Unveiling the Evidence of Utilizing Sexual and Reproductive Health Services, Knowledge Deficits and Restriction Concerns of Indigenous and Women Living with HIV and AIDS in Nepal: A Scoping Review [1]

Anup Adhikari, Bhagwan Aryal, Gyanu Maharjan & Punya Shori Suwal

Abstract

This scoping review aimed to understand Sexual and Reproductive Health and Rights (SRHR) concerns among the Indigenous and 'Women Living with Human Immunodeficiency Virus' (HIV) (WLWH) in Nepal. It identified various concerns, some of which focused on Indigenous peoples or groups and others that required community involvement. The review included an analysis of 150 articles from various platforms, of which 60 were selected for review. It focused on research papers, policy documents, and fact sheets (excluding school-based studies) from 2000 to 2023, emphasizing 2011 to 2020. Established scholars guided the methodology, significantly contributed to existing knowledge, and informed future research directions in the critical area of SRHR of People Living with HIV and AIDS (PLHA) and indigenous people. The review revealed cultural, structural, and gender-based issues that affect access to SRHR services. The indigenous populations were discriminated against and had low access to services. There was widespread stigma and violence, which are very determinant to the health and well-being of women. The synthesis reveals the necessity of specific interventions to advance knowledge dissemination and build autonomy to manage the complex problems affecting indigenous and WLWH in Nepal. Results from the scoping review identified barriers to accessing services and obtaining SRHR information among Indigenous WLWH: they

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Anup Adhikari, Ramswarup Ramsagar, M Campus Janakpur, TU, Nepal, https://orcid.org/0000-0003-1333-1039; **Bhagwan Aryal, PhD** Central Department of Education, TU, Nepal, https://orcid.org/0000-0002-9215-3551 (corresponding author); **Gyanu Maharjan,** School of Nursing, Ktm Model Hospital, Nepal, https://orcid.org/0009-0006-7735-4589; **& Punya Shori Suwal,** PhD Scholar, Noida International University, Delhi, India, https://orcid.org/0000-0003-2369-5899. E-mail: bhagwan.aryal@cded.tu.edu.np

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live in remote areas, many do not know about their SRHR, few have access to services, and many experience financial barriers. Thus, a targeted intervention needs to be created (and knowledge dissemination improved) to help mitigate the denial of rights experienced by this group.

***Keywords*:** Indigenous women, PLHA, scoping review, SRHR service, women living with HIV

Introduction

Although there are recent progresses in the study of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), concerns remain on the impact of these on Women Living with HIV (WLWH). This study looked at Indigenous people and women and girls living with HIV and AIDS in Nepal as well as various aspects of each group including Sexual and Reproductive Health and Rights (SRHR). It also identified if those using SRHR services experienced stigma and discrimination as a result; opportunistic infections suffered by PLWHA, the degree to which they had autonomy, the level of support from spouses and family members, and the extent to which WLWH encounter cultural and structural barriers to access SRHR services. As such, the subject matter of HIV and AIDS is considered sensitive in nature and is highly underexplored in the indigenous context in Nepal. This presents several research challenges with regard to ethics, research design and sampling methodology, stigma and discrimination, incentives and ensuring anonymity and confidentiality (Poudel et al., 2016).

Researchers are expected to work closely with Indigenous people when developing or conducting research, create questions that matter to their communities, and utilize an asset-based approach (Rand, 2016). Due to limited or no community involvement, some studies had limited community grounding, and there was an ethical obligation to include Indigenous peoples in quality research (Fitzpatrick et al., 2016). One major limitation is the lack of knowledge mobilization by researchers working in the areas of Indigenous gender and health/wellness.

WLWHs face barriers to health care and their lived experiences should be known. Therefore, the primary objective of this scoping review was to gather evidence and identify knowledge gaps concerning the SRHR of indigenous and WLWH in Nepal, aiming to clarify concepts and identify key features of their healthcare access.

