critically identified and reviewed 16 relevant qualitative and mixed methods articles on young people's sexual and reproductive health in Bangladesh. I conducted a thematic analysis of findings across the reviewed articles revealed four key themes: double standards around premarital sex and social risk, prevalence of sexual harassment of girls and women, lack of communication and inaccurate information around sexual and reproductive health, and a lack of reproductive autonomy for young married women. The review also highlights gaps in evidence that my doctoral research endeavours to address.

1.3.1 Descriptive and thematic findings

Thirteen of the studies were purely qualitative and three combined both qualitative and quantitative methods (Table 1.2). Nine of the articles focused on adolescent girls or young women as the key study population: five specifically looking at experiences of married girls, two at experiences of unmarried girls and the remaining two at both married and unmarried girls. Six studies collected data from unmarried young people, and one mixed-methods study involved both married and unmarried young people. None of the identified studies focused solely on married young men or unmarried boys. The age range of young people in almost all the studies was 10 to 19 years. As such, there was very little qualitative data on young people in their early 20s. Seven studies were situated in rural Bangladesh and mainly focused on reproductive health issues of married girls with no mention of sexual behaviour. Only one study – an ethnography of slum-based married adolescents in Dhaka – was based exclusively in an urban setting indicating a gap in in-depth research on urban young people (Rashid, 2006, 2007; Rashid et al., 2011).

Responses from young people in existing published research indicated that they assess premarital relationships predominantly on its associated social risks, such as confronting social stigma as well as the risk of pregnancy for girls (Cash et al., 2001; Nahar et al., 1999). Moreover, most studies reported that young people were aware of double standards with regard to consequences of premarital sex for men and women (Cash et al., 2001; Nahar et al., 2013a). For girls, the perceived penalties of sex outside of marriage centred on gendered

expectations of chastity and potential repercussions of unwanted pregnancy – including bringing dishonour to one's family, having to drop out of school, being forced to marry, being abused by a future husband, and hampering future marriage prospects (Nahar et al., 2013a; Nahar et al., 1999). In Bangladesh, sexual intercourse outside the bond of marriage was viewed as shameful, particularly for girls and women, while 'those who practise abstinence before marriage are honoured' (Muna, 2005, p. 7). An unmarried girl who departs from traditional norms of domesticity and chastity, by choice or coercion, risks being stigmatised (more so than boys) because of prevailing puritanical attitudes towards premarital sexuality (Agarwal, 1994; Kabeer, 1994; Muna, 2005; Nahar et al., 2013a). Girls who do not adhere to heteronormative rules 'reduce their chance of finding a suitable marital partner and risk their families having to pay a higher dowry', leading to many girls guarding their virginity (Nahar et al., 2013a, p. 80). Some married girls and young women demonstrate a 'strategic' understanding of social risk and benefit of reproductive behaviour – for instance, strengthening bonds with their husband and in-laws through the birth of a son – within the context of limited decision-making autonomy (Ainul & Amin, 2015; Rashid et al., 2011; Shahabuddin et al., 2016). Findings from the review of existing literature, as well as wider literature, suggest that these social rewards and penalties may compete with physical health risks in influencing young people's sexual behaviour (Cash et al., 2001; Marston & King, 2006).

In many settings, determinants connected to wider sociocultural, economic, and legal contexts overlap with determinants of gender-based violence – such as gender norms and a lack of decision-making power for women (Patton et al., 2016). Even where policies and legislation may exist, there is often a gap between policies and laws, their enforcement and the realities confronted by girls and young women (Rashid et al., 2011). Against this backdrop, gender-based violence can be interpreted as a mechanism of social control with strong connections to existing power structures (Nahar et al., 2013a). Often, girls do not reveal or report experiences of harassment for fear of being blamed and stigmatised. Wider literature supports the finding that fear of 'eve teasing' – a colloquial term in South Asia to describe public sexual harassment of girls and women – is almost ubiquitous among adolescent girls and women, leading to constant feelings of insecurity (Dhillon & Bakaya, 2014; Natarajan, 2016; Zubair, 2005). High prevalence of 'eve teasing' and feelings of fear/humiliation were echoed in recent studies of young women in neighbouring India where respondents in both rural and urban settings mentioned restrictions on girls' mobility, blame for provoking harassment and forced marriage as consequences of 'eve teasing'.

All 16 studies suggested that limited sexual and reproductive health knowledge and gender-based violence were common gendered experiences for both unmarried and married girls and young women. Even within these commonalities, however, the consequences of early marriage were emphasised in terms of increased risk of unwanted pregnancy, maternal and child health, and very limited decision-making autonomy for married girls, particularly newly married younger adolescent girls (Ainul & Amin, 2015). Discontinuation of education after marriage as well as the imposition of strict isolation, further hampers the broadening of reproductive knowledge thus increasing the risk of early and unwanted pregnancy (Ainul & Amin, 2015; Lloyd & Mensch, 2008; Shahabuddin et al., 2016). Spousal age and power differentials, as well as the age of adolescent girls at marriage, result in a lack of negotiating ability which, in turn, adversely affects informed decision-making on contraceptive use and childbearing (Shahabuddin et al., 2016). As girls become older, however, some they are better able to gain access to contraception and take measures to prevent pregnancy (Ainul & Amin, 2015).

1.3.2 Discussion and gaps

The included studies separated sexual and reproductive experiences based on marital status. This limited the narrative of men and women's sexuality by concentrating exclusively on reproductive behaviour when interviewing married women, as well as not interviewing married men at all. While certainly a relevant avenue of inquiry given the high rate of early marriage in Bangladesh and widespread gender inequality, the body of work on reproductive behaviour of married women also leads to a gap in our understanding of sexual needs of young married people. Certain health needs may, therefore, remain overlooked and underexplored when describing sexual and reproductive wellbeing. For instance, sexual pleasure and behaviour are noticeably absent in discussions with married young people. This is particularly noteworthy because many unmarried girls in other studies reported preserving their virginity and voiced concerns about sexually satisfying their future husbands. And yet, these concerns were not reflected on or examined further in existing research regarding married adolescent girls or their partners. One reason for the lack of continuity along this line of investigation could be due to a lack of ethnographic or longitudinal studies, as well as research and health priorities in the field of early marriage.

Data collection for the majority of the studies was conducted over 10 years ago, and only three were completed within the past four years. Health needs, of course, are not static; given the changing socio-political climate and the rise in internet usage[1] and social media, having

[1] According to Bangladesh Telecommunication Regulatory Commission, there are now 87 million internet subscribers throughout the country, compared to under 315,000 five years ago.

up-to-date information on young people's experiences is important to expand our understanding of diverse experiences of sexuality across different ages. The participants in almost all the studies were aged 10 to 19 years[2], implying a focus on 'adolescents' as a category rather than inclusive of all 'young people' – aged up to 24 years (UNFPA, 2014). Although the contours of life stages may be determined by health risks and research priorities, the lack of focus on the experiences of those in their early twenties may be a gap of sociodemographic relevance. Indeed, we could question the shifting demarcation and distinctions of such life stages as well as what constitutes transitioning into adulthood (Sawyer et al., 2018). For example, it is argued that the transition to adulthood is occupying a greater portion of the life course with 'delayed timing of role transitions, including completion of education, marriage, and parenthood' (Sawyer et al., 2018, p. 223).

Given the dearth of published research in the field of sexual health in Bangladesh, adapting a qualitative research approach to explore lived experiences could provide a more in-depth 'bottom-up' understanding of young people's sexuality. There appears to be a lack of 'thick description' (Geertz, 1973) and participant perspective on meanings of sexuality and SRH with very few of the reviewed studies looking at lived experience of sexual and reproductive wellbeing and illness (Rashid, 2000, 2006, 2007; Rashid et al., 2011; van Reeuwijk & Nahar, 2013). It may be appropriate to further explore sexuality from a more holistic approach to incorporate diverse lived experiences within the context of 'lifeworlds', rather than only through the language of physical health (K Dahlberg, 2018, personal communication, 12 July). The phenomenological lifeworld approach – as outlined in Chapter 3 – has the potential to provide a better understanding of young people's 'life situation' and lived experiences, beyond just what they think or say about health and healthcare (Dahlberg & Dahlberg, 2020; Dahlberg et al., 2008). Exploring 'the fundamental meaning structure' of sexuality from the perspective of young people could offer insight into the nature of their lived experiences of sexual health and, thereby, guide SRH interventions (van Wijngaarden et al., 2017, p. 1741).

[2] Although a paper on infant and young child feeding and caregiving did also interview some young women over the age of 19 (Hackett et al, 2015).

Table 1.2 Study characteristics of 16 reviewed articles

First author	Focus of study	Year of study	Funding	Type of study	Study population				Data collection methods	Sample
					Setting	Age	Gender	Marital status		
Ainul 2017	Assessment of adolescent-friendly health centres (AFHCs)	2016	- United States Agency for International Development (USAID) - Population Council	Qualitative	- Rural - Urban	15-19	Girls	Unmarried	- Focus group discussions (FGDs) - Interviews	N=50
Shahbuddin 2016	Contraceptive methods and childbearing	Not reported	European Commission	Qualitative	Rural	12-19	Girls	Married	Interviews	N=35
Hackett 2015	Barriers to infant and young child feeding and caregiving	2010	- BRAC - Canada Research Chair	Qualitative	Rural	15+	Women	- Married -Unmarried	- FGDs - Interviews	N=70
Ainul 2015	Early marriage as risk factor for mistimed pregnancy	2014	Not reported	Mixed methods	Rural	12-19	Girls	Married	Interviews	N=12
Nahar 2013[a]	Sexual harassment of girls	2009	Dutch Government	Qualitative participatory	- Rural -Urban	12-18	- Boys - Girls	Unmarried	FGDs	N=268
Van Reeuwijk 2013[a]	Positive approach in programmes	2009	Netherlands Government	Qualitative participatory	- Rural -Urban	12-18	- Boys - Girls	Unmarried	FGDs	N=268
Van Reeuwijk 2010[a]	Quality of & access to youth friendly SRH services	2009	Dutch Government	Qualitative participatory	- Rural -Urban	12-18	- Boys - Girls	Unmarried	FGDs	N=268

Rashid 2011[b]	Reproductive health & choices	2001-2003	World Health Organization (WHO)	Qualitative ethnography	Urban slums	15-19	Women	Married	- Interviews - Survey	N=153
Rashid 2007[b]	Explanations of white discharge	2001-2003	WHO	Qualitative ethnography	Urban slums	15-19	Women	Married	- Interviews - Survey	N=153
Rashid 2006[b]	Changes in behaviour	2001-2003	WHO	Qualitative ethnography	Urban slums	15-19	Women	Married	- Interviews - Survey	N=153
Uddin 2008	Reproductive health awareness	Not reported	Not reported	Mixed methods	Rural	10-19	Girls	- Married - Unmarried	- Interviews - Survey	N=40
Rashid 2003[c]	Experiences from BRAC's sex education	1999	BRAC	Qualitative	Rural	13-15	- Boys - Girls	Unmarried	- FGDs - Interviews	N=82
Rashid 2000[c]	Experiences from BRAC's sex education	1999	BRAC	Qualitative	Rural	13-15	- Boys - Girls	Unmarried	- FGDs - Interviews	N=82
Cash 2001	Vulnerabilities without sex education	1997	- USAID - International Center for Research on Women (ICRW) - Centre for Development & Population Activities (CEDPA)	Qualitative	Rural	13-18	- Boys - Girls	Unmarried	- FGDs - Interviews	N=25+
Rashid 2000	Notions of sexuality during floods	Not reported	Not reported	Qualitative	- Rural -Urban	15-19	Girls	Unmarried	Interviews	N=9
Nahar 1999	Reproductive health needs	1999	- USAID - icddr,b	Mixed methods	- Rural -Urban	10-19	- Boys - Girls	- Married - unmarried	- Interviews - Group activities	N=104+

[a] Three articles based on same 2009 study; [b] Three articles based on same 2001-03 doctoral study; [c] Two articles based on same 1999 study.

1.4 Study objectives

The overall aim of this research is to explore meanings of sexuality through lived experiences of young people (aged 18 to 24) in Dhaka and see how such a lifeworld perspective can contribute towards our understanding of sexual health and wellbeing.

The research is guided by the following interlinking objectives and sub-objectives:

1. To explore the lifeworld and lived experiences of sexuality for sexual health and wellbeing.

   1a. Critically review existing understandings of sexual health and wellbeing as experienced by young people within the context of South Asia.

2. To explore young people's lived experiences and perceptions of sexuality.

   2a. Identify and discuss perceived socio-sexual norms and how young people experience and navigate these.

   2b. Explore the role of heteronormative 'straightening devices' in shaping experiences of young people.

   2c. Explore different meanings and the 'essence' of sexuality derived from young people's lived experiences.

1.5 Thesis structure

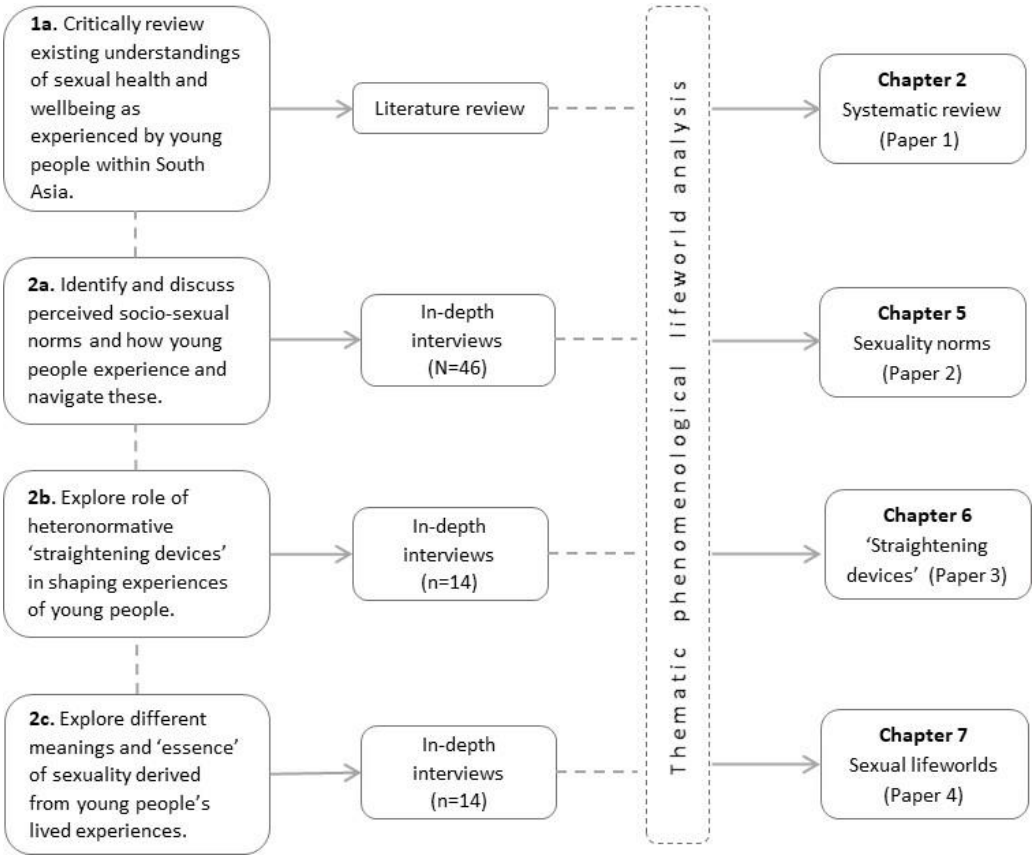

Figure 1.1 PhD components

This thesis is organised as a paper-style publication through four research papers that have been submitted or are ready for submission to peer-reviewed journals. As Figure 1.1 shows, each paper corresponds with study objectives, including a systematic review (Chapter 2) and three papers based on primary data collection and analysis (Chapter 5-7). All four chapters are prefaced by a research paper cover sheet with information about the manuscript such as author details, journal information, and my role as first author of multi-authored papers. The remaining four chapters of this thesis contain material that contextualises the overall study, including this introductory chapter where I present a background on the topic, study objectives, and the structure of this thesis.

In Chapter 2, I critically review literature on sexuality through a systematic review of qualitative research on young people's experiences of sexuality in urban settings of four South Asian countries – Bangladesh, India, Pakistan, and Nepal – published within the past decade (2010-present). The review examines what the literature can tell us about prevalent sexuality norms and restrictions, and how these affect young people's lives. I also identify major gaps.

I then discuss the theoretical framing of my research – phenomenological lifeworld perspective – in Chapter 3 followed by my research approach and methods in the methodology chapter (Chapter 4).

Chapters 5-7 comprise the empirical findings of my study across three research papers. Each of these papers address overlapping sub-objectives under Objective 2 and are based on analysis of in-depth interviews with young people. I explored aspects of socio-sexual norms and violence, heteronormative straightening devices, and sexuality lifeworlds, which I identified during data collection and analysis.

In Chapter 5, I explore lived experiences of queer young people in Dhaka, Bangladesh, to see how their perspectives can expand our understanding of sexual health and wellbeing. By adapting Ahmed's (2006) phenomenological framework of heteronormative 'straightening devices' – mechanisms working to direct people towards heterosexuality and gender conformity – I look at how young people navigate normative expectations as well as the health consequences of this.

In Chapter 6, I look at young people's lived experiences and challenges of negotiating sexual intimacy before marriage. I discuss findings on young people's lived experiences of sexual intimacy within the context of restrictive socio-sexual norms – as described by interview participants themselves – and how these experiences impact their sexual health and wellbeing.

In my final findings chapter (Chapter 7), I adapt a phenomenological reflective lifeworld research approach, as outlined by Dahlberg and colleagues (2008), to capture the essential aspects of sexual intimacy as described by lesbian, gay, bisexual, transgender, and queer (LGBTQ) identifying young people in Bangladesh.

Finally, in Chapter 8, I conclude with a summary of my findings and discussion of the strengths and limitations of the study as well as implications for further research.

CHAPTER 2. SYSTEMATIC REVIEW (PAPER 1)

Overview

The following chapter provides a literature review on young people's experiences of socio-sexual norms and sexual health in the context of South Asia. This background is presented as a manuscript of a systematic review which has been submitted to Social Science & Medicine for publication (see Paper Cover Sheet 1 for more details).

My co-authors and I systematically reviewed peer-reviewed empirical studies based on qualitative data pertaining to young people's experiences of sexuality/sexual health in Bangladesh, India, Pakistan, and Nepal. We observed that studies covered the following topics: sexual health services, programmes, and contraceptive use; sexuality education, communication, and relationships; and gender and sexual violence. Recurring findings included the following: that there are parental and societal expectations around premarital 'sexual purity' through abstinence; that there is limited communication around sexuality between young people and parents/adults; that gender norms limit young women's sexual and reproductive decision making; there was no research on experiences of sexual and gender minorities. Finally, we identified common themes, but also prominent gaps which must be addressed if we are to capture diverse experiences and build a better evidence base to design and improve sexual health services for young people in the region. The body of research fails to include experiences of young people with diverse gender, sexual orientation, and sex characteristics.

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RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	1600635	**Title**	Mx
First Name(s)	Prima Mishkat		
Surname/Family Name	Alam		
Thesis Title	Young people's lived experiences and perceptions of sexuality in Dhaka, Bangladesh		
Primary Supervisor	Cicely Marston		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?			
When was the work published?			
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion			
Have you retained the copyright for the work?*	Choose an item.	Was the work subject to academic peer review?	Choose an item.

*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	Social Science & Medicine
Please list the paper's authors in the intended authorship order:	Prima Alam, Leesa Lin, Nandan Thakkar & Cicely Marston
Stage of publication	**Submitted**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	I conceptualised the review and conducted the search. I coded the data with LL acting as second reviwer and NT as third reviewer. I analysed the data and drafted the manuscript under the guidance of my first supervisor Cicely Marston. My supervisor provided comments on the draft manuscript. All authors approved the final version of the manuscript.

SECTION E

Student Signature	[redacted]
Date	18 November 2021

Supervisor Signature	[redacted]
Date	10/12/21

Socio-sexual norms and young people's sexual health in South Asia: Systematic review of current issues in Bangladesh, India, Pakistan and Nepal

Introduction

In South Asia, widespread seclusion norms and taboos around sexuality may undermine young people's ability to make informed sexual and reproductive health (SRH) decisions (Agampodi et al., 2008; Ismail et al., 2015; van Reeuwijk & Nahar, 2013). Yet there is limited in-depth research about young people's lived experiences of SRH in the region. Rapid urbanisation as well rising internet use in recent years has also been influencing the ways in which young people experience and understand their own sexuality (GSMA, 2019; UNFPA et al., 2015; World Bank, 2016). In this article we systematically review recent qualitative publications around socio-sexual norms confronted by young people in urban contexts across South Asia.

Accounting for almost a quarter of the global population, there are now more young people, aged 15-24 years, in the world than ever before (UN, 2019; UNFPA et al., 2015). This large and still-growing demographic has specific sexual health needs which must be adequately addressed to ensure a healthy transition to adulthood (Denno et al., 2015; Salam et al., 2016; Svanemyr et al., 2015; UNFPA, 2014). According to the World Health Organization (WHO, 2006), young people's sexual health is grounded in their right to freely express their sexuality in consensual relationships, participate in activities such as marriage and having children, obtain accurate information about sexual issues, and access high quality sexual healthcare. The majority of the world's 1.2 billion young people reside in low- and middle-income countries (LMIC) where poverty and resource constraints limit access to sexual health services and education for many (Salam et al., 2016; UNFPA, 2014; UNFPA et al., 2015).

In South Asia young people often have a poor understanding of sexuality and wellbeing, partly because of limited access to SRH services and reliable information (Barkat & Majid, 2003; Bhuiya et al., 2004; Cash et al., 2001; Nahar et al., 1999; Pandey et al., 2019; UNFPA et al., 2015). The situation is exacerbated by taboos relating to gender and sexuality which limit SRH communication between young people and adults – for example in Bangladesh and India (Barkat & Majid, 2003; Bhuiya et al., 2004; Cash et al., 2001; Nahar et al., 1999; van Reeuwijk & Nahar, 2013). In some countries such as Pakistan, young people seen to be deviating from socio-sexual norms of gender binaries and heterosexuality may face victimisation and bullying as well as negative attitudes from their peers and family (Laiti et

al., 2019; Lancet, 2011; UNFPA, 2014; Wandrekar & Nigudkar, 2020). According to van Reeuwijk and Nahar, many young people approach adulthood with misconceptions and insecurities because of incomplete and incorrect information on sexuality which further perpetuates inequitable gender norms (van Reeuwijk & Nahar, 2013).

As a consequence of these, and other, factors, many young people in South Asia may face negative sexual health outcomes such as sexually transmitted infections (STIs), unwanted pregnancies, gender-based violence and risks associated with early marriage, and these may affect them more than the adult population (Barkat & Majid, 2003; Cash et al., 2001; Kabir et al., 2015; Nahar et al., 2013a; Nahar et al., 1999; UNFPA et al., 2015). While quantitative research measures prevalence of these outcomes, qualitative research can help to describe, and find reasons for, young people's sexual behaviour and its social context (Marston & King, 2006).

According to the World Health Organization, sexual health encompasses an individual's physical, emotional, mental, and social wellbeing with regard to sexuality (WHO, 2006). Lived experiences of these aspects of sexuality are embedded within a broader sociocultural context that influences young people's vulnerability or resilience to adverse sexual health outcomes (Collumbien et al., 2014; Mmari & Astone, 2014). For example, consensual same-sex sexual behaviour may have different consequences depending on varying social structures, such as prevailing norms and laws around compulsory heterosexuality (Collumbien et al., 2014).

Sociodemographic changes may also be shaping young people's experiences of their sexuality (Mmari & Astone, 2014). Rapid urbanisation is leading to increasing marginalisation of urban poor youth populations as well as rising urban health disparities within LMIC settings (Levine & Coupey, 2003; Mmari & Astone, 2014; Ramadass et al., 2017). The urban population of South Asia is projected to rise to over 880 million by 2030 from its current 632 million, with the highest annual growth rates of change in Nepal and Bangladesh (Ellis & Roberts, 2015). Having up-to-date information on qualitative research around young people's experiences is important to consolidate our current understandings of sexuality across these developing landscapes.

The huge size of the population of young people, the increasing urbanisation of the populations in South Asia and the need for good SRH services suggest that it is crucially important to understand young people's sexuality to inform services and ensure the best outcomes for this large and expanding group. We searched two leading research databases (Cochrane Library and Web of Science), using the terms 'sexuality', 'young people', 'South

Asia' and synonyms, and found that no relevant review of the literature on young people's sexuality in South Asia has yet been undertaken.

Here we present our systematic review of qualitative research on young people's experiences of sexuality in urban settings of four South Asian countries – Bangladesh, India, Pakistan, and Nepal – published within the past decade (2010-present). For the purpose of this review, we defined 'young people' as individuals aged 15 to 24 years (UNDESA, 2018).

We examine what the literature can tell us about prevalent sexuality norms and restrictions, and how these affect young people's lives. We also identify major gaps.

Methods

Search strategy

We searched for all studies reporting qualitative data on young people's sexuality from South Asia. We searched four databases (EMBASE, Global Health, Ovid-MEDLINE, and PsycINFO) on 16 January 2021 and limited year of publication from 2010 to 2021 to review contemporary sexual health issues. Our search strategy (Supplement 1) combined MeSH terms and key words relating to SRH (e.g. sexua*, sexual health, and reproduc*), young people (e.g. youth, young people, and young adult*), South Asia (e.g. Bangladesh, India, Pakistan, Nepal, and Sout* Asia) and research type (e.g. qualitative, ethnograph*, experience*, focus group*, and interview*). Additionally, we searched citations of all articles identified as relevant. We referred to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for design, analysis, and interpretation of results.

Inclusion criteria

We included all peer-reviewed qualitative or mixed methods empirical studies on young people's experiences of sexuality/sexual health based in Bangladesh, India, Pakistan and Nepal, and published between 2010 and 2020. We excluded materials that were not published in peer-reviewed journals or did not incorporate empirical evidence (e.g. book chapters, review articles, theses). Articles with a study population that did not include any young people aged 15 to 24 as defined by the United Nations Population Fund (i.e. articles with only participants under the age of 15 or over the age of 24) were excluded. Articles where the age of participants was indistinguishable (i.e. age not reported or without disaggregated data for adult population) were also not included. Only studies which encompassed urban respondents – either exclusively or in addition to rural respondents –

were included, and studies focussed solely on rural areas were excluded. Below is a list of inclusion criteria for this review (also see Supplement 2):

- Peer-reviewed empirical research published between 2010 and 2021
- Qualitative research or mixed method with qualitative analysis
- Experiential data on young people with data that can be disaggregated by age group for respondents aged 15-24 years
- Any experiential aspect of sexuality and sexual health of young people in everyday life settings (e.g. school, university, workplace, public spaces etc.)
- Studies based in Bangladesh, India, Pakistan, or Nepal
- Studies based in urban areas or urban and rural areas

Data extraction and analysis

Two reviewers (PA and LL) independently screened titles, abstracts, and full text for inclusion and extracted data from relevant articles. Before data extraction, a coding framework (Supplement 3) was developed centring on study characteristics, key findings and recommendations, prominent norms, and lifeworld domains emerging from the articles. Two authors (PA and LL) independently coded full-text articles and compared the results. A third reviewer (NT) assessed the coding in case of any discrepancies. The findings were organised and interpreted thematically through a phenomenological lifeworld perspective by identifying and synthesising most prominent and recurring socio-sexual norms to emerge from the included articles (Braun & Clarke, 2014; Thomas & Harden, 2008).

Quality appraisal

Two authors (PA and LL) appraised all 13 articles using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (Supplement 4). The third reviewer (NT) assessed the appraisal scores for any inconsistencies. We considered the 13 articles to be of high quality as all articles fulfilled criteria of reporting study validity, clarity of results, and value/contribution of research. As such, none of the eligible articles were excluded after quality appraisal.

Findings

Search outcome

Of 2378 articles identified from four databases using different keywords, 687 were duplicates and 1667 proved not to be relevant (i.e. not related to young people's sexuality in

South Asia) after title and abstract screening. Seventeen articles were assessed for eligibility and four of these were excluded after full-text screening as the study population was outside the scope of this review (i.e. respondents were not aged 15 to 24 years or rural study population only). Related citations and reference lists of all relevant articles were also checked, and two further articles were retrieved. Finally, 13 articles were included for data extraction and thematic analysis (Figure 2.1).

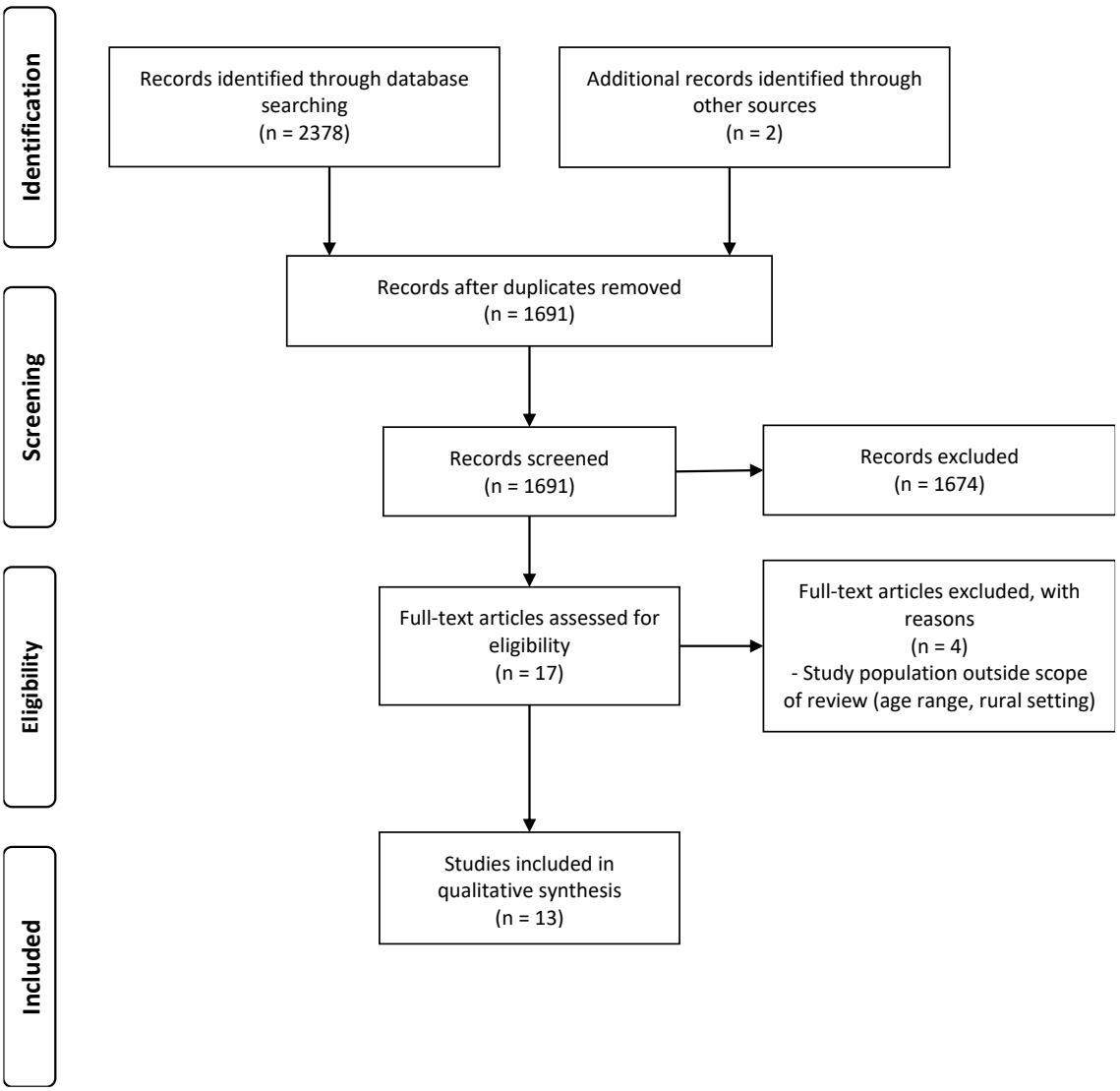

Figure 2.1 Flow diagram of study selection process

Study characteristics

Table 2.1 summarises the characteristics of the 13 included articles.

Four of the thirteen included articles were studies conducted in Nepal which focussed on barriers to sexual health services, prenatal intimate partner violence (IPV) and attitudes towards dating. Four articles were based on research in India and included data around sexual health needs, heterosocial friendship dynamics at school, understandings of gender and sexual violence, and an intervention contesting restrictive mobility norms. Three studies were based in Karachi and Islamabad in Pakistan and explored perceptions of contraceptive use and young women's experiences of marriage preparation. The remaining two articles were based on experiences of sexuality education and communication between parents and youth in Bangladesh. Eight of these studies were funded by European institutes or organisations; one was funded by an Indian institute and the remaining five studies did not specify donors.

All included studies were cross sectional in design and only two articles – based on the same study in India – used both qualitative and quantitative methods. Interviews were carried out between 2006 to 2017 and the data collection period ranged from a month to one year. Two articles did not specify the year or duration of data collection and two articles – from the same Nepal-based study – did not report the exact length of data collection.

Nine articles were based on data collected in urban settings and three included both rural and urban data collection. One article did not specify location as the interviews were conducted via Skype (Khan & Raby, 2020). Four of the nine articles exclusively in urban settings collected data from urban slums in Mumbai, India; Kathmandu, Nepal; and Karachi and Islamabad in Pakistan. Beyond study location, respondent characteristics also varied by education level, gender, age, marital status, socioeconomic status, religion, and ethnic group. For example, three of the nine urban-based articles recruited students from formal educational institutions (schools, colleges, and universities) in urban settings. Two articles – based on the same study in Nepal – focused on data from both rural and urban educational institutions as well as youth clubs.

In terms of study population, total sample size varied from 9 to 180 participants. Five articles focussed on unmarried respondents, three on married or engaged participants, and four combined both married and unmarried young respondents. One article did not specify the marital status of respondents. Most articles included both men and women as participants while three focused on women and one on men. The socioeconomic status (SES) of study

participants varied, with five articles looking at slum residents or young people from a lower caste and three articles including urban middle-class participants. Only two papers included participants from both middle and lower SES and the remaining three articles did not specify.

While included articles had different topics, the main research areas could be summarised as exploring sexual health services and contraceptive use (n = 6); sexuality education and communication (n = 5); gender and sexual violence (n = 2). Articles used the terms boys/girls and men/women and here we use the same language as the relevant article where possible.

Prevailing sexuality norms in South Asia

Four interrelated themes of norms and restrictions around sexuality were widely reported across published articles, as shown in Figure 2.2.

1. Widespread parental and societal expectations around premarital 'sexual purity' through sexual innocence and abstinence as sign of 'good virtue' – with some variations in experiences depending on socioeconomic status, gender, and age.

2. Silence or limited communication around sexuality between young people and parents as well as other adults predominantly due to mutual shame and embarrassment about the topic.

3. Restrictive gendered norms particularly limiting for young women's sexual and reproductive health decision making (gender narratives and sexual consent; mobility restrictions and access to sexuality resources; and decision making around contraception).

4. Heteronormativity as presumed and implied through lack of diverse sexual and gender representation in research.

Figure 2.2 Themes around sexuality norms as reported in included articles

Table 2.2 summarises the prevailing norms as well as how young people are reported to be experiencing and navigating these. Corresponding sexual health consequences and recommendations as outlined by included articles are also presented in the table.

Expectations of premarital 'sexual purity' through abstinence as sign of 'good virtue'

Six articles explicitly described parental and societal disapproval of premarital sex as a common phenomenon experienced by most young people (Bankar et al., 2018; Camellia et al., 2021; Hamid et al., 2010; Iyer, 2017; Khan & Raby, 2020; Regmi et al., 2011). Young people across these studies said they perceived 'sexual innocence' and premarital sexual abstinence as a way of signalling their 'good virtue' to their parents and wider family members. While sexual abstinence before marriage was reported as a widespread expectation for young people, experiences of this norm varied by socioeconomic status, gender, and age.

Regarding socioeconomic status, in addition to sexual abstinence and not mixing with the opposite sex, middle class respectability required young people to focus on academic achievements, while young women living in slums were required to display 'good virtue' through competence in household chores (Bankar et al., 2018; Camellia et al., 2021; Hamid et al., 2010; Iyer, 2017, 2018; Khan & Raby, 2020).

In the context of young women living in slums, two studies in India and Pakistan linked 'sexual purity' – described as premarital sexual abstinence as well as 'sexual innocence and ignorance' as a sign of virginity – very closely with being good daughters who take care of domestic duties (Bankar et al., 2018; Hamid et al., 2010). For example, Bankar and colleagues identified modesty, respectfulness, proficiency in household chores, and 'sexual purity' as traditional norms expected of young unmarried women. The authors explore how a sports-based programme had given participants greater skills to negotiate restrictive mobility norms with parents (Bankar et al., 2018). In the absence of such interventions, a study based in Pakistan revealed young women engaged to be married had been 'socialised into submissiveness' leading to them being more vulnerable to reproductive ill health in the future. The participants abided by rules to be 'good daughters' as they trusted that continued family support would ensure security in future life (Hamid et al., 2010, p. 5):

> "I love my mother. If she is happy so am I. I know that my parents know what is best for me as they are older and wiser. If they think I should marry this person then I am fine."

A study of middle-class boys and girls in Dhaka, Bangladesh suggested that their parents saw sexual abstinence as a way of upholding family's respectability (Camellia et al., 2021). However, respondents in this study said they were able to navigate this norm by using silence around sexuality with their parents as a way of protecting good boy/girl image, be

seen to respect parents' values, and avoid mutual embarrassment (Camellia et al., 2021, p. 9):

> "We know many things about sex and pretend that we are ignorant. We don't want our parents finding out what we know because that will be embarrassing for us and for them also."
>
> - 17-year-old girl (Camellia et al., 2021, p. 9)

Age was also a noteworthy factor in determining how young people perceived and experienced expectations around romance and sex. Iyer's study with students aged 15-17 reported that sexual activity among participants appeared to be the exception rather than norm which could reflect 'middle-class norms of premarital purity' as well as due to 'the younger age range of participants in this study' (Iyer, 2018). Age-specific norms around romantic relationships were also explored in an article where participants of a Nepal-based study – aged 15-24 – believed the community viewed dating positively if practiced by 'emerging adults' over the age of 18 rather than adolescents in their early teens (Regmi et al., 2011, p. 683):

> "People do not like teenagers' love…Even if I had such experiences, my parents would not have been happy. I think they still have traditional thoughts. Now I am matured and I am working. They treat me differently."
>
> - Unmarried woman (Regmi et al., 2011, p. 683)

Participants from the above study demonstrated a mostly positive attitude towards dating and sexual relationships. Young men and women shared their experiences of circumventing familial expectations of sexual abstinence by going out on dates rather than bringing partners home (Regmi et al., 2011, p. 682):

> "I have gone on dates with my girlfriend many times and even spent a whole night with her. In my view, it is a good practice. It allows us to share our feelings. You know, in Nepal, we cannot go to the girl's home directly and girls cannot come to our home either. We have to share our feelings somewhere else so we decide to go for a date."
>
> - Unmarried man (Regmi et al., 2011, p. 682)

The authors reported that unmarried young women challenged expectations of sexual abstinence and that considerations such as trust and opportunity were important in deciding whether to engage in sexual relations before marriage (Regmi et al., 2011, p. 687):

"...if you believe in someone very much then you can have sex before marriage. It makes no difference. We don't know when we die, do we? So we have to grab the opportunity."

Additionally, Indian college students from another article reportedly believed that age and maturity – in terms of decision-making and responsibility – were also factors in deciding when to have sex for the first time (Brahme et al., 2020). The majority of respondents in Brahme et al's study in Pune, India said they believed that the 'ideal age for initiation of sex' was between the age of 18 and 23 years as young people within this age range were better positioned to make responsible decisions compared to secondary school-aged youth (Brahme et al., 2020, p. 276):

"I feel it's not correct to initiate sexual relationships when we are in 11th and 12th standard. We are not in a position to take the decisions and responsibility of what happens."

Limited communication around sexuality between young people and parents due to embarrassment

In addition to premarital sexual abstinence, seven articles specified a culture of silence around sexuality as a widespread norm (Brahme et al., 2020; Camellia et al., 2021; Farid-ul-Hasnain et al., 2013; Gautam et al., 2018; Hamid et al., 2010; Khan & Raby, 2020; Regmi et al., 2010). Overall, young people felt embarrassed discussing sexual health with parents, elders, health professionals and friends of the opposite sex, and even sexual partners (Gautam et al., 2018; Hamid et al., 2010; Regmi et al., 2010). As a 24-year-old man in Bangladesh explained: '[Due to socio-cultural norms] people feel shy if we talk directly on sex' (Khan & Raby, 2020, p. 8). In addition to embarrassment, Farid-ul-Hasnain and colleagues suggested that the lack of intergenerational communication around sexuality was due to young people fearing harassment and violence from elders as a consequence of expressing sexual curiosity (Farid-ul-Hasnain et al., 2013).

While most young people were curious, discussing sexuality was a taboo as it went against expectations of 'good virtue' and sexual abstinence before marriage. As Khan and Raby (2020) observed, the dominant discourse that sexuality is a private, shameful, and adult matter appeared to be reproduced through silence around the subject at home and educational institutions across all four countries. When parents did offer limited guidance, 'this was only to tell them not to have sex until marriage, and to forbid girls from mixing with boys' (Khan & Raby, 2020, p. 4). The authors explore this silence or limited guidance as a way of exercising disciplinary power over young people to control their sexual behaviour and reproduce discourses like sexual abstinence before marriage.

Although respondents across all seven articles mentioned feelings of embarrassment or shame, Indian college students in a 2020 study said that they still wanted active parental involvement and open discussions on sexuality (Brahme et al., 2020). Most students learned about sexual health from peers or internet searches but felt their parents were best positioned to provide reliable information (Brahme et al., 2020, p. 277):

> "In our country, the parents do not talk openly with the children about sexual issues, however, I feel that parents are the most reliable people with whom we can share our problems and can seek guidance."

The article did not provide further details on which particular 'sexual issues' the participants wanted to discuss with parents (Brahme et al., 2020). Participants in Camellia et al's ethnographic study specified that they would have benefited from information around physical changes that occur during puberty but preferred not to talk about romance, love, or sex post-puberty because they felt awkward and uncomfortable (Camellia et al., 2021, p. 7):

"The thought of speaking with parents about love or sex feels simply awkward. We are not even comfortable watching kissing scenes on television in the presence of our parents. When I was a kid, my mother used to tell me 'Close your eyes' during such scenes. Now she does not do that anymore. Instead, she seems absolutely okay watching romantic scenes in my presence, which makes me feel even more uncomfortable."

- 17-year-old boy (Camellia et al., 2021, p. 7)

Additionally, Camellia and colleagues (2021) observed a temporal dimension of changes in youth-parent communication needs during and after puberty: as adolescents, participants wanted their parents to have open discussions about puberty but post-puberty they preferred to not communicate about sexual desire and dating.

