Exploration of factors influencing sexual reproductive health service provision to Indigenous people in Bangladesh towards an inclusive approach – a literature review

Authors: Edine Hiddink[1] and Pam Baatsen[2]

Abstract

Background: Technical capacity of health workers to provide Sexual Reproductive Health (SRH) services and information to especially vulnerable people, including indigenous people, needs strengthening. As input for the "We Care" project, which works towards the strengthening of such an inclusive approach, a literature study was done looking into what is known about indigenous people in Bangladesh in relation to SRH service delivery and information provision.

Method: A literature review was conducted to identify factors influencing SRH service access for indigenous people. The factors were analyzed on the basis of the WHO Framework for operationalizing sexual health and its linkages to reproductive health. A limitation is that the studies identified only cover a fraction of the 52 indigenous communities living in the country, each with their own social and cultural identity.

Findings: The studies reinforced the notion that SRH services are currently not inclusive. In general, lower access to antenatal, intrapartum & postnatal care for indigenous women was found than women on average in Bangladesh. This was influenced by both health system factors but also cultural notions such as pregnancy and delivery being something natural which only needs support when complications occur. The limited existing information on comprehensive sexuality education amongst indigenous people, points towards taboos in discussing issues around menstruation, puberty and (sexual) relationships. Large differences in uptake of contraceptives and counselling were found between the Mru (lower than the national average) and the Garo (higher than average). No studies were found on gender-based violence; fertility care; prevention and control of HIV/Sexual Transmitted Infections and sexual functioning in relation to indigenous people in Bangladesh. Inclusion of indigenous representatives in design and monitoring of service provision, enhancing mutual understanding between service providers and ingenious people, as well as building the capacity of service providers to use person-centered approaches whereby diversity of individuals is respected and valued, were found to contribute to inclusion.

Conclusion: Indigenous people living in Bangladesh belong to the group having the least access to SRH service provision which is influenced by health system but also cultural factors. There is a lack of research on SRH and indigenous people, with most research concentrating on maternal health. Empowering indigenous representatives to voice their needs, building mutual understanding and capacity of service providers to use inclusive approaches, could contribute to improved access to SRH services for indigenous people.

[1] Graduate School of Life Sciences, Master program: Bio Inspired Innovation
[2] Senior Advisor, Royal Tropical Institute/KIT

1. Introduction

Overall background

Government policies in Bangladesh recognize the importance of sexual and reproductive health (SRH) services and information. However, it has also been recognized that the technical capacity of health workers to provide such SRH services and information to especially vulnerable women and men, young people, people with disabilities and indigenous people, needs strengthening (KIT, 2019).

"We Care" implemented in Bangladesh by a consortium consisting of NIPORT, DGFP, KIT, Red Orange, Niketan and Rutgers with funding support from Nuffic/Netherlands Ministry of Foreign Affairs aims to change this by better equipping the health workers to deliver SRH services at the union level and in communities and schools. The project also equips supervisors with the skills, attitudes and motivation needed to provide appropriate supervision to ensure inclusive SRHR information and service delivery. Inclusion is thereby defined as “working in a person-centred way and treating everyone as an individual, as well as respecting and valuing diversity” (Mecwan et al., 2021).

An initial needs assessment and a rapid literature review at the onset of the We Care project showed a lack of information on the SRHR access of especially indigenous people in Bangladesh. In order to obtain further insight into this, a more extensive literature review was conducted in April/May 2021 looking at both factors influencing access for indigenous people as well as factors contributing to successful inclusive and sustainable interventions. The current document provides key findings from that literature review.

Indigenous groups in Bangladesh

Bangladesh has around 1.5 million indigenous people (1.8% of the total population), divided over 52 distinct ethnic groups. Indigenous people in Bangladesh are amongst the most deprived population groups (Rahman, Khan, Jahangir Hossain, & Iwuagwu, 2021). For instance, only 30% of indigenous women receive antenatal care, against 47.6% of the general population (Chowdhury 2017). While in Bangladesh teenage pregnancy rates declined, the teenage pregnancy rate of indigenous populations is still much higher (65% in the Chittagong Hill tracks) than the national average of 31%. Also, fewer adolescent indigenous women have access to maternal healthcare services (16%) compared to the national rate (80%) (Akter, Rich, Davies, & Inder, 2019).

