

Research Article

Awareness Regarding Adolescent Sexual and Reproductive Health Among School Students in Nepal: A Cross-Sectional Study

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Abstract

Adolescent sexual and reproductive health (ASRH) is a priority program in Nepal, yet significant knowledge gaps persist among adolescents. This study aimed to assess the awareness of ASRH among school adolescents and identify factors that influence their knowledge. A cross-sectional study was conducted at Bageshowari Higher Secondary School in Bhaktapur Municipality, Nepal, involving 330 students aged 14-18 years. Participants were selected using a probability simple random sampling method. Data were collected using a self-administered structured questionnaire that covered pubertal changes, sexually transmitted infections, family planning, and abortion. Descriptive statistics and chi-square tests were used for data analysis. The results revealed that 54.8% of adolescents demonstrated adequate ASRH awareness. Age was a significant factor, with older adolescents (≥ 16 years) showing higher awareness (46.6%) compared to younger adolescents (8.1%). Gender differences also existed, with females demonstrating higher awareness (35.1%) than males (19.6%). Ethnicity influenced awareness, with advantaged Janajatis showing higher awareness (31.1%). Grade-wise analysis indicated that awareness increased with higher grades, peaking at grade twelve (19.4%). Domain-specific analysis revealed the highest awareness for sexually transmitted infections (83.9%) and the lowest for abortion (35.2%). The study concluded that while ASRH awareness was moderate, there are significant gaps, especially concerning abortion. The findings suggest the need for targeted interventions, particularly for younger adolescents and male students, and recommend incorporating ASRH topics into school curricula along with specialized awareness programs focusing on underperforming areas.

Keywords

Adolescence, Sexual and Reproductive Health, Adolescent, Awareness, Nepal

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1. Introduction

Adolescents, defined by the World Health Organization as individuals aged 10–19, experience critical physical, psychological, and social transitions marked by bodily changes, a shift toward independent thinking, and increased awareness of rights and responsibilities [1]. Globally, they represent about 20% of the population, and in Nepal, adolescents account for 24% of the population, though limited access to sexual and reproductive health (SRH) services remains a barrier due to socioeconomic factors, gender inequality, and traditional beliefs [2]. The Government of Nepal acknowledges the unique SRH needs of adolescents but has implemented only a few targeted programs, often leaving adolescents inadequately informed and underserved [3]. Studies suggest that SRH awareness is moderate, with male adolescents generally more informed than females on topics like HIV/AIDS; media is the primary SRH information source (cited by 90% of respondents), followed by parents (53%) and school resources (50%) [4]. Early childbirth among adolescents is prevalent, with 17% of 15–19-year-olds becoming mothers without adequate preparation and only 14% of married adolescents using modern contraceptives, contributing to broader issues of maternal health and child development [5]. Underlying health concerns, such as high rates of anemia affecting over 80% of adolescent girls, exacerbate vulnerabilities, underscoring the need for strengthened adolescent-focused health policies across South Asia [6]. Nepal has taken steps to address these issues, implementing South Asia's first National Adolescent Health and Development Strategy in 2000, later revised in 2018, to tackle contemporary challenges adolescents face, especially regarding SRH awareness and service access [7]. This study seeks to explore awareness levels of SRH among school-aged adolescents in Bhaktapur Municipality, Nepal, aiming to uncover knowledge gaps and factors influencing SRH awareness in this demographic. Specific objectives include identifying SRH knowledge levels and examining associations between SRH awareness and socio-demographic factors, such as age, gender, and socioeconomic background. The study is motivated by the realization that although traditional norms discourage premarital sexual activity, engagement in such practices is rising among adolescents, often without adequate knowledge of safe practices, increasing the risk of unintended pregnancies and STIs [8]. By identifying SRH awareness levels, this research intends to support the development of interventions that could better equip teachers, parents, and healthcare providers to address adolescent health needs comprehensively.

2. Materials and Methods

2.1. Research Design

A cross-sectional research design was used to find out the awareness level of sexual and reproductive health among

adolescents.

2.2. Research Setting and Population Setting

The study was conducted in a community setting at a government school named Bageshowari Higher Secondary School in Bhaktapur Municipality. It is situated in the Bhaktapur district at Bhaktapur Municipality, Chamashing, about 1.5 km from Jagatai Chowk of Arniko Highway. Established in 2015 BS, the school has 5,248 students and is one of the renowned schools in the Bhaktapur district. It includes grades one through twelve, with multiple sections in various grades. The study population comprised adolescent students of grades eight to twelve, including boys and girls.