Despite this limited communication, young people were curious about their sexuality, and reiterated the need for sexual health education (Brahme et al., 2020; Camellia et al., 2021; Farid-ul-Hasnain et al., 2013; Gautam et al., 2018; Hamid et al., 2010; Khan & Raby, 2020; Regmi et al., 2010, 2011). However, as with expectations of sexual abstinence, the ways young people navigated this limited guidance varied. For example, young women engaged to be married in Pakistan expressed curiosity about married life, but said they learned that talking about sexuality was a sign of having no shame as one 19-year-old respondent explained (Hamid et al., 2010, p. 4): "I am looking forward to my marriage and I want to ask questions but I do not talk about this with my mother...she doesn't even know I menstruate. How can we talk about these things?"

Where possible, young people navigated this gap between curiosity and silence by looking for information around sexuality via the internet, media, pornography, and their peer groups. Five articles mentioned the importance of the internet/media as well as peers as alternative – and, most of the time, preferred – sources of sexual health information for young people (Brahme et al., 2020; Camellia et al., 2021; Farid-ul-Hasnain et al., 2013; Khan & Raby, 2020; Regmi et al., 2011). Respondents with access to the internet found Google searches and YouTube to be a more effective resource than parents, as this 16-year-old student from Bangladesh explained (Camellia et al., 2021, p. 8):

"There are videos on YouTube almost about everything…some of them are really good, for instance, Birds and the Bees. In no way our parents can explain sex better than those videos. They will die out of shame."

Young people were also routinely exposed to sexual content through the media without having to actively search for it. A 20-year-old woman from Nepal described how being inundated with such content affects young people (Regmi et al., 2011, p. 687):

"We watch TV and films, read papers and listen to the radio...It is all about sex. We become emotional and attempt to do such things. There are too many naked pictures found in papers and on the net. It really affects us."

Access to, and reliability of, alternative resources varied across contexts. For example, young men in Bangladesh received information about sexuality from their peers but were of the view that peers were 'unreliable sex educators' (Khan & Raby, 2020). In another study, soon-to-be-married women of a slum in Pakistan had limited and vague information from contacts approved by respondents' mothers, such as older cousins, sisters and aunts as a source of information about sexuality and childbearing near the time of their marriage (Hamid et al., 2010). For some, television adverts were the main source of information on contraception, although they lacked full understanding of how to use and access these (Farid-ul-Hasnain et al., 2013, p. 61):

"We come to know about contraceptive use through advertisements on television, i.e. pills. We assume, there may be other methods for contraception, but we know about only one, which is shown on television".

- Young man from lower-middle SES (Farid-ul-Hasnain et al., 2013, p. 61)

Restrictive gender norms limit young women's sexual and reproductive decision making

The importance of gender norms was described in all included articles. Eight articles emphasised how underlying gender norms in South Asia meant that young women were often unable to exercise sexual consent and lacked control over their own reproductive health (Bankar et al., 2018; Deuba et al., 2016; Hamid et al., 2010; Iyer, 2017, 2018; Khan & Raby, 2020; Nishtar et al., 2012; Regmi et al., 2011). These articles primarily discussed three broad sub-themes stemming from the ideal of "good virtue": gender narratives and a lack of sexual consent for girls and women; gendered mobility restrictions and limited access to sexual health information; and lack of decision making around contraception and its consequences.

Gender narratives and consent: Four articles referred to submissive/vulnerable femininity and heroic/hegemonic masculinity as dominant gender narratives in South Asia which contribute towards undermining women's sexual consent (Iyer, 2017, 2018; Khan & Raby, 2020; Regmi et al., 2011). For example, many boys in a Nepal-based study believed that most girls were 'very soft and weakhearted in nature and cannot express their feelings of love' (Regmi et al., 2011). An unmarried respondent from the same article further elaborated that young men also expected submissiveness in terms of making the first move regarding dating: "In most cases, boys act first. They always push for it [sex]." (Regmi et al., 2011, p. 684)

According to authors of a 2019 study in Bangladesh, some young men observed pornography as reinforcing sexual submissiveness of women (Khan & Raby, 2020, p. 11):

> "[Pornographic films] have a general tendency to [show] sexuality as something brutal, brutally attacking a girl. A boy is always a hero in pornography, a female is subordinate. A woman is treated like an animal."

Similarly, Iyer's (2017) article about young people's understandings of gender sexual violence identified Bollywood films as a source for dominant discourses in gender. The combination of fighting and pursuing heterosexual romance reinforced both narratives of heroic masculinity as well as vulnerable femininity. In such cases, the author asserts, girls were inevitably cast as passive and helpless, with boys fighting to determine who will 'win' her hand. The article further revealed that in the aftermath of Delhi gang rape case, vulnerable femininity held influence at home and at school through the emphasis of being alert in public spaces. As a consequence of these dominant gender discourses, boys often conflated ideas of respecting and protecting girls, thereby undermining the latter's agency

(Iyer, 2017; Khan & Raby, 2020). There was also confusion over what constituted legitimate sexual attraction as opposed to predatory sexual behaviour as boys attempted to distinguish themselves from male predator stereotypes. Within a context where sex was frequently discussed in terms of sexual violence, many boys struggled to conceptualise sexual desire in positive terms (Iyer, 2017).

Findings from the above study also suggested that 'girls' expectations of greater freedoms can lead them to vociferously challenge attempts at restriction' (Iyer, 2017, p. 14). One way girls in this study challenged the narrative of vulnerable femininity was by aspiring to independent 'can-do' narratives of girlhood in India (Iyer, 2017, p. 7):

"I think being self-dependent is the most important thing as a girl. If I get married, I don't want to get married without working in any office or – because I – don't completely want to depend on my husband, and on my family."

Restricted mobility: Five articles highlighted mobility restrictions – imposed by parents or husbands/in-laws – as one of the main constraints in everyday life of both married and unmarried young women. Public space was identified primarily from a gendered viewpoint as young women's access to public space was restricted due to safety concerns and fear of harassment and abuse from men (Bankar et al., 2018; Iyer, 2017). As this student in New Delhi explained, despite changing attitudes towards women in India, concern over safety still led to parents placing restrictions on their daughters (Iyer, 2017, p. 9):

"You know, I think that, ah – in India, the views are changing, the mindsets are changing. Girls are given more opportunities. But […] the environment, the society for girls is very bad. You know, rape cases, all these stuff, murders, are still happening. And due to this, girls are – the parents are scared if they allow their girls to go out […] Due to all this fear, we're getting less freedom."

As well as safety concerns – which were reported across all four countries – women's presence in public spaces was also seen as departing from the ideals of 'good virtue' and, therefore, raised suspicion about sexual chastity (Bankar et al., 2018; Iyer, 2017). A respondent from Pakistan gave the example of being afraid that mistrust from her future spouse could lead to restrictions after marriage (Hamid et al., 2010, p. 4):

"My fiancé is *shakki* (does not trust). In the village when we visit them, he does not like it if I talk to our other relatives. I am afraid of what will happen after my marriage."

Overall, young women felt frustration, fear, and anger at having to abide by these restrictions:

"(T)he rules they [in-laws] have, I am unable to follow them and also to understand why they are saying this…They often say, 'That's why I say girls should not go out so much…. when they get outside air then they don't like to stay at home'." (Bankar et al., 2018, p. 8)

"[…] why the boys every time, every time they feel safe, when anywhere they should go, ah, then – he is safe anywhere! Why should, why these boys are safe and we are not?" (Iyer, 2017, p. 8)

In terms of consequences, restricting girls' movement in public spaces contributes to school dropout and early marriage, and negatively affects girls' health and wellbeing (Bankar et al., 2018). Moreover, Hamid et al (2010) argued that unlike their male counterparts, young women had limited access to different types of media because of their restricted mobility and fewer opportunities from which to choose themselves (Hamid et al., 2010).

Despite this, findings from included articles also demonstrated that young women – of different ages, and educational and socioeconomic backgrounds – challenged mobility restrictions in different ways. For example, most urban participants in a Nepali study about dating and sex mentioned having some dating experience and accessing places such as restaurants, inns, hotels, cinemas, parks, and public transport on dates (Regmi et al., 2011). While there appeared to be gender segregation in the home – with opposite-sex peers often discouraged from visiting each other's homes – participants said it was commonplace for young people to form romantic partnerships through school or in their community (Regmi et al., 2011). For instance, a young woman was able to meet her boyfriend because of frequent opportunities to meet at his shop (Regmi et al., 2011, p. 684): "I used to stay near his shop and I used to get food and other items from his store . . . later on we became closer and started to love each other."

Gendered reproductive health decision making: Four articles included experiences of married or engaged participants from urban slums – in India, Pakistan, and Nepal – and touched on young women's lack of control over their own reproductive health (Bankar et al., 2018; Deuba et al., 2016; Hamid et al., 2010; Nishtar et al., 2012). Husbands and mothers-in-law appeared to be the main decision makers in contraceptive use and childbearing, with the majority of women across the four studies saying that condom use was dependent on their husbands. Conversely, young married men from a study in Karachi, Pakistan stated that the prime responsibility of avoiding unintended pregnancies lay with their partners, although the men themselves also generally avoided using contraception (Nishtar et al., 2012). Young

women identified unequal gender dynamics and hierarchy within the marital household as underlying reasons why they could not exercise autonomy over family planning:

"This is a male's world. Women in our area don't want to annoy their husbands; they would rather sacrifice their own health." (Nishtar et al., 2012, p. 88)

"In our culture we cannot take the decisions about using contraceptives without asking the elders within the household." (Farid-ul-Hasnain et al., 2013, p. 60)

As mentioned earlier, Hamid and co-authors explored this lack of reproductive autonomy by interviewing engaged women living in slums in Islamabad, Pakistan. Their findings showed how young women were underprepared for marital life with very little access to sexual health information due to a culture of silence around sexuality and parental pressures to be obedient daughters. The authors concluded that this 'socialisation into submissiveness' contributed to women's lack of control over future reproductive health. Young women in this study reportedly abided by rules and trusted that family support would ensure security in future life. Unlike young people in other studies, these women did not seem to have access to resources outside of parent-approved sources such as older cousins, sisters and aunts. As well as directing questions about sexuality and childbearing to these sources, young women also felt that television – in particular, contraceptive adverts – was a peer from which they could learn about sexuality. Bankar et al (2018) also found that young women's restricted access to public space and resources persisted after marriage.

In their study of pregnant women aged 15 to 24 in Kathmandu, Nepal, Deuba et al (2016) identified a lack of women's sexual consent and strong son preference among slum residents as contributing factors of prepartum intimate partner violence among participants. These young pregnant women were more likely to experience different forms of violence (psychological, physical, and sexual) if they refused to have sex with their husband, gave birth to a girl, or if their husband had alcohol use disorder. One of the main misconceptions around son preference was that having sex during pregnancy would result in a son. As one participant expressed, this misconception, in addition to a lack of women's sexual consent, led to experiences of sexual violence (Deuba et al., 2016, p. 6):

"Every night we argue a lot over not having sexual intercourse but I have no other alternatives. He himself has studied a lot; he has achieved a master's degree and says that it's good to have sex during pregnancy and if we do so during this period we will give birth to a son. If I say, "No it's not, the doctor has told me not to do it" - then he says that if you don't let me have sex, I will go to other girls and marry them. He is my husband after all, so I let

him have sex with me…he neither understand me nor my feelings. All he want[s] is to fulfil his desires."

Most young women in Deuba et al's (2016) study reported (mis)information around son preference from their spouses and mothers-in-law. For the above case, the article did not discuss why the doctor may have advised the participant not to have sex during her pregnancy.

In terms of coping with IPV, most of these young women reported tolerating and accepting abuse due to economic dependence on their husbands. In some cases, their in-laws interfered to prevent further escalation of physical abuse and sometimes women were able to seek informal support from close family members (Deuba et al., 2016).

Heteronormativity presumed and implied in research through absence of sexual and gender diversity

All included research appeared to be about (presumed) cisgender heterosexual and able-bodied individuals, with only two articles mentioning sexual diversity. A study about young men's experiences of sex education in Bangladesh mentioned the lack of queer representation in their research as a limitation due to difficulties in accessing 'a more diverse group of participants representing different sexualities in Bangladesh where such sexual diversity is not acknowledged socially or legally' (Khan & Raby, 2020, p. 12). A study exploring perceptions of sexuality and sexual health education among college students in Pune, India touched very briefly on the topic of 'homosexuality and anal sex'. Authors reported 'mixed reactions' on homosexuality from boys in the study – no data was presented on perceptions of girls. Boys from lower socioeconomic backgrounds were said to lack awareness about homosexuality while others described it as a 'personal choice'. The findings finally stated that many explored homosexuality as 'a different way of fun' although this was not elaborated any further. It was unclear how the authors defined homosexuality in this case or how the respondents themselves identified as this was not reported (Brahme et al., 2020).

While participants in Khan and Raby's study all self-identified as heterosexual, other articles did not explicitly report respondents' sexual or gender identity. At the same time, the included articles did not present any findings specific to experiences of non-heterosexual and non-cisgender young people. Therefore, it was not within the scope of these included articles to explore, and provide recommendations, around sexual health implications of different sexual or gender identities. Findings from articles looking at sexual health needs and barriers, for instance, focussed on overall issues such as concerns around privacy and

confidentiality of services, accessibility of services, and lack of sexual health knowledge (Farid-ul-Hasnain et al., 2013; Gautam et al., 2018; Regmi et al., 2010).

The use of particular definitions also excluded young people who may not identify as heterosexual or cisgender. For example, a paper on perceptions around dating and sex in Nepal defined dating as 'a meeting between *young women and men* for romantic and sexual purposes' without indicating that the study was concentrating only on heterosexual relationships (Regmi et al., 2011). Similarly, Iyer's mixed methods study of middle-class students in India reflected heteronormativity as default by framing heterosocial (cross-sex) friendships as having potential for romance – and therefore being discouraged by educational institutions – while homosocial (same-sex) friendships were subsequently seen as only platonic.

Table 2.1 Summary of study characteristics of 13 included articles

First author, year	Country	Funding agency	Study design	Data collection			Study setting	Study population				Sample size	Study topic	Theoretical approaches
				Methods[a]	Year	Study duration		SES	Gender	Age	Marital status			
Bankar, 2018	India	STRIVE Research Consortium, UKAid	Cross sectional qualitative	One to one interviews	Not reported	Not reported	Urban slums (Mumbai)	Slum residents	Women	18-24	Unmarried and married	10	Contesting restrictive mobility norms	Social norms theory
Brahme, 2020	India	ICMR-National AIDS Research Institute, India	Cross sectional qualitative	Focus Group Discussions (FGDs)	2016	2 months	Urban colleges (Pune)	Mixed (middle to higher-middle, and lower)	Boys and girls	20.82[b]	Not reported	74	Sexual behaviour and needs (HIV/STIs)	Not reported
Camellia, 2021	Bangladesh	Netherlands Organisation for Scientific Research	Cross sectional qualitative ethnography	- FGDs - One to one interviews	2016-17	1 year	Urban (Dhaka)	Middle class	Boys and girls	15-19	*Unmarried*	72	Communication on sexuality in the youth-parent relationship	Positive sexuality framework
Deuba, 2016	Nepal	Not reported	Cross sectional qualitative	One to one interviews	2013	5 months	Urban slums (Kathmandu)	Slum residents	Women	15-24	Married (pregnant)	20	Prepartum IPV	Not reported
Farid-ul-Hasnain, 2013	Pakistan	- SIDA, Sweden - STINT, Sweden	Cross sectional qualitative	FGDs	2008	1 month	Urban (Karachi)	Mixed (lower- to upper-middle, and low)	Men and women	17-21	Unmarried	42	Knowledge, attitudes, beliefs and perceptions on contraceptive use and HIV prevention	Note reported
Gautam, 2018	Nepal	Not reported	Cross sectional qualitative	One to one interviews	2014	2 months	Urban and rural (Dang)	Hill Dalit (Badi) community	Men and women	15-24	Unmarried and married	22	Barriers to using sexual health services	Not reported
Hamid, 2010	Pakistan	Not reported	Cross sectional qualitative	- FGDs - One to one interviews	Not reported	Not reported	Urban slums (Islamabad)	Slum residents	Women	15-24	Engaged to be married within 3 months	34	Experiences of marriage preparation; understanding of transition to marriage and start of sexual and	Not reported

													childbearing activity	
Iyer, 2018[c]	India	ESRC, UK	Mixed methods with ethnography	- FGDs - One to one interviews	2013	5 months	Urban secondary schools (New Delhi)	Middle class	Boys and girls	15-17	Unmarried	180[d]	Heterosocial dynamics within school peer cultures	Narrative analytical framework
Iyer, 2017[c]	India	- ESRC, UK - University of Sussex, UK	Mixed methods with ethnography	- FGDs - One to one interviews	2013	5 months	Urban secondary schools (New Delhi)	Middle class	Boys and girls	15-17	Unmarried	180[d]	Understandings of gender and sexual violence	Narrative analytical framework
Khan, 2020	Bangladesh	Not reported	Cross sectional qualitative	One to one interviews (virtual)	2017	2 months	Urban and rural	Not reported	Men	19-24	*Unmarried*	9	Experiences of sex education	Foucauldian poststructural framework
Nishtar, 2013	Pakistan	Not reported	Cross sectional qualitative	FGDs	2010	4 months	Urban slums (Karachi)	Slum residents	Men and women	18-24	Married (with ≥1 child)	50	Myths and fallacies about male contraceptive methods	Not reported
Regmi, 2010	Nepal	- University of Aberdeen, UK - Carnegie Trust for Universities of Scotland	Cross sectional qualitative	- FGDs - One to one interviews	2007	Not reported	Urban and rural colleges/youth clubs (Kathmandu and Chitwan)	Not reported	Boys and girls	18-22	Unmarried and married	50	Barriers to using sexual health services and condom-use	Not reported
Regmi, 2011	Nepal	- University of Aberdeen, UK - Carnegie Trust for Universities of Scotland	Cross sectional qualitative	- FGDs - One to one interviews	2007	Not reported	Urban and rural colleges/youth clubs (Kathmandu and Chitwan)	Middle class	Boys and girls	15-24	Unmarried and married	106	Attitudes towards dating and sex	Emerging adulthood framework

ESRC: Economic and Social Research Council, SES: socioeconomic status, FGD: focus group discussion, SIDA: Swedish International Development Cooperation Agency, STINT: Swedish Foundation for International Cooperation in Research and Higher Education, IPV: intimate partner violence, [a]*All interviews were conducted face to face except Khan 2020,* [b]*Article reported mean age of respondents,* [c]*Articles based on same study,* [d]*N=180 students completed initial questionnaire, of which 41 were interviewed individually or in focus groups*

Table 2.2 Summary of sexual health consequences of, ways of navigating, and recommendations around socio-sexual norms as discussed in 13 included articles

First author, year	Norms or constraints identified in included studies	Sexual health consequences of norms/constraints reported	How do young people navigate norms?	Recommendations of study
Bankar, 2018	**Gendered mobility restrictions** - Restrictive visibility norms for girls and women in public spaces **Premarital sexual purity** - Good virtue: modesty, respectfulness, proficiency in household chores and, above all, sexual purity	- Harmful gender norms structural barriers to many public health interventions - School dropout and early marriage, and negative affect on girls' wellbeing - Gender discriminatory practices and social patterning of health inequalities	- Greater negotiation skills through intervention helped win parents' trust in ability to be safe and 'respectable' in public - Parents became supporters thus co-producing daughters' identity as doing 'good work'	Not reported
Brahme, 2020	**Silence on sexuality in youth-parent/adult relationships** - Cultural barriers and taboo to discuss sexuality; no open discussion with parents	- Sex education not adequate to bring maturity, leading to problems such as unwanted pregnancies, and unprotected sex	- Use alternative sources of knowledge on sexuality (e.g. peers, internet, pornography) - Google search sexual health information	- Parental involvement and open discussions on sexuality preferred by students - Use of innovative sexual health mobile app - Develop holistic approach for culturally-sensitive sex health education and life skills model
Camellia, 2021	**Silence on sexuality in youth-parent relationships** - Lack of communication on sexuality in youth-parent relationship due to socio-sexual norms - Taboo around cross-sex communication, particularly between mothers and sons **Premarital sexual purity** - Sexual abstinence to uphold family's respectability	- Limited access to information about own bodies and physical changes during puberty; particularly problematic for boys	- Young people think it unnecessary and shameful to discuss sexual pleasure with parents - Silence used to protect good boy/girl image and be seen to respect parents' values - Internet perceived as more effective source of information than parents	- In-depth understanding of silence when researching sexuality to avoid generalising silence as always oppressive - More knowledge about when, on which topics, or for whom internet is more effective than parental communication
Deuba, 2016	**Gendered decision-making around sex and childbirth** - Lack of sexual consent for pregnant young women - Son preference	- Experiences and health consequences of IPV (e.g. negative birth outcome, trauma) - Misconceptions around son preference (e.g. having sex during pregnancy helps to get a son)	- Tolerate and accept husbands' abuse due to economic dependence - Seek informal support from close family members - In-laws interfere to prevent escalation of physical abuse	- Health workers can increase awareness in men and families with strong son preference - Interventions to improve pregnant women's abilities to tackle mental health consequences - Involve community and in-laws in IPV prevention
Farid-ul-Hasnain, 2013	**Silence on sexuality in youth-adult/parent relationships** - Lack of intergenerational communication around sexual health	- Knowledge gap concerning HIV/AIDS and contraceptive use - Susceptibility to HIV, unwanted pregnancies, unsafe abortions and sexual abuse or violence - Fear of harassment and violence from elders	- Rely on media and peers for sexual health information	- Improve access to quality clinical services with effective treatments, and accurate sex education - Supportive adult guidance on SRH matters and educational and economic opportunities - Develop public health strategies and curriculum-based programmes targeting individual behaviours and socio-structural factors that act against safe sex

Gautam, 2018	**Silence on sexuality in youth-parent/adult relationships** - Young people uncomfortable discussing sexual health with elders, family, or service providers of opposite sex	- Low utilisation of sexual health services	- Prefer visiting other health centres if service provider at nearest health facility is of opposite sex	- Community-based educational programmes and accessible youth-friendly service centres to encourage use of services
Hamid, 2010	**Silence on sexuality in youth-adult/parent relationships** - Culture of silence around sexuality and transition into adulthood in silence **Premarital sexual purity (submissiveness)** - Young women socialised into submissiveness and abide by rules to be 'good daughters'	- Lack of proper understanding of how to use and access contraception - Women's lack of control over future reproductive health	- TV as peer (e.g. contraceptive adverts) - Ask parent-approved information sources about sexuality and childbearing near time of marriage (e.g. older cousins, sisters, aunts) - Abide by rules and trust family support will ensure security in future life	- Create community-based informal groups for young women to discuss sexuality, childbearing and other marriage-related issues - Uplift women's self-identity and integrate women into decision-making with parents and husbands
Iyer, 2018	**Gender segregation/brother-sister relationships at school** - Institutional narratives of *rakhi* (brother-sister) relationships with boys respecting girls as sisters **Premarital sexual purity** - Sexual activity among students exception rather than norm reflecting middle-class norms of premarital purity	- Perpetuates regressive gendered power dynamics and restrictive concept of sexuality - Frames all male sexual desire as derogatory towards women and women who express sexual desire as unworthy of male respect	- Peer romance important source of sexual learning for students to explore experiences of pleasure and intimacy side-lined within institutional risk-based narratives of sexuality - Reject norms emphasising gender inequalities by forming heterosocial friendships	- Further research around gender dynamics within heterosocial friendships in India
Iyer, 2017	**Gender norms and sexual violence** - Institutionally reinforced gender norms through narratives of good boy/hero masculinity and can-do/vulnerable girlhood	- Confusion around boys' understandings of sexual violence and sexual pleasure - Frustration for girls as can-do girlhood often undermined and vulnerable femininity affirmed through heightened restrictions	- Aligning with narratives of 'good boy'/'hero' masculinity and 'can-do girl'/'vulnerable girl' - Challenging vulnerable narratives through can-do girlhood valued within girls' peer cultures, as celebration of modern Indian woman	- Frame conversations about sexuality in more positive terms, in formal school settings or more informal interactions - Talk about issues around consent - Schools can better support young people as they learn about gender and sexuality from diverse and contradictory sources
Khan, 2020	**Silence on sexuality in youth-adult/parent relationships** - Dominant discourse that sexuality is private, shameful and adult matter reproduced at home and school **Premarital sexual purity** - Parents expect sexual abstinence until marriage **Gendered learnings around sex and sexuality** - Learnings around sexuality strongly gendered	- Gendered knowledge about sex and sexuality reproduces hegemonic masculinity, and undermines women's consent - Uncertainty, isolation and vulnerability around sex and sexual health	- Accessing alternative sources of information through peers, pornography and learning by doing	- Good quality sex and sexuality education for Bangladeshi boys
Nishtar, 2013	**Gendered decision-making around contraception** - Men and mothers-in-law main decision makers in contraception use and childbearing	- Low use of male contraceptives due to cultural beliefs, and myths and fallacies (e.g. impotency associated with condom use) - Women have little control in adopting contraception	Not reported	- Set up user forum for advocacy about male contraception - Target cultural issues through peer counselling for husbands and mothers-in-law, and train family planning service providers - Use public messages and easy to understand booklets in local languages

Regmi, 2010	**Silence on sexuality in youth-adult and peer group relationships** - Embarrassment while talking about sexual health with friends of opposite sex, family, and even sexual partners	- Barriers to accessing information or services on sexual health - Poor negotiation and decision-making skills can lead to unsafe sex - Misinformation about sexuality from peers	- Avoid sexual health services - Engage in unsafe sexual practices - Seek sexual health advice from peers	- Ensure confidential and respectful services - Provide necessary negotiation skills to avoid risks of HIV/STIs and unwanted pregnancy - Free/discounted sexual health services, and peer education programmes - Establish convenient youth-friendly service centres
Regmi, 2011	**Gendered decision making around sex** - Girls have less negotiating and decision-making power around sex **Premarital sexual purity**	- Girls perceived to face physical, mental, and social consequences of sexual relationships	- Learn about love, dating, and relationships from media - Chatting online in cyber cafes to find partners - Meet and form partnerships with opposite sex while at college or in their community	- Discuss dating practice in formal and informal education to promote safer sex

Discussion

This review shows how parental expectations of premarital sexual abstinence and silence around sexuality contributed to inadequate sexual health information for young people, and restrictive gendered norms (such as dominant gender narratives and mobility restrictions) limited young women's sexual and reproductive decision making. None of the studies addressed diversity of sexuality or gender identity.

Findings around a lack of intergenerational sexuality communication between young people and older adults are extensively supported by literature reporting on silence around sexuality (Bastien et al., 2011; Marston & King, 2006; Rashid, 2000; van Reeuwijk & Nahar, 2013; Wamoyi et al., 2010; War & Albert, 2013). As with other global studies, our review found that lack of communication was predominantly reported as being due to embarrassment or shame around the topic of sexuality as well as expectations of premarital sexual abstinence (Bastien et al., 2011; Wamoyi et al., 2010; War & Albert, 2013). Although not all young people had access to alternative sources of sexuality information, most participants in our included studies navigated the gap in sexuality communication by looking for information via the internet, media, pornography, and their peer groups (Brahme et al., 2020; Camellia et al., 2021; Farid-ul-Hasnain et al., 2013; Khan & Raby, 2020; Regmi et al., 2011). Again, this finding is supported by wider literature (Bastien et al., 2011; Patton et al., 2016; Wamoyi et al., 2010). For example, while peer relationships were considered a valuable – although at times unreliable – source of sexual learning, there is mixed evidence on the effectiveness of peer education contributing to SRH knowledge, attitudes and behaviour (Brahme et al., 2020; Farid-ul-Hasnain et al., 2013; Iyer, 2018; Khan & Raby, 2020; Regmi et al., 2010; Siddiqui et al., 2020).

The included studies showed how gender had an impact on experiences of all relationships, particularly in terms of cross-sex communications around sexuality and in terms of gender segregation. Son preference, gender inequality, early marriage and its impact on young people in South Asia has been well documented (Nahar et al., 2013a). Our review found that parents and educational institutions encouraged gender segregation at school as a way of ensuring premarital 'sexual purity' (Camellia et al., 2021; Iyer, 2018; Khan & Raby, 2020). Restrictive gendered norms, such as dominant gender narratives around vulnerable/submissive femininity and hegemonic/heroic masculinity, particularly affected young women's sexual and reproductive decision making. Puberty has been found to be a time for expanded participation in public life for boys and intensifying restrictions for girls in South Asia (Barker et al., 2004; Population Council, 2009; UNICEF & UNFPA, 2019),

and there are high levels of institutional and societal gender discrimination across all four countries included in our review (UNICEF, 2019).

Included studies engaged with expectations of premarital 'sexual purity', silence around sexuality, and restrictive gender norms as experienced by both married and unmarried young people from different socioeconomic and educational backgrounds. However, there were noticeable gaps in terms of reporting on particular social orientations, such as young people with disabilities or gender and sexual minorities. Does the lack of reporting on LGBTQIA+ young people imply the authors presumed all their interviewees were cisgender and heterosexual? How has this gap in reporting affected our understanding of non-heterosexual and non-cisgender young people's sexual health within heteronormative societies – with the view that institutionalised heterosexuality constitutes 'the standard for legitimate and expected social and sexual relations' (Ingraham, 2002, p. 315)? We observed that the absence of more diverse narratives meant that the included articles could not provide recommendations that reflected the specific sexual health needs of these heterogenous communities – such as accessibility of sexual health services, contraceptive use, communication and education around sexuality, and experiences of harassment and violence. Could this erasure from research mean that diverse lived experiences and health needs continue to be unaddressed in mainstream research or policy? Without such research, it is difficult to contextualise, and potentially challenge, the assumption that heteronormative experiences are universal.

There is an urgent need for research examining lived experiences of, and health inequalities within, sexual and gender diverse communities (Keuroghlian et al., 2017; Laiti et al., 2019; Rashid et al., 2011; Regmi & van Teijlingen, 2015; Zeeman et al., 2019). We also need global research about 'the role of heteronormativity in healthcare and the application of diversity-affirming care into healthcare practices' (Laiti et al., 2019, p. 12). Heteronormative patriarchy continues to be a dominant paradigm in South Asia (Hapke, 2013; Karim, 2021; Khan & Raby, 2020; Ong et al., 2021; Regmi & van Teijlingen, 2015; Siddiqi, 2011b). For example, an article by one of the authors of two Nepal-based studies included in our review emphasised the 'lack of understanding of health and well-being, social exclusion, stigma, and discrimination' as experienced by LGBT+ populations in Nepal (Regmi & van Teijlingen, 2015). Research focussing on diverse sexual and gender identities could shed light on current challenges faced by SGM as well as culturally sensitive ways of navigating discrimination against SGM young people in healthcare and policy.

There was little evidence about the experiences of married young people. Only four of the included articles explored young people's experiences of marriage as an important life event

and all were based on data from urban slums in India, Pakistan, and Nepal (Bankar et al., 2018; Deuba et al., 2016; Hamid et al., 2010; Nishtar et al., 2012). Three of these looked specifically at experiences of young women and all focussed on either contraceptive use, intimate partner violence, or mobility restrictions. One reason that the included articles selected slum residents could be to explore intersections of poverty and reproductive health concerns associated with early marriage. Poorer women are statistically more likely to be married during childhood than their richer counterparts in South Asia and are therefore faced with more health consequences associated with early marriage (UNICEF & UNFPA, 2018).

While only four articles included married young people, it is plausible that the findings from these studies may also apply to some extent to 'other young women from similar backgrounds and in similar situations' (Hamid et al., 2010, p. 6). In fact, wider literature confirms that married South Asian women living in slums are confronted with IPV, a lack of decision making around reproductive health, and son preference (Ainul & Amin, 2015; Hamid et al., 2009; Jungari & Chinchore, 2020; Rashid, 2006; Sabri & Campbell, 2015; Saha et al., 2015). At the same time, there is a lack of exploratory research where young married people raise their own health needs beyond contraceptive use, childbearing, and gender-based violence. This could reflect a global development agenda to delay early marriage and pregnancy and promote access to, and use of, contraception (UNICEF & UNFPA, 2018, 2019). While these are certainly relevant avenues of inquiry given the high rate of early marriage and widespread gender inequality, the limited body of work on reproductive behaviour of married young people also leaves a gap in narratives about sexual behaviour and pleasure.

Overall, the majority of included articles focussed on young people's perceptions and attitudes around sexuality, rather than a fuller exploration of lived experiences. While offering valuable insight into sexuality norms and young people's understanding of sexuality, most studies did not fully explore lived experiences or meanings of sexuality. There was a lack of 'thick description' (Geertz, 1973) in the articles, and little exploration of participant perspectives on meanings of sexuality, sexual health, sexual wellbeing, and illness. For instance, urban college students in Pune suggested that they wanted parental involvement and discussions on sexuality to obtain knowledge and guidance (Brahme et al., 2020). However, the research did not probe further or provide in-depth details of how this would happen from an everyday standpoint given the taboo and embarrassment around discussing sexuality as well as norms of premarital purity as reported in most included articles.

Three articles were based on ethnographic research which provided more in-depth detail about the social context on silence around sexuality, and gender norms and sexual violence (Camellia et al., 2021; Iyer, 2017, 2018). More work like this is needed to 'capture the full range of influences on sexual behaviour' (Marston & King, 2006, p. 1584). Researchers must acknowledge heterogeneity of experiences and select respondents whose lived experiences may further our understanding of sexuality. For instance, Farid-ul-Hasnain et al. (2013) reported on perceptions of HIV/Aids and safe sex but did not include lived experiences of people living with HIV (PLWH). This stops the conversation at 'PLWH are stigmatised' but not how this plays out in the lifeworld of young people living with HIV and how they can be better supported.

Given the dearth of published qualitative studies on sexual and reproductive health of young people in low- and middle-income countries, the opportunities for future research are plenty (Salam et al., 2016; UNFPA, 2014; UNFPA et al., 2015). Qualitative research can provide much-needed in-depth insight into how young people give meaning to, and experience, their sexual health. The inclusion of young people with diverse lived experiences – such as those who identify as LGBTQIA+, youth living with HIV or disabilities etc. – would help to address the high unmet SRH needs of 'key populations' (UNFPA, 2014). By making the research process as participatory and inclusive as possible, young people can set their own health priorities and inform policy through sharing their lived experiences. Health needs and experiences are not static and vary across socioeconomic situations, gender and sexual identities, marital status and stages of life – the sexual health needs and lived experiences of a married young man may be different to his needs and experiences as a young adolescent boy going through puberty, for example. Thus, it is important to continue efforts to bridge research gaps and increase our understanding of these differentials within the local context of socio-sexual and gender norms. Asking more detailed questions and collecting more detailed information about social context through ethnographic health research may be amenable to capturing nuanced experiences on a continuum. Exploratory in-depth research can also be used to consider multiple perspectives, such as young people who do not conform to heteronormativity or able-bodied narratives, to reveal broader and more inclusive contextual meanings of sexuality.

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Appendices

Appendix 1. Search strategies for electronic databases

Search terms for Ovid (Embase, Medline, PyscInfo, Global Health)

1. (youth or young people or young person or young adult* or young male* or young female* or adolesc* or teen* or girl or boy or girls or boys).ti,ab.
2.exp adolescent/
3. 1 or 2
4. (sexua* or sexual health or sexual behavio?r).ti,ab.
5. (reproduc* or reproductive health or reproductive behavio?r).ti,ab.
6. (SRH or SRHR).ti,ab.
7. (sexual or reproductive) adj3 (health or behavio?r or rights).ti,ab.
8. exp sexual health/ or exp reproductive health/ or exp sexual behavior/ or exp reproductive behavior/ or exp sexuality/
9. 4 or 5 or 6 or 7 or 8
10. (Bangladesh or India or Pakistan or Nepal or Sout* Asia).ti,ab.
11. exp Bangladesh/ or exp India/ or exp Pakistan/ or exp Nepal/
12. 10 or 11
13. (qualitative or ethnograph* or phenomenol* or grounded theor* or experience* or narrative* or ethnolog* or focus group* or interview*).ti,ab.
14. exp qualitative research/
15. 13 or 14
16. 3 and 9 and 12 and 15

APA PsycInfo: The subject heading 'adolescent' and 'Bangladesh' invalid; Global Health: The subject heading 'sexual behavior' and 'qualitative research' invalid

Search terms for PubMed

1. youth[Title/Abstract] OR young people[Title/Abstract] OR young person[Title/Abstract] OR young adult*[Title/Abstract] OR young male*[Title/Abstract] OR young female*[Title/Abstract] OR adolesc*[Title/Abstract] OR teen*[Title/Abstract] OR girl[Title/Abstract] OR boy[Title/Abstract] OR girls[Title/Abstract] OR boys[Title/Abstract]
2. adolescent[MeSH Terms]
3. 1 OR 2
4. sexua*[Title/Abstract] OR "sexual health"[Title/Abstract] OR sexual behavio* [Title/Abstract]
5. reproduc*[Title/Abstract] OR "reproductive health"[Title/Abstract] OR reproductive behavio*[Title/Abstract]
6. SRH[Title/Abstract] OR SRHR[Title/Abstract]
7. sexuality[MeSH Terms] OR sexual behavior[MeSH Terms] OR reproductive health[MeSH Terms] OR reproductive behavior[MeSH Terms]
8. 4 OR 5 OR 6 OR 7
9. Bangladesh[Title/Abstract] OR India[Title/Abstract] OR Pakistan[Title/Abstract] OR Nepal[Title/Abstract] OR Sout* Asia[Title/Abstract]
10. Bangladesh[MeSH Terms] OR India[MeSH Terms] OR Pakistan[MeSH Terms] or Nepal[MeSH Terms]
11. 9 OR 10
12. qualitative[Title/Abstract] OR ethnograph*[Title/Abstract] OR phenomenol*[Title/Abstract] OR grounded theor*[Title/Abstract] OR experience*[Title/Abstract] OR narrative*[Title/Abstract] OR ethnolog*[Title/Abstract] OR focus group*[Title/Abstract] OR interview*[Title/Abstract]
13. qualitative research[MeSH Terms]
14. 12 OR 13
15. 3 AND 8 AND 11 AND 14

Appendix 2. List of inclusion-exclusion criteria

	Inclusion	Exclusion
1	Articles published in/after 2010	Articles published before 2010
2	Peer-reviewed empirical research	Reviews, opinion pieces, book chapters, papers that are not peer reviewed
3	Qualitative research or mixed method with qualitative analysis (i.e. not only as part of quantitative survey)	Quantitative studies/no qualitative data collection or analysis
4	Focussed on experiences of young people with data that can be disaggregated for respondents aged 15-24 years	Studies looking only at adults (>24) or children (<15) or indistinguishable populations (e.g. 15-49 with no disaggregated data for 15-24 year olds)
5	Focussed on any experiential aspect of sexuality and sexual health of young people in everyday life settings (e.g. school, university, workplace, public spaces etc.)	Health/non-health issues outside of SRHR (e.g. nutrition, smoking)
6	Studies based in Bangladesh, India, Pakistan and Nepal	Studies based outside Bangladesh, India, Pakistan or Nepal (e.g. Bangladeshi diaspora in the UK)
7	Studies based in urban areas or urban and rural areas	Studies focussed only on rural

Appendix 3. Coding framework for data extraction

General

- Title
- Authors
- Year of publication
- Journal
- Country of study
- Abstract
- Funding agency

Data collection and study design

- Year of data collection
- Duration of study
- Location of study
- Study setting
- Study population
- Sample size
- Sampling strategy
- Recruitment process
- Study design
- Reviewers' remarks on study design and sampling

Study findings

- Research topic
- Research findings and themes

- Quotes/findings of interest to reviewers
- Interventions
- Theories
- Norms
- Recommendations
- Reviewers' remarks on findings

Appendix 4. Results for Critical Appraisal Skills Programme (CASP) Qualitative Checklist

First author, year	Section A: Are the results of the study valid? (Yes/Can't Tell/No)						Section B: What are the results? (Yes/Can't Tell/No)			Section C: Will the results help locally? (Yes/Can't Tell/No)
	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. Is the research valuable?
Bankar, 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Brahme, 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Camellia, 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Deuba, 2016	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Farid-ul-Hasnain, 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gautam, 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hamid, 2010	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Iyer, 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Iyer, 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Khan, 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Nishtar, 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Regmi, 2010	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Regmi, 2011	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

CHAPTER 3. THEORETICAL APPROACH

Illustration 3.1 Theoretical approach artwork

3.1 Phenomenology and lifeworld perspective

3.1.1 Phenomenology and public health

Edmund Husserl's philosophy of phenomenology and its critique of positivism offers a helpful perspective for exploratory research (Creswell, 2012; Finlay, 2002; van Manen, 2016). According to Husserl, cultivating positivism as an ideal and 'superior method to attain truth' would sever scientific knowledge from the everyday world and lead to a dehumanisation of society rather than production of potential benefits (Dahlberg et al., 2008, p. 30). In other words, inquiry which loses contact with people's lived experiences of the world can also lose its importance for everyday people (Dahlberg et al., 2008).

Hemingway (2011, 2012; Ann Hemingway et al., 2015) argues that current and past public health preoccupation with decontextualised goals and superficial measures of quality risks dehumanising research and practice and often neglects the 'lifeworld' – a shared and meaningful world of emotions and memories that is textured, embodied, and experienced by

us and through us every day. Public health trends in the western world[1] reveal a primarily focus on structural changes within society and, in the era of chronic diseases, the potential to blame individuals for their health behaviour. The result, Hemingway argues, has been a research focus on causes and treatment of ill health rather than the promotion of wellbeing through a contextualised people-centred approach. This is partly because health and wellbeing are silent and, in the background, whereas lived illness clarifies what it means to have access to the world by altering one's attachment with the world (Dahlberg et al., 2008).

A phenomenological way of addressing this problem of 'dehumanised science' is to reinstate the everyday human world as the foundation of science. It seeks to avoid the reductionism offered by positivism and its preceding ideas, and instead 'grasp and describe the world as lifeworld' (Dahlberg et al., 2008, p. 36). Phenomenology, then, is the 'science of phenomena, and consequently the science of the world and its inhabitants, the 'things of experience' understood as the world of experience' (Dahlberg et al., 2008, p. 33). Phenomenological research has been defined as having an in-depth focus on 'the meaning of a particular aspect of experience, assuming that through dialogue and reflection the quintessential meaning of the experience will be reviewed' (Rossman & Rallis, 2016, p. 72). As a research methodology, it can be used to identify the essence of the human experiences about a phenomenon as described by participants (Creswell, 2012) and aims to 'uncover the essence of the phenomenon…what the 'thing' is, and without which it could not be what it is' (Hedelin & Strandmark, 2001, p. 79). In this way, phenomenological research allows us to scrutinise and make explicit the often implicit and invisible meanings around everyday experiences of phenomena. Phenomenological research can be considered 'incomplete and tentative' because it is not possible to capture a given experience in its entirety nor describe how all people will experience a particular event (van Manen, 2015, p. 281). However, phenomenological inquiry provides a 'nondualistic, nonreductionist, and holistic view on humans and existence' (van Wijngaarden et al., 2017, p. 1739).