2 Method

A literature review was conducted to identify factors influencing SRH service access for indigenous people and factors that could successfully enhance their access. The factors were analyzed on the basis of the WHO Framework for operationalizing sexual health and its linkages to reproductive health. See figure 1. This framework recognizes that SRH education, service provision and rights are very much integrated with one another.

Figure 1 Source WHO

Through Pubmed, Web of Science, Scopus and Google Scholar as well as snowballing by using the article's reference list, relevant literature published in English from 2000 onwards was identified. For the SRH needs and perspectives on indigenous people, only articles related to research in Bangladesh was included. For successful approaches on enhancing inclusion for indigenous groups, also articles in other lower middle income countries were used. Table 1 contains the search works used for finding relevant literature.

Table 1: key search words used in database search

Theme	Search words
Sexual reproductive health service provision	"Health Service, Reproductive" OR "Reproductive health services" OR "Health Services, Reproductive" OR "Reproductive Health Service" OR "Service, Reproductive Health" OR "Services, Reproductive Health" "Health Service, Sexual" OR "Sexual health Service" OR "Health Services, Sexual" OR Sexual Health Service" OR "Sexual Education" OR "Sexuality" "Health care seeking behavior" OR "Health seeking behavior" OR "health service utilization" OR "Reproductive behavior" OR "Sexual behavior" OR "Maternal Health Services" OR "contraceptives" OR "contraception" OR "STI" OR "Sexual Transmissible Infections" OR "menstrual" OR "menstruation"
Those having the least access	"Minority groups" OR "marginalized" OR "indigenous" OR "tribal" OR "indigeneity" OR "traditional"
Perceptions of those currently excluded/marginalized and SRH service providers	"Socio-cultural norms" OR "Traditional Healers" OR "Street Healers" OR "Close to community providers" OR "Indigenous Knowledge Systems" OR "attitudes" OR "views" OR "perceptions"
Moving towards inclusion	"Culturally diverse" OR "context adapted" OR "culturally sensitive" OR "holistic" OR "socio-ecological" OR "gender-transformative" OR "inclusive"

Articles included

Seven research articles on SRH service provision in relation to indigenous people in Bangladesh were found. All these used in-depth interviews, focus group discussions and/or questionnaires with women or girls of selected indigenous communities to explore their perceptions, experiences and practices. While one study focused on indigenous adolescents (Ahmmed et al., 2021), the others focused on women within a much wider age range often classified within one study as groups of <25, 25-35 and >35 years old (Islam et al., 2009; Islam, 2017; Islam & Thorvaldsen, 2012). Women from different indigenous communities (Mro, Garo, Mru, Chakma, Marma, Kashi, Tripura and Santali (Shaotal) participated in these studies. Two of the studies also included interviews with community leaders and key informants working in healthcare such as traditional birth attendants (TBAs) and medicine vendors (Ahmmed et al., 2021; Hussain et al., 2015).

The focus of the included studies was on family planning, the use of contraceptives, maternal health care, menstruation, pregnancy, abortion and the factors influencing reproductive health seeking behavior.

Study limitations

The review faces some limitations. The literature was mainly found through snowball sampling. This means that not all articles were found as first hits in the databases using the key search terms. This implies that there might be more relevant articles on the subject which are not found.

Another limitation is that the studies identified only cover just a fraction of the 52 indigenous communities with distinctive social and cultural identities across the country (Akter, Davies, Rich, & Inder, 2020). Making that a major limitation of this literature review. This means that it is difficult to draw specific conclusions, as cultural influences may be region specific. However, the review offers a first overview of the factors and aspects that might be of influence in SRH inclusivity approaches.

3 Findings

3.1 Findings on SRH service and information provision

3.1.1 Lack of sustainable and inclusive SRH provision for indigenous people

All studies reported barriers that hamper SRH service provision in general to the participating indigenous groups. Study participants brought up the issue that many of the current health and development interventions contributing to the health and wellbeing of indigenous people are only project-based and therewith temporarily. These interventions are therefore not a long term solution for ensuring inclusive SRH service and information provision for indigenous people (Hussain et al., 2015).