2.3. Sampling Technique

A probability, simple random sampling technique (lottery method) was used to select the sample for this study.

2.3.1. Sample Size

The sample size of this study was calculated using the following formula:

$$\text{Sample size (n)} = N / (1 + N \cdot d^2) \text{ (Yamane, 1967)}$$

Where,

n = sample size

N = known population of the study area.

d = allowable error.

$$n = 1910 / (1 + 1910(0.05)^2)$$

$$n = 1910 / (1 + 1910 \times 0.0025)$$

$$= 1910 / (1 + 4.775)$$

$$= 330$$

The total sample size was 330.

2.3.2. Sampling Procedure

Bhaktapur Municipality in the Bhaktapur district was selected purposively for this study. One school was chosen randomly among the five government secondary schools in the municipality. The total number of students studying in grades eight to twelve served as the study sample, and a probability simple random sampling technique was applied. The inclusion criteria consisted of all adolescent students aged 14 to 18 years who were studying in grades eight to twelve, willing to participate, available during data collection, and whose parents provided consent to participate. Conversely, students not in grades eight to twelve, those who did not meet the age requirement, and those whose parents did not consent were excluded from the study. This approach ensured that the sample was representative of the target population while maintaining ethical standards in participation.

2.4. Research Instrumentation

The researcher developed a structured, self-administered questionnaire in consultation with an advisor, subject experts, and peers, as well as through a literature review. The instrument was divided into two parts: Part I focused on socio-demographic information, consisting of 6 items, while Part II addressed Adolescent Sexual and Reproductive Health (ASRH) information, which included 28 items. This part was further categorized into specific topics: pubertal changes (5 questions), sexually transmitted infections (10 questions), family planning (5 questions), and abortion (9 questions). To ensure content validity, the questionnaire was created based on a comprehensive literature review and consultations with a research advisor from Kathmandu, Pokhara Nursing Campus faculty members, and Pokhara subject experts. The Research Committee of Pokhara Nursing Campus also reviewed the questionnaire. A pre-test was conducted with 10% of the target population, involving 33 students from two sections excluded from the main study. The instrument's reliability was assessed regarding internal consistency using Cronbach's alpha, which yielded a coefficient of 0.81.

2.5. Data Collection Procedure

Before data collection, the research proposal was approved by the Research Committee of Pokhara Nursing Campus, TU, IOM, Pokhara. Ethical clearance was obtained from the Institutional Review Committee of TU, IOM. Formal written permission for data collection was taken from the Bhaktapur Municipality administration and the Bageshowari Higher Secondary School administration. Consent forms were provided for each student's guardian, and students obtained assent. Anonymity was maintained by coding respondents, and confidentiality was ensured by restricting data access to study purposes only. Students were given the freedom to withdraw from the study at any time. Each form took 20-25 minutes to complete, and data collection lasted four weeks, from February 10 to March 10, 2021. Upon completion, the researcher thanked all respondents, teachers, and authorities for their cooperation.

2.6. Data Analysis Procedure

After the data was collected, it was checked for completeness and accuracy before being coded to facilitate easier data entry. The data was entered into EPI DATA version 3.1 and then exported to SPSS version 16 for analysis. To summarize the data, descriptive statistics were used to calculate frequencies, percentages, means, and standard deviations. Chi-square tests were conducted for inferential statistics to explore the relationships between different variables.

2.7. Ethical Considerations

This study received ethical clearance from the Institutional

Review Committee of Tribhuvan University, Institute of Medicine with ID -(IRC-2621-077/078). Written permission was obtained from the Bhaktapur Municipality administration and the Bageshowari Higher Secondary School administration. Informed consent was obtained from the guardians of all participating students, and assent was obtained from the students themselves. All participants were informed of their right to withdraw from the study at any time.

3. Results

3.1. Overview of the Demographic, Educational, and Developmental Characteristics of the Study Participants

Table 1 presents an overview of the study participants' demographic, educational, and developmental characteristics. The study included individuals aged 14 to 18, with a mean age of 15.89 (SD \pm 1.305). The age distribution was primarily skewed towards older participants, with 65.2% being 16 years or older and 34.8% below 16. The gender distribution was relatively balanced, with 53.9% female and 46.1% male participants.