3.1.2 Lifeworld perspective

Phenomenological inquiry is an exploration into the structure of the human lifeworld – the relationship between people and the 'objects' of their world (K Dahlberg, 2018, pers comm, 20 August) 'in everyday situations and relations' (van Manen, 2016, p. 101). Described as the complex and qualitative world in all its aspects, lifeworld represents the pregiven basis of all we experience and is always present as background (Dahlberg & Dahlberg, 2020;

[1] Germ theory of disease and scientific rationalism of the late 1800s, materialist philosophies and socio-political reforms from the 1950s, to the current dominant focus on 'risk' theory of disease causation due to the rise of chronic diseases.

Dahlberg et al., 2008; Dahlberg & Dahlberg, 2004; Thoresen et al., 2011). Although it is often silent and taken for granted without question or reflection, the lifeworld is a shared and meaningful world where we live 'bodily, physically and practically' (Thoresen et al., 2011, p. 258). It can be interpreted through five aspects, or domains, which describe how human beings inhabit and experience this intersubjective world of meaning: lived time (temporality); lived space (spatiality); lived relationships (intersubjectivity); lived body (embodiment); and lived emotion (mood).

Temporality is subjective time as experienced by human beings, rather than an objective 'clock' time (van Manen, 2016). It is the 'temporal way of being in the world' experienced through the landscapes of past, present, and future (van Manen, 2016, p. 104). Lived time may be experienced on a spectrum: appearing to speed up when we are enjoying ourselves or slow down when we are unwell or anxious (van Manen, 2015, 2016). It may offer options and possibilities in the present and future; or it may become oppressive, overly rigid, and dominant (Hemingway, 2011).

Spatiality refers to felt space; our experience of, and interactions with, living in the physical and social world around us 'affects the way we feel' (van Manen, 2016, p. 102). Our experience of walking through an empty open field could be different from our experience of walking through a crowded street, for example. To understand the nature of a phenomenon, 'it is helpful to inquire into the nature of the lived space that renders that particular experience its quality of meaning' (van Manen, 2016, p. 102). Experiences have their own modality of lived space and can impact our health or health behaviour (Hemingway, 2011).

Intersubjectivity refers to the lived relationships with others that are maintained within the interpersonal space that we share with them (van Manen, 2016, p. 104). Our capacity for language extends our understanding and shared meanings in our world. Through intersubjectivity we make sense of our interpersonal world and others who share it which, in turn, allows us to frame our thinking, our identity, and our relationships in time and space. Intersubjectivity also helps us navigate our cultural and traditional contexts which has an impact on our self-perception and how we view others.

Embodiment refers to the fact that 'we are always bodily in the world' (van Manen, 2016, p. 104). We experience the world by living with and through our bodies; our perceptions of our context, its possibilities and limits, and the psychosocial and sociocultural aspects. Embodiment is the means by which humans biologically incorporate physical and social environment they inhabit throughout their lives. Embodiment is also relevant to the

distinction between disease – abnormalities in structure and function of organs – and the lived experience of illness (Hemingway, 2011; A. Hemingway et al., 2015).

Mood greatly influences lived experiences and helps shape – and is, in turn, influenced by – other dimensions of the lifeworld. Manifested and experienced through the body, mood is a powerful messenger of the meaning of our situations. It is an essential element of how we are as humans and affects our ability to realise our potential (Hemingway, 2011). For example, anxiety reveals a very different lifeworld than joy and sorrow with implications on wellbeing and quality of life. Like embodiment, this aspect of the lifeworld is relevant to the lived experience of illness and the way in which ill health acquires social significance within particular contexts (Hemingway, 2011).

These five aspects of the lifeworld are not abstract concepts and can be used to better understand multifaceted, contextual and meaningful accounts of illness and wellbeing (Thoresen et al., 2011). Within the context of medical care, for instance, the struggle between the voice of the lifeworld and the voice of medicine in doctor-patient interactions fragments and supresses meaningful patient accounts, often resulting in less effective care (Barry et al., 2001). It is argued that increasing the use of the lifeworld could provide better outcomes and more 'humane' treatment of patients as unique individuals (Barry et al., 2001).

3.1.3 Embodied selfhood

The lifeworld framework with its interlinking domains emphasises how a phenomenon is simultaneously a part of the embodied, relational, and collective lived experiences across space and time. Within phenomenology, the intertwining between the 'inside' and the 'outside' found in our embodied perception can be understood as a 'double being-in' (Mensch, 2018; Wehrle, 2020). The embodied self is both subject and object as it experiences worldly things and is also experienced as a thing in the world (Wehrle, 2020). Our embodiment places us in the world and we internalise this embodiment through perception (Mensch, 2018). This 'double being-in' is of temporal significance as it enables us to not only experience the present, but also experience a remembered past and a future that is planned (Wehrle, 2020). The self can be viewed as a phenomenological, temporal manifestation, and as an agent of interaction and morality (Mookherjee, 2013).

Sedikides and colleagues further elaborate selfhood as the co-existence of 'the three selves' – individual, relational, and collective – so that we find ourselves alternating between 'perceiving the self as a distinct individual, as a relational partner, or as an interchangeable group member' (Sedikides et al., 2011, p. 98). These selves may not be of equal important

and may have different motivational utility across space and time. The individual self attributes selfhood as relatively independent of relational bonds or group memberships, while the relational and collective self reflects interpersonal attachments shared with close others or ingroups (e.g. kinship, gender, religion). Table 3.1 provides a summary of the tripartite selfhood and its relevance within South Asian research.

It is worth noting the primacy of relational selfhood in shaping notions of sexuality and gender within the context of South Asian countries like Bangladesh. Here, family is understood as a matter of extended kinship and co-dependency beyond just the realm of economics (Karim, 2012). Bangladesh is a highly patriarchal society with men having control over women's labour, sexuality, income, and assets in both public and private spheres (Kabeer, 1994; Karim, 2010). Women are often taught and made to depend on male 'guardians' – fathers, husbands, and sons – throughout their lives, which also contributes to the pressures of upholding the norm of heterosexual procreative marriage (Karim, 2010). Within this context, self-representation may reflect valued attachments to kinship and conformity to sexuality norms as influenced by relationships and social groups (see Table 3.1).

While it is important to contextualise selfhood within South Asia, we must also be aware of how 'ethnocentric biases' between the individual – presumed western, rational, autonomous, and essential for modernity – versus the collective – presumed static, identity of 'non-west' and its inhabitants – play out in global discourses (Mookherjee, 2013). Academic and policy discussions have often comprehended South Asian selfhood solely through various collective categories like kinship, religion, and community. Relying exclusively on collective narratives risks collapsing localities and their characteristics. For example, anthropological research on Bangladesh which attribute shame as being 'natural' to Bangladeshi women can lead to specific research topics becoming associated with 'bounded' groups and locales (Mookherjee, 2013).

The concepts of personhood are relevant to understanding the sexual self and self-perceptions – including sexual body-esteem, perceptions of sexual desire and pleasure, and sexual self-reflection. For the purpose of this research, I understand sexuality as part of the individual, relational, and collective lived experiences. This encompasses erotic desires, practices, and identities as well as the discourses and social arrangements which construct these possibilities (Karim, 2010).

Table 3.1 Summary of selfhood (individual, relational, collective self)

	Individual self	Relational and collective self
Description	- Highlights unique 'self'. - Consists of attributes (e.g., traits, aspirations, experiences, interests, behaviours) that differentiate from others. - Self-representation relatively independent of relational bonds or group memberships.	- Highlights interpersonal/intergroup 'self'. - Attributes shared with close others/ ingroup (e.g. kinship, gender, religion) and roles defined within relationship/ differentiated from others. - Self-representation reflects valued interpersonal attachments/social groups.
Motivational utility	- Resistant to unfavourable feedback but welcoming of favourable feedback. - Motivated to maintain or elevate self-image and to protect against possible deflation of self-image.	- Desire for formation of stable attachments, enhance and protect relationships. - Conformity influenced by relationships/ social groups.
Discourse	- Presumed Western, rational, autonomous, self-marked by freedom, potential and choice. - Deemed essential for modernity.	- Presumed collective, static, identity of 'non-west' and its inhabitants. - 'Natives' confined to places by connections to what place permits/restricts.
South Asian scholarship	- Historians in South Asia turning to individual sensibilities and person-centred self-representations (e.g. life stories, narratives, biographies) which have often been deemed inadequate sources of anthropological and ethnographic value.	- Past anthropological scholarships on South Asian personhood comprehended only through various collective categories (e.g. attributing shame as being 'natural' to Bangladeshi women) which contributed to holism.

Adapted from Mookherjee (2013) and Sedikides, Gaertner & O'Mara (2011)

3.1.4 Reflective lifeworld research

Reflective lifeworld research (RLR), as outlined by Dahlberg and colleagues, is concerned with how the implicit and tacit become explicit and heard, and how the assumed becomes problematised and reflected upon. As a methodological tool with which to reveal and understand the multifarious world of human beings, the overall aim of lifeworld research is to describe and elucidate the lived world in a way that expands our understanding of human experience (Dahlberg et al., 2008, p. 37). The concept has been used in several health-related studies looking at different phenomena such as sexual health, cancer, diabetes, and end-of-life care (Carlsson-Lalloo et al., 2018; Carlsson-Lalloo et al., 2021; Draucker et al., 2009; Klaeson et al., 2012; Thoresen et al., 2011). For example, a recent study uses RLR to find that the essence of sexuality and childbirth as experienced by women living with HIV in Sweden is that perceptions about contagiousness profoundly influence sexual behaviour and considerations around pregnancy and childbearing (Carlsson-Lalloo et al., 2018).

van Manen (2016) explains that there are multiple and different lifeworlds belonging to different human realities. For instance, the lifeworld of a child may have very different

experiential qualities than that of an adult. Moreover, lifeworld is dynamic and changing: we inhabit different lifeworlds at different times of the day, 'such as lived world of work and lived world of home' (van Manen, 2016, p. 101). In a phenomenological study about end-of-life hospice care in Norway, we see how the concept of lifeworld is significant as it raises 'attention towards what kind of knowledge and practice is present in hospice care' and helps look for dimensions as connectedness and relations in hospice practice (Thoresen et al., 2011, p. 262). The findings of this study emphasise the importance of human interactions – or 'lived relationships'. The meaningful dimensions in the life of someone close to death in a hospice could, of course, have different experiential qualities from someone who is homeless, for example. Stolte and Hodgetts (2013) explore the lived experiences of a homeless man in Auckland, New Zealand and illustrate how this individual has adopted certain 'health tactics' within, what the authors refer to as, a 'homeless lifeworld'. The emphasis in Stolte and Hodgetts' study is on how homeless people inhabit and transform unhealthy surroundings – or lived space – in order to maintain their health.

Principles of bracketing and bridling

'Bracketing' is a fundamental methodology in phenomenology to mitigate potential deleterious effects of 'unacknowledged preconceptions related to the research' and thereby increase the rigour of the study (Tufford & Newman, 2012). The process involves researchers setting aside – or 'bracketing off' as one would in a mathematical equation – any a priori knowledge, understandings, and assumptions about the phenomenon of interest so as not to influence participants' understanding of the phenomenon (Neubauer et al., 2019).

Dahlberg and colleagues (2008) expand on this practice in RLR by introducing the concept of 'bridling'. The authors describe this as: questioning pre-existing understandings and not limiting 'research openness'; not being too quick, careless, or slovenly when trying to understand the phenomena or participants; and directing energy into an 'open and respectful attitude' towards the phenomena or participants (Dahlberg et al., 2008, p. 130). A researcher is asked to 'keep in check' 'evolving understanding so that it does not happen randomly or too fast' (Dahlberg & Dahlberg, 2020, p. 3). The practice of bridling requires us to question our own understanding of a phenomenon rather than taking it for granted. In so doing, we open ourselves up to many possibilities of understanding (Dahlberg & Dahlberg, 2020).

Bridling is a methodological principle of reflective lifeworld research where researchers need to embody a phenomenological attitude by adopting an openness and flexibility towards the phenomenon under study (Dahlberg et al., 2008). It is a reflective attitude which aims to slow down the process of understanding as a whole, making what is not directly

visible become visible. It includes restraining one's preunderstanding and avoiding the act of defining what is undefinable (Dahlberg & Dahlberg, 2004). This is fundamental for research validity and transferability in studies where such a design refers to an investigator's identification of vested interests, personal experience, cultural factors, assumptions, and hunches that could influence how they views the study's data.

3.1.4 Queer(ing) phenomenology

In order to understand lived experiences of sexuality, is important to recognise tacit structures – such as socio-sexual norms – that influence sexual behaviour as well as the way sexuality is perceived and described (Collumbien et al., 2014). One such socially-enforced norm which controls expressions of human sexuality is presumed/compulsory heterosexuality (Ahmed, 2006; Collumbien et al., 2014).

In Queer Phenomenology, Sara Ahmed (2006) further explores how some social orientations – such as gender or sexual orientation – direct us in certain ways throughout our lives and come to be seen as neutral and normal starting points from which we experience the world. Using the concept of orientation within phenomenology, Ahmed (2006) develops a compelling argument around how 'heteronormative lines' – lines upholding compulsory heterosexuality, gender conformity, procreative marriage, and nuclear families – direct us in certain ways throughout our lives and come to be seen as neutral and casual starting points from which we experience the world. Ahmed explains that sexual orientation does not position homosexual and heterosexual figures as equivalent. Rather, it is the homosexual who is constituted as having 'orientation'; the heterosexual is presumed neutral while the homosexual is someone who deviates from the straight line. In this way, compulsory heteronormativity is a 'straightening device' that we are oriented towards, rather than a neutral or casual starting point.

'Straightening devices' are described as the mechanisms used to enforce the repetition of actions over time; keeping us aligned to heteronormative lines and ensure things do not become 'wonky' or 'queer'. However, these straightening devices have a way of disappearing from view and can also be that which we do not feel consciously. These lines are not static and neutral but the effects of the repetition of bodily and social actions over time: lines repeatedly traced over other lines (Ahmed, 2006). We acquire our orientations as certain objects are available to us because of lines we have already taken. Ahmed gives an example of the heterosexualisation of public space as naturalised by repetition of different forms of heterosexual conduct. Streets record the repetition of acts – heterosexual intimacy, billboards – and the passing by of some bodies and not others (Ahmed, 2006). If one does not inhabit the norm of heterosexuality, the so-called comforts of heterosexuality may feel

uncomfortable. Queer people might be asked not to make others feel uncomfortable, by not displaying signs of queer intimacy in heteronormative spaces. In this manner, availability of comfort for some bodies may depend on the labour of others, and the burden of concealment. Becoming straight means not only turning towards the objects that are given by heterosexual culture, but also turning away from objects that take us off this line (Ahmed, 2006).

Ahmed (2006) notes that life courses follow a sequence which is a matter of being directed in a certain way: birth, childhood, adolescence, marriage, reproduction, and death. For a life to count as 'decent' it must take on the direction promised as a social good, which means reaching certain points along a life course. In such a case, a queer life within straight culture might be one that fails to make such gestures of return – by not conforming to expectations of procreative marriage, for instance. In refusing to follow the lines of heterosexuality, one has failed to attain heterosexuality; in not being presumed as heterosexual, one has to 'unbecome' heterosexual. This deviance of falling 'out of line' is narrated as a loss of the possibility of happiness within queer lives and, from a lifeworld perspective, can offer insight into meanings of wellbeing.

3.2 Theoretical framework of study

For the purpose of this research, I use a phenomenological lifeworld perspective to capture people's experience of the world (Patton, 2015). Such a perspective is 'oriented towards health' (K Dahlberg, 2018, pers comm, 20 August) and enables us to see that ill health can be related to biology, for instance; but, at the same time, the lifeworld perspective can be used to explore how the 'experiential side' has a particular meaning for the person and must be attended to in order to better understand wellbeing (Dahlberg et al., 2009). Indeed, 'there is more to say about sick people than is told in biomedicine' (Mol, 2002, p. 13). For the purpose of this research, therefore, phenomenology can be used as a tool towards grasping the meanings that young people give to their everyday experiences of sexuality in order to gain a deeper understanding of young people's experiences of sexual health and wellbeing within the context of their lifeworld. Figure 3.1 illustrates the theoretical framework which incorporates these concepts and is used for this study.

In terms of age range, a simplified life course can represent an age sequence: from childhood and adolescence to adulthood and old age. One may be expected to reach certain social requirements – such as marriage or employment – at certain points along a life course in order for that life to count as a 'good life' (Ahmed, 2006). What these requirements mean, as well as the consequences of failing to fulfil them, will be discussed with young respondents transitioning from adolescence to adulthood. Sawyer and colleagues (2018) suggest that the

transition to adulthood can continue 'well into the 20s' while Arnett (2000) theorises this transition of 'emerging adulthood' as the period from 18 to 25 years.

Individual characteristics have been labelled as 'social orientation' (Ahmed, 2006), as these are not static and neutral categories, but are what comes into view; not simply given but effects of the repetition of actions over time. These social orientations, too, interact with and through the lifeworld. Finding one's 'here' – inhabiting space as an educated heterosexual man, for example – is the starting point of one's orientation and a way of seeing what is 'there' – such as 'deviant' bodies inhabiting less familiar spaces, as mentioned in the previous section.

The theoretical framework of the study situates the five domains of lifeworld at the centre of its analysis as a means of understanding the phenomenon of sexuality. Lived experiences interact with the lifeworld domains – shaping, and being shaped by, life events. Appropriate data generation and analysis methods, as outlined in the methodology section of this document, will be used to better understand the 'lifeworld' of participants by focusing on their descriptions of lived experience and important life events as identified by the research participants themselves (van Manen, 2016). One cannot escape or live outside lifeworld as we are bound to subjectivity as well as to objectivity. Being bodily, socially and culturally, and with a lifeworld theoretical approach, there is no absolute zero from where to explore the world, because we experience, perceive or explore from a perspective and are always directed towards something, and in this relationship is meaning (Dahlberg et al., 2008).

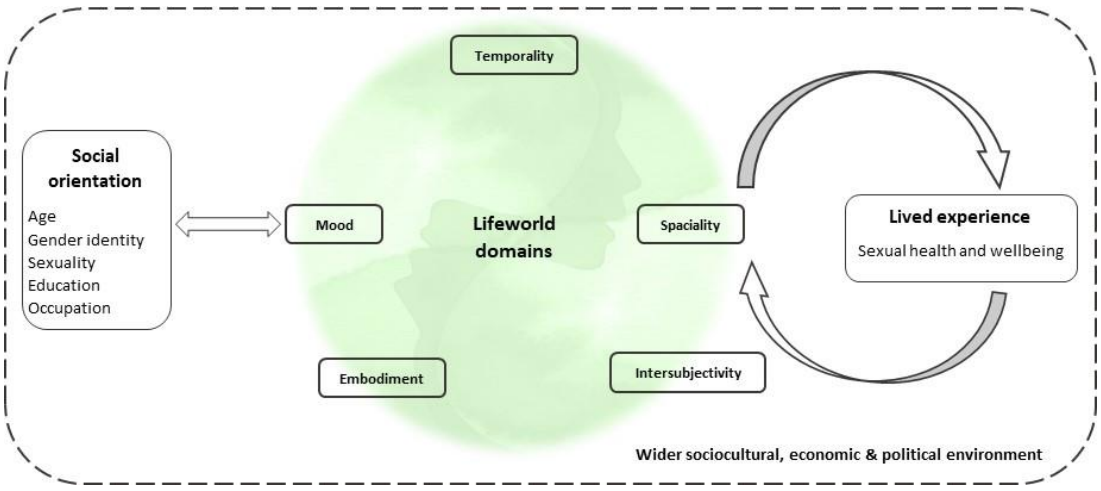

Figure 3.1 Theoretical framework of study

CHAPTER 4. METHODOLOGY

Illustration 4.1 Methodological word cloud

4.1 Research approach and paradigm

The underlying epistemological assumption of this study is that meanings are varied and multiple, leading researchers to look for the complexity of views rather than narrow findings into a few categories or ideas (Creswell, 2012; Silverman, 2017). As a researcher, I take the position that knowledge is contextual, and meanings and understandings are co-produced (Mason, 2017). In order to address the research objectives, my study design is qualitative from a social constructivist paradigm using phenomenological methods to collect experiential accounts of sexuality. Furthermore, I explore meanings young people in Bangladesh attach to their everyday experiences of sexuality through a phenomenological lifeworld approach which is methodologically suited for this epistemological position. While the study focus is the meanings and experiences of participants, I also acknowledge that researchers are as much a part of the research process as those being researched. Understanding knowledge creation as relational helps us move beyond assumptions about a dichotomy between 'objective science' and 'subjective experience' (Renedo et al., 2018). As such, I cannot claim to follow a 'pure' phenomenological approach. In this study, phenomenology relates to the 'essence' of what participants' experience (textural descriptions of consciousness or space, for example) and social constructivism focuses on the context influencing this experience (van Manen, 2015, 2016).

In general, qualitative research tends to seek answers to questions about 'what', 'how' or 'why', rather than 'how many' or 'how much' (Green & Thorogood, 2014). Qualitative inquiry aims to embrace nuances, complexities, and lived experience (Green & Thorogood, 2014). In this way, a qualitative study design is suitable for my research interest as it can provide an understanding of the sociocultural context in which sexuality is 'lived' – with an emphasis on meanings, experiences, and views of participants (Pope & Mays, 2006). Additionally, because of its flexibility, a qualitative approach 'encourages discovery and further investigation of the unexpected' and can be used to probe 'more deeply into the factors underlying decisions or attitudes' (Collumbien et al., 2014, p. 37). Thus, research of this kind attempts to interpret social phenomena in terms of the meanings people bring to these, and requires that the researcher frequently question and unpack common-sense assumptions and norms around the topic of interest (Pope & Mays, 2006).

Research decisions – such as the framing of objectives to be explored in this study and the methods of collecting experiential data – are not neutral and are partly governed by researcher's values and also reciprocally help to shape these values (Guillemin & Gillam, 2004). Consequently, the methods of data generation are dependent on the aims of my study. Different approaches vary in terms of underlying philosophical assumptions and emphasise different methods as well as values and techniques for maintaining research quality. Thus, it is important to clarify these decisions as it 'makes explicit the basic assumptions underlying the research' (Collumbien et al., 2014, p. 21). As Guba and Lincoln (1994, p. 108) eloquently stated, methodology 'cannot be reduced to a question of methods'; it must be fitted into a predetermined methodology through ontological and epistemological decisions. One must, therefore, ask the following interlinked questions:

1. What is there to be known?
2. What is the nature of the relationship between researcher and what can be known?
3. How can the researcher find out whatever they believe can be known?

My aim was not to measure a 'real' social reality as an 'objective' inquirer through the selection of appropriate methods that control for potential confounding factors to reduce bias (Guba & Lincoln, 1994). This kind of positivist paradigm is traditionally attributed to quantitative research where the purpose is to be able to discover, measure and report 'how things really are' and remove biases from data generation and analysis. While the tenets of positivism are based on universal laws, with an emphasis on objectivity and neutrality, post-positivists assert that social reality can only be approximated, not apprehended.

As mentioned, the starting point for my epistemological research stance is that realities are locally and specifically co-constructed and interpreted through the research process – by

both the researcher and the participants (Green & Thorogood, 2014; Rapley, 2001). Thus, as a 'constructivist researcher' I position myself as a co-producer of versions of the respondents' realities through my research rather than that of an invisible and objective inquirer. Data generation through interviews offers indirect representations or accounts to people's experiences rather than directly telling us about people's experiences (Silverman, 2017). These accounts are 'a window through which to view the various possible ways that the topic of the interview can be talked about' (Rapley, 2001, p. 304). In this way, constructivism can be seen to foster relativity and reflexivity rather than generality and objectivity (Charmaz, 2006). The goal is to rely as much as possible on the participants' views of the situation by attempting to minimise the distance or objective separateness between research and those being researched (Guba & Lincoln, 1994). As such, research following a constructivist paradigm may incorporate broad and general questions so that participants can construct meanings of a given situation. Unlike post-positivism, constructivist research does not begin with theory but instead inductively develops patterns of meanings (Creswell, 2012). These meanings are also often socially and historically negotiated; formed through interactions with others and through cultural norms that operate in an individual's life.

Given that my proposed research will explore lived experiences of sexuality from the perspective of young people in Bangladesh, phenomenological and narrative research methods are well suited for this focus on individuals and their experiences of the phenomenon of sexuality within the sociocultural context of urban Bangladesh (Creswell, 2012; Dahlberg & Dahlberg, 2020; Dahlberg et al., 2008). Narrative research aims to explore the life of individuals through life histories, while phenomenological research aims to understand the meaning of experiences of individuals on a shared phenomenon or concept. Table 4.1 highlights some salient characteristics of the selected qualitative approaches which were incorporated into the study from research design to report writing.

Table 4.1 Characteristics of phenomenological narrative approaches

Research focus:	Exploring life of individual and understanding meanings attached to experiences of sexuality
Type of problem:	Young people's narratives and lived experiences of sexuality
Unit of analysis:	Several individuals with shared experience (i.e. of sexuality in Dhaka)
Data generation:	In-depth interviews, observations, literature review
Data analysis:	Analysing data for significant statements and narratives, meaning units, textural and structural description, description of 'essence'
Written report:	Describing themes around 'essence' of the experience and developing narrative about stories of individual's life

Adapted from Creswell (2012)

Phenomenology (as outlined in Chapter 3) describes the meaning of lived experiences of a concept or phenomenon in order to 'grasp the nature of the thing'; the focus here is on the phenomenon being experienced rather than the lives of individuals (Creswell, 2012, p. 58). By looking to capture variations of shared lived experience, phenomenology allows the 'essence' of that common experience to be described – for example, what are the meanings of becoming sexually active for those who have experienced sexual intimacy? The phenomenon of interest for this research is sexuality and specific life events associated with sexuality such as sexual intimacy or consent. Narrative research focuses on studying individuals, gathering data through the collection of their stories, reporting individual experiences and ordering the meanings of those experiences through an individual's life course (Creswell, 2012). Data can take the form of spoken or written text which give accounts of an event or events that are chronologically connected. Both narrative and phenomenological inquiry can be used to study the multidimensional nature of a phenomenon and meanings (Patterson, 2018). This study situates itself within the discipline of sociology/social psychology and makes use of a predominantly phenomenological perspective with elements of narrative inquiry to address the research objectives (as presented in Chapter 1) by collecting experiential data through biographical in-depth interviews as well as field observations and relevant review of literature (see Chapter 2).

4.2 Data generation

4.2.1 Research team and local support

I recruited and worked with four research assistants – two men and two women – at different points during data generation. All four had previous experience in qualitative ethnographic research and interviewing and had excellent references from their previous workplace. The research assistants were all in their mid-20s and provided invaluable insights as locals growing up in Dhaka. As they were knowledgeable in qualitative research, I was able to have conversations with them around data generation tools, sampling strategies, and logistical challenges of data generation. They also assisted in discussing colloquialism and cultural references that I was less familiar with having been out of the country during most of my adolescence. One of the main reasons I wanted to recruit research assistants was that I wanted support while in Bangladesh so I would not feel isolated with my work. My supervisory team was mostly based in England, and I was not formally affiliated with a host organisation in Bangladesh. I wanted to have people in Bangladesh who were familiar with the topic and my research objectives so that we could have in-depth discussions about everyday challenges as well as interrogate research decisions together.

I organised five days of training with each research assistant to familiarise them with the theoretical framework, research topic, study approach and objectives, underlying phenomenological concepts, and the interview guide. The research assistants were primarily responsible for translating interview guides and informed consent forms from English to Bangla, piloting and giving feedback on interview questions, compiling an up-to-date list of SRH resources for respondents, and transcribing interview recordings. They also interviewed 16 respondents who had either requested same-sex interviewers, had scheduling conflicts (e.g. when I was attending events/meetings or interviewing other participants), or accessibility issues (e.g. participants with particularly strong dialects that research assistants could better comprehend, participants who wanted to be interviewed at home in their halls of residence, etc.). I had weekly debriefing meetings with the research assistants to discuss the progress of the interviews and reflect on our experiences.

Before starting data generation, I travelled to Dhaka and contacted several researchers and organisations such as Population Council Bangladesh and Marie Stopes Bangladesh. I was thus able to familiarise myself with current SRH studies being implemented and/or evaluated by these organisations and their partners. With the help of local colleagues – with whom I had worked for a month during a preliminary visit in March 2018 – I was better positioned to gain access to diverse groups of young people across Dhaka for observations. For instance, I was invited to attend a private queer event held by an activist group. Here, I observed that young people raised concerns about their safety and how many had avoided attending queer events since 2016 following the brutal murders of prominent LGBTQ+ activists Xulhaz Mannan and Mahbub Rabbi Tonoy. There were also conversations around the lack of transgender representation within the community. Population Council also arranged for me to attend a workshop for Network for Ensuring Adolescent Reproductive Health, Rights and Services (NEARS) – a national adolescent network – during my preliminary trip and I found that the event was well-attended by young representatives from various organisations around the country. During the workshop, I was able to listen to concerns raised by members of adolescent and youth clubs.

Establishing a strong research network with relevant researchers actively working in the field of sexual and reproductive health did not only benefit data generation – since these individuals were able to provide insight into my topic of inquiry and share templates for informed consent and transcription guidelines etc. – but also as avenues to share findings and evidence-based recommendations that can be feasibly implemented. For this reason, I also engaged with other local contacts. Having worked in Dhaka for five years prior to joining LSHTM, I remain in contact with several professionals from different fields, including

youth/queer activists and researchers. In addition to support from Population Council, I continued to reach out to personal and professional contacts in Bangladesh in order to reach young people with diverse backgrounds and characteristics.

4.2.2 Location

I conducted qualitative in-depth interviews in Dhaka for nine months from February till October 2019. I carried out one-to-one interviews with 46 purposively sampled young people living in different areas of the capital.

The study was set in Dhaka as an urban setting I anticipated would provide access to a diverse and growing population with migration from other parts of the country (Akhter et al., 2021). The rise in the average age of marriage has created 'greater space for social mixing' for young people 'than in any prior generation' in Dhaka (Muna, 2005, pp. xvi-xvii). While this made it difficult to identify married individuals – as the average age of marriage in urban areas is higher than in rural settings – it meant that I had access to a wide range of young people with different social orientations. Thus, I endeavoured to recruit respondents from varying educational and professional backgrounds.

As I recruited participants from different professional and educational backgrounds, they happened to be based in different low- and middle-income residential neighbourhoods of the city. This included precincts (*thana*) in Dhaka North City Corporation – such as Badda, Khilket, Mohammadpur, Mirpur, Tejgaon, and Uttara – as well as Dhaka South City Corporation – such as Dhanmondi, Lalbagh, Motijheel, Ramna, Sabujbagh, and Shahbagh. Annex A provides a map highlighting these locations. While there were no specific exclusion criteria, I did not directly recruit anyone from slum areas (such as Korail Bosti) nor from more affluent areas (such as Gulshan, Banani, Baridhara etc.) as these subgroups have distinct experiences which would not be conducive for closer examination within the scope of this research.

4.2.3 Participants and sampling

Although the inclusion criteria were otherwise relatively flexible and broad – young people living in Dhaka who are willing to share their experiences and perceptions of sexuality – it was important to consider that a heterogeneity of 'social orientations' and lifeworlds may bring up a more diverse range of issues and meanings around sexuality. Figure 4.1 shows the various social orientations that were considered for the study to be inclusive of a wide range of experiences. These social orientations were based on the focus of the study and gaps identified through literature review and communication with SRH researchers in Bangladesh.

Given the lack of research focus on SRH of young people who are 'transitioning to adulthood' in Bangladesh, I recruited participants aged 18 to 24 years to reflect on their lived experiences of sexuality. The study also included perspectives of both married and unmarried young people in Dhaka by purposively looking to recruit people of different relationship statuses.

Figure 4.1 Social orientation of participants

I began by identifying potential respondents based on education and professional backgrounds as an initial starting point to organise recruitment of diverse lifeworlds. This also intersected with socioeconomic status/income/class, age range, and location.

1. University students (from a public university, such as Dhaka University)
2. Entry-level private sector work/internships (such telemarketing, sales, teaching etc.)
3. Informal sector/lower-skilled or part-time work (including ready-made garment, beauty parlours and informal employment) or those not currently working

To recruit students from Dhaka University and other public universities, I initially contacted two current and former students – who had worked with or were known by my networks – to suggest other potential students to approach. My research assistants and I then collated a list of potential respondents according to age, gender, department of study, relationship status etc. We contacted these students and introduced the research via phone. We confirmed their willingness to participate in our study. Similarly, I recruited young people engaged in entry-level private sector work, 'low-paid' work, or those out of work by initially contacting local colleagues to suggest potential respondents to approach.

Although I did not have a minimum number of participants in mind, phenomenological researchers recommend using 5-25 respondents depending on the aim of the study (Creswell, 2012; Green & Thorogood, 2014; Morse, 2000). I interviewed around 46 individuals across these categories – 20 university students and 26 non-students – in order to generate 'information rich cases' (Green & Thorogood, 2014). Although the educational/professional distinction was not explored as analytical units, it assisted in collecting a wide range of narratives from heterogenous lifeworld experiences based on working environment and everyday activities. This also provided a starting point for sampling other social orientations and facilitated the recruitment strategy in terms of identifying students and non-students.

Sexual and gender diverse participants were recruited through personal and professional contacts. These young people were primarily contacted through members of queer advocacy groups in Bangladesh. I had previously worked with these organisations/colleagues and was familiar with their advocacy work. As such, I contacted my networks to enquire about young people who may be interested in taking part in the study. My networks provided phone numbers for LGBTQ-identifying young people whom I then contacted over text and phone.

All participants were aged 18 to 24 and self-identified as coming from middle-class or working-class backgrounds. Most identified as Muslim, while some participants also identified as Christian, Hindu, and Buddhist. The majority had, or were pursuing, university education. Most participants were unmarried, lived with parental families, on campus, or on their own at the time of the interviews. Fourteen participants identified as LGBTQ while the rest identified as cisgender and heterosexual. Table 4.2 provides a summary of sociodemographic characteristics of the 46 participants.

Table 4.2 Summary of participants' sociodemographic characteristics

Characteristic	Category	Number of participants
Age	18-21	22
	22-24	24
Gender identity	Cisgender man [a]	20
	Cisgender woman [b]	21
	Transgender/non-binary	5
Sexual orientation	Heterosexual [c]	34
	Gay/lesbian [d]	8
	Bisexual/pansexual	4
Relationship status	Single	23
	In a relationship	15
	Married	8
Religious background	Muslim	30
	Hindu	9
	Christian/Buddhist	7

Disability	None/unknown	39
	Physical/sensory	4
	Mental	3
Occupation	University student	20
	Full-time employment	13
	Informal/part-time employment	13
Residence	Living with parents/family	22
	Living in rented accommodation [e]	14
	Living in halls of residence/on campus	10
Socioeconomic background	Working class/low income	15
	Middle class/middle income	31

[a] including five gay-identifying cisgender men; [b] including five lesbian- or bisexual-identifying women; [c] including two heterosexual-identifying transgender women; [d] including one gay-identifying non-binary participant; [e] living alone, with spouse, or housemates

4.2.4 Interview guide and process

I used in-depth interviews as my primary data generation method as these are well-suited to exploring in detail the respondents' own perceptions and accounts. The aim of these interviews was not to produce 'factual' accounts but to generate mutually constructed insights into how young people experience, view, and attach meanings to social processes and practices (Mason, 2017; Silverman, 2017). From a phenomenological perspective, interviews are used as an opportunity to elicit conversation around 'textural' descriptions of what participants experienced and 'structural' descriptions of the context that influenced participants' experiences (Creswell, 2012).

I designed an interview guide (Annex B) to reflect my research objectives and theoretical framework with input from my supervisory team. Conversations with people working in the field in SRH in Bangladesh and my own literature review helped to inform the framing of questions. While the structure of interviews was open and flexible, the topic guide of open-ended questions provided a basis for conversational flow. The first part of the interview looked at meanings and perceptions of gender and sexuality. Starting interviews with more neutral topics and discussing perceptions and understandings before delving deeper into lived experiences facilitated rapport between interviewees and interviewer. The intention was that the broader focus would explore contextual narratives as well as inform the potential selection of a shared aspect of sexuality that could be explored in more detail without excluding willing respondents. This was followed by more focussed conversations around life history of sexuality and desire. Towards the end of the interview, interviewees

had an opportunity to reflect on the experiences they had shared throughout the interview and consider moments and changes within the wider context of their life.

I piloted the interview guide on myself and colleagues at LSHTM and Bangladesh before data generation. I amended wording of questions and their ordering before the start of data generation. These initial pilot interviews provided an opportunity to familiarise myself with the interview guide in both English and Bangla (see Annex B and C interview guides). I also revisited the interview guide after each interview as an anchor to reflect on the flow and comprehensiveness of each interview. The lifeworld domains, as outlined in my theoretical framework, were used to iteratively design and redesign questions. In this way, the interview guide was a useful 'living' tool in data generation.

Overall, the lifeworld was conducive to naturalistic conversations and gaining more detailed accounts of sexuality. These conversations involved an awareness/openness to the lifeworld – for both the interviewer and interviewee (Dahlberg & Dahlberg, 2020; Dahlberg et al., 2008). For example, specific negative emotions that came up when speaking of a respondent's romantic future were linked to bad experiences in past relationships (lived emotions, lived time, and lived relationships), or how a respondent's relationships with others were described and interpreted through the body (lived relationships and lived body) etc.

I scheduled interviews with participants after an initial phone and text conversation confirming that they were willing to meet with me. All interviews took place between April and October of 2019. Of the 46 interviews, four participants had to leave the interview session earlier than anticipated and asked to continue our conversation at a later date. I arranged these additional sessions within 2-3 weeks of the initial interview, depending on the participants' schedule. All participants were given a choice of interview venues that were accessible and offered privacy based on where they resided and felt comfortable meeting. Most of the interviews took place in quiet cafes, restaurants, or a private office space where I was based near Badda, Dhaka. Some interviewees also preferred to be interviewed in their home or on campus. Before the start of the formal interview, I typically spoke with respondents for 15-20 minutes about their interests, something they had mentioned on the phone, events of the week, interesting things we had seen/heard on our way to the interview venue etc. I then introduced my research and went through the informed consent form with them. I gave participants some time to read through the form themselves and asked if they had any questions. Once we had both signed the informed consent form, I turned on the audio-recorder and began the interview. All interviews were conducted in Bangla, and each

lasted between one-and-a-half to two-and-a-half hours. Although participants were not paid for their time, I arranged travel to and from interview venues and provided refreshments.

4.2.5 Observations and fieldnotes

As van Manen (2016, p. 69) elaborates: 'The best way to enter a person's lifeworld is to participate in it…[by] assuming a relation that is as close as possible while retaining a hermeneutic alertness to situations that allows us to constantly step back and reflect on the meaning of those situations.' In addition to conversational interviews, therefore, I gained access to experiential material through field observations. I interacted with participants and attended relevant events, meetings and networks with a youth focus. I visited sites of interest that are commonly frequented by young people or referred to during interviews – such as campus canteens, parks, and restaurants.

In particular, I was interested in observing discussions around perceptions of sexuality and socio-sexual norms; the language being used to discuss sexuality and sexual health; sexual health concerns being raised and how these are being framed; which lifeworld domains 'show up' in conversations; and general interactions between young people, their peers and adults. I kept a detailed field diary where I recorded all observations and activities carried out during my fieldwork. I used fieldnotes to contribute towards reflexive practices and coded and analysed these as part of my thesis.

I collected and analysed pertinent secondary documents – e.g. materials identified as relevant in shaping discourse around sexuality in Bangladesh – to supplement and add context to data from interviews and observations. In addition, I analysed secondary documents including research papers, survey data, programme evaluation reports, publications by development organisations, and peer-reviewed literature. I obtained information and evaluation reports on programmes from administering and lead organisations and official statistics from domestic and international sources such as Bangladesh Statistical Bureau, the World Bank and the United Nations. Chapter 2 presents a critical literature review of published articles to situate the findings of the study within a South Asian context.

4.3 Data analysis and dissemination

4.3.1 Transcription and translation

Verbatim Bangla transcription was completed by research assistants using a transcription protocol I adapted from Marie Stopes Bangladesh. Transcription was completed alongside data generation as and when interviews were completed. I reviewed all Bangla transcripts

before having these professionally translated from Bangla to English. I then listened to recordings and referred to the Bangla transcripts when reviewing translated transcripts. Several transcripts were reverse translated and reviewed for quality checks both by my research assistants and by me.

I coded on English transcript files using NVivo and also referred to audio recordings. Three of the interviews were not translated due to difficulties in understanding/transcribing broken speech patterns. I coded these interviews directly from audio files with the same coding software.

4.3.2 Coding and analysis

As preparation and analysis of qualitative data was expected to be time consuming and labour intensive, I carried out preliminary analysis alongside data generation (Pope et al., 2000). Not only did this allow questions to be refined and new avenues of inquiry to develop, but it also enabled me to explore emerging patterns across interviews in 'real time'. This process followed iterative cycles of capturing and writing reflections towards a robust and nuanced analysis while considering how the data contributes to evolving understanding of sexuality (Neubauer et al., 2019). As with many other phenomenological studies, I followed an overall thematic approach to analysis as this provided flexibility to interpret findings by identifying and synthesising most prominent and recurring meanings and themes (Braun & Clarke, 2014; Creswell, 2012; van Manen, 2015, 2016). Figure 4.2 illustrates the five stages of phenomenological analysis.

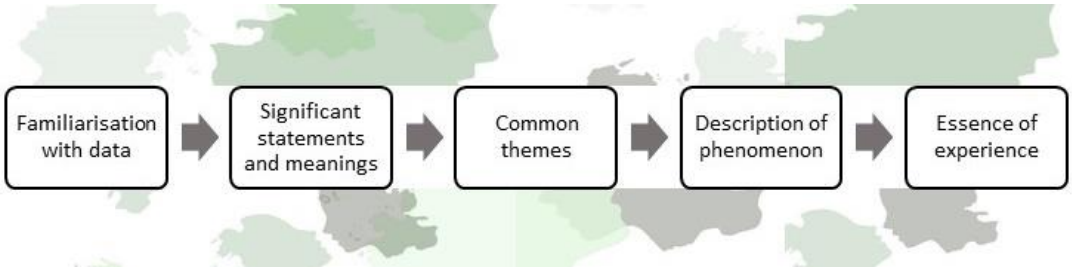

Figure 4.2 Stages of phenomenological analysis

I listened to all interview recordings multiple times during and after data generation. All interview transcripts and related fieldnotes were read and reread in order to be familiar with the data, and I then adopted an iterative coding process to develop, review, and analyse themes across different interviews. Coding was carried out electronically using NVivo software. I used the theoretical framework of this study (see Chapter 3) to guide the synthesis and analysis of these themes and incorporate different lifeworld domains into the analysis.