Methods

Scoping reviews have a key role in facilitating the amalgamation of available evidence on specific topics, exploring various forms of evidence, and determining evidence gaps (Munn et al., 2018). The current scoping review was conducted by adhering to the six-step framework for scoping reviews as initially suggested by Arksey and O'Malley and later modified by the Joanna Briggs Institute (Arksey & O'Malley, 2005). The reporting of this scoping review has been done according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Sharma & Goyal, 2023).

Review question and PCC strategy

To maintain a clear scope, this scoping review was led by the Population-Concept-Context (PCC) strategy (Sharma & Goyal, 2023)─ *Population*: Indigenous women and WLWH; *Concept*: Evidence of SRHR utilization, knowledge deficits, and restriction concerns; *Context*: The geographical and cultural setting of Nepal; *Primary Research Question:* What is the nature and extent of available evidence regarding the SRHR concerns and service utilization among indigenous and WLWH in Nepal?

Inclusion and exclusion criteria

Timeline: Sources published between 2000 and 2023, with a focus from 2011 to 2020; *Document Types*: National-level policy documents, program reports, fact sheets, books, and peer-reviewed research papers; *Data Focus*: For the contextual relevance, the literature using Nepalese information were included in this study; *Exclusion Criteria*: School-based studies were excluded because education is a known protective factor that could skew results on general SRHR vulnerability in the community.

Search strategy

The comprehensive search of relevant literature was conducted on Google Scholar, PubMed, Web of Science, and Library of Congress, using the keywords with combinations, for maximizing the number─ *Indigenous women + Sexual and reproductive health + PLHA in Nepal; Indigenous women + HIV + access to treatment in Nepal; Indigenous women + Health services and/or Family planning services for PLHA in Nepal*

Evidence screening and selection

The selection process included a multi-stage screening as per PRISMA-ScR standards (Sharma & Goyal, 2023). *Identification*: A total of 150 records were identified

(45 from Google Scholar, 35 from PubMed, 25 from Web of Science, and another 50, i.e., 20 from Library of Congress, 15 from Policy/gray literature, and 15 from hand search); *Screening*: 25 duplicates were removed; *Eligibility Assessment*: The remaining 125 articles were screened by title and abstract; 40 articles were excluded due to the unavailability of full-text versions; *Inclusion*: A final total of 60 distinct sources (35 research papers, 4 policy documents, 2 books, and 1 fact sheet) met the criteria for qualitative synthesis.

Data extraction and charting

Data were 'charted' using a descriptive approach to capture key characteristics. For each included source, the following information was extracted: author, year of publication, type of document, and key findings related to SRHR knowledge, barriers, and stigma.

Quality assessment and analysis

No critical appraisal or risk-of-bias assessment was conducted as part of the traditional scoping review methodology; thus, there are no formal assessments of the quality of the included studies. Therefore, the emphasis on mapping literature rather than assessing the quality of each study determines the type of data analysis conducted for this study. In this study, the authors used basic descriptive statistics (e.g., counts of publication years) to identify temporal patterns and research gaps.

Results

A systematic review was conducted of articles on Nepal's national-level policy and reports, using open-access/full-text sources published from 2000 to 2023 to document the evolution of knowledge. The objective was to focus on Nepalese sources to provide a localized view of the evidence for this topic. This resulted in the generation of five main themes. We also included the synthesis of the results in this section.

Knowledge of SRHR and HIV

Both women and men are important decision-makers in antenatal care (ANC) and childbirth services. The male partner has a stronger role in making those decisions than the female partner. However, male partners of young women between the ages of 10 and 24 years old are more likely to be involved in the decision-making process than the female partner (Upadhyay et al., 2014). This highlights the need to address the impact of age-related factors on maternal healthcare decision-making.

The consistent use of condoms and contraceptives are associated with a heightened risk of HIV transmission, high-risk behaviors, injecting drugs, heterosexual

contact, and sexually transmitted diseases within indigenous communities (Negin et al., 2015). A study revealed that 96% of the respondents believed AIDS could be transferred from sexual intercourse however, only 40% knew about the transmission from an infected mother to her baby, and 3.33% of respondents did not know about the mode of transmission of sexually transmitted infections (STIs) and HIV and AIDS (Shrestha, 2009). In the same study, a discrepancy in knowledge of the mode of HIV transmission was found.