3.1.2 Poor access to antenatal, intrapartum & postnatal care

In this section first overall factors influencing the access to antenatal care (ANC), delivery, and postnatal care (PNC) are provided. This is than followed by cultural perspectives on pregnancy and related services.

The studies show that remoteness and lack of transport to healthcare facilities to receive ANC, PNC or to deliver at a healthcare facility are important determinants of maternal health care

utilization among indigenous women (Akter et al., 2020; Hussain et al., 2015; R. Islam & Thorvaldsen, 2012). In addition, lack of knowledge or awareness about the available services is another challenge. For one study among Chakma, Marma and Tripura communities, users and non-users of maternal care were interviewed. Of the fourteen users interviewed, only one had used ANC, facility delivery and PNC, while most others only used one of these services. Many of the participants interviewed assumed that ANC services where only provided in private health facilities and were not aware of the availability of these in public health facilities. They also assumed that it would cost a lot of money to be able to use this service (Akter et al., 2020).

Mistrust in healthcare providers was indicated as another important barrier. Fear of episiotomy and C-section was reported. Other trust related factors raised were: 1) a lack of trust in the quality of care at public facilities, 2) the fear of unofficial costs that were asked to be payed and 3) maltreatment by the hospital staff as this was experienced by women having used maternal health care services. This maltreatment included shouting towards the patients and delivering practices without consent. One user of facility delivery reported the placement of an intra-uterine device as contraceptive after delivery through a C-section without informed consent (Akter et al., 2020)

Health care provider characteristics were also influencing access to ANC, facility delivery care and PNC, e.g.: 95% of participating women in the study among the Santal community stated that they would rather not consult a male doctor (Tarafder & Sultan, 2014).

Availability of outreach to people's homes and personal connections with health practitioners increased the use of maternal health care services among indigenous women (Akter et al., 2020; Hussain et al., 2015). Relatives working as health care workers could encourage pregnant women to access such services (Akter et al., 2020).

In conclusion, the factors that play a role in indigenous women's poor access to antenatal, intrapartum and postnatal healthcare are 1) remoteness and lack of transport options, 2) lack of knowledge about the available services, 3) lack of trust in healthcare providers, 4) experiences of maltreatment by healthcare providers, 5) lack of familiarity or encouragement to access services and 6) healthcare provider characteristics not matching pregnant women's preferences.

Specific cultural factors contributing to poor access of ANC, delivery care and PNC

In the Chakma, Marma and Tripura communities, both for users and non-users of maternal health care services, the main perspective was that these services are for women with complications during pregnancy and delivery or after giving birth (Akter et al., 2020) Facility delivery services were only used when complications occurred, such as high blood pressure, prolonged and obstructed labor and when a first child had been delivered via C-section. Accessing facility delivery due to complications was perceived as bad luck for a woman.

The notion of pregnancy and delivery as natural processes that do not need extra support from healthcare services, was shared among the community members of adolescents from marginalized groups, including the indigenous Khasi community (Ahmmed et al., 2021). It was reported that participants who had been pregnant while being under the age of 18 faced serious complications, but received little support from their families (Ahmmed et al., 2021).

The importance of home delivery was shared by all participants in the study among the Chakma, Marma and Tripura communities. Traditional Birth Attendants (TBAs), often untrained, were preferred over other health care workers in home delivery settings. Even community skilled birth attendants, who were available closer to the villages of the participants were not accessed initially. Differences in their way of working was coined as reason. Skilled birth attendants work with medical items (such as gloves and injections) while TBAs would use oil, warm water and if needed herbal medicines. In addition to that, flexible payment options (paying according to affordability and/or not having to pay upfront) were indicated as motivators to prefer TBAs rather than other MHC services (Akter et al., 2020). The study of Hussain et al. (2015) among the Mru and Tripura population also found that community members heavily relied on TBAs during delivery.

The Santal community reported the traditional rule of staying in-doors for forty days after delivery to prevent newborn children to be taken away by "Chora Chunni" (malicious spirits). Heavy blood loss after giving birth was believed to attract malicious spirits if the women does not stay in-doors. After forty days the women are allowed to live with their family members again, perform household activities and attending religious practices (Tarafder & Sultan, 2014).