I coded transcripts line-by-line, to identify inductive, in vivo codes as well as themes I had identified while listening to and rereading interviews. While I used open coding, I paid particular attention to participant descriptions of social phenomena as well as discussing the perceptions pertaining to these. After the completion of first level coding, I started to develop a coding framework inductively from the entire data set (Charmaz, 2006). Completed interviews were then analysed to identify the meaning of participants' experience and develop a composite description to better understand the 'essence' of this phenomenon (Creswell, 2012).

I synthesised and presented my analysis of empirical data into three separate research papers: lived experiences of heteronormative straightening devices; sexuality and sexual violence; and lifeworld of sexual intimacy. For the first research paper on findings (Chapter 5), I focussed on common themes around socio-sexual normativity as experienced by queer participants. In particular, this involved analysis on participants' accounts of encountering heteronormative straightening devices. Analysis for the second findings paper centred on young people's lived experiences and their perceived challenges of navigating sexuality, specifically sexual violence. For the final paper (Chapter 7), I developed an inclusive description of the 'sexual intimacy' by incorporating all relevant themes. I used this to produce the fundamental structure by condensing description down to a short, dense statement that captures just those aspects deemed to be the essence of the phenomenon (Figure 4.2). In this way, the lifeworld domains shaped analysis of young people's experiences of sexuality.

4.3.3 Dissemination and accessibility of findings

Other than disseminating findings to academic audiences through journal articles (Chapter 2, 5, 6, 7), I had planned to organise three workshops in Bangladesh to share preliminary findings in 2020. However, I was not able to travel due to the coronavirus pandemic, so these workshops have been rescheduled for the end of 2022. Group interactions through dissemination workshops would foster discussion and perhaps challenge or expand on some of the findings in this study (Creswell, 2012).

I plan to share information with sexual and reproductive health researchers (organised in partnership with local organisations such as Population Council Bangladesh), with Public Health students (organised with North South University) as well as with other university students, and other demographic groups included in the study. I also plan to prepare a collection of stories as vignettes as well as policy briefs in Bangla and English to be distributed through my networks in Bangladesh. I facilitated a creative public engagement

workshop – ‘Sexual diversity in public health research: Creative workshop with LGBTQ+ youth’ – in Dhaka 2019 with funding from LSHTM – where similar strategies helped to foster conversation. I plan to use these networks again when disseminating findings from my thesis.

4.4 Ethical considerations and reflexivity

Ethical approval for all data sources was obtained from LSHTM and North South University (NSU), Dhaka (see Annex D and E). Additionally, I referred to ethical guidelines set out by the Economic and Social Research Council (ESRC) – who funded my doctoral studies – and the Association of Social Anthropologists of the United Kingdom and Commonwealth. Local organisations, including Population Council and Marie Stopes, assisted in discussing potential risks and how to best assess and mitigate possible concerns in the field. Prior to data generation, my research assistant and I spent time familiarising ourselves with in-country safety protocols to meet the safety needs of all participants and to know what actions can be taken if participants report incidents of sexual violence or any other type of abuse. I also consulted wider literature and adhered to global guidelines on domestic violence and gender-based violence research – including Partners4Prevention’s document on ‘Ethical and Safety Guidelines for Research on Gender-based Violence’, World Health Organization’s ‘Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies’, and Ellsberg and Heise’s paper ‘Bearing Witness: Ethics in Domestic Violence Research’ (2002).

Additionally, I prepared a list of reputable services for participants who wanted to receive more information about sexual and reproductive health. This included referring participants who may require care and support from reputed legal aid services – such as Bangladesh Legal Aid and Services Trust (BLAST) and Ain o Salish Kendro (ASK) – and young people’s counselling services/helplines – such as Naripokkho, Kaan Pete Roi and Plan International’s ‘Dosh Unisher Mor’. These organisations have a track record of providing quality and youth-friendly services.

Population Council and Marie Stopes International shared informed consent form templates which I referred to and adapted. I obtained written consent from respondents who agreed to voluntarily participate in the study. The information was made available in both Bangla and English (see Annex F and G). Participants were also given a copy of the signed informed consent form for their reference. All respondents were informed about the nature of the research and their right to decline involvement and to refuse participation at any time. To ensure confidentiality and anonymity, the identities of, and information that can be used to

identify, respondents were not disclosed in any communication concerning this research. Voluntariness of participation was emphasised with all potential participants who I contacted firstly via text message/email, and then via phone. Voluntariness was also emphasised before and during the interview.

My supervisory team and local partners Population Council assisted me in reviewing topic guides, discussing potential risks and how to best assess and mitigate possible concerns in the field. As mentioned, I referred to in-country safety protocols to meet the safety needs of all participants and to know what actions can be taken if participants report incidents of sexual violence or any other type of abuse.

Given Bangladesh's sexual conservatism and lack of queer rights, protection of confidentiality and privacy of respondents was paramount to ensuring physical safety. The interview venue was selected based on safety and privacy of participants and the researcher. All interview venues were agreed upon by respondents – such as their home or a friend's home – and my research assistants and I carried out a scoping exercise to various sites to locate venue options which ensured privacy and confidentiality could be maintained. All recordings were stored in encrypted devices, all identifiable data was erased, and all quotations were anonymised. Verbatim transcription and translation were done by research assistants and professional translators who all signed a confidentiality agreement (Annex H) and deleted all interview files after the completion of their contract. All other interview notes and fieldnotes were stored in encrypted password protected files. A data management plan, as outlined in Annex I, was followed.

In terms of psychological distress, I pre-tested the interview guide with queer colleagues to improve sensitivity of content and identify potential triggers and how to mitigate these. I also did not interview prominent activists in order to avoid unwanted attention from law enforcement. My research assistants and I continued to do ongoing risk assessment (activity, hazard, who might be harmed and how, measures to control risk, likelihood etc.) for all respondents and researchers.

As mentioned in the previous chapter, I take a reflexive stance as this aligns with my underlying ontological and epistemological assumptions. Although not synonymous with bridling, reflexivity also involves the critical scrutiny of knowledge construction and reproduction across all stages of the research process (Finlay, 2002). As a strategy for quality control, reflexivity ensures more rigorous research rather than focussing on reducing bias (Finlay, 2002; Guillemin & Gillam, 2004; Rapley, 2001). Green and Thorogood (2014, p. 230) underscore four good practices that demonstrate 'reflexive awareness of the research process and increase the rigour of analysis':

1. Methodological openness: Being explicit about steps taken to ensure data protection and analysis, decisions made, alternatives not pursued.
2. Theoretical openness: Being clear about starting points and assumptions made, accounting for ways in which they shape the study.
3. Awareness of social setting: Constantly being aware that in interviews or fieldwork, 'data' results from interactions.
4. Awareness of wider social context: Being aware what/how socio-political values made possible this research, as well as constrained it, and how contexts shape data.

Furthermore, I refer to Rae and Green's (2016) 'reflexivity matrix' for health systems research as a practical guide to consider at different research stages – pre-research, during data generation, and analysis (Table 4.3). I initially used the reflexivity matrix to encourage reflexive thinking around my positionality within the research (see Annex J) and returned to the table while keeping a reflexivity diary during data generation and analysis.

Table 4.3 Reflexivity matrix

	Social space	**Space of specialists**	**Scholastic space**
Pre-research	- How does researcher's broader motivations affect reason to conduct research in the first place, choice of topic and research question, and choice of methodology? - What is researcher's conceptualisation of 'health'?	- What is the relationship between researcher and research field? - How is the choice of topic relevant to healthcare?	- Where does researcher's interests lie within relevant literature and its interpretations?
Data generation	- What are shared and divergent understandings between researcher and participants about research and to health-related topic? - Are there any social differences (e.g. gender, education, experience)? - To what extent are meanings negotiated between researcher and participants, and how is this influenced by life experiences? - Is the researcher prepared to undergo change as a result of interaction with research? - What is the potential for change in participant?	- Do researcher and participants share the same language, especially if they come from different health disciplines? - Are there any power differentials between researcher and participant, based on positions held (present or past), health discipline, or education?	- Are questions or prompts inadvertently shaped by popular scholarly opinion?

Data analysis		- How does researcher's experience with the field shape analysis? - Are some data dismissed as being commonplace, whereas they might warrant deeper interrogation? - To what extent does researcher consider balance of analytical authority to rest with participant or with researcher?	- How does researcher moderate any drive for outcomes that might inadvertently lead to data omissions or fabrications?

Adapted from Rae & Green (2016)

4.5 Reflections and methodological limitations

4.5.1 Interview process

One of the main challenges of conducting a study using phenomenological study stems from its reliance on interviews with individuals who are accessible and willing to provide information on a specific phenomenon (Creswell, 2012). We must assume that all research participants can articulate their thoughts and feelings about lived experiences of sexuality. Yet, given the social taboos around sexuality in Bangladesh, it was difficult for some young people to express themselves and share accounts that may be perceived as shameful or controversial.

Although in-depth interviews were an appropriate method for generating narratives given the exploratory nature of this research, additional creative methods of generating data would potentially have added even more depth. Not all participants were able to articulate their experiences in detail. Young people were more able to engage with topics they knew about as was evident from how they spoke about their interests (their hobbies and interests, what they enjoyed, experiences etc.) prior to and during the interviews. For some who had interests in dance, theatre, and art, gender and societal norms were part of their work and in how they expressed themselves through different mediums. For instance, Shaan shared a video of his recent dance performance which was based on his gender identity. We also spent some time looking through his TikTok videos where he presented as a woman and performed to Hindi songs. Similarly, another participant shared their interest in filmmaking and described how the plots of his films reflected his own experiences in different ways (Figure 4.3). Some of these materials could have been collected and analysed through a visual ethnography to understand non-verbal meanings of sexual lifeworlds. However, there were some participants – such as Anika – who said they had no particular hobbies and were most comfortable just 'chatting' about their life.

Group activities and discussions could also have been an insightful addition to constructing collective meanings of sexuality as demonstrated during the public engagement workshop I co-facilitated with queer individuals in Dhaka.

Storytelling

Today SB spoke with me about how he puts all his negative experiences into stories and films as a way of coping. His protagonists seem to face a lot of internal upheaval. He narrated a story where an older man attempts to rape a young girl and accidentally kills her and then goes mad. He linked this to his own experiences of sexual desire and feelings of remorse and self-loathing.

- 14 April 2019

Figure 4.3 Fieldnotes extract A

Recording interviews and conversational flow

At the start of most interviews, I spent some time speaking informally with participants in order to get to know them. After this, we would discuss my research and go through informed consent forms etc. Sometimes participants were quite eager to speak about their lives during these 'introductory' conversations. Often these would flow very organically and having to interrupt this to introduce informed consent forms shifted the verbal energy. However, the audio recording could only be turned on after informed consent forms were signed. As such, much of these conversations, although interesting and relevant, were 'off the record'. Sometimes we would come back to the points of conversations, and I would also take detailed notes from memory after the interview, but generally the 'small talk' was not documented as accurately. At one point, a participant started going into detail about their recent sexual encounter before the 'formal' interview started. I did not interject and waited until the recording started to bring up what they had said to me. But as soon as we had begun recording, the participant lost track of what they had been saying and so we continued with the interview although we returned to their experience later on.

Similarly, most participants did not narrate their lived experiences in chronological order. I attempted to clarify timelines around their experiences by asking for dates and ascertaining whether 'x' happened before or after 'y'. However, I could have paid more attention to the temporal aspect within participants' accounts. Why did event 'x' come up for them when they were talking about even 'y', for instance? This is also true of other lifeworld aspects that may have come up outside of conventional conversational flow.

Co-construction of data and reflexivity

Despite acknowledging that data generation was co-constructed, I was not able to present detailed analysis of my own role in data generation. In fact, I presented extracts from interviews included in the research papers entirely in participants' words and excluded my own voice in the conversation. This was predominantly because my attention was on analysing data around exploratory topics within the structure of empirical journal articles. The actual practice of being reflexive while undertaking research was sometimes elusive and slippery (Nicholls, 2019). Practicing reflexivity takes practice and this research process provided an opportunity for me to develop as a reflexive researcher. However, it was a struggle at times to interrogate my position as a researcher as well as the research process itself without experiencing existential crises! Tools such as the reflexivity matrix (Table 4.3) assisted in negating these feelings in favour of more practical 'solutions'. Nonetheless, I am not yet well versed in addressing my own emotionality within an academic setting and struggled to find spaces to demonstrate reflexivity and question my role in the research within this thesis beyond the purpose of 'rigour' and 'transparency'. Looking back at many of my fieldnotes (e.g. Figure 4.4) and conversations with colleagues and friends, I wish I had taken the time to address my own emotions within this thesis.

Will this make a difference?

H read through the consent form and asked me: "Do you think this research will make a difference?"

This is the first time I was asked this question by a participant, and it gives me the feels. My answer is quite generic: "We can try to at least generate conversation."

I asked him if he is apprehensive. He said no, he was just curious because there had been other projects that had not changed anything – in fact, these projects made him feel more at risk. This question was more intense because we had just been talking about Xulhaz. Will my research protect young LGBTQ people against death threats and hate? No.

I struggle with this and similar questions always – why am I doing this research? Will it even make a difference? Am I just here to exploit respondents for their stories only to piss off back to the comforts of a faraway home (maybe to later return with a different hat and agenda)?

- 10 May 2019

Figure 4.4 Fieldnotes extract B

Sample and location

I used nonprobability purposive sampling to recruit young people in this research which was effective in finding willing participants to speak about sensitive topics. It was difficult to split the analysis in a way that would be reflective of the nuances of subgroups within the sample. My sample included people with disabilities, for example, but the various intersections of such 'categories' were not explored further because certain subgroups were too small, or the findings were not specific to sexuality (e.g. none of the participants with disabilities were married and all except one identified as heterosexual). Nonconformity can be investigated further as there are many avenues affecting sexuality. Additionally, I included people of different socioeconomic backgrounds but did not incorporate class or materialist analysis into the research due to the already-broad research focus on sexuality and sexual health.

Data generation was situated in Dhaka to maximise time with, and access to, diverse participants with greater space for socialising (Muna, 2005). Although I was able to speak with young people of varying 'social orientations', I did not look at the lived experiences of populations in rural settings or other locations around Bangladesh. These decisions were partly due to time, budgetary constraints, and ease of accessibility, but also because of research interests in urban health and the specific aim of this study.

Interview sessions and timing

I had initially planned phenomenon-focus repeat interviews with a small group of participants but could not arrange these due to time. The intention was to explore a specific phenomenon in more detail with only respondents who had experienced it. I interviewed four participants through two interview sessions as they asked to continue after their first interview. The second sessions were very detailed, and the participants seemed to be more comfortable. Participants also brought up more topics of discussion about events that happened in between the first and second sessions.

Although my research was cross-sectional and did not incorporate repeat interviews, I witnessed changes in participants' lifeworlds within the two years since completing data generation. For example, Trishna went from being single when I interviewed her in July 2019 to being in a serious relationship which then ended in November 2019 (Figure 4.5). Her outlook regarding the future changed drastically between these stages: from wanting to focus on her career and not think about love during the interview, followed by romantic aspirations

of moving in with her boyfriend soon after data generation, and back to being single at the time of writing this thesis.

Another participant was in a long-distance relationship with someone they had not met. After data generation, their partner came to visit them in Bangladesh. Their perceptions of what being in a relationship entailed – having to be home in time to call their partner, being on the phone for extended periods of time, etc. – changed.

Ria, who had believed her parents would be supportive of her gender identity, had to leave home and move in with her partner. Her family dynamic had changed entirely since our interview. During her interview, Ria reported identifying as coming from a respectable family and what this meant about her sexual behaviour (Chapter 7). There may be some methodological interest in examining these transitional moments as they happen as well as participants' narratives during and after such changes. While it may not be feasible to conduct ongoing research over the whole life course of individuals, further research could elaborate life moments through more purposive sampling around the 'turning points' I have explored in the research papers presented in this thesis. Repeat interviews would also have facilitated more information about the changing dynamics of a participant's lifeworld.

Changing lifeworlds

Met up with T again today: She has a long-term boyfriend now! They're going to move in together soon. He's coming to the workshop so I'll meet him there.

She's thinking about leaving the country with her partner. Also applying for a masters. She is worried about getting more work stuff to make some more money as hormone replacement therapy is costly.

- 6 September 2019

T updated me over text: She broke up with her boyfriend and is finding it hard to afford housing etc. as they were planning on moving in together.

- 13 November 2019

Figure 4.5 Fieldnotes extract C

4.5.2 Language

As Green and Thorogood (2014, p. 97) note, 'Language is reciprocal – we think as we speak and think as we hear, such that in face-to-face conversations meanings are produced and reproduced in a continuous process.' I was able to conduct the research in Bangla because I am fluent in the language. Despite this proficiency, much of my education has been based in the United Kingdom (UK). I also think in English. The internal process of translating my

thoughts before expressing them in Bangla is something I have observed throughout most of my life. It has also often worked as a form of self-censoring as Bangla is usually something I associate with speaking to family. Difficulties in articulating my thoughts around sexuality and gender experiences in Bangla to a Bangla-speaking audience meant questioning my own reservations around sexual taboos. For instance, when explaining my research topic to older relatives, I would simply say it is about 'sexual and reproductive health' and gloss over the relevance of sexual intimacy or pleasure. This was perhaps paralleled by participants' narratives of sexuality where sexual pleasure was not always at the forefront of conversation. It also seemed to me that some participants were beginning to form opinions around certain concepts during the interview and feel comfortable with using language around sexuality while others were already more fluent in speaking about sexuality.

My comprehension of the language is also limited by the contexts in which I have used it in the past. To an extent, this helped to facilitate further dialogue – both with research assistants and participants – around etymology and imagery of certain phrases created during data generation. For example, '*pera*' (প্যারা) is a sweet dish in Bangladesh. But to eat or take a *pera*, commonly means to take on stress/headache. This was used in terms of avoiding relationships or people who would cause stress. As Figure 4.6 illustrates, English words and phrases, too, were adapted to have slightly different meanings. 'Pain' was often used to mean 'pain in the neck' or someone causing the speaker stress. Again, this presented an opportunity for me to ask for clarification by following up with a question (e.g. 'why do you say they are 'callous'?') or asking for an example (e.g. 'what did they do to give you '*pera*'?'). At the same time, I was familiar with some of the phrases that could have been examined further. This could have resulted in deeper interpretations of the language used.

On language

I noticed that the word 'callous' is quite popular – many people use it on the regs [regularly]. But sometimes it is used to mean 'dumb' rather than 'unfeeling' or any other definition of the word. I wonder what other English words are being used to mean slightly different things.

- 18 March 2019

Figure 4.6 Fieldnotes extract D

Language and silence as discourse

There were silences as well as language switching when describing sex. The Bangla verb '*kora*' (to do) was used to mean sex as well as filler words such as 'ye'. 'To do' someone was used exclusively to mean penetrating with the penis. While Bangla grammar is gender

neutral, certain terminology around sexuality is gendered and centred around masculine dominance. For example, '*hathmara*' (হাতমারা) which literally translates to 'hand hitting' is a slang term used to describe masturbation with a penis. A young transgender participant mentioned not masturbating in this way because she identified as a woman and did not want to pleasure herself in a way that brought attention to her genitalia. The terminology did not only describe a 'neutral' action but was also associated with masculinity and aggression.

Although I attempted to note down all the silence and changes in participants' body language, mood etc. it was difficult to capture nuances in their entirety. Interview notes provided further context to audio recordings. I coded using both audio and transcripts to facilitate the preservation of certain meanings and convey intention fully while presenting findings.

As language is a route to understanding how the respondents see their lifeworld and categories that shape the world, it was important to contextualise language within conversations where possible. I attempted to pay close attention to checking the quality of translations against the original context of the interviews. This was facilitated by having professional experienced translators – as recommended by colleagues – working on transcripts as close to the interview date as possible so that the content was still 'fresh' in my mind. Additionally, I listened to recordings and referred to the Bangla transcripts when reviewing translated transcripts. Several transcripts were reverse translated and reviewed for quality checks both by my research assistants and by me.

Translating theory

Accessing the concepts of critical theory through (queer) phenomenology was a difficult journey as many of the more philosophical aspects had a language of their own. It was a huge task to learn about the theory and not only attempt to apply it to my study but also present it in a way that is accessible to an audience beyond academia. I have been conscious about using accessible language in my research papers so that these may be read by a wider audience. However, the potential reach of these papers is still limited by its publication in (English language) academic research journals. This may have been a requirement of my doctoral programme, but I will endeavour to broaden the scope of my research contributions through further dissemination. Although previous dissemination plans were delayed due to Covid-19 disruptions, I will be condensing and translating findings and making these available to young people and researchers in Bangladesh during 2022.

CHAPTER 5. SEXUAL NORMS AND VIOLENCE (PAPER 2)

Overview

In chapters 5 to 7, I report on data analyses which I present here as draft manuscripts for journal submission (see Paper Cover Sheet 2-4 for more details). The introduction and methods sections of these chapters reiterate some material presented in other chapters.

In the following chapter, I present my first research paper which addressed Objective 2a. I explore young people's lived experiences of navigating sexual norms and challenges such as coercion and violence. I discuss these experiences within the context of restrictive socio-sexual norms – as described by interview participants themselves – and how these experiences impact their sexual health and wellbeing. Using thematic analysis, I draw on experiences of sexual norms and violence from biographical in-depth interviews with 46 purposively sampled individuals aged 18 to 24.

Findings indicate that young people's lives are punctuated by episodes of sexual violence. This is supported by social norms about gender and sex that help ensure silence and lack of accountability or justice for survivors. Interviewees highlighted two key challenges in negotiating sexual intimacy before marriage:

1. Widespread perception that penetrative sex 'bonds' a person to one sexual partner for life contributed to coercive behaviour

2. Experiences of, and silence around, sexual abuse and harassment affected young people's confidence in subsequent sexual interactions

The evidence presented in this paper suggests that young people were often alone in healing from sexual abuse and would benefit from mental health support. Conversations around sexuality must go beyond a focus on ill health by considering how to inform and empower young people's socio-sexual agency and interaction skills. As researchers and practitioners, we need to better understand the nuances and impact of socio-sexual norms as experienced by young people throughout their lives. The lack of research on this has meant that these harmful dynamics go unexplored and more easily ignored.

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RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	1600635	**Title**	Mx
First Name(s)	Prima Mishkat		
Surname/Family Name	Alam		
Thesis Title	Young people's lived experiences and perceptions of sexuality in Dhaka, Bangladesh		
Primary Supervisor	Cicely Marston		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?			
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If the work was published prior to registration for your research degree, give a brief rationale for its inclusion			
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Where is the work intended to be published?	Sexual and Reproductive Health Matters
Please list the paper's authors in the intended authorship order:	Prima Alam & Cicely Marston
Stage of publication	**Not yet submitted**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	I conducted the study, analysed data, and prepared the manuscripts included in this thesis under the guidance of my first supervisor Cicely Marston. My supervisor provided comments on manuscripts. Both authors approved the final version of the included manuscript.

SECTION E

Student Signature	[redacted]
Date	18 November 2021

Supervisor Signature	[redacted]
Date	10/12/21

"I have taken your izzath (honour), so you can't betray me": Young people's lived experiences of navigating sexual norms and violence in Bangladesh

Introduction

Across South Asia, young people have to traverse restrictive sexuality norms governed by traditional monogamy and patriarchal procreative marriage (Bankar et al., 2018; Camellia et al., 2021; Hamid et al., 2010; Iyer, 2017, 2018; Karim, 2021; Khan & Raby, 2020; Regmi et al., 2010). Parental and societal disapproval of premarital sex further limits sexual and reproductive health (SRH) communication as young people do not have SRH conversations with adults due to embarrassment or fear of judgement (Brahme et al., 2020; Camellia et al., 2021; Farid-ul-Hasnain et al., 2013; Hamid et al., 2010; Khan & Raby, 2020; Regmi et al., 2010). This culture of silence around sexuality is a widespread norm in South Asia (Brahme et al., 2020; Camellia et al., 2021; Farid-ul-Hasnain et al., 2013; Gautam et al., 2018; Khan & Raby, 2020; Regmi et al., 2010).

Expectations around sexual behaviour are also heavily gendered. Restrictive gendered norms, such as dominant narratives around submissive femininity and hegemonic masculinity, particularly affects young women's SRH decision making (Bankar et al., 2018; Brahme et al., 2020; Khan & Raby, 2020; Zietz & Das, 2018). Puberty has been found to be a time for expanded participation in public life for boys and intensifying restrictions for girls in the region (Barker et al., 2004; Population Council, 2009; UNICEF & UNFPA, 2019), and there are high levels of institutional and societal gender discrimination across South Asia (UNICEF, 2019).

Similarly, taboos about discussing sexuality and widespread gender discrimination in Bangladesh restrict young people's access to reliable SRH information and services (Barkat & Majid, 2003; Bhuiya et al., 2004; Cash et al., 2010; Cash et al., 2001; Nahar et al., 2013a; Nahar et al., 1999; van Reeuwijk & Nahar, 2013). Many young people, therefore, approach adulthood with 'misconceptions, fears and insecurities that arise through incomplete and incorrect information on sexuality' which further perpetuates inequitable gender norms and stigmatisation (van Reeuwijk & Nahar, 2013, p. 69).

According Nahar et al (2013a), most young people in Bangladesh are aware that their sexuality is negotiated within a complex and gendered reality. For example, the perceived penalties of sex outside of marriage centred on gendered expectations of women's chastity and potential repercussions from an unwanted pregnancy (Nahar et al., 2013a). There is also

evidence that concern about ‘eve teasing’ – a colloquial term in South Asia to describe public sexual harassment of girls and women – is almost ubiquitous among adolescent girls and young women, leading to constant feelings of insecurity (Dhillon & Bakaya, 2014; Nahar et al., 2013a; Natarajan, 2016; Rashid, 2000; Talboys et al., 2017; Tripathi et al., 2017). Such non-consensual sexual behaviour or expressions violating sexual autonomy may be normalised under dominant sociocultural norms (Nahar et al., 2013a). Moreover, Bangladesh also has one of the highest prevalence of martial violence with 53% of married women reporting physical and/or sexual violence by their husbands (Kamal & Ulas, 2021; Rahman et al., 2013). Dimensions of gender inequities were significant predictors of intimate partner violence (IPV) among married women (Rahman et al., 2013). Additionally, many married women remained silent about their experiences of abuse due to ‘acceptance of violence within society, fear of repercussion, tarnishing family honour and own reputation, jeopardizing children's future, and lack of an alternative place to stay’ (Wahed & Bhuiya, 2007, p. 341).

While the presence of taboos and gender disparities around sexuality have been well documented for the purpose of public health interventions, there is very little in-depth research on how young people in Bangladesh navigate socio-sexual norms in their everyday lives within this ‘culture of silence’ (Camellia et al., 2021). The first author (PA) systematically searched five electronic databases – using terms relating to SRH, young people, and Bangladesh – and found only 13 qualitative articles. Moreover, very few of these studies were ethnographic or included in-depth analysis of lived experiences. In this article, we explore young people’s lived experiences and challenges of negotiating sexual intimacy before marriage. Drawing from data collected as part of the first author’s doctoral fieldwork, we discuss findings on young people’s lived experiences of sexual intimacy within the context of restrictive socio-sexual norms – as described by interview participants themselves – and how these experiences impact their sexual health and wellbeing.

Methods

This qualitative ethnographic study involved interviews and observations by the first author (PA) in Dhaka, Bangladesh over nine months from February to October in 2019 as part of their doctoral research. CM guided the research as PA’s primary supervisor. We predominantly draw on themes of sexuality norms and sexual violence from biographical interviews with young people aged 18 to 24.

PA used purposive sampling to recruit 46 young people (aged 18 to 24) of varying social orientations – gender and sexual identity, religion, educational background, occupation etc. –

based in Dhaka. The recruitment strategy was open and flexible in order to include a diverse range of experiences. Initially, PA approached potential participants through a range of academic and personal networks. Local research assistants working with PA were also asked to utilise their networks to identify suitable individuals who may be interested in participating in the research. Participants included students at public universities, recent graduates, and young people in full- or part-time employment (both private and informal: such as teachers, garment factory employees, shop assistants etc.).

PA conducted in-depth one-to-one biographic interviews with each participant in Bangla, consisting of open-ended questions about lived experiences of gender and sexuality and life history. Interviews were audio recorded and took between one and two and a half hours. Interview venues depended on where the respondents lived and were comfortable speaking, such as quiet cafes or private office space. All respondents provided written informed consent for participation in the research and were provided with details of local SRH services.

Four research assistants transcribed interviews in Bangla using a verbatim transcription protocol prepared by PA. Professional translators then translated these transcripts to English. Both Bangla and English transcripts were reviewed for quality and accuracy by PA and research assistants. PA used a phenomenological lifeworld approach to explore sexuality as identified and discussed in biographic interviews with 46 respondents in Bangladesh. PA followed a phenomenological thematic approach to analysis by identifying and synthesising most prominent and recurring themes around sexuality through line-by-line open coding. PA iteratively coded the interview transcripts using NVivo software and used the open coding nodes to formulate a codebook which was used for secondary coding through in vivo and process codes (Saldana, 2015). Additionally, PA also coded around the five domains of the phenomenological lifeworld (intersubjectivity, temporality, embodiment, emotions, and space) for more details around experiences. PA clustered and reviewed codes into common (sub)themes and then analysed how these related to sexuality and violence.

Ethical approval was granted by the London School of Hygiene & Tropical Medicine, United Kingdom, and from North South University, Bangladesh. PA obtained informed written consent from all respondents and used pseudonyms to maintain anonymity. Recordings and documentation related to the research did not contain any identifiable data.

Findings

Young people experienced numerous challenges while navigating sex and gender norms. These challenges were applicable to sexual and gender diverse participants as well as cisgender heterosexual participants. Their experiences related to sexual coercion, widespread harassment, sexual abuse during childhood, and intimate partner violence. Young people identified sexual abstinence before marriage as a key norm primarily arising from religious rules. While some participants reported thinking that sexual abstinence was a means of avoiding sexual violence and safeguarding women's reputation, others reported not adhering to this norm in practice. Religious beliefs and protection of women's chastity or reputation were cited by respondents as two main reasons why some young people thought sexual abstinence before marriage could be beneficial. Furthermore, interviewees highlighted two main challenges in navigating sexual intimacy before marriage:

1. Widespread perception that penetrative sex 'bonds' a person to one sexual partner for life contributed to coercive behaviour

2. Experiences of sexual abuse affects young people's confidence in subsequent relationships and adversely impacts their mental wellbeing

Coercion: Penetrative sexual intercourse perceived as act that 'bonds' a person to one sexual partner for life

Half of all 38 unmarried respondents reported being sexually active and three of 8 married respondents reported having been sexually active before marriage. Some participants had sex while with long-term partners, while seven participants also reported having sex outside of established relationships. Respondents reported ways to navigate sexual abstinence before marriage such as committing to one sexual partner for life. At the same time, for some participants this concept also made it challenging to negotiate sexual intimacy with potential partners.

Several participants commented that certain social rules were 'safety measures' to protect women – and their reputations – from 'being cheated' and possibly abused by men. As first-year university student Ritu pointed out:

"There is a fear of being cheated so it's better not to go there. …If I'm in a physical [sexual] relationship with a person, if I have sex with him, there is no guarantee that he will marry me five years later. …I think it's better not to do it. Then my trust will never be broken. I will not be deceived." (Ritu, 19-year-old woman)

Many participants highlighted the gendered inequality around 'reputation' when women were perceived to have had sexual experiences before marriage as opposed to when men did the same. Twenty-two-year-old blind student Topu explained that, irrespective of disabilities, women's reputation was far more scrutinised than men's when it came to sexual activity outside of marriage. He suggested that one reason for this imbalance was because men did not experience any 'physical changes after sex' and could, therefore, lie to their future-wife about their sexual history:

"Men do not have any physical changes after sex, so their reputation is safe. Even if he committed a sin [had sex before marriage], he would be able to present himself as an angel to his wife. But if a girl does this kind of thing, she will have physical changes and her mentality will also change. I have even heard that her voice will also change." (Topu, 22-year-old man)

James, a 23-year-old gay man, added that there were similar expectations around 'virginity' within the gay community where 'tops' – usually the person who penetrates – are dominant and expect bottoms to be submissive and less sexually experienced:

"When you go into a relationship, everybody wants a virgin. …I don't mean literally a virgin. People want partners with less experience. They want a bottom who has less experience. In the straight community, males are dominant, and for us, tops are dominant. The bottoms are actually really submissive. If one of us is a little outspoken, then there are problems." (James, 23-year-old gay man)

Farukh, a young man employed at a university campus in Dhaka, had decided to marry his girlfriend "so that she does not leave me". The 19-year-old also mentioned love and the prospect of marriage as important factors in deciding to be sexually intimate with his girlfriend: "I actually thought that I love her, I will marry her. So, can't we have sex?"

Similarly, many participants described penetrative sex between a man and a woman as an act which 'bonds' couples together; not only as something you do with someone you intend to marry but also to coerce a partner to stay with you. For example, 24-year-old security guard Khaled described how he had unprotected sex with a long-term girlfriend – whom he ended up leaving later – to ensure that she could not refuse to marry him. By 'taking' his girlfriend's 'honour' Khaled reportedly believed that she could not betray him due to an implicit importance of virginity for unmarried women:

"I told her, 'I will marry you and I want to do something with you so that you can't refuse me.' [I said] 'You won't forget me. You keep this [ejaculation] inside you. I have taken your *izzath* [honour], so you can't betray me.'" (Khaled, 24-year-old man)

Brishti, a married young professional living with her in-laws, mentioned that she could have been in 'a lot of trouble' if she had become sexually involved with someone before marriage due to societal expectations of sexual abstinence:

"If I was in a relationship with someone else and if we had a sexual relationship then I could have gotten into a lot of trouble. This is seen as an accident in a girl's life. Even though I don't think like that. Still these things create a lot of problems for women." (Brishti, married woman in her early 20s)

When 19-year-old Rabia started university, her boyfriend of two years felt insecure about her becoming too busy to 'give him any attention'. Rabia's boyfriend then started pressuring her for sex so that she would be 'bound' to him and could not leave him:

"He started putting pressure on me to have a physical relationship with him, saying, 'You should come here, and we should do this. Because, if we do this, you will be bound to me.' The thing is, he was feeling that way, thinking, 'You will forget all about me. You will try to leave me.'" (Rabia, 19-year-old woman)

Anu had a similar experience when an ex-boyfriend at college began to pressure her for sex:

"He wanted to have a physical [sexual] relationship. I think he had physical demands. …He touched me and tried to kiss me. I did not have the same physical need then, and I still don't accept this." (Anu, 18-year-old woman)

While Rabia and Anu both broke off their relationships because they did not want to have sex before marriage, Shonali – a 21-year-old bisexual student – expressed that one of the reasons she stayed with an abusive boyfriend was because they had already been sexually intimate:

"If I didn't have sex with him, I would have [had] the courage to actually leave him. But since we had sex… [I thought] 'I had sex with him so now I can't go back'. So, do I let him go then? No. Let him torture me. Things will get better at one point." (Shonali, 21-year-old woman)

She identified that the importance she placed on staying with one sexual partner for life stemmed from perceived parental expectation of monogamy:

"I used to have this perception - you know, the one parents have, that if you have something [sexual] with someone, you have to stay with them. You can't think about anything else. So, that is the thought that I had in my mind. …It was because I had sex with him and I thought that 'oh my god, I cannot go back to anyone else'." (Shonali, 21-year-old woman)

Although queer-identifying participants did not directly speak about the prospect of marriage, they expressed similar concerns about expectations around long-term monogamy. In James' case, he described the act of anal penetration as 'totally surrendering' his body to someone and worried that a future partner could judge him for his sexual promiscuity. He struggled with the concept that maybe he should have 'saved' himself for the 'right' person:

"I totally surrendered my body to someone else, and so easily. …I had quite a few one-time hook ups. I still feel guilty about those. That I so easily gave up [my body] to people. …I should have protected it [my body] better. Maybe saved it for the right person.

In future, I will have a relationship with somebody or live together with someone. I hope those things will not have any impact on that. These are the things that I worry about. Like, what if he judges me because I have hooked up with so many people before? I can get judged so easily." (James, 23-year-old gay man)

Trishna, a transgender woman in her 20s who had previously wanted to be in a committed monogamous relationship, reported feeling weary of men's 'dishonesty' within relationships. Unlike Rabia and others, however, Trisha reported navigating this distrust by actively choosing sex over relationships and love:

"Guys are deceitful. This learning will stay with me forever that every man is dishonest. To look for honesty, I mean, to want him to be honest is like, to cast pearls before swine or wasting time on unimportant things. So, it's better to read a good novel than to look for honesty. And right now, …if someone is proposing love [a relationship]. And another person is offering me sex. I will choose sex without any hesitation. But not love." (Trishna, transgender woman in her early 20s)

Experiences of sexual abuse affects young people's confidence in subsequent relationships and adversely impacts their mental wellbeing

Participants reported that the taboo of talking about sexuality extended to silence around sexual abuse and harassment. Only two of the ten participants who reported experiencing or witnessing sexual abuse remembered telling anyone about the incidents. The three most common reasons for this as discussed by the participants were that: 1. they blamed

themselves for the abuse and felt guilty or ashamed; 2. they felt they would be judged or blamed by others; 3. there was nothing anyone could do to make the situation better.

'Dealing with' street harassment by oneself

Eighteen-year-old participant, Kaniz, mentioned practical ramifications of telling her family about the frequent street harassment she faced on her way to night school. Kaniz explained that although she was often frightened by boys stalking and catcalling her, she did not want to tell her family as they would stop Kaniz from attending night school on the outskirts of Uttara, Dhaka. Instead, she gave herself 'courage' and continued:

"As a girl walking on my own with a boy following me, I would often feel quite frightened. Despite that, I would give myself courage. Because I know that if I get scared, then I would be finished. If anyone in my household found out, then my education would be at an end. …I try to handle this by myself." (Kaniz, 18-year-old woman)

Participants described street harassment, such as unwanted touching, as an inevitability for young women as they navigated public spaces. Shilpa – a 19-year-old living in Old Dhaka – recounted several incidents of street harassment including a recent encounter in Chawk Bazaar, a marketplace in Old Dhaka. Despite her efforts to 'protect' herself, she was inappropriately touched by a stranger and felt like there was nothing that could have been done about it:

"I held my bag behind or in front of me, so that no-one could touch in my body. But at one point, a man who sells biryani was passing by. When I was crossing him, it was really crowded. The man was holding the handles [of the biriyani pot] and as I passed him, he touched me here [inner thigh] with his hand." (Shilpa, 19-year-old woman)

Shilpa recalled not wanting to talk about the incident, or the marketplace where it took place, as it made her 'angry and upset': "I cannot even bear to hear the name of 'Chawk Bazaar' now. If I hear it, I feel very angry and upset."

Similar to experiences described by gender-conforming participants, three queer-identifying participants mentioned feeling insecure and traumatised when encountering persistent street harassment by men. Non-binary 22-year-old master's student Auvi who lives with their family near Dhanmondi reported 'just dealing' with the constant stares and harassment they confronted as a femme-presenting person, even though they still had 'no idea how to deal with it':

"If I want to go for a run, I could, it would be very traumatic for me as a person. It's like, 'OK, you're going to go out now. You're going to be seen by people and these people are going to be like dicks to you, how do you deal with that?' I don't. I still have no idea how to deal with it." (Auvi, 22-year-old non-binary person)

Auvi reported trying to manage these exchanges by themselves, either by conforming to gender norms around clothing or by 'dressing more like myself' as a way to navigate public spaces:

"I tried covering up, made me feel worse. I tried dressing more like myself. I got more attention. Started being like I don't give a fuck about this shit because it's too hot to wear an *orna* [scarf] and to have long hair and to wear full-pants and I'll just deal with the fact that people are looking at me." (Auvi, 22-year-old non-binary person)

Shayan – a 24-year-old dance instructor who identifies as a gay crossdresser – also narrated several instances of street harassment by men. As Shayan was estranged from his family and living on his own, he did not tell anyone about the harassment. He generally ignored the verbal taunting although he worried for his safety:

"The thing is, the way I look at it, let them say whatever they are going to say. As long as they don't come near me, as long as they don't create problems, I will not say another word. Because it is when you try to talk to them, that you will have problems.