Educationally, the participants were spread almost equally across grades eight to twelve, with each grade comprising approximately 19-21% of the sample. Ethnic background was primarily represented by advantaged Janajati groups (54.5%), followed by upper-caste participants (27%), and disadvantaged Janajati groups (18.5%). Parental education varied considerably. Most fathers (96.3%) were literate; among them, 51.8% had secondary education, while 32% had completed SLC or higher. Mothers had a lower literacy rate, with 78.8% able to read and write. Of those, 42.3% had secondary education, and 22.3% had SLC or higher.

Regarding physical and pubertal development, 63.3% of participants reported noticeable physical transformations from child to adult forms. Nearly all participants (98.5%) experienced physical changes associated with puberty, while emotional (70.9%), sexual (55.5%), and social changes (46.7%) were also frequently reported. Additionally, 90% noted hormonal changes as part of their pubertal experience. For boys, key developments included attraction to the opposite sex (92.1%), voice deepening (70.6%), and physical growth of the testes, scrotum, and body hair. For girls, primary changes included breast development (93.3%), growth of body hair (82.7%), height increase (77.6%), and the onset of menstruation (65.2%).

Table 1. Socio-Demographic Characteristics.

Characteristics	Number	Percent (%)
Age (years)		

Characteristics	Number	Percent (%)	Characteristics	Number	Percent (%)
<16	115	34.8	Social	154	46.7
≥16	215	65.2	Hormonal changes due to puberty	297	90.0
Mean age ±SD	15.89 ±1.305		Pubertal Changes in Boys*		
Range	(14-18)		Attraction to the opposite sex	304	92.1
Gender			Hoarseness of voice	233	70.6
Female	178	53.9	Development of testes and scrotum	212	64.2
Male	152	46.1	Hair growth on arms, legs, and genital area	211	63.9
Grade			Pubertal Changes in Girls*		
Eight	66	20.0	Breast development	308	93.3
Nine	67	20.3	Hair growth on arms and genital area	273	82.7
Ten	65	19.7	Height increase, longer extremities	256	77.6
Eleven	68	20.6	Start of menstruation cycle	215	65.2
Twelve	64	19.4			
Ethnicity					
Janajatis (advantaged)	180	54.5			
Upper caste	89	27.0			
Disadvantaged Janajatis	61	18.5			
Educational Status of Father					
Cannot read and write	12	3.6			
Can read and write	318	96.3			
Level of Father's Education (n=318)					
Primary education	51	16.0			
Secondary education	165	51.8			
SLC and above	102	32.0			
Educational Status of Mother					
Cannot read and write	70	21.2			
Can read and write	260	78.8			
Level of Mother's Education (n=260)					
Primary education	92	35.3			
Secondary education	110	42.3			
SLC and above	58	22.3			
Physical Transformation from Child to Adult					
Physical transformation	209	63.3			
Pubertal Changes*					
Physical	325	98.5			
Emotional	234	70.9			
Sexual	183	55.5			

Multiple Response*

3.2. Educational and Health Awareness Characteristics of Study Participants

Table 2 provides insights into the participants' knowledge and awareness of sexually transmitted infections (STIs), family planning (FP), emergency contraceptives, and abortion. The data reveal that 59.7% of participants understood that STIs affect the genital tract, with bacteria (86.4%) and viruses (62.4%) commonly identified as causes. HIV/AIDS was the most widely recognized STI (90%), followed by gonorrhea (75.5%) and syphilis (65.5%). Participants were also familiar with common symptoms, including whitish discharge (81.2%), genital itching (77.3%), and painful urination (72.7%), demonstrating a general awareness of STI symptoms.

Preventive measures for STIs were widely understood, with 90.9% of participants recognizing the importance of avoiding unsafe sex, 83.6% advocating for hygiene, and 80.6% acknowledging condom use as protective. These figures indicate a high level of awareness regarding STI prevention. Additionally, participants recognized serious STI complications, including cervical cancer (67.6%), infertility (61.2%), and miscarriage (53%).

In terms of family planning, 91.2% of participants understood FP as a way to control childbirth numbers, with many citing its benefits for spacing births (79.7%), preventing unwanted pregnancies (72.1%), and improving maternal and child health (70.9%). All participants were aware of FP methods, whether permanent, temporary, or both, indicating a

comprehensive understanding of FP options.

Knowledge of emergency contraceptives was more limited, with only 54.2% aware of their intended use within 72 hours of unprotected sex, highlighting an area where additional education might be beneficial. Abortion knowledge was widespread, with 100% of participants aware of Nepal's abortion laws. Around 53.9% understood abortion as pregnancy termination before 22 weeks, and 44.2% were aware of

the option to terminate voluntarily up to 12 weeks, while only 17% knew about terminations permitted up to 28 weeks in certain cases. Nearly half (47.6%) recognized unsafe abortions as those performed by untrained individuals.