Woog et al. (2015) revealed that indigenous women experience a higher prevalence of forced sexual contact and domestic violence in comparison to non-indigenous women. There was also a lack of knowledge about HIV among indigenous people, and consequently, they had low perceived vulnerability and lower testing behavior (Negin et al., 2015). Another study emphasized the minimum utilization of health services by both indigenous and non-indigenous people because of a lack of adequate knowledge and skills of healthcare providers who assist HIV-positive patients (Shalini & Vaishali, 2007).

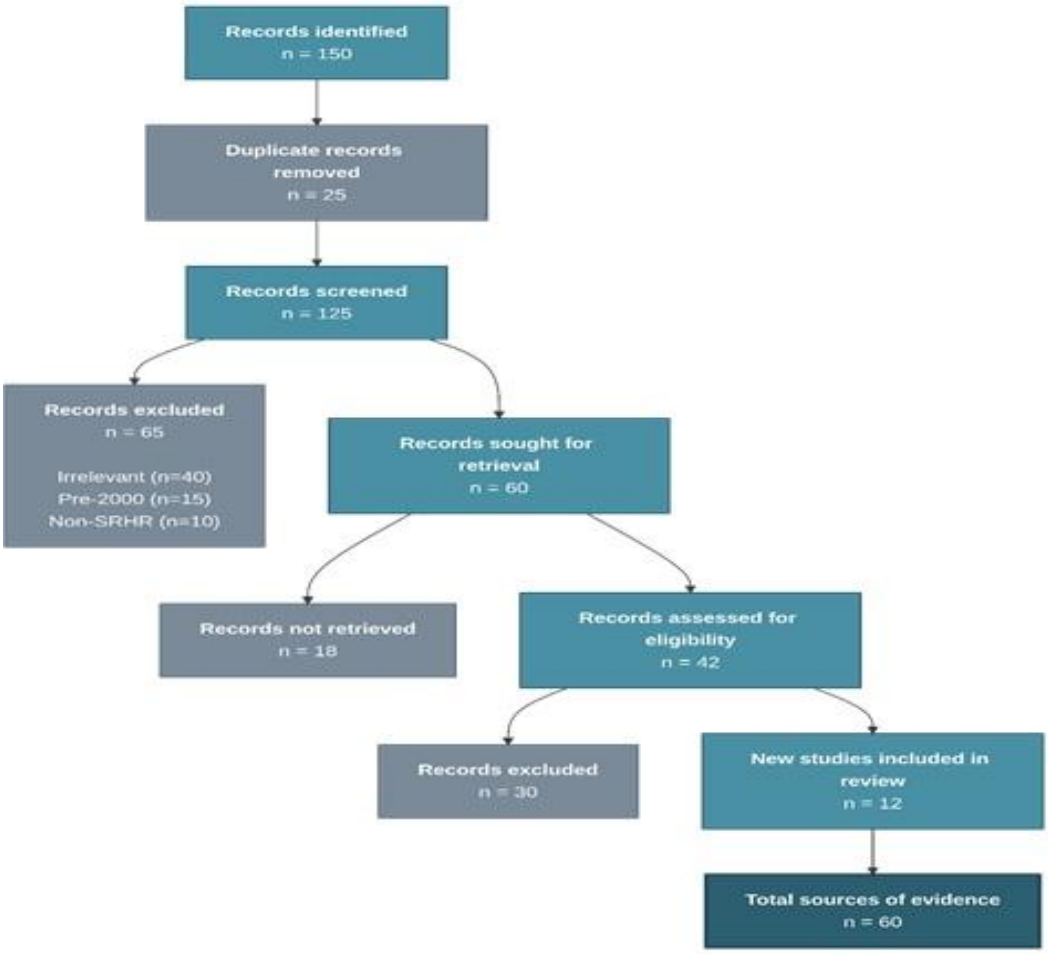
The cultural barriers set by traditional members of families affected the decisions of adolescent girls as individuals, especially regarding health-related decisions (Wehr & Tum, 2013). A large percentage of indigenous people decided not to seek primary health care, instead opting for consultations from paramedics for illnesses and home births, especially for indigenous women in Hill and Terai districts, excluding Newars (Subba et al., 2014).