…Sometimes, you know, I feel a little irritated. I check to see if anyone is nearby. I do feel that sense of insecurity – about who is nearby, and who among them might create a scene. At times like that, I feel very [insecure]." (Shayan, 24-year-old gay man)

Childhood sexual abuse perpetrated by relatives and questioning of self

James and Raqib both did not tell anyone about past sexual abuse by much-older male relatives as they reportedly felt afraid, confused, and guilty. Raqib – a 22-year-old heterosexual-identifying schoolteacher living with his family in Mirpur – was sexually abused multiple times during his childhood. Raqib said that he was 'too young to understand anything' and that – unlike James, who identified as gay – the incident did not lead Raqib to subsequently question his own sexuality as he had only been attracted to women. He did, however, question why his abusers had targeted him. Raqib reported being further conflicted by the experiences as his abusers would often give gifts in exchange for sexual interactions:

"They would lure me to the rooftop to play sports. They got me kites. I played kites and used to perform the sex acts out of greed. They used to take me to the rooftop. They would give

me gifts when we were alone. Used to buy me chips [crisps], and this and that." (Raqib, 22-year-old man)

Although he felt 'bad' about the abuse, Raqib remembered being too afraid and ashamed to tell anyone. Raqib's abusers, men in their 20s, would also scare him:

"I was very young when it started. I was five or six years old at the time. I wasn't able to tell anyone. I felt bad about it. That they were using me. I used to question myself… I felt ashamed. They would scare me as I was younger than them. So that's why I didn't tell anyone." (Raqib, 22-year-old man)

James felt alienated because of his sexuality as well as the abuse and would question whether there was something wrong with him that encouraged the abuse:

"I would sometimes feel really, really bad, thinking about whether this was a problem with me? I wondered if there was something in me that was the reason why these things were being experimented with me." (James, 23-year-old gay man)

As Shayan pointed out, the idea that sexuality was a 'secret issue' was not restricted to the queer community but contributed towards silence around sexual abuse and harassment for most young people in general:

"[It is] a secret issue. Because this entire sex thing is actually a secret issue in Bangladesh – whether you are talking about straight people or gay people, lesbians, or whoever. Even if a straight person is harassed, they will think a hundred times before deciding, 'Should I tell my parents about this or not?' It is the same thing for gays and lesbians." (Shayan, 24-year-old gay man)

Witnessing and learning about sexual abuse

For Jannat, a young professional in her early 20s, safety had been a palpable concern when she started thinking about sexual intimacy as a young girl growing up in Mohammadpur, Dhaka. She recalled first learning about sex through an older cousin who had equated sexual violence as something that happened to women who wore 'short revealing clothes' by men in poor neighbourhoods. Jannat remembered being too terrified to talk about it with anyone:

"My introduction to sex was through the idea of rape. So, it was very terrifying to me. The way [my cousin] said it made me think it was something bad. I was so terrified that I couldn't sleep that night. I mean, she explained it in a horrible way. She started by saying, 'If

you ever go to a slum type area wearing short revealing clothes then you will be raped.'" (Jannat, woman in her early 20s)

University student Tasnim was only eight years old when she witnessed the violent rape of a boy while she was wandering around at her local mosque. Tasnim vividly recalled what she had thought at the time, as she hid unnoticed outside the room and peered through a window:

"I didn't understand what rape was [at the time]. …The *mullahs* [Islamic clerics] at the mosque had a tendency to hand out quite frequent beatings. They used a cane for the beatings. So I thought he [*mullah*] was giving that boy some kind of a punishment. …The boy was really small. He was perhaps six or seven years old. …I only realised what had happened after I was older – what the real [meaning of the] incident was, that the child had been raped." (Tasnim, 19-year-old woman)

Although the perpetrator was reportedly later apprehended, Tasnim explained why she has never told her parents – whom she was still living with at the time of the interview – about the incident:

"If I had told my mother this, she would have instead said, 'What nonsense, talking about what you have seen or not seen!' She would just scold me. She would not understand. She will say, 'These things should not be talked about.'" (Tasnim, 19-year-old woman)

Like James and others, Tasnim recounted perceiving discussions around sexual abuse and rape – as well as consensual sex in general – 'should not be brought up' in conversation:

"The thing is, my mother would treat this incident of rape like traditional Bengali mothers have done through the ages, saying that you don't need to tell anyone about it, saying that you will lose your honour as a result of it, that incidents of rape should not be brought up. What I mean is, rape, sex and such things are matters that she does not want brought up. So my mother's advice in these situations is to remain silent. "As long as something has not happened to me directly, I will not protest" – this is the standard Bengali attitude to things, so it's like that, you see." (Tasnim, 19-year-old woman)

The respondent said she had not shared the incident with her peers either as they would think 'worse' of her. As such, she reported feeling this was something she would have to keep to herself:

"There is no question of discussing any of this with them [classmates]. If I tell them, then I will become worse in their eyes. Nobody knows about this trauma that I have experienced. Nobody knows, so I keep this to myself." (Tasnim, 19-year-old woman)

Intimate partner violence

As well as the taboo around talking about sex, participants who had experienced abuse reported feeling guilty for somehow inviting abusive behaviour from intimate partners through their own perceived 'nonconformity':

"When I was growing up everyone used to say I'm too *fast* [reckless] and like I don't know what I'm doing but I'll do it anyways. So, then I began to think- 'oh no, I brought this upon myself'." (Shonali, 21-year-old woman)

Like Tasnim, Shonali perceived that she had strayed from maternal advice about staying safe and blamed herself for being 'stupid':

"Mothers always warn you about these things. To be careful about visiting someone's house. Not to do everything. I was just stupid. I didn't think of myself." (Shonali, 21-year-old woman)

Shonali elaborated further about how she continued to feel responsible for past physical and sexual abuse perpetrated by consecutive ex-boyfriends:

"I actually understood that, no, whatever my ex-boyfriend did it was not them. And whatever happened to me…It happened because of myself and I cannot blame anyone else. I cannot blame the guys or anyone. 'Coz what I experienced was because of myself, right?

'Coz I was too naive, and I mean, after the first incident, I could just have left him – I shouldn't have taken it. If I had stopped him earlier, he couldn't have done what he did. Right?

The guy who raped [me, that] thing was on me too. To go and meet him that day. If I didn't do that then he wouldn't have gotten that chance." (Shonali, 21-year-old woman)

Although Shonali's parents were aware of her relationship, her father had a 'weird feeling' about her ex-boyfriend and did not want to speak about it:

Ammu [Mum] was OK but my dad always had like this weird feeling about the guy. I mean, he just said that he [boyfriend] is not the one. …When I tried to talk to my dad about it, he used to [be] like, 'I don't want to talk about it.'" (Shonali, 21-year-old woman)

Shonali recalled times when her father scolded and slapped her for coming home late from her ex-boyfriend's house:

"So, there were even times when like, I came home late from his [boyfriend's] place and *Abbu* [Dad] would be screaming at me and scolding me. …There was this one time because of him [boyfriend] *Abbu* slapped me so hard that my vein started popping out of my forehead and I had a fever immediately." (Shonali, 21-year-old woman)

These negative interactions discouraged her from sharing information about her situation when she faced abuse from her ex-boyfriend as she knew that her father already disapproved:

"So, I totally started avoiding that subject at home. I didn't used to say anything to them. After all that, I started avoiding this subject because if I were to share with him [dad] – [he would say] 'you chose the wrong person yourself' [and] I would get into a lot of trouble." (Shonali, 21-year-old woman)

As with other participants, Shonali decided to 'deal with' the abuse on her own, as "these things cannot be shared with others". However, she said that she would have left the relationship if her then-boyfriend cheated on her: "I started to believe that I can deal with anything that he does with me but the endgame would be like, if he cheats."

Unlike in Shonali's previous relationships, she reported that her current boyfriend was 'very understanding' with her during sex: "Like, he knows I don't like [giving] blowjobs, right? So, he never forces me." Conversely, Shonali also recalled an incident when her boyfriend 'just actually went in' for anal sex without her consent:

"He's like very much into anal, OK? Once, I actually told him not to. I mean, I didn't want to. So, he - just to try out - he just actually went in, OK? And I screamed! I ran to the washroom. Because I was dying of pain." (Shonali, 21-year-old woman)

She did not suggest this was assault, however, and said that her boyfriend regretted his actions soon after: "He was like, 'you can open up your ass for me but I won't get in because I saw you dealing with that pain. I'm not gonna make you go through it again'."

Auvi also confronted an abusive sexual experience where they were forced to engage in a sexual act by someone they were casually dating. They mentioned taking 'time off' through celibacy to deal with the incident on their own:

"This person was emotionally and sexually abusive because I didn't share the kink they had and even though I said I didn't want to engage in that, they forced it on me during play [sex] and that was something that also took me back by a while because after that I think I sort of strengthened the idea that I just want to be celibate and then just took some time off. …I

spent my whole second year [at university] almost celibate intentionally being like, 'I don't think I want to do anything'… and then I'm glad that I eased into this relationship with the person that I am [with] now." (Auvi, 22-year-old non-binary person)

Living with trauma and impact on wellbeing

Participants who experienced abuse all spoke about tackling ongoing trauma and depression. Auvi – who was also abused by an 'older brother figure' when they were 17 – remembered feeling 'very traumatised' by the incident: "It wasn't on the scale of assault. It wasn't that bad, but it was still something that was boundary crossing and that's what abuse is to me."

After the incident, beginning to study at university offered Auvi a 'fresh start' in terms of how they wanted to be:

"I retreated and I was very upset. I didn't understand how I was feeling because I had no sexual relations with my own body. I didn't masturbate. I didn't think about myself as a sexual person yet. That was one of my first interactions. It was very confusing. I tried to not let it affect my view of how I wanted to be, so I went into uni and because all these people didn't know me, and it was a chance to get a fresh start on things." (Auvi, 22-year-old non-binary person)

Shonali reflected on how the trauma of surviving rape negatively affected her sexual and social life:

"I used to be like very fucked up. That is the time when my panic attacks and depression and anxiety attacks all started. I couldn't sleep at night. Whenever I used to sleep- I mean, every single time I used to have the same nightmare. Same one. That someone is forcing himself on me. And I used to wake myself up from that nightmare. It became long term thing and it came to a point where I was like, I was scared to go out. I stopped going to all my coaching classes. I stayed home an entire year. Legit. I didn't make any friends. I was totally freaked out by then. So, after that, I didn't talk about it with anyone." (Shonali, 21-year-old woman)

Despite past abusive relationships, Shonali's views on long-term monogamy remained unchanged. She said she was determined to continue her current relationship as she trusted that her boyfriend would not be abusive: "Now that I know him so well, I don't think he's capable of doing anything [abusive]. So, I will only love him. If I'm gonna take it, I'm gonna take it from him. I'm not gonna invest myself in another relationship or another guy."

Auvi found that 'taking control' of their own sexuality – through celibacy or being 'slutty' – was a 'coping mechanism' in dealing with past sexual abuse:

“I was the person that would be slutty as a way to be like, ‘I'm taking control.’ I'm going to go party and do drugs and have sex as much as I want without anybody getting to have control over me in any way. That was my coping mechanism for a while in university. Still is to a certain extent. I feel I've just gotten better about it but there was a time when I intentionally stayed away from possibilities because I was giving myself space.” (Auvi, 22-year-old non-binary person)

Nineteen-year-old Tasnim, who witnessed a rape, described experiencing a lot of problems due to the fear triggered by trauma:

“Sometimes the trauma from this rape returns to haunt me. I become frightened. When I get scared, I start thinking, ‘Could something like this happen to me?’ What this incident has done is that I always have a lurking fear about what would happen if someone ever did something bad like this to me.” (Tasnim, 19-year-old woman)

Consequently, the experience had not only negatively affected how she viewed sexual intimacy but also in other social situations such as with male classmates at university:

“When my class friends are giving me a hard time or when anyone has shown enmity to me - I know that they would never do that [rape]. But despite that, that fear enters my mind. Wherever I go, whatever happens, that fear comes back, and I remember that incident. When I am hurt, when I feel bad, that scene appears before my eyes, and I feel even weaker.” (Tasnim, 19-year-old woman)

Tasnim also reported feeling hesitant about being too vocal against other sexual harassment issues at university as she feared male classmates could ‘do something bad’ to her ‘just to make a point’: “They [male classmates] might do something bad to me just to make a point. [Something like] ‘So you feel harassed about sexual issues, now see what harassment really is!’”

James remembered questioning whether the sexual abuse somehow shaped his sexuality and how people knew that he was ‘different’. As he could not speak with anyone about the abuse, he felt very alone and said that he ‘suffered from guilt for a very long time’:

“I don’t know how people can somehow understand…that I might be like this [gay]. If that was not the case, then I would not have been abused so many times. I was very confused at that time, wondering whether this was a problem with me. Wondering, ‘Is it OK? Is it natural?’ …Because of that, afterwards I suffered from guilt for a very long time - like, I was

really confused. …[I thought] I am different, that's why I got molested." (James, 23-year-old gay man)

Of all 10 respondents who had experienced sexual abuse or harassment, only Tasnim mentioned seeking help from a counsellor after starting university. While Shonali and James both also wanted to see a therapist, they had not had a chance to talk to anyone. Shonali still struggled with feelings of negativity and worthlessness triggered by past incidents of abuse:

"If those things didn't happen, I would have been a different person. I would have been a better person, right? I mean, someone without any trauma. More positive. Right now, I have so much negativity inside me.

Even in this [current] relationship there are times – I feel very worthless. Do you understand? Like since those things happened to me before, so even if something similar were to happen to me in the future, I deserve it.

I'm bound to have all this negative experience all the time and like, even if something positive happens to me even for two minutes, I feel it's just gonna go to all negative again. And I mean, nothing is constant. Everything is just gonna turn negative. I kinda feel that I attract negativity a lot." (Shonali, 21-year-old woman)

Discussion

Young people described lives punctuated by sexual violence supported by social norms about gender and sex that helped ensure silence and lack of accountability or justice for survivors. Expectations of sexual abstinence inform how both heterosexual- and queer-identifying young people conceptualise intimacy within relationships as well as presenting specific challenges. For some heterosexual-identifying respondents, negotiating sexual intimacy before marriage was dependent on love or trust shared with a partner as well as the promise of marriage. Young people in a Nepal-based study similarly challenged expectations of sexual abstinence and considered trust and opportunity when deciding to engage in sexual relations before marriage (Regmi et al., 2011). On the other hand, sexual abstinence before marriage provided security against perceived stigma and abuse or betrayal for many young women in our study. These findings are in line with past studies showing that many young people assessed premarital relationships predominantly on its associated social risks, such as confronting gendered social stigma for girls and young women (Cash et al., 2001; Nahar et al., 1999). Young women who had witnessed abuse or left coercive relationships reassessed risks of sexual intimacy based on their previous experiences. For example, they further reinforced sexual boundaries based on a fear that men could enact sexual violence on women

at any time: ‘I won’t be intimate with anyone before marriage because something bad could happen to me.’ Notably, perceptions or experiences of spousal abuse were not discussed by any of our participants although research suggests marital violence is prevalent in Bangladesh (Kamal & Ulas, 2021; Rahman et al., 2013).

Interviewees’ accounts suggest that the dominant model of traditional monogamy – staying with one sexual partner over a lifetime – as well as a focus on women’s chastity was also a strong driving factor in decision-making around premarital sex. This contributed to the practice and acceptance of, as well as silence around, abusive behaviour. In this way, men may use sex – both implicitly and explicitly – as a coercion tactic: taking her ‘honour’ to ensure she cannot leave or betray him. Prevailing hegemonic masculinity in South Asia reinforces such coercive behaviour as well as contributing to both the internalisation and reproduction of patriarchal violence-supportive norms (Fattah & Camellia, 2020; Karim, 2021; Khan & Raby, 2020; Shannon et al., 2013; Siddiqi, 2011b). While there is a breadth of evidence around widespread gender disparities within the context of South Asia the effects of this are not often spelled out in depth in terms of lived experiences of individuals (Hapke, 2013; Karim, 2021; Khan & Raby, 2020; Ong et al., 2021; Regmi & van Teijlingen, 2015; Siddiqi, 2011b; Zietz & Das, 2018). By exploring diverse lived experiences of young people, our research also expands on the existing body of work with a predominant focus on the high prevalence of intimate partner violence among married women in (rural) Bangladesh (Akhter et al., 2020; Islam, 2020; Johnston & Naved, 2008; Sanawar et al., 2019).

Our study suggests that young people’s lives were punctuated by episodes of harassment and violence which had a major negative impact on their mental and physical wellbeing. Moreover, negative past experiences influenced young people’s perception of self as well as their ability to conceptualise having pleasurable and consensual sexual experiences, free of coercion and violence (WHO, 2006). This closely corresponds with Goffman’s work around self-stigma and ‘spoiled identity’ (Goffman, 2009). According to Goffman, individuals who belong to socially discredited groups (e.g. queer people) internalise feelings of shame and worthlessness due to their ‘spoiled’ identity (Goffman, 2009; Livingston & Boyd, 2010). Interviewees suggested that they had been abused because their abusers ‘discovered’ that they were not ‘normal’ – too ‘reckless’, too ‘queer/non-conforming’, or too ‘powerless/emotional’. As such, young people in our study expressed holding themselves responsible for being abused in the past and, therefore, felt they would likely be subjected to abuse in future relationships. It is plausible that past bad experiences with partners lowered expectations of future partners, potentially opening young people up to further abuse. A number of young people in our study who had experienced recurring incidences of abuse

considered past experiences to determine their current intimate relationships. For example, even though Shonali's boyfriend attempted to initiate anal sex without her consent, she described him as 'very understanding' because he does not force her to give him oral sex. It is also clear from our interviews that respondents reflected on trauma and questioned what they did to deserve abusive behaviour in the past. At the same time, they looked at peers who had avoided abusive situations and consider why they were inept at 'protecting' themselves.

Further research

This study examined young people's lived experiences and challenges of navigating sexuality in Dhaka, Bangladesh. The sample for this study consisted of young people living in Dhaka and, although some of the participants grew up in different areas of the country, most of the narratives referred to urban settings. Further research is needed to understand the experiences of rural young people. Similarly, while recruited young people with varying characteristics – such as different religions, disabilities, sexual and gender identities – it was not feasible to explore all these intersections in depth. For example, we were not able to report on distinctions between young people from matrilineal ethnic groups and their peers. From a phenomenological standpoint, it would be useful to explore lived experiences of sexual violence in more depth to better understand the essence of lived experiences. As our research focus was lived experiences of young people, we did not address the perspective of others such as parents, teachers, and healthcare practitioners. Further research on interpersonal relations may provide more context-specific information on how to effectively advocate for young people. While interviewees themselves brought up perceptions and experiences of sexual violence, these narratives were co-constructed with the interviewer. PA reflects on the interview process in their doctoral thesis. It would be useful to incorporate the perspective of perpetrators of sexual violence to further our understanding of mechanisms that maintain such behaviour. Finally, due to the lack of research on unmarried young people's experiences of sexual intimacy and violence in Bangladesh, our findings were exploratory. There is a need for more in-depth research around the nuances of consent as well as wider implications of, and healing from, sexual violence on young people at various stages of their lives (Draucker et al., 2009; O'Callaghan et al., 2019).

Conclusion

Our findings on navigating sexual intimacy and violence reiterate a need for more research and discussions around consent and sexual autonomy. The evidence presented in this article suggests that young people were often alone in healing from sexual abuse and could benefit from mental health support to serve their diverse needs (Bhuiya et al., 2004; Cash et al.,

2010; Khan & Raby, 2020; Nahar et al., 1999; Rashid, 2000; van Reeuwijk & Nahar, 2013). Conversations around sexuality must go beyond a focus on ill health by considering how to inform and empower young people's socio-sexual agency and interaction skills (Fattah & Camellia, 2020, p. 16; Iyer, 2017; Nahar et al., 2013a). As researchers and practitioners, we need to better understand the nuances and impact of socio-sexual norms as experienced by young people throughout their lives. It may be beneficial to further research ways of approaching such taboo conversations in more positive and up-to-date terms in order to uncover and challenge violence-supportive norms (Fattah & Camellia, 2020; Iyer, 2017; Nahar et al., 2013a). The lack of research on this has meant that these harmful dynamics go unexplored and are more easily ignored.

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CHAPTER 6. HETERONORMATIVE STRAIGHTENING DEVICES (PAPER 3)

Overview

This chapter addresses Objective 2b of my research. Here I report on analysis from interviews with 14 sexual and gender diverse young people in Dhaka from my second findings paper. I use the phenomenological framework of heteronormative 'straightening devices' – mechanisms working to direct people towards heterosexuality, gender conformity, and procreative marriage – to identify 'invisible' structures upholding normative sexual behaviours and see how young people in Bangladesh navigate these in their everyday lives. The paper highlights four main themes around straightening devices include marriage norms for women; harassment of feminine-presenting bodies in public spaces; heteronormative healthcare; and failure to embody heteronormativity. I conclude by suggesting further research needed to understand experiences of young people living in rural areas as well as perspectives of other actors who may be upholding heteronormative straightening devices – such as healthcare professionals or parents of young people.

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‘Bending’ against heteronormative straightening devices: queer young people’s lived experiences of sexuality and sexual health in Bangladesh

Introduction

Health needs and experiences of sexual and gender diverse populations – such as lesbian, gay, bisexual, transgender, queer etc. (LGBTQ+)[1] individuals – are often overlooked within healthcare settings or assumed to be indistinguishable from that of their heterosexual and/or cisgender-conforming contemporaries (Colpitts & Gahagan, 2016; Nieder et al., 2020; Regmi & van Teijlingen, 2015; Zeeman et al., 2019). Consequently, health disparities persist and reflect larger sociostructural inequities which negatively impact the health of LGBTQ+ young people around the world (Argüello, 2020; Laiti et al., 2019; Nieder et al., 2020; Searle, 2019; Zeeman et al., 2019). Global data reveal increased risk of poor mental health, violence, and higher rates of suicide as well as substance use among young LGBTQ+ populations (Bowling et al., 2019; Kuper et al., 2018; Perez-Brumer et al., 2019; Regmi & van Teijlingen, 2015; Rivers et al., 2018).

Despite such statistics around ‘increased health risks’, there is very little research investigating young LGBTQ+ people's views and lived experiences of such behaviours (Kuper et al., 2018). Given that LGBTQ+ youth face challenges related to identity during adolescence, they could benefit from the support of health professionals to tackle them (Laiti et al., 2019). For instance, LGBTQ+ youth may confront victimisation, discrimination, and bullying at multiple levels – individual, interpersonal, community and societal – as well as negative attitudes from peers and family due to their nonconformity (Earnshaw et al., 2016; Laiti et al., 2019; Lancet, 2011; Nieder et al., 2020; UNFPA, 2014; Zeeman et al., 2019).

Lived experiences of sexual and gender diverse young people have been largely ignored in mainstream health research and policy, particularly in countries where the rights of sexual and gender minorities are not recognised (Bowling et al., 2019; Colpitts & Gahagan, 2016; Pollitt et al., 2021; Zeeman et al., 2019). There is a scarcity of research on the sexual practices, lived experiences, and health concerns of LGBTQ+ youth in South Asia where heteronormative patriarchy continues to be a dominant paradigm (Collumbien et al., 2014; Ingraham, 2002; Karim, 2010, 2021; Khan & Raby, 2020; Pollitt et al., 2021). For example, Bowling and colleagues (2019, p. 269) argue that the criminalisation of same-sex sexuality in India had ‘laid the foundation for ostracisation, sanctioned stigma and furthered injustices

[1] Where appropriate, we have used the terms ‘LGBT’, ‘LGBTQ+’, or ‘queer’ as reported in literature and by participants in our study. ‘Queer’ is used when describing theoretical framing. ‘Sexual and gender minorities’ and ‘sexual and gender diversity’ are also used as umbrella terms.

for many' by forcing individuals to hide their sexuality. However, research in the area of LGBTQ+ health in South Asia has disproportionately focused on HIV risk and prevention (Bowling et al., 2019; Deuba et al., 2017; Hossain, 2017; Khan et al., 2005; Krishan et al., 2018). This absence of diverse narratives around sexuality further perpetuates prejudices against LGBTQ+ people and may negatively influence their access to high-quality healthcare.

As sexual diversity in Bangladesh 'is not acknowledged socially or legally', there is a lack of research around the sexual lives and health of LGBTQ+ young people (Khan & Raby, 2020, p. 12). Unlike neighbouring Nepal and India, Bangladesh continues to criminalise consensual same-sex sexual conduct under Section 377 of its penal code as introduced by British colonial rule. Discrimination and violence against sexual and gender minorities in Bangladesh has been described as 'pervasive and ongoing' (Rashid et al., 2011). The brutal murders of prominent LGBT activists Xulhaz Mannan and Mahbub Rabbi Tonoy in April 2016 has made the situation even more dangerous for Bangladesh's LGBTQ+ community (BBC News, 2016; Hossain, 2020). Since the incident, many LGBTQ+ people have either left the country or gone 'underground' due to safety concerns (Hossain, 2020).

Heteronormative straightening devices

Using the concept of orientation within phenomenology, Sara Ahmed (2006) develops a compelling argument around how 'heteronormative lines' – lines upholding compulsory heterosexuality, gender conformity, procreative marriage, and nuclear families – direct us in certain ways throughout our lives and come to be seen as neutral and casual starting points from which we experience the world. However, these lines are not static and neutral but the effects of the repetition of bodily and social actions over time: lines repeatedly traced over other lines (Ahmed, 2006).

'Straightening devices' are described as the mechanisms used to enforce the repetition of actions over time; keeping us aligned to heteronormative lines and ensure things do not become 'wonky' or 'queer'. However, these straightening devices have a way of disappearing from view and can also be that which we do not feel consciously. For example, the heterosexualisation of public space is naturalised by repetition of different forms of heterosexual conduct. Streets record the repetition of acts – heterosexual intimacy, nuclear families on billboards – and the passing by of some (conforming) bodies and not others (Ahmed, 2006). For those who do not inhabit the norm of heterosexuality, these so-called everyday comforts of heterosexuality may feel uncomfortable. 'Becoming' straight means not only turning towards the objects that are given by heterosexual culture, but also turning

away from objects that take us off this line such as queer desire. Queer people might also be asked not to make others feel uncomfortable, by not displaying signs of queer intimacy in heteronormative spaces (Ahmed, 2006).

Ahmed (2006) notes that life courses follow a sequence which is a matter of being directed in a certain way: birth, childhood, adolescence, marriage, reproduction, and death. For a life to count as 'decent' it must take on the direction promised as a social good, which means reaching certain points along a life course. In such a case, a queer life within straight culture might be one that fails to make such gestures of return – by not conforming to expectations of procreative marriage, for instance. In refusing to follow the lines of heterosexuality, one has failed to attain heterosexuality; in not being presumed as heterosexual, one has to 'unbecome' one. This deviance of falling 'out of line' is narrated as a loss of the possibility of happiness within queer lives and, from a lifeworld perspective, can offer insight into meanings of wellbeing.

In this article, we use the framework of heteronormative straightening devices to identify 'invisible' structures upholding normative sexual behaviours and see how young people in Bangladesh navigate these in their everyday lives. Our analysis of empirical data provides an opportunity to find out whether this framework is applicable within the context of Bangladesh as we have little information from existing studies to assess this.

Methods

The findings for this paper are based on qualitative data the first author collected in Dhaka, Bangladesh over nine months from February to October in 2019 as part of their doctoral research. CM guided the research as PA's primary supervisor. We predominantly draw on themes of heteronormativity from biographical interviews with LGBTQ-identifying university students and young professionals aged 19 to 24.

PA used purposive sampling to recruit 46 young people (aged 18 to 24) of varying social orientations – gender and sexual identity, religion, educational background, occupation etc. – based in Dhaka. The recruitment strategy was open and flexible in order to include a diverse range of experiences. Initially, PA approached potential participants through a range of academic and personal networks. Local research assistants working with PA were also asked to utilise their networks to identify suitable individuals who may be interested in participating in the research. Participants included students at public universities, recent graduates, and young people in full- or part-time employment (both private and informal: such as teachers, garment factory employees, shop assistants etc.). Of the 46 total interviewees, 14 self-identified as LGBTQ.

In-depth one-to-one biographic interviews comprised open-ended questions around lived experiences of gender and sexuality as well as life history. PA conducted interviews in Bangla. All interviews were audio recorded. The interviews took between one and two and a half hours. Interview venues depended on where the respondents lived and were comfortable speaking, such as quiet cafes or private office space. All respondents provided written informed consent for participation in the research and were provided with details of local SRH services.

Four research assistants transcribed interviews in Bangla using a verbatim transcription protocol prepared by PA. Professional translators then translated these transcripts to English. Both Bangla and English transcripts were reviewed for quality and accuracy by PA and research assistants. PA used a phenomenological lifeworld approach to explore heteronormative straightening devices as identified and discussed in biographic interviews with LGBTQ+ respondents in Bangladesh. PA followed a phenomenological thematic approach to analysis by identifying and synthesising most prominent and recurring themes around sexuality through line-by-line open coding. PA iteratively coded the interview transcripts using NVivo software and used the open coding nodes to formulate a codebook which was used for secondary coding through in vivo and process codes (Saldana, 2015). Additionally, PA also coded around the five domains of the phenomenological lifeworld (intersubjectivity, temporality, embodiment, emotions, and space) for more details around experiences. PA clustered and reviewed codes into common (sub)themes and then analysed how these related to heteronormative straightening devices.

Ethical approval was granted by the London School of Hygiene & Tropical Medicine, United Kingdom, and from North South University, Bangladesh. PA obtained informed written consent from all respondents and used pseudonyms to maintain anonymity. Recordings and documentation related to the research did not contain any identifiable data.

Findings

Heteronormative expectations were apparent in participants' narratives around gender norms of traditional masculine/feminine behaviour and presentation for men and women as well as compulsory heterosexuality through marriage (as expected by parents). Findings suggest that straightening devices operate at multiple levels, including individual, interpersonal, community, and societal. The four main themes around 'straightening devices' discussed in this paper include: marriage normativity for women; heteronormativity in public space; heteronormativity in healthcare; and failing to embody heteronormativity.

Straightening the life course: marriage normativity

Participants brought up family expectations around heterosexual marriage and suggested that most women in Bangladesh faced pressure from their families to get married. Amina – a lesbian woman in her early 20s living with her family in Dhanmondi, Dhaka – described expectations of being married by a certain age as commonplace for women:

"Most go through the same norms that say, 'you are a girl and you have to live like this.' One of the rules is that since you are a girl, you have to get married. This is because of age. After a certain age, girls are more pressurised for marriage." (Amina, lesbian woman in her early 20s)

For Amina, the pressure to marry started as soon as she began university. She recalled having to see over 100 suitors in meetings organised by her mother; "They used to come to see me. Every time I had to sit in front of them."

Her parents 'approved' of 30 or so potential grooms out of the 100 men she had met. Amina explained how she was able to negate these marriage proposals by making anonymous phone calls to potential grooms and spreading rumours about herself: "…I used to make my friends and cousins make those calls. I used to buy different SIMs [SIM cards] to make those calls too. I switched off the number after making a call."

Amina was able to avoid these arranged marriages for a while, until her grandmother's death and her father's ill health resulted in renewed pressure for her to get married:

"They started to look for a groom with new enthusiasm because my grandmother couldn't live to see my wedding and my father was very unwell at that time. So, that my father can at least see me get married. So, it all started again." (Amina, lesbian woman in her early 20s)

While Amina felt she could not tell her family the truth about her sexuality, she had told them that she was not ready to get married. Despite this, her mother and brother kept insisting that Amina get married to avoid being judged and disowned by their extended family:

"I was being pressurised a lot for marriage and I already told family that I won't marry anyone. I didn't tell them the real reason. I just told them I wasn't ready for marriage.

My mother and brother were mentally torturing me. My extended family knew about that. My own [immediate] family was scared that our extended family would judge us. They would disown us. They were saying a lot of rubbish. They even went as far as to blackmail

me emotionally so that I wouldn't reach out to any other family member." (Amina, lesbian woman in her early 20s)

As the 'mental torture' persisted, Amina became very distraught to the point that she was contemplating suicide. Amina decided to leave home as she felt she could not negotiate any further with her parents:

"I was going through tremendous mental pressure for around three weeks. Every day of those weeks I spent thinking about suicide. I couldn't take it anymore. I just wanted to escape. …Such an environment was created that the next morning I took a shower, got ready and left home with just a bag … and I remember just taking the file that had all my certificates with me. And I just left." (Amina, lesbian woman in her early 20s)

After about a week of travelling around northern Bangladesh, Amina ran out of what little money she had and went to stay with her girlfriend. At this point Amina got in touch with her extended family and they assured her that if she came back home no one would pressure her to get married: "They told me, 'Just come home. Your mother and brother won't do anything to you.' So, I decided to go back home based on their word."

Amina explained how many other queer women in her friend group were also confronting similar pressures to get married, and that not all of them are able to navigate these pressures as she had:

"I have a friend-I tell her that, if you are being pressurised for marriage, handle it *technically* [methodically rather than emotionally]. My friend tells me, 'Not everyone can think technically like you.' That's true that not everyone can think technically like me. But people I'm in contact with, I always tell them they can ask me for help on this. But not everyone can even be helped. There is a girl I know, she's in a dire situation at home. There are a few in similar situations. Another person has been kicked out by her family. They are living on their own now." (Amina, lesbian woman in her early 20s)

For Badol – a 20-year-old transgender man who was assigned female at birth and previously identified as a lesbian – marriage was used more directly as a straightening device. Unlike Amina, who did not disclose her sexuality to her family, Badol initially came out to his parents as queer. In response, Badol's father arranged to get him married:

"I said that I like a girl. They said, 'You like a girl!?' They asked why I am sometimes with a girl, and sometimes with a guy. …My father pushed me to get married…as he knew about

me and Noor [Badol's girlfriend at the time]. And he fixed up a guy for me and pushed me into that marriage." (Badol, 20-year-old transgender man)

Badol found out about the marriage a week before the wedding ceremony and was convinced to make a promise to his father that he would go through with the marriage. From the start of their marriage, Badol's husband was physically and emotionally abusive. Badol described feeling like a prisoner while enduring the 'living hell' of mental and sexual violence for two months:

"During those two months, I was being mentally and sexually tortured. …I was being mentally tortured every moment and I felt like I was in prison. …He forced me from the first day of marriage. …At every moment I did not feel like myself. I mean, it felt like marital rape." (Badol, 20-year-old transgender man)

Despite being isolated from his family, Badol had "faith that Allah would find a way out for me". He was finally able to leave the home of his abusive husband and file for divorce, with the help of his father:

"My father talked to my mother-in-law and told her that usually we went to *Ijtema* [annual Islamic three-day congregation] together and after the *Ijtema* I will attend my best friend's wedding and then will go back to my husband's home.

My father knew that he had tortured me brutally. He [husband] beat me [because] I denied him physical relationship [sex], and he was a drug addict. Then, my father handled the situation. He said he would not send his daughter to him [husband], as they were unhappy. Later, we sent the divorce papers to him. And finally, I divorced him." (Badol, 20-year-old transgender man)

After returning home, Badol continued to be open with his parents about his sexuality – at the time, he identified as a lesbian woman – but was told that his sexuality was unacceptable and that he would be ostracised in society. Badol faced further violence from his father in an attempt to 'straighten' him: "I fought a lot with my parent and my family, they even beat me for this [Badol's sexuality]. My father beat me. He even arranged for goons to beat me up."

Performing straightness: heterosexualisation of public space

Outside of the home, straightening devices also became visible for the majority of queer respondents navigating public spaces. In particular, three queer participants shared in depth their experiences of public harassment and trauma when navigating public spaces.

Shayan – a 24-year-old dance instructor who identifies as a gay crossdresser – narrated numerous incidents of harassment by men throughout his life for as long as he could remember. For him, harassment was an everyday concern. Shayan generally tried to ignore verbal taunting as he was worried that the situation might escalate:

"The thing is, the way I look at it, let them say whatever they are going to say. As long as they don't come near me, as long as they don't create problems, I will not say another word. Because it is when you try to talk to them, that you will have problems." (Shayan, 24-year-old gay man)

Like Shayan, Trishna – a transgender woman working in the development sector – also used to stay quiet and ignore such encounters in an attempt to avoid escalating the harassment while growing up:

"I was a very quiet person back then [pre-transitioning]. …I mean, I was afraid back then. Because whenever I tried to speak people would just mock me. They would make fun of me. I mean, I always felt uncomfortable." (Trishna, transgender woman in her early 20s)

Non-binary student, Auvi, spoke of public harassment and emotional trauma as a wider issue not only for 'queer-presenting' people but also for women navigating public spaces:

"As women, you're very limited to where you can go, what you can do, how you can do it. If I want to go for a run, I could, it would be very traumatic for me as a person. And there was a point where I when I left the home it used to take me a lot of emotional-- You have to be like, 'OK, you're going to go out now. You're going to be seen by people and these people are going to be like dicks to you, how do you deal with that?' I don't. I still have no idea how to deal with it." (Auvi, 22-year-old non-binary person)

Moreover, Auvi shared their past experiences of being able to 'blend in' when passing as man as well as being misgendered and seen as a woman in public spaces:

"So, when I used to pass more as a guy when I had a smaller chest, back then it was easier for me to blend in as a-- Somehow that's more neutral because when you look like a dude, people don't look at you. When you look like a woman, you get attention regardless of what you look like. And that's something that's been very very common and for me persistently present. Every single time I was either made to feel like a little girl or like a woman in some way and that was never a good thing." (Auvi, 22-year-old non-binary person)

It was apparent that persistent harassment affected the respondents' emotional wellbeing. For instance, Shayan would remember various incidents from earlier in the day after returning home and this would 'ruin' his mood:

"They say many things behind my back. Let us say I am heading out from my house, and then damn it, I have to hear these kinds of comments. And when I am just about to go in, then I remember [that these things were said] and it ruins my mood." (Shayan, 24-year-old gay man)

Shayan was not always able to ignore derogatory comments, however. He recalled a recent experience when speaking back to a harasser, commenting on wanting to 'chop off' Shayan's long hair, led to physical violence:

"There is one day in my life when I cried a lot. … I was walking on the road, and a boy said to me, 'Look at him! When I see him, I feel like yanking a fist full of his hair and chopping it off!' He said something like that. So it was really irritating for me. Why should anyone, you know, talk to me like this? So I just turned around and said, 'What is your problem?' He replied, 'So you talk!' He said that, and then he grabbed hold of me and threw me on the road. …So then I said, 'Why did you raise your hand to me?' And he responded really harshly, 'What are you going to do about it?'" (Shayan, 24-year-old gay man)

After arguing for a while longer, Shayan called his cousin for help and the cousin was able to intimidate the man who backed off immediately. However, the confrontation left Shayan deeply upset:

"After this situation had been created, for a few days I became completely *abnormal* [depressed]. It's like in our own country, we have no, you know, rights. My hair was perhaps slightly longer than normal. I don't see why that should be such a problem for us. What I mean is, I felt really bad about it." (Shayan, 24-year-old gay man)

Trishna, who was assigned male at birth, also described the emotional impact of being questioned throughout her life – not only in public spaces but also by her family and peers – because she did not adhere to masculine gender norms:

"I was always spoken down on. I was being verbally abused with bad language and bad signs because I - my behaviour and attitude was feminine. My manner of speaking was feminine. Why did I behave more like a girl than a boy? Why was I like that? There were a lot of 'whys'. It disturbed me a lot." (Trishna, transgender woman in her early 20s)

Auvi mentioned the emotional impact of having to negotiate their gender expression in public spaces by conforming to gender norms or presenting as queer:

"I tried covering up, made me feel worse. I tried dressing more like myself. I got more attention… Started being like, 'I don't give a fuck about this shit because it's too hot to wear an *orna* [scarf] and to have long hair and to wear full pants [trousers] and I'll just deal with the fact that people are looking at me.'" (Auvi, 22-year-old non-binary person)

As a result, Auvi limited themself in terms of where they go and with whom. They avoided using public transport and going out alone:

"I usually go to friends' houses. I don't go out much unless somebody is with me. …I used to get on public transport but it was very traumatising and it's really hard to be in a space like that where there is no space to- …there's no space to escape the fact that somebody is being so pervasive – when they're being invasive." (Auvi, 22-year-old non-binary person)

Shayan, who lives by himself in a relatively low-income neighbourhood, mentioned that facing street harassment was unavoidable for him. Although Shayan tried to keep a 'sense of courage', he reported feeling particularly 'insecure' and 'tense' because he does not live in an affluent area of Dhaka:

"I have to tolerate it [harassment in public spaces]. …It is not possible for me to live in a place like Gulshan or Banani. …So in local areas, these things are bound to happen.

Sometimes I feel a little, you know, tense – for example, I go there very late at night or I bring a lot of things/people with me. There is no [alternative]. But then later I think, whatever will happen will happen, and I will face it, so let me just see what happens.

What I mean is, I keep that sense of courage alive within myself. I think that perhaps sometimes, just sometimes, you know, I feel a little irritated. I check to see if anyone is nearby. I do feel that sense of insecurity – about who is nearby, and who among them might create a scene. At times like that, I feel very [insecure]." (Shayan, 24-year-old gay man)

At the time of the interview, Auvi was about to go to Europe to do their master's degree. For them, this presented an opportunity to be as queer as they wanted without the same sort of restrictions as they faced in Dhaka:

"I know I'm going to have more opportunities to be as queer as I want to be [abroad]. I imagine that a lot of this will change and not necessarily that I'll become more sexual, but also just being able to present myself as somebody who doesn't necessarily need to act in a

particular way. Coz the idea that I have to act feminine is not just something that I have to do because I'm female-bodied but also because there's a lot of expectations that comes with how you look." (Auvi, 22-year-old non-binary person)

It was notable that the respondents who reported being harassed thought they were harassed because they were seen to be presenting as feminine in public. Two queer-identifying participants, Farhana and Minhaj, both alluded to this as a product of patriarchy and gender expectations whereby women presenting as masculine were considered to be 'upgrading' and thus applauded, while men presenting as feminine were considered to be 'downgrading' and stigmatised:

"A girl wearing a shirt or suit is considered a 'brave girl' but a man wearing a skirt would be stigmatised… Patriarchy works both ways." (Minhaj, gay man)

"When women are more like men it is considered 'upgrading' but [when] men are more like women then it is considered 'downgrading'." (Farhana, 23-year-old lesbian woman)

Straightening as 'care': heteronormativity within healthcare

Healthcare was an important institutional straightening device as discussed by queer participants. In particular, transgender and gay participants spoke of concerns around, and experiences of, being discriminated against by healthcare professionals. In terms of perceptions, queer participants were of the view that disclosing their sexuality/being 'found' to be queer could result in discrimination from most healthcare providers. Most queer respondents, therefore, preferred to seek out LGBT-friendly doctors for sexual health issues.

For example, James – a 23-year-old gay master's student – acknowledged that he wanted to have frequent three-monthly sexual health check-ups but faced difficulties in finding LGBTQ-friendly facilities:

"I am facing this problem with regard to having the STD check-up [sexually transmitted infection testing] done. I have been unable to find a place in Bangladesh where I can go and have the check-up done. …The thing is, I had an STD check-up done quite a while ago. It has been almost a year, and the thing is, I have been wanting to have the check-up done once again. I think the check-up should be done quite frequently. Like, with a gap of about three months." (James, 23-year-old gay man)

For James, being tested was an important part of the process of negotiating safer sex – or deciding to have sex without a condom – when 'hooking up' with sexual partners:

"Obviously, I would of course prefer safe sex. And once things are finalised, obviously it is a good idea to have an STD check, in my opinion. Just to be sure. Then after having a discussion about it – what I mean is, after having a discussion, we can come to a decision, about whether you prefer safe sex or not." (James, 23-year-old gay man)

Previously, James had used a confidential referral service organised by Roopbaan – a non-profit LGBTQ+ platform – for sexually transmitted infection (STI) testing. However, increasing safety concerns for the LGBTQ+ community following the 2016 murders of Roopbaan's founder, Xulhaz Mannan – as well as fellow activist Mahbub Rabbi Tonoy – meant that such events had been discontinued:

"There was an event… known as The Pink Slip. That was so that they established some kind of association with a hospital, and then they organised The Pink Slip event there. I think that took place two days in a week. On those two days, all of the [queer] community people could go to that place and have the STD check-up done. But now everything has become totally challenging. I think that there are many security concerns." (James, 23-year-old gay man)

While the respondent did not share any experiences of discrimination at health facilities, he felt unsure about how health professionals would react to him requesting STI tests and did not want to 'take that risk':

"Though the truth is I don't know whether or not they would take it [well] if I went to a random hospital and asked for an STD check-up. I don't actually know about this. …I don't want to take that risk." (James, 23-year-old gay man)

Although James had not been able to find a workaround to the absence of appropriate sexual health services available to him, he had approached queer allies to advocate for this: "I have approached some of the doctors I know who are friends of the [queer] community. They have told me that they will try."

The participant also pointed out that this was part of a wider sexual health issue, and that testing should be implemented by the government and made available to the whole population:

"The thing is, I think that this is also a concern for straight people, the STD check-up. I don't know whether it is less for those *normal* [straight] people, or how frequently they are having this test done. With regard to this, the thing is, it is a government issue. What I mean is, some steps need to be taken. Maybe a month-long programme needs to be organised, whereby anyone who goes there can have an STD check-up done. That is not any sexual

[orientation] thing – something separate for gay people or lesbians. [It is for] the whole population." (James, 23-year-old gay man)

While James and others spoke of their perceptions, three transgender respondents reported actually having negative experiences of being dismissed or misdiagnosed by psychiatrists. While Trishna – a transgender woman in her 20s living on her own near Tejgaon, Dhaka – had sought out a healthcare provider for herself, transgender respondents Badol and Ria's families had arranged for them to see psychiatrists as an intervention. Badol – who was assigned female at birth – explained that his parents thought he had 'gone mad' after he escaped an abusive marriage (arranged by Badol's father in an attempt to steer Badol away from being in a lesbian relationship):

"My father thought I was mad. …Sometimes I used to joke with my mum that she was doing all the household work alone, what if I brought a bride to help her? …They thought I was becoming more and more mad by the day.