Reasons for unsafe abortions among young girls included a lack of knowledge (71.5%), financial barriers (52.7%), fear of exposure (41.4%), and unwanted pregnancy (37.9%), indicating that socioeconomic factors play a significant role.

Table 2. Educational and Health Awareness Characteristics of Study Participants.

Variables	Number	Percent (%)
STI Knowledge*		
STI means an infection of the genital tract	197	59.7
Causes of STI*		
Bacteria	285	86.4
Virus	206	62.4
Fungus	79	23.9
Protozoa	75	22.7
Types of STI*		
HIV/AIDS	297	90.0
Gonorrhea	249	75.5
Syphilis	216	65.5
Trichomoniasis	86	26.1
Signs and Symptoms of STI*		
Whitish discharge from the vagina and penis	268	81.2
Genital itching	255	77.3
Painful urination	240	72.7
Rashes around the genital area	157	47.6
Preventive Measures for STI*		
Discourage unsafe sex	300	90.9
Maintain hygiene	276	83.6
Use of condom during sex	266	80.6
No needle exchange	249	75.5
Complications of STI*		
Cervical cancer	223	67.6
Infertility	202	61.2
Miscarriage	175	53.0
Stillbirth	110	33.3
Family Planning Knowledge*		
FP means controlling the number of childbirths	301	91.2
Importance of Family Planning*		

Variables	Number	Percent (%)
Space births	263	79.7
Prevent unwanted pregnancy	238	72.1
Improve the health of mother and child	234	70.9
Make children as needed	226	68.5
Methods of Family Planning		
Permanent, Temporary, or Both	330	100.0
Emergency Contraceptives		
Taken within 72 hours of unprotected sex	179	54.2
Abortion Knowledge*		
Abortion means termination of pregnancy before 22 weeks	178	53.9
Legalization of abortion in Nepal	330	100.0
Pregnancy terminated voluntarily up to 12 weeks	146	44.2
Termination up to 28 weeks in certain circumstances	56	17.0
Untrained person performs an unsafe abortion	157	47.6
Reasons for Unsafe Abortion in Young Girls*		
Lack of knowledge	236	71.5
Lack of money	174	52.7
Fear of exposure to others	145	41.4
Unwanted pregnancy	144	37.9
Complications of Abortion*		
Heavy bleeding	256	77.6
Incomplete abortion	218	66.1
Infection of uterus	198	60.0
Damage to reproductive organs	182	55.2
Preventive Measures for Unsafe Abortion*		
Launch awareness programs	273	82.7
Maintain strict law	264	80.0
Incorporate into the school curriculum	221	67.0
Proper monitoring	175	53.0

Multiple Response*

3.3. Awareness Levels by Source and Domain

Table 3 shows awareness levels regarding various health topics assessed from different sources. The results indicated that the highest levels of adequate awareness were observed in sexually transmitted infections (83.9%) and family planning (67.0%), while awareness regarding abortion was notably low, with only 35.2% demonstrating adequate knowledge. Among personal sources of information, siblings (70.8%) and peers

(69.5%) showed relatively high awareness levels, whereas parents had an equal distribution of adequate and inadequate awareness (50.0%). School teachers also had a significant portion of inadequate awareness (44.6%). The internet was a valuable resource, with 62.8% of respondents reporting adequate awareness. 54.8% of participants displayed adequate awareness levels, while 45.2% fell into the inadequate category. These findings highlight critical areas for improving health education and awareness strategies, particularly regarding abortion and the role of school teachers and parents in

disseminating health information.

Table 3. Awareness Levels by Source and Domain.

Variable/Domain	Adequate Awareness (No, %)	Inadequate Awareness (No, %)
Sibling	85 (70.8%)	35 (29.2%)
School Teacher	139 (55.3%)	112 (44.6%)
Peers	41 (69.5%)	18 (30.5%)
Radio/Television	54 (71.0%)	22 (29.0%)
Parents	125 (50.0%)	125 (50.0%)
Internet	105 (62.8%)	62 (37.2%)
Pubertal Changes	218 (66.1%)	112 (33.9%)
Family Planning	221 (67.0%)	109 (33.0%)
Sexually Transmitted Infections	277 (83.9%)	53 (16.1%)
Abortion	116 (35.2%)	214 (64.8%)

3.4. Overall Level of Awareness

Table 4 summarizes the overall level of awareness among participants. Of 330 respondents, 181 (54.8%) exhibited adequate awareness, scoring 47 or higher, while 149 (45.2%) had inadequate awareness, scoring below 47. This distribution underscores a slightly more favorable awareness landscape, although a significant portion of the population remains under-informed. These results emphasize the need for targeted educational interventions to improve overall health knowledge and address specific deficiencies in awareness, particularly regarding critical health issues.