Nepal's constitution recognizes the right of every woman to safe motherhood and reproductive health (Pizzarossa & Perehudoff, 2017). In spite of the importance of women's autonomy in improving maternal health service use, women in Nepal showed low autonomy, which could be explained by factors related to society and culture in terms of their ability to seek health care (Regmi et al., 2008; Upadhyay et al., 2014). The use of family planning methods, of which condoms were the most preferred, was high among PLHA and newly married women, although a small percentage of them abstained from sexual activity because of both partners being HIV-positive (Bhoosal et al., 2020). A recent study showed that most of them do not wish to have children (Pokharel et al., 2018). Various factors influence the use of family planning methods, including gender, caste, education level of both partners, and whether one of the partners was HIV-positive (Bhoosal et al., 2020).

Unprotected sexual intercourse is significantly correlated with 1) sex of partner, 2) if the partner has and is being treated for HIV infection, and 3) the amount of alcohol consumed during the last sexual encounter between partners, both of whom are regular partners (Angdembe et al., 2015). Even the condom using decisions are only made by males. Overall, these data illustrate that there are many different types of influences on reproductive and sexual health behaviors and underscore the urgency to provide interventions that target, and the need for culturally appropriate interventions in the healthcare system.

Figure 1

Selection Process of the Articles for Scoping Review



Access to SRHR services

The lack of effective and affordable measures within society that promote gender equality is seen to impact how readily individuals access SRHR services; this affects many populations, but Indigenous communities in particular (Castillo, 2015). There are many reasons why Indigenous peoples do not utilize SRHR services; these include geographical distance from facilities that provide these services, not having enough information about services available to them, and a lack of access to youth-friendly services (Regmi et al., 2008). In fact, individuals who practice the traditional form of *Chhaupadi* are 14.6 times more likely to encounter issues with reproductive health than non-*Chhaupadi* practitioners - showing the level of statistical significance of practicing this tradition (Ranabhat et al., 2015).

Indigenous women living in distant and rural communities face a myriad of obstacles in accessing their basic human rights, including inadequate access to healthy foods and safe housing, negatively impacting their physical health(Castillo, 2015). A second study reported on a continuum of cultural and structural obstacles to accessing safe, effective SRHR services through long distances to health services, limited availability of services, limited numbers of health care providers, lack of public transport, language barriers, unaffordable healthcare, and low representation of Indigenous individuals in the health workforce, among others (Thummapol et al., 2020).

In indigenous communities, gender discrimination makes women more susceptible to adverse health outcomes. Because men's work is given more value than women's work (Vinding & Kampbel, 2012), women frequently have less access and control over important resources, such as land, employment, and financial assets, than men do. Limited access and control over these resources make women in indigenous communities more susceptible to adverse health outcomes (Silva et al., 2019). Furthermore, due to cultural barriers, many indigenous people do not trust health service providers (Hiddink et al., 2019), which can also lead to a lack of faith in ART for people living with HIV and poor access to SRHR services (Wasti et al., 2012).

Adolescents lack adequate knowledge about SRH issues at school, which results in confusion, anxiety, and discomfort when trying to access SRH services (Pandey et al., 2019; Shrestha & Bhadra, 2021). In order to improve adolescent health, the Ministry of Health and Population supports interventions that focus on providing information, enhancing skills, providing access to health services, providing individualized

counselling, and creating a supportive and safe environment for young people (Ministry of Health and Population, 2000). Some authors noted that there is also a significant gap in the types of interventions being used to address the sexuality of adolescents (Corosky & Blystad, 2016).

Women with disabilities have several distinctive obstacles that impede their access to SRH. These obstacles include breaches of personal privacy during the doctor's examination, including physical touching, sexual comments about the woman's body, and all of the aforementioned activities serve as additional impediments for women with disabilities to obtain SRH services (Gurung, 2021). The World Health Organization (WHO) developed a Universal Health Coverage (UHC) Compendium to support and assist decision-makers / administrators to adequately prioritize and focus on SRH services, including gender-based violence (GBV), abortion, and post-abortion care within UHC (Gruending et al., 2020).