Another traditional practice reported by the Santal women during FGDs, was discarding the first breast milk as it was considered impure (Tarafder & Sultan, 2014). In the Mru society the mother is only given salted rice to eat and sits beside a fire for a period of 9-30 days after delivery, depending on the village she lives in (Islam & Thorvaldsen, 2012). In addition to staying in-doors after delivering, pregnant women were advised not to enter homes where someone is dying and not to go to graveyards (Tarafder & Sultan, 2014). In the Khasi communities, adolescents continued physical labour during pregnancy, which increases risk of complications and miscarriage (Ahmmed et al., 2021).

In conclusion, the notion of pregnancy and delivery as something natural and only needing support when complications occurred, prevented women from using ANC, facility delivery care and PNC. The importance of home delivery was reported and there was a strong reliance on care from TBAs. Traditional practices included seclusion after giving birth, throwing away the first milk and dietary restrictions for the women who gave birth. Pregnant women were also expected to follow traditional norms, depending on the communities they belong to.

3.1.2 Limited information on *comprehensive sexuality education* pointing to limited access to SRH information leading amongst others to poor menstrual hygiene

Only limited information was found on comprehensive sexuality education and information in relation to indigenous people. Research in three isolated communities in Bangladesh, which included Kashi, found that bodily changes that are inherent to puberty, is a much-avoided topic by parents and even teachers. This resulted in peers and friends being the main sources of information for adolescents on topics as sex, menstruation and pregnancy, and as such increasing risk of misconceptions. Because of the beliefs around menstruation, menstrual hygiene and health among young girls was put at risk. Most girls used cloths during their periods and cleaning them was a hurdle, because washing them and putting them to dry was shameful (Ahmmed et al., 2021).

Specific cultural factors on comprehensive sexuality education

Adolescent girls from the Kashi community reported that menstrual blood was seen as poisonous. Menstruating girls were believed to be vulnerable to evil spirits and bad air. Movement and cooking were therefore restricted. Food restrictions were also common, based on the belief that such restrictions would reduce menstrual duration (Ahmmed et al., 2021).

3.1.3 Differences in *uptake of contraceptive use and counselling*

The Mru community is said to be the most underprivileged indigenous community in Bangladesh. A study among married Mru women in Bandarban found that only 40% of respondents knew about family planning (FP) methods or had ever heard messages about it resulting in a current contraceptive prevalence of 25.1%. Older women were found to be more likely to use contraceptives than those under 25 years. Demographic isolation and lack of education were mentioned as key factors in this low use of modern contraceptive among Mru women (Islam & Thorvaldsen, 2012).

Very different results are seen in a study on the Garo community. The Garo community is a matrilineal indigenous community of Bangladesh, mostly living in the Mymensingh and Tangail districts. 79.5% of the respondents currently used contraceptives against the national contraceptive use average of 55.8%. Those under 25 years of age had a slightly lower use (76,5%) than those between 25 – 35 years of age (80.7%). Their use of contraception was less likely until they had at least one girl (Islam et al., 2009).

Outreach services and satellite clinics are indicated as factors that can enhance access to FP services for women of the Mru community. Health education in local languages for mothers and FP programs with special emphasis on awareness through local training among the Mru girls may also have a significant influence on FP knowledge and the use of contraceptives in the Mru society, as Islam and Thorvaldsen (2014) suggest. Visits from FP personnel on a regular basis may influence attitude towards FP methods as well as including men in FP counselling and information provision (Islam et al., 2009).

Specific cultural factors on contraceptive use and counselling

Islam and Thorvaldsen coin that the low rate of contraceptive use among Mru women might be due to the traditional use of medicinal plants. However, this needs to be investigated much more as it is not known what their traditional contraceptive practices exactly are (Islam & Thorvaldsen, 2012).

3.1.4 Unsafe abortion by unskilled providers still common

One study on indigenous SRH perspectives, attitudes, knowledge and practices reported on abortion. Induced abortion is strictly regulated by law in Bangladesh and illegal unless it is to save a woman's life. Menstrual regulation, a procedure that uses oral tablets or manual vacuum aspiration to "regulate the menstrual cycle" is allowed up to 10 – 12 weeks after a woman's last period. Despite the availability of such MR services, illegal abortion by untrained service providers is still common (Guttmacher, 2017), including among Khasi (Ahmmed et al., 2021). The Khasi community lacks knowledge about serious health risks associated to abortion performed about untrained services providers (Ahmmed et al., 2021).