Table 4. Overall Level of Awareness.

Level of Awareness	Number	Percent
Adequate (≥ 47)	181	54.8%
Inadequate (< 47)	149	45.2%
Total	330	100.0%

3.5. Association Between Awareness Level of ASRH and Socio-demographic Variables of Adolescents

Table 5 presents the statistically significant associations between adolescent awareness regarding sexual and reproductive health and the variables of age, gender, ethnicity, and grade. Only these associated variables are shown here due to the large number of variables considered in the study. The results indicate a strong association between awareness levels and age, with adolescents aged 16 and above showing significantly higher adequate awareness (46.6%) compared to those under 16 (8.1%) ($\chi^2 = 70.141$, $p = 0.000$). Gender was also a significant factor; females demonstrated a higher adequate awareness (35.1%) than males (19.6%) ($\chi^2 = 16.619$, $p = 0.000$). Ethnicity further influenced awareness, as advantaged Janajaties (31.1%) had higher adequate awareness than disadvantaged Janajaties (10.6%) and upper-caste groups (12.4%) ($\chi^2 = 3.811$, $p = 0.001$). Lastly, grade level showed a marked impact, with awareness levels increasing as grade level rose, culminating in 19.4% adequate awareness among twelfth graders and a complete absence of inadequate awareness at that level ($\chi^2 = 1.279$, $p = 0.000$). These findings emphasize the role of demographic and educational factors in shaping awareness levels of critical health topics among adolescents.

Table 5. Association between Awareness level of ASRH and socio-demographic variables of Adolescents.

Variables	Levels of Adequate No (%)	Awareness Inadequate No (%)	Chi-square (χ^2)	p-value
Age				
<16 years	27 (8.1)	88 (26.6)	70.141	0.000*
≥ 16 years	154 (46.6)	61 (18.5)		
Gender				
Male	65 (19.6)	87 (26.3)	16.619	0.000*
Female	116 (35.1)	62 (18.8)		
Ethnicity				
Disadvantages Janajaties	35 (10.6)	26 (7.9)	3.811	0.001*
Advantages Janajaties	105 (31.1)	75 (22.7)		

Variables	Levels of Adequate No (%)	Awareness Inadequate No (%)	Chi-square (χ^2)	p-value
Upper caste	41 (12.4)	48 (14.6)	1.279	0.000*
Group				
Grade				
Eight	7 (2.1)	59 (17.8)		
Nine	22 (6.6)	45 (13.6)		
Ten	38 (11.5)	27 (8.1)		
Eleven	50 (15.1)	18 (5.4)		
Twelve	64 (19.4)	0 (0)		

4. Discussion

The study aimed to assess the awareness of adolescent sexual and reproductive health among school adolescents and examine the association between awareness levels and selected variables. The findings revealed that 63.3% of adolescents understood the meaning of puberty, consistent with 68.4% having similar knowledge. Most adolescents (98.5%) recognized physical changes during puberty, aligning with Subedi and Dwivedy (2009) [9], who found that 94.8% noticed these changes. Additionally, 90% identified hormonal changes as the cause of puberty, similar to Prajapati et al. (2023), where 87.6% were aware of this. Breast development in girls was recognized by 93.3% of respondents, followed by hair growth in the axilla and genital areas (82.7%), [10] reflecting findings from Subedi and Dwivedy (2009) and Khanal (2016), where 89% noted physical changes with age.

Regarding sexually transmitted infections (STIs), 59.7% of adolescents could define them, in line with Subedi and Dwivedy (2009), which reported 53%. Almost all (90%) were aware of HIV/AIDS and STIs, corroborating Thapa et al. (2023), where 80% had similar awareness. Specific STI knowledge included awareness of symptoms like whitish discharge (81.2%) and genital itching (77.3%) [11], akin to D et al. (2013). More than half identified cervical cancer (67.6%) and infertility (61.2%) as complications of STIs [12]; adolescents (80.6%) recognized the importance of condom use for STI prevention, contrasting with Tamang et al. (2017), where 94% reported similar awareness.