Nepal's patriarchal society discriminates and bullies against the Lesbian, Gay, Bisexual, and Transgender (LGBT) community, resulting in their inability or unwillingness to disclose their identity and subsequently dropping out of school (Pokhrel et al., 2014). In addition, widows have barriers to accessing healthcare providers, with some needing to lie about their marital status or hide their use of contraceptives to receive care (Haviland et al., 2014). Finally, structural barriers will also be measured through the relationship between the patient and provider and the ability to obtain SRHR services (Darj et al., 2019). Thus, the combination of cultural, structural, and gender-based barriers illustrates the need for targeted interventions and policy solutions to improve access to SRHR services for diverse and marginalized populations.

Opportunistic infection

For women and girls, access to sexual and reproductive health and rights (SRHR) services is critical, and they need parental assistance. Unfortunately, when there are family controversies, disagreements, or no family/spousal support, there can be obstacles preventing women from accessing SRHR services, which directly impacts their health status. Women who are unable to access SRHR services will be at greater risk of experiencing co-infections and will be at a higher level of susceptibility to opportunistic infections (Wasti et al., 2012).

A study focusing on PLHA revealed a higher prevalence of co-infection with Hepatitis B Virus (HBV) compared to Hepatitis C Virus (HCV) among PLHA.

Furthermore, instances of triple infection involving HIV, HCV, and HBV were observed. Various factors were identified as joint contributors to opportunistic infections in HIV, including gender, age, marital status, engagement in multiple sexual partnerships, occupation, education level, and migration (Ionita et al., 2017).

Stigma and discrimination

Widows encounter discrimination within their families when expressing a desire to use female contraceptive devices. Participants in a study noted that their families and communities closely monitored their actions, and they could face ostracism if it was discovered that they accessed family-planning services (Haviland et al., 2014).

Despite Nepal's commitment to various human rights treaties and conventions, PLHA and their relatives experienced human rights violations (Adhikari & Adhikari, 2018). Family disputes, arguments, and a lack of familial and spousal support have been identified as significant barriers preventing many women with HIV from utilizing ART services (Wasti et al., 2012). Verbal and physical assaults, cultural discrimination, Denial of love and care, and negative emotions were reported challenges, mainly when there was minimal male and family involvement (Pandey et al., 2019; Thapa et al., 2018).

Despite the challenges, disclosing HIV status can bring benefits such as increased social support, kindness, and easier access to healthcare treatment for WLWH (Paudel & Baral, 2015). Another study emphasized the positive correlation between increased empowerment and a higher quality of life for WLWH (Bhatta & Liabsuetrakul, 2017). Enhancing the economic status of WLWH has the potential to contribute to reducing stigma, discrimination, and rights violations (Lama, 2015). Alcohol use has detrimental effects on the lives of PLHA, compromising the management of HIV and AIDS treatment along with their physical, emotional, mental, and spiritual health. Both actual and perceived alcohol use are recognized as significant barriers to HIV care and treatment (Masching et al., 2014). Therefore, it seeks targeted interventions of support systems for the vulnerable groups, enabling them to live a quality of life, and responding to the socio-cultural factors that cause barriers in service.

Male participation and family support

WLWH frequently face social isolation and trauma when their HIV status is exposed to their family and friends (Sanderson et al., 2021). More than 90% of the women studied report being subjected to one or more forms of violence as described in the literature (Aryal et al., 2012). Emotional violence occurs in most of the women who

reported violence as a result of disclosing their HIV status. Reports of women experiencing economic violence after revealing their HIV status were not found. Physical violence includes beating, slapping, kicking, strangling, stabbing, and hitting with an object. Verbal abuse and expulsion are examples of psychological violence. In addition, emotional violence exists where society isolates the woman (Aryal et al., 2012).