[They thought that] I had gone through a lot in my life and had been hurt. Or a virus had attacked me. When I told my father about my relationship and Joba [Badol's girlfriend at the time], he told me that this is not right and took me to a psychiatrist." (Badol, 20-year-old transgender man)

Both Badol and Trishna mentioned being misdiagnosed by psychiatrists who treated their sexual and gender identity as a mental illness:

"The psychiatrist prescribed me lots of drugs. … I wasn't able to function properly after taking those medicines. He also said that this [sexual identity] is a hallucination and a mental disorder." (Badol, 20-year-old transgender man)

"They [psychiatrists] were treating it as some kind of a disease. They were thinking in that manner. I suffered from the side effects of wrongly prescribed medicine. I was prescribed medicine used to treat to people with psychosocial disorder." (Trishna, transgender woman in her early 20s)

For 19-year-old transgender student Ria, her first interaction with a counsellor – recommended to Ria's sister through a family-friend – left her feeling dismissed and not heard when speaking about wanting to transition:

"The counsellor asked me, 'What would you even do in life as a woman?' What does that mean?! I found that question so odd. Because, say, you were born a woman, so wouldn't it be strange to ask why were you born a woman? What's the answer to that? I feel like I am a

woman. I am a woman. So why would you ask me that? You could ask, 'What are your life plans as a woman?' But you can't ask me what's the point of being a woman or man. Am I meant to be thinking about the costs and benefits?" (Ria, 19-year-old transgender woman)

After this negative interaction, a queer friend referred Ria to an LGBTQ-friendly psychiatrist. However, Ria was again disappointed as she was advised to 'take more time' before deciding to transition. In fact, the psychiatrist told her to come back when she was 25 years old:

"[They said] to take more time and that I wouldn't be able to change anything about my body until 25. Oh they also said it [gender reassignment surgery] was illegal in Bangladesh. They said nothing is possible and told me to come see them again after I am 25." (Ria, 19-year-old transgender woman)

This left Ria even more frustrated as she expected the psychiatrist to be more understanding of her situation. She mentioned constantly struggling with her gender identity to the point where she attempted suicide. Ria felt like she was being asked to keep struggling and put her life on pause:

"I was so fed up already. I had already tried to run away from home three times, and attempted suicide twice. How can I wait another six years like this? She was telling me to struggle for another six years and then she just might be able to help me. Can you imagine?

I asked her if I could start the hormone therapy at least. But she wouldn't even agree to that. …I was so hurt. …I would just start the [hormone] therapy at 25…then my life won't begin until after 30." (Ria, 19-year-old transgender woman)

In an attempt to convince his parents that he was not 'going mad', Badol took matters into his own hands and also made an appointment with a more sympathetic queer-friendly psychiatrist. In contrast to Ria's experience, Badol was pleased with the appointment:

"I did some research so that I can make my father understand that this is completely normal. So, there is this renowned psychiatrist, I can't recall his name. I fixed an appointment with him. When we met that psychiatrist, he told my father that this is completely normal, it's natural and it's not my fault." (Badol, 20-year-old transgender man)

However, Badol's father was not swayed by this second opinion because of concerns of social stigma due to Badol's sexuality:

“My father was still in denial. My father’s perspective was that, ‘OK fine, I agree that this is normal. But society won’t accept this and we don’t live abroad.’ If we were living abroad then it would be fine with him. But, in Bangladesh, it is prohibited. ‘I can accept her the way she is, but society wouldn’t accept her, they will ostracise us.’ This was my father’s only concern.” (Badol, 20-year-old transgender man)

Trishna sought the help of a psychiatrist once she had decided she wanted to transition. Although she could not recall the medication she was prescribed when she was misdiagnosed, Trishna remembered noticing multiple side effects – such as drowsiness, weakness, and back pain. These side effects not only adversely affected her efficiency and enjoyment of everyday activities at the time, but being on the medication also affected her ability to work as a performer:

“I started to notice my body was weakening. I mean, I felt drowsy all the time. So, it was like - if I took the medicine at night, I kept on sleeping throughout the whole morning and woke up around 11- 11:30am or noon. I couldn’t keep my eyes open at all. I would eat something and then go back to sleep again. But that’s not like me at all. I’m a very hard worker. I enjoy working hard. My - that was not like my lifestyle.

…I didn’t enjoy my [dance] practice sessions anymore. I just sat around and stopped going to practice. I was a regular dancer back then. I mean, dancing was my sole income source. I used to earn money through my dancing. That’s how I was living back then.” (Trishna, transgender woman in her early 20s)

The respondent decided on her own to discontinue the medication after about six months. One reason for this was because she felt she could not trust her psychiatrist as he did not listen to her concerns:

“It was like- suppose, I went to see him, he kept me waiting for a long time. Whenever I went to see him, he wouldn’t even look at me. It was like that. How can someone prescribe me medicine if he won’t even listen to my problems?

…He is a doctor. He should understand me first. I need that eye contact from him. ...A person who is not taking me seriously- I started to lose faith in his medicine or in him. Afterwards, I- I decided to stop taking the medicine myself. …I still had some medicine left with me. I still stopped.” (Trishna, transgender woman in her early 20s)

Trishna summarised how distressing the whole ordeal was for her as she had expected better care from a medical professional:

"…I tore up all my prescriptions and everything else. I spent two nights away from home. Two entire days. Because I felt something like that happened to me - OK so my friends did that to me, my family did that to me. They made fun of me. They didn't treat me well. But how can a medical professional treat me the same?" (Trishna, transgender woman in her early 20s)

As a result, she no longer trusts Bangladesh's healthcare system:

"*Apu* [sister], I can't even trust to take paracetamols prescribed by Bangladeshi doctors (*laughs*). This is the situation. …all of you should be ashamed that I can't trust the doctors of our own country. So, this is not my fault. …I wanted to believe them that's why went to them first. He was the one who couldn't keep that respect. So, now this is not my fault- I mean, I'm not responsible for that." (Trishna, transgender woman in her early 20s)

With the help of transgender friends in India, Trishna was able to begin hormone replacement therapy with a doctor in Kolkata, India:

"I went to Kolkata. Then, my doctor... I went-went to see him. He gave a lot of tests at first. Tests for my whole body. Tests for my hormones I mean, for androgen, oestrogen then [testosterone], I mean, T-3, T-4, HS—I mean, liver function test. Creatinine – I mean, everything. Even sugar.

Yes, he checked everything. He prescribed medicine only after doing all the tests. I completed a three-month course. I went to see him after. Then, he gave me more tests. He looked through my reports. I started my medication afterwards again. Then, what happened was that I started to change gradually. I mean, structural change. I am really well because of that, honestly." (Trishna, transgender woman in her early 20s)

Continuing the therapy was financially challenging for Trishna as she had to visit Kolkata every three months:

"There are months when I have to be very careful with my money. Because I don't have any extra income sources. I barely manage to save up and bear all my expenses with my salary. I mean, I am still struggling now. …I have to spend a lot. It's a lot of money." (Trishna, transgender woman in her early 20s)

Unbecoming straight: consequences of 'failing' to embody heteronormativity

Participants brought up multiple experiences of, and emotions around, not conforming to norms around heterosexuality and gender throughout their lives. In particular, respondents

gave examples of confronting feeling 'different' from a young age and dealing with internalised homophobia as well as confusion over sexuality and gender identity through attraction to the same sex/gender dysphoria. Many described feeling 'abnormal', 'unnatural', 'gross', 'dirty', and 'uncomfortable' while exploring their own sexuality and gender identity.

Participants spoke about how they were identified and perceived to be different from their gender and sexuality conforming peers. For example, Shayan highlighted how failing to conform to heteronormative masculine traits in public was associated with being 'found' to be different and harassed as a result of this difference. Shayan mentioned that he had been persistently confronted by this type of harassment throughout his life, even when he himself did not understand what it meant:

"I was perhaps five years old, or maybe six, and many people would call me 'half ladies'. From the time when I was little [they did that]. And I didn't even understand what that meant.

…You could see it in the way I moved, there were some biological issues. Those were things that they picked up on at that time. Or perhaps they just felt that there was 'something a little effeminate about this one'. Because of that, they used to behave in this way with me." (Shayan, 24-year-old gay man)

Shayan, believed that it was something 'genetic' or 'biological' that made him identifiable as 'different' from men who conformed to masculine norms:

"Some of this is genetic for me. I go to a store and buy a few odds and ends, and that is all there is for them to see. I walk past on my way there, and I walk past on my way back, and that is all there is for them to see.

As they watch me, they realise that there is something about the way that I move which perhaps makes them understand that there is something different about me. So they say things [about me] like, 'Hey, *bhabi* [sister-in-law] is here.'" (Shayan, 24-year-old gay man)

For some, gender dysphoria was felt more acutely during puberty. Ria and Trishna, two trans women who were assigned male at birth, both described feeling emotionally troubled or restless and physically uncomfortable within their bodies throughout their childhood and teenage years. Ria described being restlessness about her gender from a very early age as well as feeling like she was trapped inside a male body: "[It is like] you're one thing on the outside but you're something else on the inside. …This feeling was coming from inside me. I was so restless. I couldn't resolve the matter."

Ria was in Year 7 when she first heard about gender reassignment and felt like she had to realise her 'dream' of becoming a woman by running away from home and becoming financially independently:

"The first time I heard that it was possible to change to be a woman, my eyes were opened. That was my dream. …[I thought] now I have to solve my own problem. I felt like I had to get a job, had to save up money [for gender reassignment surgery] and be independent." (Ria, 19-year-old transgender woman)

Like Ria, Trishna recalled a similar feeling of constant discomfort within her body throughout her childhood and teenage years:

"My body wasn't responding the way a male body should. The male organs weren't functioning the way they would do at that age. Instead it was the opposite with me. What was I supposed to do with an incompatible body? …Afterwards, when I realised that I couldn't take it anymore - this went on until my university. My change started after that. That's when I took that decision [to transition]." (Trishna, transgender woman in her early 20s)

She went on to describe how she kept questioning whether she was 'normal' and 'natural'. Finding answers to these 'whys' adversely affected her mental health and confidence, leading to a suicide attempt:

"I went through a lot of mental trauma. I was- at a point I started questioning myself. Why am I like this? Why is this happening to me? That caused me to lose self-confidence and which caused me to one point attempt suicide. Just to find the answers to all the 'whys'. Am I not a normal human being then? Am I really unnatural then?" (Trishna, transgender woman in her early 20s)

Questions around being 'normal' came up in most interviews. There were assumptions that failing to embody heterosexuality was associated with past sexual abuse and life challenges, contributing to feelings of guilt and confusion around sexual trauma. James described being sexually abused by a much-older male relative from the age of 10 to 13:

"He [an older male relative], how can I put it, introduced me to kissing and other things like that. But I was not interested. Then again, what can I say, at such a young age, I did experiment with this new thing. And I also enjoyed what came out of my curiosity." (James, 23-year-old gay man)

As it was also around this age that James became more curious about his own sexuality, he remembered questioning whether the sexual abuse somehow shaped his sexuality and how people knew that he was 'different':

"I don't know how people can somehow understand…that I might be like this [gay]. If that was not the case, then I would not have been abused so many times. I was very confused at that time, wondering whether this was a problem with me. Wondering, 'Is it OK? Is it natural?' …Because of that, afterwards I suffered from guilt for a very long time - like, I was really confused. …[I thought,] 'I am different, that's why I got molested.'" (James, 23-year-old gay man)

Auvi also pointed out that they thought people generally perceived trauma as causing deviance from normative behaviour:

"When I was explaining these things [experiences of trauma and being queer] to people and they were like, 'Did you go through the trauma and then become queer?' I was like, 'No, I was queer, that's why I was given all this shit that caused the trauma.' That was something a middle-aged woman brought up and I was like, 'That makes sense that you would think that though.' That's also how people think about these things. I think I was basically queer since I was born. I just didn't have the words for it until I was a lot [older]." (Auvi, 22-year-old non-binary person)

Participants also spoke about difficulties in accepting their sexual identity. For example, James revealed that although he knew he was attracted to men, he felt 'confused' and was unable to accept this about himself for several years: "I was confused for a long time – I was unable to accept my own sexuality. For a long time, since 2009, I have known this about myself. But I was unable to accept it."

Two bisexual women, Deepa and Zohra, recalled their first experience of same-sex attraction and described initially thinking it was 'gross', 'dirty', and 'uncomfortable'. Both respondents acknowledged that these negative feelings were influenced by homophobia. They reconsidered the experiences on their own and started to be more accepting of their sexuality:

"I started to have romantic thoughts about her [a friend from school], but I pushed those ideas away. Because I myself was kind of a homophobe. …My cousin was a lesbian but - I didn't like this about her. I used to think of it as something dirty. So, when the same thing started to grow in me - I couldn't accept it at first. I wasn't scared of it, but I felt uncomfortable. I-I mean, I wanted to repress it. But I started to see that I can't push these

thoughts away anymore. I couldn't stop thinking about her. And whenever I used to close my eyes, I had sexual thoughts about her. I would imagine things about her. Then I thought, 'OK, fine. I should just accept it. That I like her.'" (Deepa, bisexual woman in her early 20s)

"The first time it happened I was like all-uh-I mean grossed out. I got grossed out by the experience. But, later on, I was like that- after I got grossed out, I was like- wait, no. If I was truly grossed out by it then it would be a bit different - I would have reacted a bit differently, right?" (Zohra, 18-year-old bisexual woman)

While Deepa and Zohra's narratives focussed on self-reflection around internalised homophobia in accepting their bisexuality, other participants mentioned finding support from peers, television shows, and the internet. Most queer young people identified LGBTQ+ visibility and representation as a point when they began feeling 'natural', 'normal', and 'less alone' regarding their sexual and gender identities. Three participants gave examples of specific Hindi and English television shows which helped them to discover more about sexuality. For instance, Ria said that the first time she came across non-heterosexual representation as something 'normal' was while watching an Indian television show called '*Kaisi Yeh Yaariaan*' ('How is This Friendship') which had a gay storyline. She specifically recalled one of the characters coming out to his mother as gay, which made Ria think it might be possible for her to confide in her own parents. Amina also mentioned feeling excited to see lesbian intimacy represented for the first time on an Indian show called 'The Other Love Story'. She remembered really looking forward to the show: "Addheyian and Anchaal were the names of the two characters. I started watching that. I used to wait for new episodes every week."

James remembered seeing his sexuality as something 'natural' and feeling very 'supported' when he first started watching British television show 'Queer as Folk':

"There was a television series that really influenced me. The subject was learning to accept oneself. … 'Queer as Folk'. I felt so supported after I watched that TV series. I liked it so much, that I thought, No, it's quite natural. People can be like this. There is nothing wrong with that." (James, 23-year-old gay man)

Participants also spoke about forming friendships with others within the LGBTQ+ community – both virtually and in person – while first learning about sexual and gender diversity. For example, Trishna said having online transgender friends made her feel more 'relaxed' and 'less alone'. Trishna's friendships also helped improve her mental health by giving her a sense of relief and stopping what she referred to as an 'addiction' to suicidal thoughts:

"I was also browsing the internet a lot at that time. I made a lot of friends over the internet. …I realised that I wasn't alone and that there were a lot of people who were in similar situations as me. I relaxed a bit after finding that space for myself.

It helped me to stop my suicidal *addiction.* I had developed an addiction to suicidal thoughts. When I saw that I wasn't alone. I have- I mean- many friends who are like me. There are many people who are facing similar situations so, this is normal. I felt relieved after that." (Trishna, transgender woman in her early 20s)

Trishna fondly remembered how she was 'inspired' to transition by a transgender friend in India – a friend who sadly later took her own life. As well as inspiring Trishna, Asha also provided practical support by taking Trishna to see a doctor in Kolkata, India:

"I had an internet friend called Asha. She is no more. She committed suicide. …She was a transgender woman. I was inspired by her. [I thought] she's doing it, so why not me? Why am I not taking the step? I should. She was my main inspiration behind my decision to change. She was the one who took me to the doctor. I spoke with the doctor there." (Trishna, transgender woman in her early 20s)

Discussion and conclusion

This article presents young people's everyday experiences of having to 'bend' to – and against – heteronormative straightening devices at home, in public spaces, and within institutions such as healthcare. Additionally, participants in our study had very little social support and navigated this by seeking representation in the media and friendships with other LGBTQ-identifying people. Our findings support global literature about discrimination and inequalities confronted by LGBTQ+ youth and adverse consequences for their mental health and wellbeing (Bowling et al., 2019; Earnshaw et al., 2016; Kuper et al., 2018; Laiti et al., 2019; Lancet, 2011; Nieder et al., 2020; UNFPA, 2014; Zeeman et al., 2019).

Concern around concealing sexual or gender identity as a matter of personal safety in public spaces and healthcare facilities resulted in feelings of discomfort among queer young people. Ahmed (2006) described these emotions as a common feature for individuals who do not conform to heteronormative society. As a straightening device, queer people may be asked not to make others feel uncomfortable, by not displaying signs of queerness in heteronormative spaces (Ahmed, 2006). In this manner, availability of comfort for conforming bodies depends on the labour of non-conforming bodies through concealment. This burden of concealment and perceived 'failure' to embody heteronormativity resulted in feelings of guilt and shame for participants in our study. Experiences and expectations of

concealment varied depending on factors such as ability to pass as cisgender and heterosexual. For example, as women routinely face street harassment due to widespread gender discrimination in South Asia (Dhillon & Bakaya, 2014; Nahar et al., 2013b; Rashid, 2000; Zietz & Das, 2018), participants perceived that passing as masculine in public spaces would draw less attention.

Overall, perceived insensitivity towards gender and sexual diversity – in addition to social stigma of nonconformity and taboos around sexuality – left LGBTQ+ young people without adequate support from institutions as well as from their families and wider community. Evidence from global research suggests that lack of supportive environments at home, in school and healthcare settings further compounds the emotional challenges of living outside of heteronormativity (Bidell, 2014; Day et al., 2019; Earnshaw et al., 2016; Fantus & Newman, 2021; Keuroghlian et al., 2017; McDermott et al., 2021; Ryan et al., 2010). Adverse health implications such as trauma, depression, anxiety, and suicidal thoughts as described by all participants in our studies are also widely reported in mainstream research on LGBTQ+ experiences (Barragán-Medero & Pérez-Jorge, 2020; Bowling et al., 2019; Earnshaw et al., 2016; Kuper et al., 2018; Laiti et al., 2019; Lancet, 2011; Nieder et al., 2020; Regmi & van Teijlingen, 2015; Rivers et al., 2018; Searle, 2019; UNFPA, 2014; Zeeman et al., 2019). In particular, transgender youth in our study reported being the most affected by heteronormativity in healthcare because they felt disrespected and stigmatised for their gender identity – the very reason they had sought help in the first place. Moreover, healthcare providers were perceived to have inadequate knowledge of gender reassignment and often misdiagnosed transgender patients. Transgender youth in high-income settings also reported having similar negative healthcare experiences (Reisner et al., 2016; Safer et al., 2016; Winter et al., 2016).

Wider research recommends a range of interventions to reduce health disparities by improving social support for LGBTQ+ youth – such as promoting family acceptance, providing safety nets for youth in case family relationships breakdown, and training health professionals (Laiti et al., 2019; McDermott et al., 2021; Ryan et al., 2010). Narratives of young people in our research indicate perceived sociostructural barriers to implementing such interventions. In this context, how could we as researchers and practitioners ensure the same level of support in places where queer rights are not recognised? Who would be willing to support these initiatives and how effective would these be at facilitating 'bending' against straightening devices in Bangladesh?

This study examined lived experiences of self-identifying LGBTQ young people in Dhaka within the phenomenological framework of heteronormative straightening devices. Although

some of the participants grew up in different areas of the country, most of the narratives referring to public spaces and health services were based on urban settings. As such, further research is needed to understand the experiences of peri-urban and rural areas where young people may be facing different challenges. Similarly, we were unable to recruit intersex people and their experiences should also be investigated in future work. From a phenomenological standpoint, it would be useful to explore each of the 'straightening devices' – as well as specific sexual and gender identities – in more depth to better understand the essence of lived experiences. Given that our research focus was lived experiences of young people, we could not address the perspective of other actors who may be upholding heteronormative straightening devices – such as healthcare professionals or parents of young people. Examining structural challenges may provide more context-specific information on how to effectively advocate for the rights of queer young people. Finally, due to the dearth of research on sexual and gender diverse young people in Bangladesh, we had to rely on reviewing global literature. As many of these other studies were based in high-income countries, the recommendations need to be further examined to be applicable in Bangladesh.

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CHAPTER 7. SEXUALITY LIFEWORLD (PAPER 4)

Overview

In the following chapter, I address Objective 2c by looking at the sexual lifeworlds of lesbian, gay, bisexual, transgender, and queer (LGBTQ) identifying young people in Bangladesh.

I adapt a phenomenological reflective lifeworld research approach, as outlined by Dahlberg and colleagues (2008), to capture the essential aspects of sexual intimacy as described by participants.

Using thematic analysis, I observed five interlinked themes which encompassed the sexual lifeworld of young people in the study: desire for romantic intimacy in sexual interactions; need for discretion when navigating sex and relationships; 'matching' sexual roles in sexual partnerships and attraction; challenges to relational power dynamics of masculinity and domination; and embodying notions of sexual morality. According to participants, sexual intimacy as experienced by LGBTQ young people in Bangladesh meant desiring consensual sexual and romantic relationships with sexually 'matched' partner(s) while navigating heteropatriarchal sexuality norms.

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Surname/Family Name	Alam		
Thesis Title	Young people's lived experiences and perceptions of sexuality in Dhaka, Bangladesh		
Primary Supervisor	Cicely Marston		

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“People are having lots of other kinds of sex”: Exploring sexual lifeworld of LGBTQ young people in Bangladesh

Introduction

Lived experiences of sexual and gender diverse (SGD) young people are often overlooked by mainstream public health research (Bowling et al., 2019; Pollitt et al., 2021; Zeeman et al., 2019). In Bangladesh, where discrimination and violence against SGD people is pervasive and ongoing, a lack of recognition of sexual diversity continues to contribute to a scarcity in research around the experiences of SGD young people (Khan & Raby, 2020; Rashid et al., 2011).

Research in the field of sexuality in Bangladesh has focused explicitly on male-to-male sexual health governed by a global interest in Aids and disease prevention (Gagnon, 2006; Hossain, 2017, 2020; Siddiqi, 2011b). Such studies emphasise measuring transmission and responses to interventions, rather than the role of sexuality within young people’s lives (Gagnon, 2006). Furthermore, categories such as ‘men who have sex with men’ used by public health professionals and donors do not capture 'highly context-specific ways’ in which SGD people understand themselves (Hossain, 2017; Siddiqi, 2011b).

As John Gagnon (2006) argued, public health research can sometimes neglect what sex means for young people in favour of quantitative measures such as ‘how often, how many, and did you use a condom the last time’. This preoccupation with ‘decontextualised goals and superficial measures of quality’ risks dehumanising research and practice and often neglects the ‘lifeworld’ – a shared and meaningful world of emotions and memories that is textured, embodied and experienced by us and through us every day (Hemingway, 2011; A. Hemingway et al., 2015). The result has been a research focus on causes and treatment of ill health rather than a contextualised people-centred approach to understanding wellbeing.

In this article, we explore young people’s lived experiences of sexuality in Dhaka, Bangladesh. We adapted a phenomenological reflective lifeworld research approach, as outlined by Dahlberg and colleagues (2008), to capture the essential aspects of sexual intimacy as described by lesbian, gay, bisexual, transgender, and queer (LGBTQ) identifying young people.

Phenomenological Approach

Reflective lifeworld research is concerned with how the implicit and tacit become explicit and heard, and how the assumed becomes problematised and reflected upon. As a

methodological tool with which to reveal and understand the multifarious world of human beings, the overall aim of lifeworld research is to describe and elucidate the lived world in a way that expands our understanding of human experience (Dahlberg & Dahlberg, 2020; Dahlberg et al., 2008). The concept has been used in several health-related studies looking at different phenomena such as sexuality and sexual wellbeing (Carlsson-Lalloo et al., 2018; Carlsson-Lalloo et al., 2021; Klaeson et al., 2012; Thoresen et al., 2011). For example, a recent study uses reflective lifeworld research to find that the essence of sexuality and childbirth as experienced by women living with HIV in Sweden is that perceptions about contagiousness profoundly influence sexual behaviour and considerations around pregnancy and childbearing (Carlsson-Lalloo et al., 2018).

PA's doctoral research used a phenomenological lifeworld approach to capture people's experience of the world. The lifeworld perspective can be used to explore how the 'experiential side' has a particular meaning for the person and must be attended to in order to better understand wellbeing (Dahlberg et al., 2008). PA used phenomenology as a tool towards grasping the meanings that young people give to their everyday experiences of sexuality in order to gain a deeper understanding of young people's experiences of sexual health and wellbeing within the context of their lifeworld. Figure 3.1 illustrates the theoretical framework which incorporates these concepts.

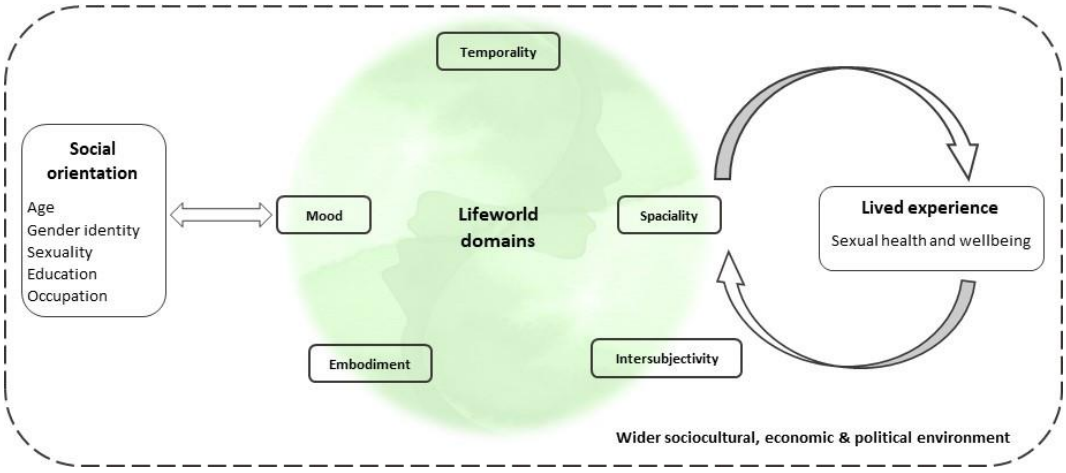

Figure 3.1 Theoretical lifeworld framework

Individual characteristics have been labelled as 'social orientation' (Ahmed, 2006), as these are not static and neutral categories, but are what comes into view; not simply given but effects of the repetition of actions over time. These social orientations, too, interact with and through the lifeworld. A broad range of factors – such as age, gender, sexuality, and so on – shape embodied experiences (Ahmed, 2006; Dolezal, 2015). Phenomenological research

attempts to reveal these taken for granted structures as well as the 'hidden' assumptions that inform lived experience with respect to these categories (Dolezal, 2015).

Through the theoretical framework of the study PA situates the five domains of lifeworld at the centre of analysis as a means of understanding the phenomenon of sexual intimacy as experienced by queer young people in Bangladesh. Lived experiences interact with the lifeworld domains – shaping, and being shaped by, life events. This study explores 'lifeworlds' of participants by focusing on their descriptions of lived experiences and important life events around sexual intimacy as identified by the research participants themselves (Dahlberg et al., 2008; van Manen, 2016).

Methods

This qualitative, ethnographic study involved interviews and observations by the first author (PA) in Dhaka, Bangladesh over nine months from February to October in 2019 as part of their doctoral research. CM guided the research as PA's primary supervisor. We predominantly draw on themes of heteronormativity from biographical interviews with LGBTQ-identifying university students and young professionals aged 19 to 24.

PA used purposive sampling to recruit 46 young people (aged 18 to 24) of varying social orientations – gender and sexual identity, religion, educational background, occupation etc. – based in Dhaka. The recruitment strategy was open and flexible in order to include a diverse range of experiences. Initially, PA approached potential participants through a range of academic and personal networks. Local research assistants working with PA were also asked to utilise their networks to identify suitable individuals who may be interested in participating in the research. Participants included students at public universities, recent graduates, and young people in full- or part-time employment (both private and informal: such as teachers, garment factory employees, shop assistants etc.). Of the 46 total interviewees, 14 self-identified as LGBTQ.

PA conducted in-depth one-to-one biographic interviews with each participant in Bangla, consisting of open-ended questions about lived experiences of gender and sexuality and life history. Interviews were audio recorded and took between one and two and a half hours. Interview venues depended on where the respondents lived and were comfortable speaking, such as quiet cafes or private office space. All respondents provided written informed consent for participation in the research and were provided with details of local SRH services.

Four research assistants transcribed interviews in Bangla using a verbatim transcription protocol prepared by PA. Professional translators then translated these transcripts to English. Both Bangla and English transcripts were reviewed for quality and accuracy by PA and research assistants. PA used a phenomenological approach to explore sexual lifeworlds as identified and discussed in biographic interviews with the LGBTQ+ respondents. PA followed a phenomenological thematic approach to analysis by identifying and synthesising most prominent and recurring themes around sexuality through line-by-line open coding. PA iteratively coded the interview transcripts using NVivo software and used the open coding nodes to formulate a codebook which was used for secondary coding through in vivo and process codes (Saldana, 2015). PA also coded around the five domains of the phenomenological lifeworld (intersubjectivity, temporality, embodiment, emotions, and space) for more details around experiences. PA clustered and reviewed codes into common (sub)themes and then analysed how these related to sexuality. PA then developed an inclusive description of the phenomenon incorporating common themes.

Ethical approval was granted by the London School of Hygiene & Tropical Medicine, United Kingdom, and from North South University, Bangladesh. PA obtained informed written consent from all respondents and used pseudonyms to maintain anonymity. Recordings and documentation related to the research did not contain any identifiable data.

Findings

In the in-depth interviews, sexual intimacy as experienced by LGBTQ young people in Bangladesh meant: "Desiring consensual sexual and romantic relationships with sexually 'matched' partner(s) while navigating heteropatriarchal sexuality norms."

We analysed five interlinked themes which encompassed the sexual lifeworld of young people in our study:

1. Desire for romantic intimacy in sexual interactions
2. Need for discretion when navigating sex and relationships
3. 'Matching' sexual roles in sexual partnerships and attraction
4. Challenges to relational power dynamics of masculinity and domination
5. Embodying notions of sexual morality

'More than just sex': Desire for romantic intimacy in sexual interactions

"I search for a mental attachment not just a physical attachment. But also, mental attachment and mental satisfaction."

- Trishna, transgender woman in her early 20s

Like Trishna – a transgender woman in her 20s – all participants reported wanting some degree of 'mental satisfaction' and 'romance' with sexual partners when speaking about positive sexual experiences. For instance, Shayan – a 22-year-old who identified as a crossdressing gay man – stressed the importance of having a 'mental connection' with someone before engaging in sex. While Shayan participated in what he and other interviewees said they perceived as the norm of having multiple sexual partners, he reported not feeling 'entirely satisfied' as he had wanted to be dating his partners:

"I like it better to be [in a relationship] with someone. In the meantime, I had physical encounters with a lot of people. But I was never entirely satisfied living like that. It was more that I found it necessary, or everyone else in the community is like that." (Shayan, 24-year-old gay man)

When speaking about his first sexual experience, Badol – a 20-year-old pansexual transgender man who used to identify as a lesbian woman – also vividly remembered feelings of romantic love and commitment for their partner which led to sex:

"When you are with the person you love, you feel butterflies in your stomach. When you are with the person you love everything is possible. I was determined that if I want someone as my life partner, I want her." (Badol, 20-year-old transgender man)

Trishna recalled always wanting romantic interactions, such as holding hands and kissing, with someone she was interested in romantically: "I used to think we would go somewhere, hold hands or kiss. Or maybe we could hang out somewhere. Go to watch movies."

Farhana – a 23-year-old lesbian woman – only had what she described as 'room dates' with women she was dating or 'crushing on'. Like other respondents, she explained that she was looking for romantic connections with sexual partners rather than 'one-night stands'.

James – a gay student – on the other hand, was 'very curious' about 'random hook ups' when he first became sexually active: "In the beginning, it seemed very surprising to me that I could just have a one-time hook up with a person." At the same time, James mentioned that he had always been attracted to men whom he found to be intellectually stimulating and thus

regarded himself as ‘sapiosexual’ – someone sexually attracted to intelligent people: “I think that even from my childhood, I was a sapiosexual. At that time, I didn’t even know this term ‘sapiosexual’. Now I know it. I understand it.”

According to participants, learning the terminology around sexuality and different relationship styles assisted them in explicitly finding and asking for what they wanted from partnerships. For example, James further mentioned preferring ‘foreplay’ more than ‘the main anal thing’ as he reported felt it was ‘more romantic’. Although he recognised that he enjoyed ‘foreplay’ a lot, James said he was not always able to negotiate this during his earlier hook ups with his partners because he ‘did not know these terms’. However, he was able to use other terms to accurately describe what he enjoyed:

“I actually get more pleasure out of foreplay than the main anal thing. It’s more romantic…In the beginning, with the hook ups, as far as I can recall some people used to do foreplay, but most were just doing their own thing. At that time, I did not know these terms, like foreplay. So, I would just say that I liked kissing and hugging, these things, very much.” (James, 23-year-old gay man)

Participants were also able to express their preferences for being in either monogamous or polyamorous relationships. Trishna, for example, explained that although she thought polyamory was commonplace within the queer community, she did not like this style of relationship and intentionally sought a monogamous relationship: “I'm mono [monogamous], I'm not poly [polyamorous]. I don't like polyamory. He [my partner] has to be mono.”

Need for discretion when navigating sex and relationships

“Things are so underground here. It is easy for us to meet up and hook up. Nobody will even know about it.”

- James, 23-year-old gay man

James elaborated why he thought open relationships would be ‘more practical’ within the context of the gay community in Bangladesh where men can – and, according to James, do – discreetly ‘meet up and hook up’ with other men. James said he would not break up with someone if they were to hook up with other men. However, he would rather be told about this than find out from others:

“In order for the relationship to work out [open relationships are more practical]. ...If my boyfriend hooks up with someone else, I don’t have to break up with him. But he has to tell

me that beforehand so that I don't hear about it from other people." (James, 23-year-old gay man)

Auvi – a non-binary student – mentioned discretion around sexuality as something inherent within the queer community due to wider concerns about safety and stigma. As such, they explained that it was easier to negotiate relationship parameters – such as polyamory – within the queer community because of this overall level of discretion 'about sexual things'. They themself had wanted to explore polyamory within their own relationship but found it more difficult to negotiate with their monogamous heterosexual male partner who was not a part of the queer community:

"I wasn't able to explore that for myself because my partner was monogamous, and I don't want to be and that's something I've negotiated for a while. But being discreet is something that's very common about sexual things especially in the [queer] community. They're able to find people to have one-night stands with or people in the community who are also polyamorous." (Auvi, 22-year-old non-binary person)

Badol also spoke about a 'discreet' gay friend who presented as a 'straight guy' with whom he was sexually involved. Badol felt comfortable to explore his dominant side by anally penetrating his friend with a strap-on. Badol remembered realising that not only did he enjoy being a 'hard dom' but also that he felt he was 'completely a man' during sex:

"I have a friend from my area. If you see the guy, he will seem like a straight guy. But actually he is a bottom. And he is quite discreet about his sexuality but he knew that I loved this. So, I had a physical relationship with him and had sex using a packing strap-on. That's when I realised that I love [being a top]. That's when I realised, I am completely a man and I am getting complete pleasure from this." (Badol, 20-year-old transgender man)

Shayan explained that the logistics of same-sex hook ups were sometimes 'easier to manage' than straight ones. Shayan gave the example of a time when he went over to a partner's flat as they lived alone. Although the partner was concerned about the neighbours seeing the two of them together, Shayan explained that people wouldn't think anything of it:

"The thing is, we are both boys. People don't usually think anything of a situation like that. You can always say that a cousin was visiting you, or something like that. I look a lot younger than him as well. He was a lot older than me. So, it really wasn't such a big deal." (Shayan, 24-year-old gay man)

Before her transition, Trishna's first long-term relationship was with man whom she lived with for a year. She said that it had not been difficult to keep their relationship a secret from neighbours as people assumed the two were bothers: "They [neighbours] thought we were brothers. I had just started my counselling [for gender dysphoria] by the end of our relationship. But I didn't start my medication at that time."

Badol explained how he was able to have his first sexual experience with his girlfriend when he used to identify as a woman:

"I went to her place in Tangail. She introduced me as her best friend and told her family that I was there for work. Her mother knew that I was working for [a human rights organisation]. I went there as a girl, and they took it normally [were not suspicious]. I stayed there for two days. That was my first time, and actually that's when I understood how two girls can have a physical relationship with each other." (Badol, 20-year-old transgender man)

However, Badol was only able to stay at his girlfriend's home once during their eight-month relationship: "We met up a lot, but we were only physical once."

As a teenager, James would meet other gay men online from cybercafes and arrange meet ups to have sex. The first time James hooked up with someone online, he arranged to go to an unknown location for sex as suggested by his date. James was told that the landlord of a nearby saloon did not care who rented out the rooms for hook ups:

"[He said,] "There is a three-storey market. On the third floor, there is a saloon." And in that saloon, apparently if anyone wants to hook up or do something like that – straight or gay – they don't care. They just give you a room. If you wanna do stuff, you can do it." (James, 23-year-old gay man)

Auvi reported that there was far more communication around sex within the queer community. They advocated for more open communication about sexuality and sexual desires between sexual partners outside of the queer community as well: "A lot of people are having lots of other kinds of sex and they don't really know how to be safe for it. There needs to be a lot more communication around sexuality between people that are being sexual."

'Matching' sexual roles in sexual partnerships and attraction

"There are many who like you to really be a man, because they like manly men. There are also many who prefer more feminine men role-playing as women..."

- Shayan, 22-year-old gay man

Queer participants identified as dominant/tops or submissive/bottoms within sexual relationships and looked for sexually compatible partners who identified as the opposite. All respondents described their sexual role as fixed. For example, Badol stressed that he always thought of himself as a top and hated the idea of being submissive during sex.

Shayan mentioned that he had known he was a 'pure bottom' from the time Hijra members of his dance group had described him as a '*kothi*' – a term used by the Hijra community for effeminate gay men who want to be penetrated during sex:

"They said that, 'You are a *kothi*.' What it means is, those of us who are gay bottoms. They are also called *kothis.* It was from them that I learnt that boys could have this kind of relationship together. It was from them that I found out about all this." (Shayan, 24-year-old gay man)

James was introduced to the terminology of 'top' and 'bottom' (in English) during his first gay sexual experience. However, he knew immediately that he wanted to do 'bottom stuff':

"At that time, I didn't even know what was 'top' and what was 'bottom'? He [first sexual partner] asked me, 'Are you top or bottom?' I said, 'I have no idea. I don't understand.' I had never even heard that term before. Anyway, after that, he explained things to me, and I knew I felt like doing bottom stuff. After he had explained, I said, 'I am this. I am bottom.'" (James, 23-year-old gay man)

In terms of navigating sexual compatibility, Shayan suggested that this happened 'automatically' because he was not attracted to 'feminine men':

"I am pure bottom. I have never [done anything else]. I have never wanted to change my role, nor do I have any plans to do that. So, that is how I am. I will not be attracted to any feminine man. I like a man who is masculine or manly. So in that case, automatically that issue gets taken care of." (Shayan, 24-year-old gay man)

For James, however, there was not always such a clear-cut distinction between his sexual attraction towards men and his role as a 'pure bottom': "Surprisingly, you can't always tell

right from the beginning [whether someone you like is a top or bottom].” As an example, James spoke about his attraction towards ‘typical twinks’ – young slim attractive gay men – who often also identified as bottoms. As such, he was able to appreciate them as ‘eye candy’ but not as sexually compatible partners:

“The thing with me is, I really like the typical twinks, and it invariably turns out that the typical twinks are most often bottoms. But they tend to be very much eye candy and since eye candy usually looks good, it is just for looking at, and I like looking.” (James, 23-year-old gay man)

James also shared a situation where his friend, also a bottom, wanted to start a romantic relationship with him. James thought that such a relationship would be short lived as neither partner would be satisfied:

“At one stage, he really liked me and he really wanted to be in a relationship with me. Then I said, ‘Look, the thing is we are both bottoms. What would we do if we went into a relationship? The relationship would not last very long.’” (James, 23-year-old gay man)

Similarly, Badol – who used to identify as a straight woman at the time – and his ex-boyfriend ended their romantic relationship after finding out that they were not sexually compatible as both wanted to be dominant during sex:

“I actually wanted to take control while having sex. I mean, I wanted to be dominant and my partner to be submissive. He didn’t want that. So, there was a problem in our relationship because of this. There was a distance between us.” (Badol, 20-year-old transgender man)

Farhana recalled the lack of sexual compatibility the first time she had sex with her girlfriend had attempted to be dominant: “She [girlfriend] couldn’t turn me on, that’s why we broke up. Because I wasn’t turned on by her during our room date [to have sex].”

She reflected on her sexual inexperience and not knowing what she liked or what she was supposed to do. Instead of exploring their preferences further, her partner at the time saw this as a rejection and broke up with Farhana:

“I was like very naive. I was like super naive. I couldn’t figure out what I was supposed to do. It wasn’t coming naturally to me. I wasn’t uncomfortable, but I didn’t know anything. Because I had never been intimate with anyone before so I didn’t know what to do. She [partner at the time] thought that was a rejection. And she told me that I wasn’t her type. I know now why she said that.” (Farhana, 23-year-old lesbian woman)

Badol recalled wanting to be in a relationship with someone who identified as a 'tomboy'. She explained to Badol that it was not possible to be in a relationship with 'another tomboy'.

"She said, 'I am also a tomboy.' I wasn't aware of this term. I just knew the term lesbian. [She explained that it was] a girl who thinks of herself as a guy [rather than] a girl. I said to her, 'I think of myself as a guy that means I am also a tomboy.' She replied, 'Then how is it possible to get involved in a relationship with another tomboy?' She said, 'If I were a bit girly then she could consider me for a relationship.'" (Badol, 20-year-old transgender man)

Challenges to relational power dynamics of masculinity and domination

"Masculine behaviour is more common among tomboys and trans men. They are more patriarchal [and dominating]. In order to make themselves appear more manly they adhere to patriarchy so much that you end up hating them."