Specific cultural factors on abortion

Khasi adolescents reported the use of herbal medicine for abortion. The ingredients for this medicine were provided by trees that grew in participants' gardens (Ahmmed et al., 2021).

3.1.5 No information found on other SRHR components and indigenous people

No studies were found on the other component mentioned in the WHO framework being gender-based violence; fertility care; prevention and control of HIV and sexual functioning in relation to indigenous people in Bangladesh.

3.2 (Ingredients for) *Inclusive SRHR services*

Global attention for inclusive approaches towards sexual and reproductive health services underline that Bangladesh is not the only country that faces the inclusion challenge. A few studies, both within and beyond the boundaries of Bangladesh, were identified that provide inspiration on how to include marginalized indigenous groups and how to work with various perspectives and diversity in the SRHR field. It was found that many approaches are focused on attitudinal and behavioral change of SRH healthcare practitioners. The aim of this section is to describe the aspects to be considered when developing inclusive and sustainable SRHR approaches for indigenous people.

Inclusion in practice

To create an inclusive approach, the perspectives of indigenous stakeholders need to be heard. Engaging adolescents in monitoring the quality of SRH services was a key concept of the inclusivity approach for indigenous adolescent SRH services in Gujarat, western rural India (Mecwan et al., 2021). In this approach, peer leader adolescents were invited to organize adolescent groups in their villages and engage with service providers in order to strengthen relationships with them and sensitize them on their role as supporters of adolescent SRH. The aim was to mobilize peer adolescents to assess and be critical on the quality of SRH service provision. Support structures such as parent groups were formed to protect adolescents involved from backlashes from the community.

Intersectionality was at the core of the approach and as the researcher conclude, they succeeded to put their intersectional approach into practice: "Bringing together young people with different vulnerabilities and strengths in a sustained way has resulted in a deep appreciation of each other's concerns and in increased empathy".

Moving towards a more inclusive approach also included adjustments of very practical issues. For example, indigenous adolescents were not able to meet frequently due to remoteness. After addressing this, meetings would take place less frequent, but the sessions became longer so it would be easier for them to attend. Belonging to a collective enhanced confidence of young people. Also, it increased solidarity towards their peers, due to learning from each other. This safe space made them feel entitled to share their own opinion.

A study among 115 SRH service providers from 10 low-income countries aimed to explore what individual and environmental aspects predict the providers' actions and inactions regarding SRHR provision. Exploring these factors could provide information for designing behavioral

change interventions (Tumwine, Agardh, Gummesson, Okong, & Östergren, 2020). Providers' attitudes and behaviour were indicated as normative or non-normative using a survey. Providers who strongly agreed with SRHR for all and reporting proactive behaviour in enhancing SRHR access for all were indicated as normative. Non-normative indicated that providers showed a low level of agreement with SRHR and they did not consider taking steps to enhance access for all. Contrary to what was hypothesized, religion and culture were no significant predictors of SRHR attitudes and practices. Active SRHR knowledge seeking came out as the most important characteristic for normative providers. Targeting and enhancing practitioners self-drive to acquire knowledge (which is a form of self-regulated learning) through training holds potential to positively impact SRH attitudes and practices among providers. However, such training should still be developed (Tumwine et al., 2020).

Due to acknowledgment of diverse ontologies, SRH need to be culturally sensitive in order to be inclusive for minority groups. However, Kelly (2013) states that 'cultural sensitivity and cultural awareness' is not enough to decolonize indigenous sexual and reproductive health services. When delivering SRH services, the providers need to ensure 'cultural safety' instead. What this means in practice, is that providers need to be able to reflect on their own position related to their patient. They also need to be able to critically reflect on where their own knowledge comes from and how this is similar to or complements the knowledge of the person they are serving. Cited from Kelly (2013): "Cultural safety is positioned beyond cultural awareness and cultural sensitivity. Instead of focusing on the learning rituals, customs, and practices of a group in a "checklist" approach" (Kelly, 2013). All the studies above included in this section, do focus on integration of different worldviews, going beyond the understanding that different worldviews exist. These integrations are never a quick fix.