Furthermore, women who experience sexual violence are 2.3 times more likely than those who do not to report unplanned pregnancies (Acharya et al., 2019). The stigma and discrimination associated with WLWH create barriers to accessing health care, which exacerbates their health conditions. Self-stigma leads to self-blame and guilt, reluctance to seek health care, and deteriorating health (FPAN, 2011). The challenges associated with living with HIV or AIDS include the panic experienced from being HIV positive and/or AIDS-related, as well as the significant impact of stigma and discrimination; these include experiencing social isolation and/or violence from family and community members, and receiving the same treatment from health, counselling, and support professionals (FIAN Nepal, 2020).

Among PLHA, coping strategies vary. The most utilized strategy is seeking social support (18%), followed by positive reappraisal (15%), confronted coping (13%), distancing (13%), problem-solving (12%), and self-controlling (10%) (Masching et al., 2014).

Despite every woman and girl having the right to sexual and reproductive health services, including abortion, pregnancy, and safe delivery (Law Commission of Nepal, 2018)**,** most are deprived of this fundamental right. Identifying and addressing gaps between desired and actual performance should be viewed as an opportunity for improvement (Family Welfare Division, 2020)**.** While national policies, guidelines, and protocols aim to enhance health service delivery, they fail to address the specific needs of Indigenous WLWH, resulting in their undue suffering (Ministry of Health and Population, 2000)**.** Community and health service institutions are mobilized to make healthcare readily available, better, and practical, providing financial support to poor indigenous people (Lawyers' Association for Human Rights of Nepalese Indigenous Peoples, 2021)**.**

Synthesis of the results

Indigenous women's awareness of SRHR components, excluding family planning, is limited. Condoms are most indigenous women's preferred practical family planning

method (Pokharel et al., 2018). Lack of knowledge about the availability of Family Planning (FP) services, resource constraints, and fear of stigma and discrimination are significant impediments to FP service utilization (Mishra et al., 2014)**.** The disconnect between health service providers and indigenous women/girls stems from inadequate awareness of SRHR services (Shrestha & Bhadra, 2021)

Awareness regarding the availability of drugs for abortion is low, and concerns about potential social corruption, such as pre-marital sex among young girls, hinder the acceptance of medical abortion (Tamang & Tamang, 2005). Women's advocacy plays a crucial role in effectively utilizing SRHR services. However, Nepalese women exhibit low autonomy, leading to inadequate SRHR service utilization (Osamor & Grady, 2016).

Several barriers contribute to the poor access and utilization of SRHR services among indigenous girls/women, including remoteness, lack of awareness, limited access to youth-friendly services, geographic restrictions, poverty, service availability, insufficient healthcare providers, transportation issues, distance to health services, language barriers, unaffordable healthcare, lack of indigenous representation in the health workforce, misconceptions, and mistrust of healthcare providers (Hiddink et al., 2019; Thummapol et al., 2020).

Upon disclosing their HIV status, women/girls and their families encounter discrimination and social exclusion (Sanderson et al., 2021). The consequences of HIV include physical, psychological, and emotional violence against affected women/girls (Aryal et al., 2012). Living with HIV or AIDS exposes individuals to panic and the detrimental effects of stigma and discrimination, including social rejection and violence from family, community, and healthcare professionals (FIAN Nepal, 2020). Analysis of existing documents reveals that supportive efforts have gradually improved the lives of PLHA and key populations. Advocacy at national, regional, and local levels has raised awareness among local leaders, government authorities, law enforcement, and political leaders (National Centre for AIDS and STD Control, 2015).

Discussion

HIV non-disclosure could be an emerging issue in the future, as shown by the scoping review. PLHAs faced much discrimination, social exclusion, violence, and traumatizing experiences after disclosing their positive status (Paudel & Baral, 2015; Sanderson et al., 2021). Globally, 35% of women and girls are subject to physical and sexual violence by an intimate partner or sexual violence by a non-partner during their

lifetime (Heidari & Moreno, 2016). Verbal and physical assault, cultural discrimination, Denial of love and care, and negative emotions were the problems that PLHA reported (Thapa et al., 2018).