- Farhana, 23-year-old lesbian woman

According to participants' perceptions and experiences, queer relationship dynamics were shaped by inequitable patriarchal norms, with some individuals reproducing heteronormative behaviour to appear more 'masculine'. Not only did participants report viewing sexual roles as gendered and needing to be 'matched' by partners, but they also commented on how these gender roles had an impact on their relationship dynamics. Farhana expressed that masculine-identifying queer people associated dominant patriarchal behaviour with masculinity.

Auvi also mentioned receiving sexual interest from men because of their androgyny but then wanted them to be more 'feminine' and 'submissive':

"They were interested in the fact that I was 'exotic' and then uninterested in me when they were unable to make me into the woman that they wanted me to be. …They would come into the connection being like, 'I like you as you are' but then it would be like, 'You have to be more feminine. You have to be more submissive.'"

Transgender women participants, Ria and Trishna, brought up relational moments where they most felt like 'the girlfriend' or 'the wife'. Ria – who often presented as male in public – mentioned feeling like 'the girlfriend' when a male schoolfriend would be dominating and 'aggressive' towards her as this indicated that he had romantic feelings for her. This included times when the schoolfriend would have heated arguments with her as well as physically hurting her. During Trishna's first relationship, she remembered feeling like her ex-boyfriend was 'the husband and I was the wife'. This meant that while they were living

together, Trishna managed most of the household chores – such as cooking and laundry – that were she claimed were typically carried out by women while her partner focused on chores outside of the house – such as shopping for groceries.

Shayan described an issue within the gay community where bottoms confronted broader problems that 'women of Bangladesh typically face' within relationships. He argued that many tops wanted to dominate bottoms not just during sex but in all aspects of the relationship:

"In the straight community, males are dominant, and for us, tops are dominant. The kind of problems that women of Bangladesh typically face; these are the same for the bottoms in my community." (Shayan, 24-year-old gay man)

James described wanting a 'balanced' relationship in terms of decision making with a romantic partner:

"I don't want to totally dominate the relationship. There are some points on which I want to be dominant. There are some points on which he can be dominant. The thing should be balanced. When one person starts taking the lead in everything, then the whole thing becomes toxic." (James, 23-year-old gay man)

Farhana reported being exasperated by what she perceived to be paternalistic behaviour from 'tomboys' – masculine presenting lesbian women:

"[They think that,] 'Since I am the guy, I will protect you. When you're crossing the street, you won't stand on the side with oncoming traffic.' Why? Do you think I don't know how to cross the street? Were you helping me cross streets all those years that I haven't known you?" (Farhana, 23-year-old lesbian woman)

Farhana had not wanted to be in an open relationship until she began dating her current girlfriend. During this relationship Farhana said she began to realise that she was 'both masculine and feminine'. While she wanted to express her sexuality and gender within her relationship, Farhana was unable to do so with her primary partner because they were 'totally masculine' and did not take the issue seriously:

"It's like our choices didn't match. There was also some problem when it came to our attitude towards each other. I'm both masculine and feminine. But my partner is totally masculine. So, maybe my feminine part was satisfied with her. But my masculine part was not. But whenever I brought this topic up with her, she laughed it off. I mean, she did not take it seriously. It's one kind of disrespect. I felt ridiculed. All these insults made me feel

distant from her. She ruined [our relationship] for me with her dominating and patriarchal behaviour." (Farhana, 23-year-old lesbian woman)

As a non-binary person assigned female at birth, Auvi said they found sexual experiences with cisgender men to be highly gendered – where men were expected to be dominant and women to be submissive. They said that having to 'perform as the woman' during sex made the experience less enjoyable for them:

"When I did have sex, I was usually performing as the woman. There's also a lot of connotations that come with what being feminine means. I don't know. That takes away from the experience for me." (Auvi, 22-year-old non-binary person)

They elaborated further by sharing their growing discomfort at having to perform the role of a woman, 'even when you're on top':

"The older I got, I wasn't comfortable being seen as a woman, so I wasn't comfortable constantly having to perform that role even when you're on top, this is how it looks and all of that." (Auvi, 22-year-old non-binary person)

Auvi identified as a 'soft dom' and was not comfortable being too 'aggressive' in sexual spaces. They described how this was something they were negotiating with their straight-identifying male partner:

"I've gotten a bit more aggressive in sexual spaces and that's also something I'm not particularly comfortable with because I'm a very soft dom… I'm exploring like what it would be to use a strap on or to actually dominate my partner, actually talk about it and dominate my partner."

Embodying notions of sexual morality

"I have a very weird relationship with sexuality, where hypersexuality can be like a form of self-harm for me and also just not engaging. It has also just been a few times where I've sort of cleansed myself or just tried not to have another person in my space as a way to just be OK with myself again."

- Auvi, 22-year-old non-binary person

Participants associated experiences of sexual pleasure with casual partner(s) outside of romantic relationships with feelings of regret, guilt, and naivety. Several respondents reported regretting not 'protecting' their bodies from certain casual sexual encounters. Like

Auvi, others also reported that they associated having a lot of sex – particularly 'casual sex' – with 'self-harm', and associated celibacy or sex within a monogamous relationship with self-protection. Auvi reported that their sexual behaviour was heavily influenced by their mental health as well as how they felt about their own body. They recalled how too much sex was like 'self-harm' whereas celibacy felt like 'a way to just be OK with myself'.

Shonali, a bisexual student, stated the importance she placed on staying with one sexual partner – in her case, a heterosexual man – for life. In Shonali's case, she reported feeling that she could not possibly be with 'anyone else' after engaging in sexual intercourse with her boyfriend. She explained that this view stemmed from what she perceived as parental expectation of monogamy:

"I used to have this perception - you know, the one parents have, that if you have something [sexual] with someone, you have to stay with them. You can't think about anything else. ...It was because I had sex with him and I thought that 'oh my god, I cannot go back to anyone else'." (Shonali, 21-year-old bisexual woman)

According to gay participants, however, this expectation of monogamy was not universal. As Shayan explained, it was very common for gay men to casually date multiple partners, unlike 'Bangladesh's straight culture':

"Like in Bangladesh's straight culture, it is not normal to date someone today, and date someone else another day. This is not normal in the straight culture of Bangladesh. But this is quite normal in my [gay] community's culture – that I am dating someone today, and tomorrow I might of course date someone else." (Shayan, 24-year-old gay man)

Nineteen-year-old transgender student, Ria, who had recently started attending queer events also suggested that many people within the gay community were 'crazy for sex'. She noted that people would speak very openly about sex at these events:

"There's a lot of people in the [gay] community who go crazy for sex. Like, when I go to any community event, people will always be talking about sex. [They'll ask,] "How many times have you done it [had sex]? Who did you do it with?"" (Ria, 19-year-old transgender woman)

However, Ria equated these open discussions about 'promiscuous' behaviour as something 'respectable' people did not participate in. She said that because she was 'respectable' and came from a 'respectable family', she did not want to engage in, or speak about, casual sex

with people she did not know: “I come from a respectable family...I am respectable. I only share myself [sexually] with those I am close to.”

Both James and Shayan reported engaging in casual ‘hook ups’ with multiple people. Despite this, they described feeling guilty for having had sex with people they did not know rather than sex with long-term monogamous partners. Shayan remembered feeling like ‘a prostitute’ during certain sexual interactions and felt ‘guilty afterwards’:

“You just meet someone and right away you [have sex] ... I have never liked this. I feel guilty afterwards. I feel as though – it’s like being a prostitute or something. It’s as if someone comes there, sleeps with me, and then he goes off. For me, this feels very demeaning.” (Shayan, 24-year-old gay man)

James reflected on his earlier sexual experiences and being ‘very curious’ about the newness of everything. However, he regretted having a lot of casual sex:

“What I now regret in my life – is that at that time, out of curiosity, I met up with a lot of people. And I also hooked up with a lot of people, to be frank. I now feel that I should not have done that.” (James, 23-year-old gay man)

James expressed his guilt over having multiple hook ups as ‘giving up’ his body and not ‘protecting’ it better or ‘saving it for the right person’: “I feel guilty that I so easily gave up my body to people. This is what bothers me. Like, I should have protected it better. Maybe saved it for the right person.”

Moreover, James considered the negative health implications having 'too many hook ups' in hindsight:

“How many people I have hooked up with to date, is something that I cannot give a proper account of. But if I attempt to count that, I think it would be more than fifty or sixty people. So, I think that there is a risk involved here. There are of course health issues for us. There is the matter of HIV/AIDS. For that reason, now I feel that at that time I was very young; I was very naive.” (James, 23-year-old gay man)

Discussion

Discussion of findings

Our study shows how sexual intimacy as experienced by LGBTQ young people in Bangladesh consists of a desire for consensual sexual and romantic relationships with

sexually ‘matched’ partner(s) while navigating heteropatriarchal sexuality norms. The statement captures the essence of young people’s sexual lifeworlds in our study and indicates a universality around sexuality while still making space for intersections of diverse lived experiences and social orientation (Ahmed, 2006; Dolezal, 2015).

In terms of norms, participants in our study acknowledged that openly discussing or displaying queer sexual desire was a taboo as it went against prevailing heteropatriarchal sexuality norms. Other authors also note that the dominant discourse in Bangladesh is that sexuality is private and shameful (Camellia et al., 2021; Khan & Raby, 2020; Siddiqi, 2011b). Consequently, it may be difficult for young people to articulate nonnormative sexual desires (Karim, 2010). According to our research, young people appeared to have three avenues of navigating their queer sexual desires within the structure of dominant sexuality norms: conforming to heteronormativity and rejecting queer desires; implicitly rejecting heteronormative expectations and concealing nonnormative behaviours while passing as heteronormative; explicitly rejecting heteronormative expectations and being visibly queer. As our participants all self-identified as LGBTQ, none of them reported explicitly rejecting queer desires, although they remembered questioning and supressing these desires at different stages of their lives while growing up.

Our data demonstrate a complexity in having to conceal queer desire. Discretion is considered a safer option than visibility and is, therefore, a widely accepted way of being within the queer community. At the same time, there is a constant fear of being found out. A recent ethnographic study looks at how heterosexual young people in Bangladesh use silence around sexuality as a way to circumvent uncomfortable conversations with parents and protect good boy/girl image (Camellia et al., 2021). For sexual and gender diverse young people, the burden of concealment is often more pronounced due to insecurities about being ‘discovered’ to be queer with subsequent familial and social ramifications.

As Siddiqi (2011b) explained, certain sexual behaviours are tolerated or ignored as long as these remain hidden from the public gaze and do not disrupt the visible order of things such as the ideal of procreative heterosexual marriage. Ahmed (2006) suggested that to be found out as queer constitutes a failure to perform heteronormativity and achieve social respectability reserved for those who are seen to visibly conform. In other words, not being presumed as heterosexual or cisgender means that an individual has to ‘unbecome’ heterosexual or cisgender (Ahmed, 2006). This deviance is often narrated as a loss of the possibility of becoming happy and, from a lifeworld perspective, can offer insight into meanings of wellbeing. As only cisgender heterosexual relationships are considered socially

legitimate within the context of Bangladesh, these less tangible aspects of the queer lifeworld of love and romantic partnerships require further exploration.

Our findings around relational power dynamics associated with sexual roles are indicative of a plurality of lived experiences and needs within the queer community. Heteropatriarchal sexuality norms were more challenging for some participants than others. For instance, we observed parallels between widespread inequitable gender roles and those described by feminine-identifying queer participants – including transgender women, gay bottoms, and femme-lesbians. Conversely, participants mentioned hegemonic masculinity as predominantly perpetrated by transgender men and gay tops. It is important to address these differences in sexual behaviour based on 'matching' sexual roles in order to gain a deeper understanding of sexuality within the context of Bangladesh. It is also relevant to consider how sexual and gender nonconforming young people conceptualise and form romantic partnerships when these are not considered legitimate within wider society. What does this mean for current sexual health interventions? A better understanding the relational dynamics within the spectrum of LGBTQ+ community is essential to ensure health interventions are tailored correctly.

Against the backdrop of upholding respectability and honour through sexual abstinence before marriage, our data demonstrate a link between young people's understandings of heteropatriarchal sexual morality and the type and frequency of queer sexual interactions. Having sex with someone one is close to is considered more aligned with sociosexual norms than having sex with multiple unacquainted partners. Too many 'casual hook ups' for those being penetrated meant a failure to 'protect' their bodies which is equated to self-harm and a lack of self-respect, for instance. Reflections on past sexual experiences outside of romantic partnerships also predominantly centred on dissatisfaction with one's own 'promiscuous' behaviour and negative emotional consequences such as feelings of guilt and shame. As a result, there was very little discussion around sexual pleasure, particularly outside of monogamous relationships. This can partly be seen from the lens of internalised shame, which is fundamentally an embodied experience shaped by larger social and political contexts (Dolezal, 2015). There was also a sense of permanence in the experience of embodied shame, 'I have deviated from sexual norms by disrespecting my body and my body remembers my failure to protect it.'

On the other hand, participants perceived positive experiences of sexual intimacy as driven by desire for romantic or 'intellectual' connection with potential sexual partners. Our data show that young people desired sexual intimacy with partners they are acquainted with and felt close to. This corresponds with a recent study on of college students reported

nonphysical aspects of partnered sex – such as emotions, trust, connection with partners – to be as pleasurable as more physical aspects – such as bodily sensations (Beckmeyer et al., 2021).

As with global research, our study reveals how perceived and actual discrimination contributes to chronic minority stress and places SGD young people at risk of adverse mental health outcomes (Goldbach et al., 2021; Green et al., 2021; Inderbinen et al., 2021). Our analysis explored negative emotions around discretion, safety concerns, and stigma over heteropatriarchal sexual morality. Similarly, a systematic review of transgender populations reveals links between self-stigmatisation and mental health stressors while 'community connectedness' was a strong protective factor for mental health (Inderbinen et al., 2021). It is vital to continue investigating associations between lived experiences of sexuality and mental health concerns among LGBTQ+ youth as well as identifying effective resilience and coping mechanisms (Ahmed, 2006; Earnshaw et al., 2016; Goldbach et al., 2021; Green et al., 2021; Inderbinen et al., 2021; Kuper et al., 2018; Ramírez et al., 2020; Rivers et al., 2018; Zeeman et al., 2019). How can we promote community connectedness while acknowledging that queer visibility presents real safety concerns for SGD youth, for example? Further exploration of how interventions promoting mental health can be adapted in a Bangladeshi context.

Further research

This study examined lived experiences of self-identifying LGBTQ young people in Dhaka within the phenomenological lifeworld framework. Although some of the participants grew up in different areas of the country, most of the narratives referring to public spaces and health services were based on urban settings. As such, further research is needed to understand the experiences of peri-urban and rural areas where young people may be facing different challenges. Similarly, we were unable to recruit intersex people, gay men who identified as 'tops', or individuals from the Hijra community and their experiences should also be investigated in future work (Hossain, 2017; Zeeman & Aranda, 2020). From a phenomenological standpoint, it would be useful to explore each of the five themes in more depth to better understand the various aspects of these lived experiences. Given that our research focus was lived experiences of young people, we could not address the perspective of other actors – such as healthcare professionals or parents of young people. Examining structural challenges may provide more context-specific information on how to effectively advocate for the rights of queer young people. Due to the dearth of research on sexual and gender diverse young people in Bangladesh, we had to rely on reviewing global literature. As many of these other studies were based in high-income countries, the recommendations

need to be further examined to be applicable in Bangladesh. Likewise, while we reported – and carefully translated – verbatim terminology as used by our participants, it was outside the scope of this article to examine how their use of language may have impacted meaning construction. It would be beneficial to further explore normative 'global' discourses and anglophone linguistic hegemony of queer experiences (Kao, 2021; Siddiqi, 2011b).

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CHAPTER 8. DISCUSSION

Illustration 8.1 Discussion artwork

8.1 Summary of findings

In this thesis, I have explored meanings of sexuality through lived experiences of 46 young people in Dhaka and demonstrated the ways in which a lifeworld perspective can contribute towards our understanding of sexual health and wellbeing.

Firstly, I critically reviewed what we currently know about sexual health and wellbeing as experienced by young people in Bangladesh, India, Pakistan, and Nepal. The review (Chapter 2) highlighted how parental expectations of premarital sexual abstinence and silence around sexuality contributed to inadequate sexual health information for young people in South Asia. Restrictive gendered norms – such as dominant gender narratives and mobility restrictions – also limited young women's sexual and reproductive decision-making. None of the 13 studies included in the review addressed diversity of sexuality or gender identity. The absence of such narratives underscores an urgent need for research examining lived experiences of, and health inequalities within, sexual and gender diverse communities (Keuroghlian et al., 2017; Laiti et al., 2019; Rashid et al., 2011; Regmi & van Teijlingen, 2015; Zeeman et al., 2019).

My empirical data revealed more about young people's lived experiences and challenges of navigating sexuality (Chapter 5). Young people described lives punctuated by sexual violence supported by social norms about gender and sex that helped ensure silence and lack of accountability or justice for survivors. Negative experiences affected their ability to conceptualise having pleasurable and consensual sexual experiences, free of coercion and violence (WHO, 2006). The dominant model of traditional monogamy – staying with one sexual partner over a lifetime – as well as a focus on women's chastity was a strong driving factor in decision-making around premarital sex. This contributed to the practice and acceptance of, as well as silence around, abusive behaviour.

Ahmed's (2006) phenomenological framework of heteronormative 'straightening devices' – mechanisms directing people towards heterosexuality, gender conformity, and procreative marriage – helped me to identify structures upholding normative sexual behaviours and to understand how queer young people in Bangladesh navigate these in their everyday lives. Young people have to 'bend' to – and against – heteronormative straightening devices at home, in public spaces, and within healthcare and other institutions. Participants spoke about confronting marriage normativity (straightening the life course), compulsory heteronormativity in public space (performing straightness), heteronormativity within healthcare (straightening as 'care'), and consequences of failing to embody heteronormativity (unbecoming straight). Young people in the study had very little social support and navigated this by seeking representation in the media and friendships with other LGBTQ-identifying people. These findings support global literature about discrimination and inequalities confronted by queer youth and adverse consequences for their mental health and wellbeing (Bowling et al., 2019; Earnshaw et al., 2016; Kuper et al., 2018; Laiti et al., 2019; Lancet, 2011; Nieder et al., 2020; UNFPA, 2014; Zeeman et al., 2019). My analysis also provided an opportunity to see whether this framework was applicable within the context of Bangladesh as there is little information from existing studies to assess this.

Finally, I presented sexual lifeworlds of LGBTQ-identifying young people in Bangladesh (Chapter 7). I adapted a phenomenological reflective lifeworld research approach (Dahlberg et al., 2008) to capture the essential aspects of sexual intimacy as described by 14 LGBTQ participants. This paper showed how sexual intimacy as experienced by LGBTQ young people in Bangladesh consists of a desire for consensual sexual and romantic relationships with sexually 'matched' partner(s) while navigating heteropatriarchal sexuality norms. The statement captures the essence of young people's sexual lifeworlds and indicates a universality around sexuality while still making space for intersections of diverse lived experiences and social orientations (Ahmed, 2006; Dolezal, 2015). In particular, the analysis

explored negative emotions around discretion, safety concerns, and stigma over heteropatriarchal sexual morality.

Annex K provides a summary of the main findings and further research recommendations from each of the four papers presented in this thesis. Annex L also provides an overview of the research themes across sample groups.

8.2 Discussion of research themes

This qualitative study adds to existing research in South Asia and elsewhere exploring young people's lived experiences of sexuality and the challenges they face when navigating socio-sexual norms. In terms of themes, the research contributes to expanding evidence around relationship dynamics and sexual lifeworlds, prevalence and consequences of sexual violence, gender norms and 'straightening devices' as experienced by non-conforming young people.

A key strength of this thesis is its incorporation of diverse lived experiences of sexuality within the context of co-constructed 'lifeworlds'. My theoretical framework (Chapter 3) also emphasised the five aspects of the lifeworld – lived time, lived space, lived relationships, lived body, and lived emotions. Rather than centring my research on predetermined 'health risks' (Kuper et al., 2018), sexuality-focussed biographical interviews made it possible for participants to prioritise their own lived experiences of sexual wellbeing. The research focus intended to move away from causes and treatment of ill health in favour of a contextualised people-centred approach to understanding wellbeing. For example, I was able to analyse the 'lived body' and 'lived emotions' aspects of queer young people's lifeworlds through their negative feelings of failing to embody heterosexual norms. This is an important contribution as there is limited published qualitative research in the field of sexual health in Bangladesh. Furthermore, health needs highlighted by participants – such as widespread experiences of coercion and sexual violence and a lack of support available to survivors – have implications for further research as well as future interventions. Annex M presents a summary of main themes across all five lifeworld domains.

The lifeworld framework allowed me to scrutinise and make explicit the implicit and invisible meanings around everyday experiences of sexuality. My analysis described the world as embodied, physical, and practical, although I did not explicitly differentiate the interlinked domains. Instead, the lifeworld domains collectively informed the 'richness' of experiences and allowed me to further explore 'thick descriptions' with participants (Geertz, 1973). While it is not possible to capture any given experience in its entirety, Annex M

shows how the lifeworld domains encapsulate different elements of the key themes from this thesis. For instance, findings around harassment of feminine-presenting bodies in public spaces incorporated all five domains: lived space (e.g. safety concerns outside the home, affluent areas perceived as providing more safety, places becoming associated with abuse), lived time (e.g. experiencing harassment on an almost daily basis, safety concerns at night), lived relationships (e.g. not sharing experiences of everyday harassment with others), lived body (e.g. appearing non-normative to the world, being gendered and harassed as a result of being feminine-presenting), and lived emotions (e.g. anger, a sense of helplessness, self-blame).

My doctoral research also provided an opportunity to see whether heteronormative straightening devices were applicable within the context of Bangladesh as there is little information from existing studies to assess this. Further research using the framework of straightening devices can help public health professionals to identify more 'barriers' confronted by non-conforming young people.

Previous qualitative research in Bangladesh – and South Asia – has focussed on cisgender heterosexual health needs (Chapter 2). The inclusion of queer experiences in this study provides new insights into crucial 'context-specific ways' in which sexual and gender diverse people understand themselves (Hossain, 2017; Siddiqi, 2011b). This thesis highlights important questions for those advocating for queer rights in Bangladesh. How can interventions support queer youth while acknowledging that queer visibility presents safety concerns, for example?

My thesis highlights the multifaceted nature of silence, discretion, and concealment around sexuality. For instance, taboo of talking about sexuality extended to silence around sexual harassment and abuse (Chapter 5). This, in turn, meant that young people whose lives were punctuated by violence had to 'deal with' the consequences without any support. Young people cited feelings of guilt or shame and a fear of being judged or blamed by others as common reasons for not sharing/reporting abuse. These findings correspond with global research on sexual violence (Hayati et al., 2011; Moraes et al., 2012; Sutherland et al., 2014; Sweeney et al., 2019; Tankink, 2013). At the same time, an ethnographic article from my systematic review (Camellia et al., 2021) also shows how heterosexual-identifying young people in Bangladesh use silence around sexuality as a way to negate uncomfortable conversations with parents and protect their good boy/girl image (Chapter 2).

Similarly, LGBTQ-identifying participants also used discretion to ensure safety and avoid homophobia (Chapter 6 and 7). However, I identified a complexity in having to conceal

queerness as a ‘protective’ or ‘risk’ factor. Discretion was considered a safer option than visibility and, therefore, a widely accepted way of being sexual within the queer community. There was also a constant fear of being ‘outed’ as queer. As such, the burden of concealment was often more pronounced due to insecurities about being ‘discovered’ to be queer with subsequent familial and social ramifications. This analysis supports existing research on discrimination against queer people as well as ‘minority stress’ (Gower et al., 2018; Green et al., 2021; Inderbinen et al., 2021; Kuper et al., 2018; Laiti et al., 2019; Lancet, 2011; Pollitt et al., 2021).

8.3 Further research

My research explored meanings and lived experiences of sexuality and see how a lifeworld perspective can improve our understanding of sexual health and wellbeing. While I endeavoured to be inclusive of a wide range of experiences, there are many avenues for further research in addition to those I have outlined throughout this chapter. Overall, more large-scale research is needed to ensure policy, education, and healthcare advances with greater inclusivity and accountability (Zeeman & Aranda, 2020).

Various social orientations were considered for the study, including sexual and gender identity, marital status, ethnicity and religion, education and professional background, sexual experience, and age etc. (see Chapter 4). These social orientations were based on the focus of the study and gaps identified through literature review and communication with sexual and reproductive health researchers in Bangladesh.

It was not possible to include or analyse all these different intersections. Intersections between the categories can be investigated in more depth. For example, a younger demographic (15-17 years) could be included to explore the sexual lifeworld of students in school. Class analysis around different lived experiences of sexual and gender identities could also provide insight into broader challenges confronted by young people. Although some of the participants grew up in different areas of the country, most of the narratives referring to public spaces and health services in this study were based on urban settings. As such, further research is needed to understand the experiences of peri-urban and rural areas where young people may be facing different challenges.

Again, while I recruited young people with varying characteristics – such as different religions, disabilities, and sexual and gender identities – it was not feasible to explore all these intersections in depth. For example, I was not able to report on distinctions between young people from matrilineal ethnic groups and their peers or married and unmarried young

people. Similarly, I was unable to recruit intersex people, gay men who identified as 'tops', or individuals from the Hijra community and their experiences should also be investigated in future work. It would also be useful to explore themes (such as straightening devices and sexual violence) in more depth using a larger sample to better understand the various aspects of lived experiences. From a phenomenological standpoint, it would be useful to explore different subgroups, such as specific sexual and gender identities, as well as narrowing down the phenomenon of study.

Given that my research focus was lived experiences of young people, I could not address the perspective of other actors – such as healthcare professionals, teachers, or parents of young people. Examining interpersonal relationships, structural challenges as well as current sexual and reproductive health-related policies and interventions would provide more context-specific information on how to effectively advocate for the rights of diverse young people.

Due to the dearth of research on sexual and gender diverse young people in Bangladesh, I had to rely on reviewing global literature. As many of these other studies were based in high-income countries – such as the UK and USA – the recommendations from these studies need to be further examined to be applicable in Bangladesh. The lack of research on unmarried young people's experiences of sexual intimacy and violence in Bangladesh means that my findings are exploratory. There is a need for more in-depth research around the nuances of consent as well as wider implications of, and healing from, sexual violence on young people at various stages of their lives (Draucker et al., 2009; O'Callaghan et al., 2019). This could be investigated through more specific research questions around the consequences of sexual violence as the phenomenon of interest, for instance. Likewise, while I reported – and carefully translated – verbatim terminology as used by my participants, it was outside the scope of this thesis to examine how their use of language may have impacted meaning construction. It would be beneficial to further explore normative 'global' discourses and anglophone linguistic hegemony of queer experiences (Kao, 2021; Siddiqi, 2011b).

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APPENDICES

Annex A:	Map of Dhaka
Annex B-C:	In-depth interview guide (English and Bangla)
Annex D-E:	Ethical approval letters (LSHTM and NSU)
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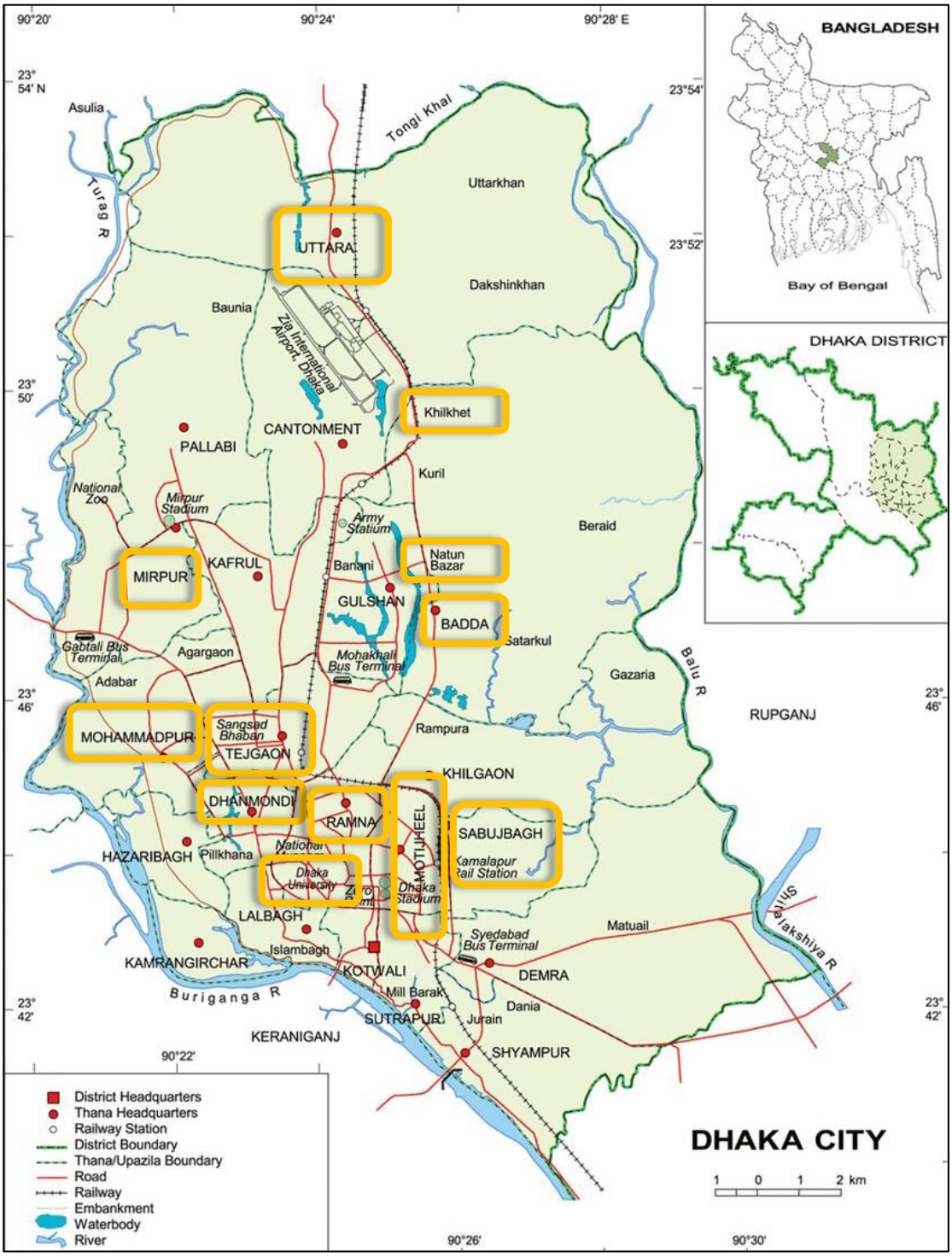
Annex A. Map of Dhaka



Adapted from Swapan et al (2017)

Where participants reported currently living

Annex B. In-depth interview guide (English)

Purpose: To explore young people's lived experiences and perceptions of sexuality. Interview process will be naturalistic, open, and responsive. Questions listed are a guide to what may be explored through conversation.

Format: Open-ended

Duration: 1-2 hour through 1-2 sessions

Venue: Respondent's home/office space/private space in quiet café

Notetaking: Audio recording and memos

SECTION 1. MEANINGS & PERCEPTIONS OF SEXUALITY

A. GENDER

For the purpose of this research, gender refers to "the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health" (WHO, 2011)

A1. How would you describe your gender?

A2. How important is your gender to you?

A3. What does being your gender encompass (*'doing' gender*)? What does it mean to you?

A4. Can you think of a time when you first felt you were that gender? What happened? Where were you and who were you with?

A5. Do you think people treat you in particular ways because of your gender?

> **A5.1.** How does this affect your interactions with others?
>
> **A5.2.** Can you give an example of something recent that has happened? How about an early example? One of the first you can remember?

A6. What are some of the advantages and disadvantages of living as this gender?

> **A6.1.** Can you think of any recent examples when you felt positively or negatively about your gender? What about an early example?

B. SEXUALITY

B1. What does 'sexuality' mean to you? What does this encompass?

For the purpose of this research, we define sexuality as "…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors." (WHO, 2006a)

B1.1. Would you want to change or add anything to this definition?

B2. How do your peers see sexuality? What do they think about their sexuality, in your opinion?

B2.1. Can you think of any examples of differences in views and/or experiences to the ones you've mentioned? What are these and what reasons? (e.g. religious beliefs, gender, family background/'class', educational level.)

B3. In your experience and/or opinion, how would you describe the expectations around sexual behaviour in your life and social group?

[If respondent finds it difficult to answer, can prompt with marriage normativity, heterosexuality, no sex before marriage.]

B3.1. How are these 'rules' maintained or enforced in practice? Can you think of any recent examples?

B3.2. Who enforces these rules and on to whom? Where is this most and least visible for you? (e.g. at home, at school, social media.)

B4. How do you **feel** about these norms or expectations you have described?

B4.1. Can you think of any recent instances when these 'rules' have impacted you personally? What about any early examples?

B4.2. Has or does this affect your romantic or sexual interactions? In what ways?

B4.3. Have you had to change your behaviour to fit these norms? Have there been times you have wanted to behave and/or behaved in ways that may be contradictory to these norms?

B4.4. Of the norms discussed, which ones do you personally find most and least difficult to adhere to and why?

SECTION 2. LIFE HISTORY IN RELATION TO SEXUALITY

C. SEXUALITY AND DESIRE

C1. Can you remember the first conversations you had about sex?

- Where were you?
- How old were you?
- Who were you with?
- How did it come up?
- What was said?
- How did you feel about it?

C1.1. Looking back, what do you wish you had known?

C1.2. What were you curious about, if anything?

- Did you have any questions? What were these?
- Who did you direct these towards/where did you look for answers?

C1.3. How have/had these early interactions you've described affected your interactions, positively or otherwise?

C2. What were your first experiences of (sexual) attraction? (*First 'crush'.*)

- Towards whom?
- What happened?
- How did you feel about it?
- Where were you?
- Who, if anyone, did you confide in?

C2.1. Did you feel this was the 'norm' or something outside of the norm?

C2.2. Has this had any impact on subsequent experiences of desire?

C3. What were some of your first sexual experiences (or 'romantic' experiences)?

- What happened?
- How old were you?
- How did you feel at the time?

C3.1. Looking back, how do you feel about these early experiences now?

C4. How would you describe your romantic and/or sexual life now? Can you share any recent experiences?

C4.1. Do you talk about your romantic and/or sexual experiences with others? If so, who?

C4.2. What do your friends/family think about this? How do you feel about it?

D. LIFE HISTORY

D1. From what we've discussed or other experiences, can you identify any important events or moments that you felt were big changes in your life?

D1.1. How do these experiences make you feel?

D2. Were there any difficult moments that you can recall? Please describe in detail, if possible.

D3. Can you describe if and how these experiences have impacted the way you feel about yourself and your sexuality?

INFORMATION FOR INTERVIEWERS

LIFEWORLD DOMAINS

Follow-up questions to elaborate any mention of important lifeworld domains from life story to provide more context for participants' narratives: **temporality; spatiality; intersubjectivity; embodiment; and mood**.

- **WHEN** (timing, age, time of day, etc.)
- **WHERE** (public spaces, at school, at home, etc.)
- **WHO** (relationships: strangers, love interests, family, peers, mentors, etc.)
- **SELF** (body, awareness, self-image, identity etc.)
- **EMOTIONS** (positive -> neutral -> negative spectrum, dynamic, ever-present, expression, consequences, emotional wellbeing etc.)

FOLLOW-UP PROMPTS

- Can you elaborate on that point?
- Can you please give me an example of that experience?
- Could you tell me more about this experience?
- How did that make you feel?
- Where were you when…? Who was with you/who did you talk to…?
- Has this changed over time?

Activity 1: *co-draw/construct 'life course' of life events.* (After ice breaking/introduction.)

- Looking at the life events we've discussed/drawn, where and how have these experiences of sexuality come up for you? Have there been changes over time?

Activity 2: *walk and talk in respondent's environment.* (After main discussion/before beginning second interview.)

- Informal discussions using visual prompts: can describe feelings about surroundings through everyday experiences of being in the space? (e.g. Is this how you get to your classes? Where do you usually sit to have tea? What do you see/how do you feel when you walk past this building? etc.)

WORKING WHO DEFINITIONS

SEXUAL HEALTH

"…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 2006a)

SEXUALITY

Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The working definition of sexuality is:

"…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors." (WHO, 2006a)

SEXUAL RIGHTS

"The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws.

Rights critical to the realization of sexual health include:

- the rights to equality and non-discrimination
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
- the right to privacy
- the rights to the highest attainable standard of health (including sexual health) and social security
- the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- the right to decide the number and spacing of one's children
- the rights to information, as well as education
- the rights to freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights.

The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination." (WHO, 2006a, updated 2010).

GENDER

Gender refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not “fit” established gender norms they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health. It is important to be sensitive to different identities that do not necessarily fit into binary male or female sex categories.

Gender norms, roles and relations influence people’s susceptibility to different health conditions and diseases and affect their enjoyment of good mental, physical health and wellbeing. They also have a bearing on people’s access to and uptake of health services and on the health outcomes they experience throughout the life-course. (WHO, 2011).

GENDER NORMS

Refer to beliefs about women and men, boys and girls that are passed from generation to generation through the process of socialization. They change over time and differ in different cultures and populations. Gender norms lead to inequality if they reinforce:

a) mistreatment of one group or sex over the other; b) differences in power and opportunities. (WHO, 2011)

GENDER ROLES

Refers to what males and females are expected to do (in the household, community, and workplace) in a given society. (WHO, 2011)

GENDER RELATIONS

Refers to social relations between and among women and men that are based on gender norms and roles. Gender relations often create to hierarchies between and among groups of men and women that can lead to unequal power relations, disadvantaging one group over another. (WHO, 2011)

GENDER STEREOTYPES

Images, beliefs, attitudes or assumptions about certain groups of women and men. Stereotypes are usually negative and based on assumed gender norms, roles and relations. (WHO, 2011)

INTERSECTIONALITY

The complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups.

HETERONORMATIVITY

Normalisation of heterosexuality and gender within understanding that men and women are biologically and socially opposite and meant to come together within monogamous coupled relationships.

Annex C. In-depth interview guide (Bangla)

যৌনতা নিয়ে যুব সম্প্রদায়ের চিন্তা চেতনা এবং তাদের বাস্তব জীবনের অভিজ্ঞতা নিয়ে
গুনগত গবেষণা সংক্রান্ত গাইডের বিস্তারিত সাক্ষাৎকার (বাংলা ভার্সন)

উদ্দেশ্যঃ যৌনতা নিয়ে যুব সম্প্রদায়ের চিন্তা চেতনা এবং তাদের বাস্তব জীবনের অভিজ্ঞতা তুলে আনা (উদ্দেশ্য-১)। সাক্ষাৎকার প্রক্রিয়াটি হবে বাস্তব জীবন সম্পর্কিত , খোলাখুলি এবং দায়িত্বশীল। প্রশ্নগুলো গাইড করবে আলোচনার মাধ্যমে যা চাওয়া হচ্ছে তা তুলে আনতে।

ফরমেটঃ ওপেন এন্ডেড অর্থাৎ প্রশ্নগুলো এমনভাবে সাজাতে হবে যাতে উত্তর সংক্ষিপ্ত ‘হ্যাঁ’ অথবা ‘না’ এর বদলে আরও বিস্তারিত হয়।

স্থায়িত্বঃ ১ থেকে ২ ঘণ্টা

ভেনুঃ অফিস/ ব্যক্তিগত এলাকায় নিরব কোন ক্যাফেতে।

নোট গ্রহণঃ অডিও এবং মেমোস্।

A. জেন্ডার

A1. আপনি আপনার লিঙ্গ সম্পর্কে কিভাবে বর্ণনা করবেন?

A2. আপনার লিঙ্গ আপনার কাছে কতটা গুরুত্বপুর্ন?

A3. আপনি যে এই লিঙ্গের মানুষ তা আপনি কখন অনুভব করলেন? আপনার কাছে এটার মানে কি?

A4. আপনি যখন আপনার লিংগ সম্পর্কে সচেতন হলেন সে সময়টা কি আপনি মনে করতে পারেন? তখন আপনি কোথায় ছিলেন? এবং কারা আপনার সাথে ছিল?

A5. আপনি কি মনে করেন যে লোকেরা আপনার লিঙ্গের কারণে আপনার সাথে বিশেষ আচরণ করে?

A5.1. আপনার লিঙ্গের কারনে আপনার সাথে অন্যেরা কিভাবে আচরণ করে?

A5.2 আপনি কি এমন একটা উদাহরণ দিতে পারেন ইদানিং ঘটেছে আপনার সাথে? আপনার মনে আছে এরকম কোন উদাহরন দিতে পারেন?

A6. এই লিঙ্গের কারনে আপনার কি ধরনের সুবিধা ও অসুবিধা হয়?

A6.1. আপনি আপনার লিং সম্পর্কে ইদানিং কালে ভালো বা খারাপ অনুভূতির কোন উদাহরণ মনে করতে পারেন?

B. যৌনতার অর্থ এবং চিন্তা চেতনা

B1. আপনার কাছে যৌনতা কি? এটা কিসের সাথে সম্পর্কিত?

B1.1. আপনি কি যৌনতার সংগাটিকে পরিবর্তন বা আরও কিছু যোগ করতে চান?

B2. আপনার বন্ধু/বান্ধবীরা যৌনতাকে কিভাবে দেখে? তারা যৌনতা নিয়ে কিভাবে চিন্তা করে। সে সম্পর্কে আপনার মতামত দিন।

B2.1. আপনার মতামত এবং অভিজ্ঞতার মধ্যে পার্থক্য আছে এমন কোন উদাহরণ কি মনে করতে পারেন যা আপনি ইতিমধ্যে উল্লেখ করেছেন। এগুলো কি এবং এর কি কারণ?

B3. আপনার অভিজ্ঞতার আলোকে আপনার জীবন এবং সামাজিক গোষ্ঠীর যৌন আচরণের প্রত্যাশাগুলি কীভাবে বর্ণনা করবেন?

B3.1 কিভাবে এই নিয়ম এবং প্রথাগুলোর চর্চা করা হয়? আপনি কোন সাম্প্রতিক উদাহরণ মনে করতে পারেন?

B3.2 কে এই নিয়ম প্রয়োগ করে এবং কার উপর? আপনি কোথায় এটা সবচেয়ে বেশী বা কম দেখেন? (বাড়ই, স্কুল অথবা সামাজিক মাধ্যমে)

B4. আলোচিত নিয়ম ও প্রত্যাশাগুলোর বিষয়ে আপনার অনুভূতি কি।

B4.1 সাম্প্রতিককালের কোন ঘটনা আপনি মনে করতে পারেন যাতে এই নিয়ম ব্যক্তিগতভাবে আপনাকে প্রভাবিত করেছে? প্রাথমিক কোন উদাহরণ দিতে পারেন কি?

B4.2 এটি কি আপনার রোমান্টিক বা যৌন জীবনকে প্রভাবিত করে?কি ভাবে?

B4.3. এই নিয়মের সাথে খাপ খাওয়াতে আপনার আচরণে পরিবর্তন আনতে হয়েছে? আপনি এমন আচরণ করতে চান এবং / অথবা এমন আচরণ করেছেন যেগুলি এই নিয়মগুলির সাথে দ্বন্দ্বপূর্ণ হতে পারে?