As can be read above, interventions on inclusion can be targeted on capacity building of both healthcare practitioners and target groups. According to Vanwesenbeeck et al. (2019), combination of strategies is likely to be the most effective and sustainable. They point out that, specifically in situations where SRHR is controversial, multicomponent approached are preferred over single-component interventions. The strength lies in both addressing demand and supply in the uptake of SRH services, as seen in the approach were adolescents were invited to organize adolescent groups to engage with service providers (Mecwan et al., 2021). They also stress the use of various methods and strategies, as this also helps to reach various groups, all having distinct needs und different circumstances (Vanwesenbeeck, Flink, van Reeuwijk, & Westeneng, 2019).

4. Discussion

This review aimed to explore the factors that need to be taken into account in developing sustainable SRH service provision approaches, focusing on the inclusion of indigenous people in Bangladesh.

The main focus of the literature on indigenous groups was on 'Antenatal, intrapartum & postnatal care'. It was found that cultural norms prescribe if and where to seek treatment for ailments during pregnancy, delivery and thereafter. The importance of home delivery was reported and pregnancy was viewed as a natural process, not needing extra support when there are no complications. There was a strong preference for healthcare providers they, or their relatives, were familiar with. Findings on the themes 'Comprehensive education and information and 'Safe abortion care' only came from a study focusing on one group of indigenous adolescents. There were no findings on the themes 'Sexual function & psychosexual counselling' and 'Gender-based violence prevention, support & care' in the included literature on indigenous people in Bangladesh. This might result in indigenous adolescents being overlooked in their need for information and service provision on these themes. All of the studies were focusing on women's SRH, while none of them included men's attitudes, perspectives and knowledge on SRH. There needs to be a close watch on what is considered important for both groups, according to research.

While perspective and attitudes from indigenous women were studied in all of the included studies, there were no findings on the perspectives and attitudes from indigenous healthcare workers on SRH. Indigenous women stated that familiarity with the provider and sharing the same cultural background was a facilitator in accessing SRH services, especially for accessing maternal health care. Further research on indigenous healthcare providers needs to be done, in order to explore their possible role in bridging the gap between SRH service provision and SRH-needs of indigenous people in Bangladesh.

The aim of including literature on the inclusion of indigenous people in SRH approaches, was to identify ways to target exclusionary mechanism. It was found that all of the included articles on inclusive, sustainable (longterm) approaches, focused solely on SRH service providers, except for one study that focused on active engagement of adolescents with service providers (Mecwan, Sheth, & Khanna, 2021)

Attitudinal and behavioral changes where aimed for, using different approaches. Monitoring of SRH service provision by the users, accompanied by support structures was one of them (Mecwan et al., 2020). Stigma reduction of providers through targeted trainings was reported as effective tool to change providers' attitudes towards marginalized groups (Geibel et al., 2017). Moreover, it was found that providers who were actively seeking new knowledge on SRH topics were most positive towards providing services to all, including minorities (Tumwine et al., 2020).

Acknowledgement of diverse ontologies, without devaluing one or another, was found as core concept of ensuring a safe and respectful way of service provision. Enhancing providers' reflectivity, and receptivity for new knowledge was targeted at. This should help them to remain attentive and adaptive towards challenges that come with diversity. It should be noted

though, that specific and practical implementation of these tools should be further investigated. Effectivity has been reported, but it needs further assessment on a larger scale.

5. Conclusion

Indigenous people living in Bangladesh belong to the group having the least access to SRH service provision. Findings on (cultural) factors affecting both their demand for and access to quality SRH services were collected. Studies focusing on indigenous SRHR were mainly concentrated around maternal health seeking behavior.

An inclusivity approach therefore needs to include collective action and collective learning in peer groups and between indigenous people and service providers.

Next to empowering users to voice their needs, it was found that mutual understanding between providers and targeted groups was important. Therefore, attitudes and behaviour of providers are considered effective targets for inclusion approaches. Active knowledge seeking of SRH providers was reported as an important trait in enabling them to be adaptable to any kind of situation and any form of diversity. Being open to new knowledge and perspective creates and sustains an adaptive environment where service providers meet SRH users.

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