The coronavirus disease 2019 (COVID-19) affects reproductive and sexual health service delivery. Because of that, there could be up to 7 million unintended pregnancies worldwide, which was predicted by the United Nations Population Fund (UNFPA) (Cousins, 2020). Emerging diseases pose challenges for PLHA, affecting access and treatment availability. Disruptions in global contraception supply chains may heighten STI rates, including HIV (Bateson et al., 2020). Moreover, a significant unmet demand for SRH services is observed among vulnerable groups: adolescents, impoverished communities, rural and urban slum dwellers, individuals with HIV, internally displaced persons, and those amidst humanitarian disasters. Addressing these disparities is critical for equitable healthcare provision (Sigdel et al., 2023).

One research shows that individuals who follow *Chhaupadi* were 14.6 times at risk for reproductive health (Ranabhat et al., 2015). Furthermore, many studies conclude that structural and cultural barriers could be the future problem for using SRHR services for the women and girls of the indigenous community (Thummapol et al., 2020). The need for more sustainable and inclusive provisions for Indigenous people will detach the Indigenous community from different types of essential healthcare services and social security (Pandey et al., 2019).

Young people in Nepal have yet to be a public priority. There are no specific policies or interventions focused on young people. This is one of the emerging issues (Pandey et al., 2019). Indigenous women and their children increasingly become vulnerable to HIV and AIDS (Woog et al., 2015). Gender inequality, discrimination based on sex, and all forms of violence against women are the root causes that foster the spread of the disease among the indigenous community (Dunaway et al., 2022). Drop-out of antiretroviral therapy is and could be another emerging issue seen in the indigenous community (Bhatta et al., 2019; Wasti et al., 2012).

This study shows some similarities in the literature. Socio-economic, demographic, and cultural factors have been identified as encouraging factors for risk-taking behavior among young people (Regmi et al., 2008). Indigenous people were restricted to health service utilization because of geographical constraints, lack of indigenous health workers, and limited availability of health services (Shalini & Vaishali,

2007; Thummapol et al., 2020). A maximum number of people know the contraceptive device and family planning process, and most use family planning devices after being diagnosed with AIDS (Pokharel et al., 2018).

PLHA, especially indigenous communities, lack confidentiality from health workers and mistrust health services. Because of this, they did not go for health checkups, resulting in Indigenous people being more susceptible to unsafe abortion than non-Indigenous people (Hiddink et al., 2019). For HIV transmission, high-risk behavior includes injecting drugs, heterosexual contact, and multiple sex partners, poverty, political instability, gender inequalities, low level of education, and increased vulnerability of women to HIV risk behavior (Negin et al., 2015).

In Nepal, a low level of autonomy has been seen among indigenous women for the utilization of SRHR services. However, urban migration has offered greater personal autonomy to some indigenous women who can earn their own money (Osamor & Grady, 2016). Telemedicine and other services were developed because of the COVID-19 crisis, which can be related to the positive part. COVID-19 has accelerated telemedicine service and shifted from surgical to medical abortion (Bateson et al., 2020). Several studies focused on risk groups show that tremendous effort is needed to minimize the risk among indigenous people; it will also increase empowerment to ensure the inclusion of indigenous peoples (Corosky & Blystad, 2016).

Early marriage has been a common practice in Nepal and other South Asian countries (Pandey, 2017). Asian indigenous women face various kinds of discrimination, and 1/3 of women experience physical and sexual violence by an intimate partner or sexual violence by a non-partner during their lifetime (Heidari & Moreno, 2016). In developing and underdeveloped countries, Pulmonary and Extrapulmonary tuberculosis, Jaundice, Syphilis, Diarrhea, and Herpes Zoster are the common Opportunistic Infections encountered (Darj et al., 2019; Thummapol et al., 2020).

In addition to these similarities, there are differences in the knowledge regarding this. In the United Nations Declaration on the Rights of Indigenous Peoples, Indigenous peoples have the right to traditional medicine and to maintain their health practices, including conserving their vital medicinal plants, animals, and minerals. Nepal, being rich in such resources, has several medicinal plants that can be used as an alternative to allopathic medicine (Subedi, 2023). Indigenous people also have the right to access, without any discrimination, all social and health services (UN General Assembly, 2007).