B4.4. এই নিয়মগুলোর মধ্যে কোনটি আপনার কাছে সবচেয়ে কঠিন নয় বলে বিবেচিত হয় এবং কেন?

C. যৌনতা এবং আকাঙ্ক্ষা

C1. আপনি কি মনে করতে পারেন কখন আপনি প্রথম যৌনতা নিয়ে কথা বলেছিলেন?

- আপনি কোথায় ছিলেন?
- তখন বয়স কত ছিল?
- কার সাথে বলেছিলেন?
- আলোচনাটা কিভাবে এসেছিল?
- আলোচনায় কি কথা হয়েছিল?

- কি বলা হয়েছিল?
- আপনার অনুভুতি কেমন ছিল?

C1.1. ঐ সময়টায় আপনার আরো কিছু জানার ইচ্ছা ছিলো?

C1.2. কি বিষয়ে জানার উৎসাহ ছিল?

- আপনার মনে কি কোন প্রশ্ন ছিল? যদি থাকে তবে সেগুলো কি ছিল?
- আপনার প্রশ্নগুলোর উত্তর খোজার জন্য কি কারো সাথে আলোচনা করেছিলেন?

C1.3. আপনার পারস্পরিক আলোচনাগুলি ইতিবাচক বা অন্যভাবে আপনাকে প্রভাবিত করেছে?

C2. আপনার প্রথম যৌনতা বা এটার প্রতি আকর্ষণ সম্পর্কে বলুন।

- কার প্রতি আকর্ষণ অনুভব করেছিলেন?
- কি হয়েছিল?
- এ ব্যাপারে আপনার অনুভুতি কেমন ছিল?
- ঐ সময়ে আপনি কোথায় ছিলেন?

C2.1. আপনি কি এটাকে আদর্শ বা আদর্শের বাইরে কিছু মনে করেন?
C2.2. পরবর্তী আকাঙ্ক্ষার উপর এর কি কোনো প্রভাব পড়েছিল?

C3. আপনার কি যৌন অভিজ্ঞতা আছে বা যৌন অভিজ্ঞতা থেকে থাকলে আপনার প্রথম অভিজ্ঞতা সম্পর্কে বলুন।

- কি ঘটেছিল?
- তখন আপনার বয়স কত ছিল?
- সে সময় আপনার অনুভূতি কি ছিল?

C3.1 পুর্বের অবিজ্ঞতাগুলো সম্পর্কে এখন আপনার অনুভূতি কি?

C4. আপনি আপনার বর্তমানের রোমান্টিক বা যৌন জীবনকে কিভাবে ব্যাখ্যা করবেন? আপনার রোমান্টিক বা যৌন জীবনের অভিজ্ঞতা অন্য কারো সাথে আলোচনা করেন?

C4.1 যদি কারো কাছে আপনার অনুভুতি বর্ণনা করেন - তবে সে কে?

C4.2 আপনার বন্ধু বা পরিবারের সদস্যরা এটাকে কিভাবে দেখে? আপনি নিজে এটাকে কিভাবে দেখে থাকেন?

C7. আপনার সাথে আলাপ করে যা জানতে পারলাম - এগুলো কি আপনার জীবনে কোন প্রভাব ফেলেছিল? যদি ফেলে থাকে তাহলে আমাদের সাথে বিস্তারিত আলোচনা করুন।

D. কার্যক্রমঃ জীবনকাল সম্পর্কে আলোচনা

D1. আমরা এতক্ষন ধরে যে আলোচনা করলাম, আপনি কি মনে করতে পারেন এমন কোন ঘটনা বা এমন কোন বিষয় যা আপনার জীবনে বড় কোন পরিবর্তন এনে দিয়েছে?

D1.1. এসব অভিজ্ঞতা আপনার মনে কি ধরনের অনুভূতি তৈরী করে ছিল?

D2. ঐ ঘটনার মধ্য দিয়ে আপনি কি কোন কঠিন মুহুর্তের কথা মনে করতে পারেন। যদি সম্ভব হয় ঘটনাগুলো খুলে বলুন।

D3. আপনি কি বিস্তারিতভাবে বলতে পারেন এই ঘটনাগুলোর মধ্যে দিয়ে আপনার জীবনে ও যৌন জীবনের উপর কি প্রভাব পড়েছিল?

ফলোআপ প্রশ্ন

- আপনি কি বিষয়টি বিস্তারিত বলতে পারেন?
- আপনি কি বিষয়টির উপর একটি উদাহরণ দিতে পারেন?
- এই অভিজ্ঞতাটা কি আরো বিস্তারিতভাবে বলা যাবে?
- এটা আপনি কিভাবে অনুভব করেন?

- কোথায় ছিলেন আপনি এবং কখন.....? কে আপনার সাথে ছিল/কার সম্পর্কে বলছেন.....?
- সময়ের সাথে সাথে বিষয়টি কি পরিবর্তিত হয়েছিল?

ফলোআপ প্রশ্ন তখনই হবে যখন জীবনের কোন গুরুত্বপূর্ণ বিষয় উঠে আসবেঃ পার্থিব বিষয়; স্থানিক; আন্তঃ বিষয়ী; প্রতিমূর্তি; এবং মন।

Annex D. LSHTM ethical approval

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT
United Kingdom
Switchboard: +44 (0)20 7636 8636

www.lshtm.ac.uk

Observational / Interventions Research Ethics Committee

Ms. Prima Alam
LSHTM

2 April 2019

Dear Prima,

Study Title: Young people's perceptions and lived experiences of sexuality in Dhaka, Bangladesh

LSHTM Ethics Ref: 14703

Thank you for responding to the Observational Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

Approval is dependent on local ethical approval having been received, where relevant.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type	File Name	Date	Version
Investigator CV	Prima_Alam_CV	14/11/2018	1
Protocol / Proposal	IDI_guide_EnglishV1_300119	30/01/2019	1
Information Sheet	Informed consent form English_V2_24032019	24/03/2019	2
Covering Letter	Cover Letter_V1_270319	27/03/2019	1
Protocol / Proposal	Protocol_V2_270319	27/03/2019	2

After ethical review

The Chief Investigator (CI) or delegate is responsible for informing the ethics committee of any subsequent changes to the application. These must be submitted to the Committee for review using an Amendment form. Amendments must not be initiated before receipt of written favourable opinion from the committee.

The CI or delegate is also required to notify the ethics committee of any protocol violations and/or Suspected Unexpected Serious Adverse Reactions (SUSARs) which occur during the project by submitting a Serious Adverse Event form.

An annual report should be submitted to the committee using an Annual Report form on the anniversary of the approval of the study during the lifetime of the study.

At the end of the study, the CI or delegate must notify the committee using an End of Study form.

All aforementioned forms are available on the ethics online applications website and can only be submitted to the committee via the website at: http://leo.lshtm.ac.uk

Additional information is available at: www.lshtm.ac.uk/ethics

Yours sincerely,

[redacted]

Professor John DH Porter
Chair

ethics@lshtm.ac.uk

http://www.lshtm.ac.uk/ethics/

Annex E. North South University ethical approval

NORTH SOUTH UNIVERSITY
Plot # 15, Block # B, Bashundhara, Dhaka-1229, Bangladesh
Center of excellence in higher education

Memorandum

Date : 23 April 2019

To : Ms. Prima Alam
Adjunct Faculty, Department of Public Health

From : Professor Dipak Kumar Mitra
Chairperson
Intuitional Review Board (IRB) [redacted]

Subject : **Approval of Research Protocol #2019/OR-NSU/IRB-No.0410**

Dear Ms. Alam,

Thank you for your application dated 28 March 2019 requesting for approval of your research protocol #2019/OR-NSU/IRB-No.0410 titled "Young people's perceptions and lived experiences of sexual and reproductive health in Dhaka, Bangladesh". I am glad to inform you that the committee has approved your research protocol. You will be required to observe the following terms and conditions in implementing the research protocol:

1. As principal investigator, the ultimate responsibility for scientific and ethical conduct including the protection of the rights and welfare of study participants vest upon you. You shall also be responsible for ensuring competence, integrity, and ethical conduct of other investigators and staff directly involved in the research protocol.

2. You shall conduct the activity in accordance with the IRB-approved protocol and shall fully comply with any subsequent determinations by IRB.

3. You shall obtain prior approval from the IRB for any modification in the approved research protocol and/or approved consent form(s), except in case of emergency to safeguard/eliminate apparent immediate hazards to study participants. Such changes must immediately be reported to the IRB Chairman.

4. You shall recruit/enroll participants for the study strictly adhering to the criteria mentioned in the approved research protocol.

5. You shall obtain legally effective informed consent (i.e. consent should be free from coercion or undue influence) from the selected study participants or their legally responsible representative, as approved in the protocol, using the approved consent forms prior to their enrollment in the study. Before obtaining consent, all prospective study participants must be adequately informed about the purpose(s) of the study, its methods and procedures, and also what would be done if they agree and also if they do not agree

Phone: 880 (2) 55668200, Fax: 880 (2) 55668202, 55037165, e-mail: info@northsouth.edu, Website: http://www.northsouth.edu

to participate in the study. They must be informed that their participation in the study is voluntary and that they can withdraw their participation any time without prejudice. Used consent form should be preserved for a period of at least three years following official termination of the study.

6. You shall promptly report the occurrence of any Adverse Event or Serious Adverse Event or unanticipated problems of potential risk to the study participants or others to the ERC in writing within 24 hours of such occurrences.

7. Any significant new findings, developing during the course of this study that might affect the risks and benefits and thus influence either participation in the study or continuation of participation should be reported in writing to the participants and the IRB.

8. Data and/or samples should be collected, as specified in the IRB-approved protocol, and confidentiality must be maintained. Data/samples must be protected by reasonable security, safeguarding against risks as their loss or unauthorized access, destruction, used by others, and modification or disclosure of data. Data/samples should not be disclosed, made available to or use for purposes other than those specified in the protocol, and shall be preserved for a period, as specified under NSU policy/practices.

9. You shall promptly and fully comply with the decision of IRB to suspend or withdraw its approval for the research protocol.

10. You shall report progress of research to the IRB on annual basis.

I wish you success in running the above-mentioned study.

cc: Dean, School of Health and Life Sciences
Director, Research
Chairman, Department of Public Health
Research Officer, RO

Annex F. Informed consent form (English)

Hello, my name is _____, and I am working on a PhD study with the London School of Hygiene and Tropical Medicine about young people's experiences and perceptions of sexual and reproductive health in Dhaka.

You are invited to take part in a research study. Before you decide whether to participate, you need to understand why the research is being done and what it would involve. Please take the time to read or to listen as I read the following information. You may talk to others about the study if you wish. Please ask me if there is anything that is not clear, or if you would like more information. When all of your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study, and if yes, to sign this informed consent form. You will be given a signed copy to keep.

Purpose of the Study and Study Requirements

What is the study? The purpose of the study is to find out about how young people in Dhaka experience different aspects of sexuality and see how such their perspective can expand our understanding of sexual health and wellbeing.

Why have I been invited to take part? You have been invited to take part because you are aged between 18 to 24 and live in Dhaka.

What will happen if I take part? If you agree to take part in the study, we will ask you to sign this form. After that you will be asked some questions about topics relating to sexuality, socio-sexual expectations and gender, including your own thoughts and experiences. To help us to recall your answers correctly, we will make an audio recording of the interview. After the interview, we will type your answers into the computer, after that we will destroy the recording.

How long will the interview last? It will take about one to one and a half hours and we can conduct it now, or we can arrange another time within the next week.

Risks

What are the risks of the study? There are no physical risks, but the interview includes some personal questions that you may be find difficult to answer or could make you feel upset. You do not have to answer any question that makes you uncomfortable, you can just ask me to go to the next question and you can also choose to stop the interview at any time you want. A further risk is that something you say is accidentally found out by others but we have very strict procedures in place to make sure that this does not happen.

Benefits

What are the benefits of participating? You may find an indirect benefit in knowing you have participated in an important that could help others in the future.

Confidentiality

Will my participation in the study be kept confidential? The information that is collected during the interview will be kept private. No-one will be told that you have participated in the study. The study team will make every effort to protect your privacy and maintain confidentiality of all the information that you provide. Your name or other information that could be used to identify you will not be included in reports from this study. Data will be stored in a locked location dedicated to this study that only the study team can access.

Voluntariness

What are my rights as a research participant/subject? Your participation in this study is completely voluntary. If you agree to participate in this study, you may end your participation at any time. If you decide to take part, you are free to say you do not want to answer any of the questions. If you decline participation in the study, or to cease to participate, this will not affect your access to services and/or benefits to which you may be entitled.

Additional Information

What will happen to the results of the research study? The results of the study will be shared with the government and national organisations in Bangladesh. They will also be presented at conferences internationally and published in journals. Any excerpts or quotes from your interview used in the report will be anonymised and all identifying details will be deleted.

Who has reviewed the study for ethical issues? This study has been reviewed by the London School of Hygiene and Tropical Medicine Ethics Committee and North South University's Institutional Review Board in Bangladesh. You can contact Professor Dipak Kumar Mitra at…. if you have any questions about your rights as a participant in this study.

What if I need more information? If you have a concern about any aspect of the study, you should ask to speak to the researchers who will do their best to answer your questions. You may contact Prima Alam at ….

What if there is a problem? Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. Please contact Dr Ladly Faiz at...

Do I have to decide now? If you want, you can take some time to think about whether you want to do this interview, or to talk to someone else before deciding. You can do the interview any time in the next week.

Do you have any questions about what I have told you so far?

Do you want to have time to think about it or would you like to do the interview now?

Subject Statement: I have read the informed consent for this study. I have received an explanation of the planned research, procedures, risks and benefits and privacy of my personal information. I agree to take part in this study, and I am aware that

this means that audio recording will take place. I understand that my participation in this study is voluntary.

Your name: _____

Your signature: _____**Date:** _____

Interviewer who conducted informed consent discussion: I confirm that I have personally explained the nature and extent of the planned research, study procedures, potential risks and benefits, and confidentiality of personal information.

Name of person obtaining consent: _____

Signature of person obtaining consent: _____**Date:** _____

Annex G. Informed consent form (Bangla)

হ্যালো, আমার নাম _____ এবং আমি একজন পি এইচ ডি'র ছাত্রী, লন্ডন স্কুল অব হাইজিন অ্যান্ড ট্রপিক্যাল মেডিসিন থেকে একটা গবেষণা কাজে অংশগ্রহণ করছি, যা ঢাকা শহরের যুব সম্প্রদায়ের যৌনতা এবং প্রজনন স্বাস্থ্য নিয়ে তাদের নিজস্ব ভাবনা এবং বাস্তব জীবনের অভিজ্ঞতা উঠিয়ে আনা হবে।

আপনাকে উক্ত গবেষণা কাজটির একজন অংশ গ্রহণকারী হবার জন্য আমন্ত্রণ জানাচ্ছি। এই গবেষণায় অংশ গ্রহনের পূর্বে আপনাকে আমার এই গবেষণাটি সম্পর্কে জানা উচিত আর এই গবেষণাটি কেন হচ্ছে আর এর সাথে কি কি যুক্ত থাকতে পারে। দয়া করে কিছুটা সময় নিন এটা পড়ার জন্য অথবা আমি এই তথ্য গুলো আপনাকে পড়ে শুনাচ্ছি। আপনি এই গবেষণাটি সম্পর্কে অন্য যে কারো সাথে কথা বলতে পারেন। দয়া করে আপনি আমাকে-ও অনেক কিছু জিজ্ঞেস করতে পারেন যা আপনার কাছে পরিষ্কার না অথবা আপনার যদি আরও অনেক বেশী তথ্য জানার ইচ্ছে থেকে থাকে। যখন আপনার সব ধরনের প্রশ্নের উত্তর শেষ হবে বা আপনি যখন সব কিছু অনুধাবন করতে পারবেন তখন আপনি তাকে এই গবেষণা কাজটিতে অংশগ্রহণ করবে কিনা তা জানতে চাইবেন এবং যদি 'হ্যাঁ' বলে তবে সন্মতি পত্রে স্বাক্ষর গ্রহণ করুন।

<u>গবেষণার উদ্দেশ্য এবং এর প্রয়োজনীয়তাঃ</u>

গবেষণাটি কিসের উপর? গবেষণাটির উদ্দেশ্য হচ্ছে ঢাকা শহরের মধ্যে যুব সম্প্রদায়ের মধ্যে যৌনতা নিয়ে অভিজ্ঞতার বিভিন্নতা দেখা এবং প্রজনন স্বাস্থ্য ও নিজেদের সুস্থতা নিয়ে তাদের এই চিন্তা চেতনা আমাদের ভাবনাটাকে কতটুকু সামনের দিকে এগিয়ে নিয়ে যেতে পারে।

কেন আমি আপনাকে এই গবেষণার জন্য আমন্ত্রণ জানাচ্ছি? আপনার বয়স ১৮ থেকে ২৪ বছরের মধ্যে এবং আপনি ঢাকাতে বসবাস করছেন বিধায় আমি আপনাকে এই গবেষণায় অংশগ্রহণের জন্য আমন্ত্রণ জানাচ্ছি।

যদি আমি এই গবেষণার একজন অংশ হই তবে কি হবে? যদি আপনি এই গবেষণার একজন অংশগ্রহণকারী হন তবে আপনাকে এই ফর্মটি দস্তখত করতে হবে। এর পর আপনাকে যৌনতা, সমাজ-যৌনতা নিয়ে আশাবাদ এবং জেন্ডার সম্পর্কে যেখানে আপনার চিন্তা চেতনা এবং অভিজ্ঞতার উপর কিছু প্রশ্ন করা হবে। আমরা উক্ত আলোচনাটি অডিও রেকর্ড করব যাতে পরবর্তীতে আপনার কথাগুলো মনে করতে সহায়তা করবে। সাক্ষাৎকার শেষে আপনার উত্তরগুলো কম্পিউটার-এ টাইপ করা হবে এবং পরবর্তীতে রেকর্ডিংটি ধ্বংস করে ফেলা হবে।

সাক্ষাৎকারটি কতক্ষণ যাবৎ চলবে? সাক্ষাৎকারটি এক থেকে এক এবং ত্রিশ মিনিট যাবৎ চলবে। যা আমরা এখনি করতে পারি অথবা আগামী সপ্তাহের অন্য কোন সময় আয়োজন করতে পারি।

ঝুকি সমূহঃ

এই গবেষণার ঝুকি সমূহ কি হতে পারে? এই গবেষণায় কোন শারীরিক ঝুকি নেই। কিন্তু এখানে কিছু ব্যক্তিগত প্রশ্ন থাকবে যা হয়ত আপনার পক্ষে উত্তর দেয়া কিছুটা কঠিন হতে পারে বা আপনাকে কিছুটা বিষণ্ন করে দিতে পারে। আপনার এখানে এমন কোন প্রশ্নের উত্তর দেবার কোন দরকার নাই যেটার উত্তর করতে গিয়ে আপনার কোন অস্বস্তিকর অবস্থার মধ্যে পরতে হয়। আপনি পরবর্তী প্রশ্ন সম্পর্কে জানতে পারেন বা যেকোনো সময় আপনি সাক্ষাৎকারটি বন্ধ করে দিতে পারেন যদি আপনি চান। আবার অন্য ধরনের একটা ঝুকি হতে পারে, যেমন আপনি কোন ঘটনা বলতে গিয়ে কারো নাম চলে আসল, তবে আমরা খুবই শক্তভাবে সে গোপনিয়তা বজায় রাখব।

লাভ সমূহঃ

এখানে অংশগ্রহন করলে কি ধরনের লাভ হতে পারে? আপনি এখানে পরোক্ষভাবে লাভবান হতে পারেন যে আপনি এমন ধরনের একটি গবেষণার কাজে অংশগ্রহণ করতে পেরেছেন যা অন্যকে ভবিৎষতে এ ধরনের গবেষণায় সাহায্য করবে।

গোপনীয়তাঃ

এই গবেষণায় অংশগ্রহণের ক্ষেত্রে আমার গোপনীয়তার কি রক্ষা হবে? সাক্ষাৎকারের সময় সম্পূর্ণ গোপনীয়তা বজায় রাখা হবে। কেউ-ই বলতে পারবে না যে আপনি এ ধরনের গবেষণায় অংশগ্রহণ করেছেন। পুরো গবেষণা দল প্রতি ক্ষেত্রে আপনার গোপনীয়তা রক্ষা করবে এবং আপনি যত ধরনের তথ্য আমাদের দিবেন তার সবগুলোর ক্ষেত্রে সর্বচ্চো গোপনীয়তা বজায় রাখা হবে। এই গবেষণার কোথাও আপনার নাম বা কোন তথ্য আপনাকে চিহ্নিত করতে পারে তা দেয়া হবে না। তথ্য ও উপাত্তগুলো একটি তালা দেয়া লকারের মধ্যে রাখা হবে যার চাবি শুধু গবেষণা দলের সদস্যদের কাছে থাকবে।

স্বেচ্ছামূলকঃ

একজন গবেষণার অংশ হয়ে আমার অধিকার কি হবে? এয় গবেষণায় আপনার অংশগ্রহন হবে সম্পূর্ণভাবে স্বেচ্ছামূলক। যদি আপনি এই গবেষণায় অংশগ্রহন করতে ইচ্ছুক থাকেন তবে আপনি এই গবেষণায় অংশগ্রহনকালীন সময়ে যেকোনো প্রশ্নের উত্তর দেয়া থেকে বিরত থাকতে পারেন।

অতিরিক্ত তথ্যাদিঃ

এই গবেষণার ফলাফল দিয়ে কি হবে? এই গবেষণার ফলাফলটি বাংলাদেশের বিভিন্ন জাতীয় সংস্থাসমূহ ও সরকারের সাথে আলোচনা করা হবে। এর ফলাফল আন্তর্জাতিক বিভিন্ন সেমিনারে এবং জার্নালে প্রকাশ করা হবে। রিপোর্ট হতে আপনার দেয়া সকল উদ্ধিতি পরিহার করা হবে যা অসঙ্গতিপূর্ণ ও অসামঞ্জস্য।

গবেষণার নৈতিক বিষয়গুলো কে পর্যালোচনা করবেন? এই গবেষণাটি লন্ডন স্কুল অফ হাইজিন এন্ড ট্রপিক্যাল মেডিসিন ইথিকস কমিটি এবং স্থানীয় গবেষণা প্রতিষ্ঠান পর্যালোচনা করবেন। আপনি ইচ্ছে করলে এই গবেষণা প্রতিষ্ঠানের সাথে যোগাযোগ করতে পারেন যদি এই গবেষোণায় আপনার অধিকার নিয়ে কিছু জানার থাকে।

আমার যদি আরোও তথ্যের প্রয়োজন হয়? যদি আপনি আরোও কোন তথ্য সম্পর্কে জানতে উৎসুক হোন তবে তার সম্পর্কে পরিষ্কার ধারণা পেতে আপনি এই গবেষণার গবেষকের সাথে সরাসরি যোগাযোগ করতে পারেন। আপনি এই গবেষণার গবেষক **প্রিমা আলম, মোবাইলঃ ইমেল**

যদি কোনো সমস্যা হয়? গবেষণার সময় যেকোন সমস্যাকে গুরুত্বের সাথে দেখা হবে এবং তা সমাধানে যথাযথ ব্যবস্থা নেয়া হবে। প্রয়োজনে যোগাযোগ করুনঃ Dr Ladly Faiz **মোবাইলঃ ইমেল**

আমি কী এখুনি সিদ্ধান্ত নিতে পারি? যদি আপনি চান, তবে আপনি কিছুক্ষণ সময় নিতে পারেন অথবা আপনি অন্য কারো সাথে আলোচনা করে নিতে পারেন।

আপনি আগামী সপ্তাহের যেকোন সময় সাক্ষাৎকারে অংশগ্রহণ করতে পারেন।

আমি যা বলেছি সে সম্পর্কে কি আপনার কোন প্রশ্ন আছে?

আপনি কি এ বিষয় নিয়ে আরোও ভাবতে চান বা আপনি এখনি সাক্ষাৎকারে অংশগ্রহন করতে চান? **সাক্ষাৎকারকারীর মন্তব্যঃ** আমি এই স্টাডিটির সন্মতিপত্রটি পরেছি। আমি এই গবেষণাটিতে অংশগ্রহণ করতে গেলে গবেষণার পরিকল্পনা ও প্রক্রিয়া এবং আমার দেয়া

তথ্যের কি ধরনের ঝুকি এবং লাভ বা গোপনীয়তা রক্ষা করা হবে সে সম্পর্কে ব্যাখ্যা করা হয়েছে। আমি এই গবেষণায় অংশগ্রহণ করতে সন্মত আছি এবং আমি এ বিষয়েও সচেতন আছি যে আমার সাক্ষাৎকারটি রেকর্ড করা হবে। আমি বুঝতে পেরেছি যে এই গবেষণায় আমার অংশগ্রহণটি হবে স্বেচ্ছাসেবকমূলক।

আপনার নাম.....

আপনার স্বাক্ষর.....**তারিখ** .....

সাক্ষাৎকার গ্রহণকারী যিনি সন্মতিপত্রটি আলোচনা করেছেনঃ আমি এটা নিশ্চিত করেছি যে, আমি বাক্তিগতভাবে তাকে এই গবেষণার প্রকৃতি এবং বর্ধিত পরিকল্পনা, কার্যপ্রণালী, ঝুকি এবং লাভবান হবার অংশ এবং বাক্তিগত তথ্যের গোপনীয়তা সম্পর্কে ব্যাখ্যা করেছি।

সন্মতিপত্র গ্রহণকারীর নাম.....

সন্মতিপত্র গ্রহণকারীর স্বাক্ষর.....**তারিখ** .....

Annex H. Confidentiality agreement for translators

Research Project: Young People's Lived Experiences and Perceptions of Sexuality and Sexual Health in Dhaka, Bangladesh

AGREEMENT OF CONFIDENTIALITY

In my capacity as a translator of interviews for the above research project, I [insert name] …….. hereby agree to keep all information that I hear completely confidential. I agree that:

1. I will not speak of the specific content of these recordings and transcripts to anybody else.
2. I will not share any information contained in these recordings or transcripts with anybody else in any format.
3. I will keep all electronic files containing interview content in a password protected folder on my computer.
4. If I need to have any written documentation of any content from the interviews, this will be stored in a locked cabinet that only I have access to.
5. I agree that on completion of this work, and after sharing all files with the Principe Investigator, I will destroy all copies and extracts of the audio recordings and transcripts **within 5 days of the termination of this contract**.

Signed: ……

Date: ……

Annex I. Data management plan

1. **What data or other resources will you be working with in your study?**

- Interview guide and data from face-to-face in-depth interviews with ~40 young people. Collected by self and research assistants.
- Published literature collected from electronic databases. Searched and collected by self.

2. **What software/hardware tools and file formats/standards will you use?**
   - MS Word: transcripts (text) and write-up of analysis
   - NVivo: coding
3. **What data-related activities will be performed during your research?**
   - Design and pilot in month 4
   - Data generation in month 6-11
   - Translation and transcription in month 5-11
   - Coding, analysis and write-up in month 8-21
   - Archiving in month 21
4. **What quality checks will you perform to ensure data are fit for purpose?**
   - Design and pilot: supervisor and local partner to review interview guides; researcher and research assistant to check for biases in interview guides during pilot; make appropriate changes and notes
   - Data generation: provide clear instructions before and during interviews; use standardised methods for capturing responses; use repeat interviews where possible
   - Translation and transcription: verbatim transcriptions; double-check translation and transcription with audio recordings; correcting errors made during transcription; accompanying notes and documentations
   - Coding, analysis and write-up: use standardised coding style; develop coding list; independent coding check; documentation on coding decisions
   - Archiving: keep a single master file of data; archive copies of master files at regular intervals; develop a procedure for the deletion of master files; read-only access to master versions of data files; record all changes to master files
5. **How will you address ethical and/or rights issues associated with current and future use of data?**
   - Written informed consent will be obtained from all research participants.
6. **What documentation is needed to understand your data?**
   - Full codebook with examples.
   - Audit trail of activities and decisions/changes.
   - User guide on saved data.

7. **Where will you store data during the project lifetime? (choose one or more)**

My desktop PC at home		My Laptop or tablet	X	Personal area on university network (e.g. drive H:)		University Shared Network drive accessible to all (I: drive)	
Server at collaborator institution		University-based project server		LSHTM Secure Data Server (for confidential data)		LSHTM Open Data Kit server	
For-cost cloud service (e.g. Amazon S3)		Free cloud service (e.g. Dropbox)		Portable storage (e.g.USB disk or memory stick)	X	LSHTM SharePoint	
Other							

8. **What security measures will you apply to protect data? (choose one or more)**

I will not collect any data considered personal, sensitive, or otherwise confidential		Store personal details in a separate secure location & link it via an identifier		Delete confidential details at earliest opportunity (e.g. via anonymisation)	X
Use digital storage systems that require a username/ password or other security feature in order to access files	X	Physical security (such as locked cabinet or room)		Protect portable devices using biometric, passwords, or other security features	X
Encrypt data storage devices	X	Encrypt data during transfer		Avoid use of cloud services located outside EU	X
Other					

9. **How will you organise and label data to make it easy to find and analyse?**
- Clearly labelled filenames for each interview transcript.
- In-depth interview folder with subfolders for each participant (~40 subfolders).

10. **What resources should be kept as evidence of your research?**
- All interview transcripts.
- Available to researchers (subject to ethical clearance).

11. **If resources can be made available, when is this likely to happen?**

During the project lifetime		On thesis submission		On publication of thesis	
At the same time as research findings are published in an academic journal	X	A set time period after project end (e.g. 12 months). Please specify time period			
Other					

12. **Where will these be stored after you've completed your thesis? (choose one or more)**

I will look after the data myself	X	My supervisor will look after the resources		They will be looked after by the project team	
Submitted to the LSHTM digital repository	X	Held in a university project system		Held in a 3rd party data repository. (Specify which in Other field)	
Other:					

13. **What actions will you perform to ensure your resources can be accessed and used in the long-term? (choose one or more)**

Prepare a user guide that provides a high-level overview of data	X	Ensure codebooks and other documentation are accurate and made available alongside data	X	Use open formats to ensure data can be easily accessed, e.g. CSV	X
Remove personal and confidential data	X	Adopt an appropriate licence that clearly states allowed/non-allowed uses		Apply appropriate domain standards for labelling data	X

A description will be published in a digital repository and a DOI obtained					
Other:					

14. What are the primary data management challenges in your research?

- Interview recordings will be translated from Bangla and transcribed in English. Checking the accuracy of translation for nuances may be quite time consuming.

15. How can LSHTM & others help you to better manage your data?

- Archiving and storage, if necessary.

Annex J. Reflexivity exercise using reflexivity matrix

	Social space		**Space of specialists**		**Scholastic space**	
	Questions	***Comments***	***Questions***	***Comments***	***Questions***	***Comments***
Pre-research	How does researcher's broader motivations affect reason to conduct research, choice of topic, research question, and methodology? What is researcher's conceptualisation of 'health'?	- Working in health sector in Bangladesh meant I want to address gaps through qualitative research with focus on marginalised groups. - Wellbeing as contextual and people-centred, not just cause/treatment of illness.	What is the relationship between researcher and research field? How is choice of topic relevant to healthcare?	- I pursued MSc for 'theoretical knowledge' in sexual health as well as doing research in healthcare interventions. - Exploratory in-depth study to guide policy/ interventions and contribute to knowledge of diverse experiences.	Where does researcher's interests lie within relevant literature and its interpretations?	- Engaged in critical queer theory (heteronormativity) and English-language texts often by authors based in global North. Interpretation influenced by both local and global queer and feminist activism.
Data generation	What are shared and divergent understandings between researcher and participants about research and to health-related topic? Are there any social differences (e.g. gender, education, experience)?	- Shared/divergent understandings of gender/ sexuality depending on participant (e.g. conservative beliefs around premarital sex) - Yes. Where needed, younger interviewers of different gender/ educational backgrounds can lead interviews.	Do researcher and participants share the same language, especially if they come from different health disciplines? Any power differentials between researcher and participant, based on positions held, health discipline, or education?	- As bilingual Bangla speaker, my colloquial vocabulary and local 'health speak' is limited. - Questions not around specific health disciplines. - Education difference as a PhD student based abroad studying young people from different backgrounds. Questions not based on knowledge of health but of all lived experiences as 'valid'.	Are questions or prompts inadvertently shaped by popular scholarly opinion?	- Questions shaped by feminist queer readings and sexuality studies. Captures phenomenological lifeworld domains and experiences. Questions open-ended and conversational. Interest in critique of postpositivist research, shift towards anthropologies in global South shaped epistemological framing of questions.

	To what extent are meanings negotiated between researcher and participants, and how is this influenced by life experiences? Is the researcher prepared to undergo change as result of interaction with research? What is the potential for change in participant?	- Meanings negotiated through biographical interviews based on participants' lived experiences. - Yes, in terms of awareness of different lived experiences presented through interviews. Being witness/co-constructor of diverse narratives. - Potential through re-telling and co-constructing lifeworld.				
Data analysis			How does researcher's experience with field shape analysis? Are some data dismissed as being commonplace, whereas they might warrant deeper interrogation? To what extent does researcher consider balance of analytical authority to rest with participant or researcher?	- Influence of global north education system. First anthropological and phenomenological undertaking as researcher. - Analysis within scope of sexual health research. 'Unique' contribution required for PhD. - Participants not involved in analysis process. PhD candidates required to lead on analysis.	How does researcher moderate any drive for outcomes that might inadvertently lead to data omissions or fabrications?	- Consider ethics in practice. Speak with other PhD students and those working in the field. Focus on research themes requiring exploration of all relevant data and staying close to data as recorded (e.g. audio files and transcripts). Supervisory team also contributes to analysis.

Annex K. Summary table of main findings and further research recommendations from papers included in thesis

Title of paper	Objective	Analysis	Main findings	Recommendations for further research
Paper 1 (Chapter 2): Socio-sexual norms and young people's sexual health in South Asia: Systematic review of current issues in Bangladesh, India, Pakistan and Nepal	1a	Systematic review of 13 peer-reviewed articles using phenomenological lifeworld perspective	- Widespread parental and societal expectations around premarital 'sexual purity' through sexual innocence and abstinence as sign of 'good virtue' – with some variations in experiences depending on socioeconomic status, gender, and age. - Silence or limited communication around sexuality between young people and parents as well as other adults predominantly due to mutual shame and embarrassment about the topic. - Restrictive gendered norms particularly limiting for young women's sexual and reproductive health decision making (gender narratives and sexual consent; mobility restrictions and access to sexuality resources; and decision making around contraception). - Heteronormativity presumed and implied through lack of diverse sexual and gender representation in research.	- Need for more in-depth qualitative research on SRH in general. - Need for research examining lived experiences of, and health inequalities within, sexual and gender diverse communities.
Paper 2 (Chapter 5): "I have taken your *izzath* (honour), so you can't betray me": Young people's lived experiences of navigating sexual norms and violence in Bangladesh	2a	Phenomenological lifeworld analysis of 46 interviews	- Young people's lives punctuated by episodes of harassment and violence with negative impact on their mental and physical wellbeing. - Widespread perception that penetrative sex 'bonds' a person to one sexual partner for life contributed to coercive behaviour. - Experiences of, and silence around, sexual abuse and harassment impacted young people's agency/confidence in subsequent sexual interactions as well as adversely affecting their mental wellbeing.	- Examine nuances of consent and sexual violence at various life stages. - Explore interpersonal relations (e.g. parents, teachers, healthcare practitioners) for context-specific information on how to effectively advocate for young people. - Research lived experiences of sexual violence in more depth to better understand the essence of phenomenon. - Collect perspective of perpetrators of sexual violence to further our understanding of mechanisms that maintain such behaviour.

Paper 3 (Chapter 6): 'Bending' against heteronormative straightening devices: Queer young people's lived experiences of sexuality and sexual health in Bangladesh	2b	Phenomenological lifeworld analysis of 14 LGBTQ interviews using framework of 'straightening devices'	- Heteronormative expectations apparent in narratives around gender norms of masculinity/femininity as well as compulsory heterosexuality through marriage (as expected by parents). Straightening devices operate at multiple levels (individual, interpersonal, community, societal). - Four main devices were identified: marriage normativity (straightening the life course); compulsory heteronormativity in public space (performing straightness); heteronormativity within healthcare (straightening as 'care'); and consequences of failing to embody heteronormativity (unbecoming straight).	- Investigate lived experiences of more diverse young people (e.g. intersex individuals, individuals from the Hijra community). - Further examine structural challenges and health disparities. - Explore each 'straightening device' as well as specific sexual and gender identities in more depth to better understand essence of lived experiences. - How can researchers and practitioners ensure support in places where queer rights are not recognised?
Paper 4 (Chapter 7): "People are having lots of other kinds of sex": Exploring sexual lifeworld of LGBTQ young people in Bangladesh	2c	Phenomenological lifeworld analysis of 14 LGBTQ interviews	- Sexual intimacy as experienced by LGBTQ young people in Bangladesh meant desiring consensual sexual and romantic relationships with sexually 'matched' partner(s) while navigating heteropatriarchal sexuality norms. - Key themes include desire for romantic intimacy in sexual interactions, need for discretion when navigating sex and relationships, 'matching' sexual roles in sexual partnerships and attraction, challenges to dynamics of masculinity and domination.	- Better understand relational dynamics within LGBTQ+ spectrum essential to ensure effective health interventions. - Investigate associations between lived experiences of sexuality and mental health concerns among LGBTQ+ youth as well as identifying effective resilience and coping mechanisms. - Explore each theme in more depth to better understand various aspects of these lived experiences. - Explore how interventions promoting mental health can be adapted in a Bangladeshi context.

Annex L. Overview of themes included in thesis across participant groups

Themes		Sample		
		LGBTQ+	Cis men (heterosexual)	Cis women (heterosexual)
		n=14	*n=16*	*n=16*
Paper 2 (Chapter 5): Sexual violence				
1	Lives punctuated by episodes of harassment and violence with negative impact on wellbeing and agency/confidence in subsequent sexual interactions	**X**	**X**	**X**
1a	'Dealing with' street harassment by oneself	**X**		**X**
1b	Childhood sexual abuse perpetrated by relatives and questioning of self	**X**	**X**	**X**
1c	Experiences of intimate partner violence	**X**		**X**
2	Penetrative sex perceived as 'bonding' person to one sexual partner for life and contributed to coercive behaviour	**X**	**X**	**X**
Paper 3 (Chapter 6): Heteronormative straightening devices				
3	Marriage normativity (straightening life course)	**X**		**X**
4	Compulsory heteronormativity in public space (performing straightness)	**X**		
5	Heteronormativity within healthcare (straightening as 'care')	**X**		
6	Consequences of failing to embody heteronormativity (unbecoming straight)	**X**		
Paper 4 (Chapter 7): Sexual intimacy through lifeworld				
7	Desire for romantic intimacy in sexual interactions	**X**	**X**	**X**
8	Need for discretion when navigating sex and relationships	**X**	**X**	**X**
9	'Matching' sexual roles in sexual partnerships and attraction	**X**		
10	Challenges to dynamics of masculinity and domination	**X**		**X**
11	Embodying notions of sexual morality	**X**		**X**

X Key themes emerging from participants in sample group and included in analysis

Annex M. Summary of key themes from Paper 1-4 across lifeworld domains

	Lived space	Lived time	Lived relationships	Lived body	Lived emotions
Description	Experience of, and interactions with, living in physical and social world affects way we feel. E.g. walking through open field could be different experience from walking through a crowded street. Experiences can impact health.	Subjective time as experienced by humans. Experienced through landscapes of past, present, and future. E.g. appearing to speed up when we enjoy ourselves or slow down when we are unwell or anxious.	Relationships with others maintained within shared interpersonal space. Capacity for language extends understanding and shared meanings in our world. Helps navigate cultural contexts which in turn impact self-perception and view of others.	Perceptions of our context, experienced by living with and through our bodies. Means by which humans incorporate physical and social environment with implications for self-perception and wellbeing.	Mood is a powerful messenger of meaning of situations. Essential element of how we are as humans and affects our ability to realise our potential. E.g. anxiety reveals very different lifeworld than joy with implications on wellbeing and quality of life.
Paper 1	- Limited communication about sexuality at home. - Restricted mobility for girls - Similarities in sexuality norms across South Asian contexts.	- Ideal age for sexual debut as described by respondents. - Transition from adolescence to youth (e.g. becoming more mature and wanting to date/ know more about sex).	- Limited communication about sexuality with adults. - Expectations of premarital sexual abstinence as sign of 'good virtue'.	- Gender norms limit young women's sexual and reproductive decision making (e.g. lack of women's sexual consent).	- Shame and embarrassment in speaking about sexuality with adults. - Young women negatively impacted from tolerating intimate partner violence.
Paper 2	- 'Dealing with' street harassment by oneself. - Some spaces of harassment cannot be avoided which has impact on wellbeing. - Spaces become associated with experience of harassment (e.g. Chawk Bazaar).	- Childhood sexual abuse perpetrated by relatives and questioning of self. - Transitioning from adolescence to early 20s and changes in perception of sex.	- Experiences of intimate partner violence - Expectations of long-term monogamy. - Silence around sexual abuse due to self-blame and stigma - Gendered double standards of sexual behaviour.	- Penetrative sex as an act which 'bonds' couples together. - Body as needing to be protected from penetration. - Belief that others can perceive non-normativity.	- Living with trauma of abuse and impact on wellbeing. - Self-blame and shame around sexual abuse.
Paper 3	- Compulsory heteronormativity in public spaces: harassment of femme-presenting bodies. - Affluent areas perceived to be less violent.	- Harassment for non-conformity experienced since childhood. - Having to wait to begin life as transgender person waiting to transition.	- Pressure from family to conform to marriage normativity. - Lack of trust in healthcare professionals.	- Consequences of failing to embody heteronormativity. - Experiences of gender identity/dysphoria.	- Exploring non-normative sexualities and gender identity initially seen as 'confusing', 'abnormal', 'unnatural', 'dirty', 'uncomfortable'. - Fear, uncertainty, and internalised homophobia.

Paper 4	- Need for discretion when navigating sex and relationships limits places where young people go to have sex. - Importance of virtual spaces and representation (e.g. offering some anonymity and community).	- Not knowing terminology/language around non-normative sexual desires. - Coming to terms with sexuality/gender identity over time.	- Desire for romantic intimacy in sexual interactions. - Need for discretion when navigating sex and relationships (e.g. 'passing' as cousins/relatives when hooking up with same sex). - 'Matching' sexual roles in sexual partnerships. - Challenges to dynamics of masculinity and domination (e.g. having to conform to heteronormative roles within queer relationship).	- Embodying notions of sexual morality: need to 'protect' body, particularly from penetrative sex. - Importance of virtual spaces and representation (e.g. feeling 'normal' by seeing queer representation/finding online queer community). - Attempting to 'pass' as straight/gender conforming person.	- Challenges to dynamics of masculinity and domination (e.g. frustration, stress). - Fear and insecurity around being outed to 'wrong' people.