On family planning, 91.2% understood its meaning, while 79.7% acknowledged its importance. This differs from Subedi and Dwivedy (2009), where 78.2% understood the meaning and 85.3% the importance. Only 54.2% knew that emergency contraception should be taken within 72 hours after unprotected sex, contrasting with Subedi and Dwivedy (2009), where only 33% had similar knowledge. All respondents recognized temporary and permanent family planning methods, unlike Panta et al. (2019), where only 59% were aware

[13].

Regarding abortion, 53.9% understood its meaning, aligning with previous studies by Subedi and Dwivedy (2009). All adolescents knew that abortion is legalized in Nepal, but the specifics of accessing legal abortion were less clear [14-16].

The study found significant associations between adolescents' awareness of sexual and reproductive health and factors such as age, gender, grade, and ethnicity, as indicated by the respective p-values: age ($p=0.000$), gender ($p=0.000$), grade ($p=0.000$), and ethnicity ($p=0.0149$). The association with age suggests that older adolescents have higher awareness, possibly due to increased exposure to educational content and greater maturity, which encourages interest in these topics [17, 18]. The significant gender difference in awareness may stem from societal norms and the way information is often directed at different genders, highlighting the need for balanced educational approaches for both boys and girls [19]. Grade level was also strongly associated with awareness, as higher-graders generally have more access to comprehensive health education. This underscores the importance of introducing sexual and reproductive health topics early in school curricula to build foundational knowledge [20]. Finally, the association with ethnicity suggests that cultural background influences access to and acceptance of sexual and reproductive health information, as certain ethnic groups may face cultural restrictions on discussing these subjects [21-23]. These findings indicate the need for tailored, culturally sensitive strategies to improve awareness across all adolescent demographics.

5. Conclusions

In conclusion, this study highlights a moderate level of awareness regarding adolescent sexual and reproductive health among school adolescents. While many participants demonstrated an understanding of key concepts such as puberty, STIs, family planning, and abortion, significant gaps remain, particularly in understanding the nuances of legal access to abortion and comprehensive family planning

methods. The findings indicate a need for targeted educational interventions that address these gaps, especially considering the identified associations between awareness levels and demographic variables such as age, gender, and grade. Enhancing knowledge in these areas is crucial for empowering adolescents to make informed decisions about their sexual and reproductive health. Overall, this study underscores the importance of ongoing educational initiatives in schools to promote comprehensive awareness and understanding of sexual and reproductive health issues among adolescents.

6. Recommendations

To enhance adolescents' awareness of sexual and reproductive health, several key recommendations arise from the study's findings. Schools should implement comprehensive education programs on topics like puberty, STIs, family planning, and safe abortion practices, ensuring the content is age-appropriate and culturally sensitive. Involving parents through workshops can foster open discussions at home, while peer educators can effectively share information in relatable ways. Providing accessible educational materials in schools and community centers will help students obtain accurate information easily. Regular assessments of knowledge will identify gaps and guide program adjustments. Collaboration with local healthcare providers for workshops can address misconceptions and offer expert insights. Advocating for policy changes to include sexual health education in the school curriculum will standardize access to essential knowledge. Finally, creating safe spaces for open discussions about sexual and reproductive health will encourage dialogue without judgment. These recommendations can empower adolescents to make informed choices and lead healthier lives.

Abbreviations

ASRH	Adolescent Sexual and Reproductive Health
STI	Sexually Transmitted Infection
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
FP	Family Planning
SRH	Sexual and Reproductive Health
BS	Bikram Sambat (Nepali Calendar)
SLC	School Leaving Certificate
TU	Tribhuvan University
IOM	Institute of Medicine

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Author Contributions

Rekha Bhandari: Conceptualization, methodology, data collection, and writing the original draft

Shreesti Sharma: Supervision, validation, review & editing, Statistical analysis, interpretation

Rajendra Gorkhali: Statistical analysis and interpretation

Sushmita Bhandari: Statistical analysis, interpretation, Data collection, literature review

Mandira Onta: Supervision and manuscript review

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NA.

Data Availability Statement

The dataset generated and analyzed during the current study is available from the corresponding author upon reasonable request. The data is not publicly available due to privacy concerns and to protect participant confidentiality, as it contains information from minor participants.

Conflicts of Interest

The authors declare no conflicts of interest.

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