Many other developing and underdeveloped countries needed rights and declarations for the indigenous community (Dudgeon & Bray, 2019).

Among the dimensions of gender inequity is education inequality, i.e., women were more educated than their partners in Namibia. In contrast, women in Nepal were less educated than their partners, resulting in less access to skilled antenatal care (Namasivayam et al., 2012). Husbands influenced the decision to utilize ANC and delivery care services, especially in Nepalese teens and young adults, whereas, in different developed countries, women are more influenced by themselves for the utilization of SRHR services (Osamor & Grady, 2016; Upadhyay et al., 2014). The knowledge of menstruation management, perinatal care, and HIV and AIDS was found to be lower among women with disabilities than among women without disabilities (Kakchapati et al., 2022). Research articles have indicated various opinions regarding HIV and AIDS based on the knowledge and cultural understanding of the respondents. Illiterate people associate HIV with impurity and extramarital relationships due to cultural misconceptions. However, those who know about reproductive health and SRHR view STIs as not being associated with any shame (Thapa et al., 2018). Comprehensive Sexuality Education (CSE) seems important for educating them regarding SRHR and for them to make proper decisions regarding their sexuality in relationships (Aryal et al., 2023).

Conclusions

This study identifies several main reasons why Indigenous women do not receive SRHR services. These include being isolated by location, lack of education and/or knowledge about SRHR, not being able to access HIV and SRHR services due to location, being poor, and having language barriers. The systematic reflective review has highlighted several major gaps in the Indigenous community, including how Indigenous women, especially young women and girls living with HIV, experience multiple violations of their rights due to a lack of trust in the health system. This lack of trust leads to Indigenous women experiencing negative emotions, violence, and abuse from their families, friends, and community. It reveals significant information that has created a better understanding of the many barriers and challenges faced by Indigenous WLWH. There are many aspects of being an Indigenous woman, especially a young WLWH, including social isolation due to being a member of two marginalized groups, racism, being a victim of violence, and the increase of discrimination against them caused by the

stigma surrounding HIV. Access to SRHR services is impeded by gender inequalities and cultural barriers, which have been identified as recurring themes in the systematic reflective review. The high levels of violence against WLWH, as well as the multiple effects of stigma against WLWH, are high-priority issues requiring urgent attention. The influence of culture on reproductive health through practices like *Chhaupadi* indicates the need for culturally appropriate interventions.

Many challenges require a comprehensive, interdisciplinary approach to be dealt with properly. To be effective, policies and interventions aimed at Indigenous people need to be culturally responsive and geared toward their unique needs. A need exists for more in-depth research into some of the "grey" areas between socio-economic factors and cultural practices and their effects, or lack thereof, on SRHR. Initiatives and strategies aimed at supporting Indigenous women should include the promotion of women's empowerment to allow women to take control of their lives and work toward an end to female discrimination. Continuing to assist communities in becoming more informed about HIV and AIDS will be important to dispel many of the myths and misconceptions that exist within these communities about HIV and AIDS.

It is important for researchers to conduct more meta-analyses and systematic reviews using rigorous methodology. Although the foundational scoping review was able to provide an overview of existing studies, future studies should use more rigorous methodologies to quantify the body of research available about this subject. Advanced research methods will provide a greater understanding of the interaction between cultural, social, and health-related issues that PLHA and indigenous people face. Analyzing this issue in greater detail is critical for providing targeted interventions and redesigning policy, as well as improving the overall wellbeing of these vulnerable groups.

Limitations

The study used articles from 2000 to 2023 for a scoping review, using only two search engines, Google Scholar and Endnote Library, and limited keywords like Indigenous women, HIV, health services, SRHR, family planning, and HIV access to treatment in Nepal.

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Authors' Contributions

The article was conceived and written equally by AA and BA. BA also communicated with the publication processes. GM and PSS assisted in the literature review and discussion. The final version of the article that will be published has the consent of all authors.

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