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Awareness of Sexual and Reproductive Health among School-Going Adolescents in Selected Schools of Lalitpur District, Nepal

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Abstract

Adolescence is a crucial development phase with several changes. It requires knowledge about sexual and reproductive health (SRH) to empower them with informed health choices to reduce unintended pregnancies and sexually transmitted infections. However, many of them lack accurate information, leading to confusion and misinformation. This study evaluates the impact of an educational intervention on SRH knowledge among 115 eighth and ninth-grade students in Lalitpur, Nepal. This 'pre-post-test' study assesses changes in knowledge regarding reproductive health, contraceptive methods, abortion, STIs, and menstruation before and after the intervention of an educational awareness package during 2023. A total of 25 multiple-choice test questions were administered to the students. Results indicate significant improvements across all domains: awareness of reproductive health increased from 13.9% to 36.5%, knowledge of contraceptive methods such as pills rose from 45.2% to 59.6%, and understanding of STIs surged from 34.8% to 75.7%. Additionally, misconceptions about

menstruation decreased markedly. The mean knowledge score improved significantly from 8.18 (SD = 2.47) to 10.91 (SD = 2.78), with a p-value of 0.000 indicating statistical significance at the 1% level. These findings underscore the need for comprehensive school SRH education to equip adolescents with essential knowledge and skills, ultimately fostering healthier behaviors and reducing health risks within this vulnerable population. It highlights that while a one-time educational intervention can improve knowledge on SRH, the prevalence of certain misconceptions and knowledge gaps needs ongoing holistic education.

Keywords: adolescents, contraceptive awareness, educational intervention, knowledge improvement, sexual and reproductive health

1. Introduction

Adolescence marks a pivotal stage in human development, with significant physical, emotional, and social changes. This period is critical for personal growth and acquiring knowledge regarding sexual and reproductive health (SRH). An informed understanding of SRH empowers adolescents to make healthier choices, thereby reducing the incidence of unintended pregnancies and sexually transmitted infections (STIs) among youth. However, despite the importance of SRH education, many adolescents lack access to accurate information and supportive resources, leading to confusion and misinformation about their bodies and health needs (American Academy of Pediatrics, 2024; UNFPA, 2014).

Globally, adolescents aged 10 to 19 years represent a substantial proportion of the population, yet they face numerous challenges related to sexual and reproductive health. Cultural norms and societal taboos often hinder open discussions about these topics, resulting in young people's lack of awareness and understanding. Research indicates that many adolescents are eager for information about reproductive health but often do not receive it from schools or families. For instance, a study highlighted that over two-thirds of adolescents expressed a desire for more information on reproduction and contraception (UNFPA, 2022; WHO, 2025).

The World Health Organization (WHO) defines an adolescent as an individual in the 10-19 age group, while a "young person" typically refers to those between 10 and 24 years old. This definition is crucial for understanding the problems faced by young individuals and designing appropriate interventions (Open Learning Create, 2024). Today’s generation of young people is the largest in history; nearly half of the world’s population is under 25, with about 85% in developing countries. The poorest nations tend to have the most prominent and significant young people as a proportion of their populations (Inter-agency Working Group on Reproductive Health in Crises, 2010).

The International Conference on Population and Development (ICPD) held in Cairo in 1994 recognized reproductive health as crucial to overall health and human development. The new paradigm established through the ICPD emphasizes human rights, development, and individual well-being at the center of program policies. The Programme of Action (PoA) adopted during this conference provides foundational guidelines for reproductive health initiatives (McIntosh & Finkle, 1995).

In Nepal, the current National Health Policy recognizes Sexual and Reproductive Health as an integrated service essential for all citizens' fundamental human rights (Constituent Assembly Secretariat, 2015; MoHP, 2014). The National Health Policy of Nepal recognizes SRH as a basic human right, emphasizing the necessity for integrated services to ensure comprehensive health care for all citizens. Since 2006, the policy has established guidelines for implementing sexual health education within schools, aiming to equip adolescents with essential knowledge and skills regarding their reproductive health (Rivenes Lafontan et al., 2024). Furthermore, the National Reproductive Health Strategy outlines a framework for providing reproductive health services, including educational initiatives tailored to adolescents. The government has also introduced various policies, such as the Safe Motherhood and Reproductive Health Rights Act (2018), reinforcing its commitment to delivering comprehensive reproductive health services. The government has made some provisions to address the harassment of females as well (Sharma et al., 2024). Despite these advancements, there are significant disparities in how teachers implement sexual health education guidelines across different regions. Cultural norms, insufficient teacher training, and personal discomfort in discussing sexual topics contribute to the inconsistent delivery of SRH education in schools (Aryal et al., 2023; MoHP, 2014).

The school is a suitable institution where sexuality education can be provided systematically (Iudici, 2015). Just as school teachers play a key role in delivering sexuality and reproductive health education, education also plays an important role in guiding and changing young people's behavior (Acharya et al., 2009).

Many educators feel embarrassed discussing sexual topics or lack adequate knowledge themselves, leading to inadequate sexual and reproductive health education. Consequently, young people often rely on peers or mass media for information about their sexual health. Schools serve as suitable institutions for systematically providing sexuality education. Teachers play a key role in delivering this education, which is vital for guiding young people's behavior. From early childhood through adolescence, young individuals require information and skills to lead healthy sexual lives. Such education nurtures positive relationships and is foundational for developing healthy attitudes toward sexuality. However, many adolescents, including adolescents with disabilities (Aryal et al., 2024), still lack access to reliable information about sex and sexuality due to insufficient educational resources or support from their teachers (Acharya et al., 2009; Aryal et al., 2023).

This study aimed to increase the knowledge of SRH among school-going adolescents of selected schools in Lalitpur district and assess the change in SRH awareness levels before and after the intervention of an SRH educational package.

The research significantly contributes to filling important knowledge gaps in Sexual and Reproductive Health and Rights (SRHR) among adolescents, the group that is most likely exposed to misinformation. There is a need to include holistic SRHR education in school curricula, which will address Nepal's National Health Policy and school health sector plan, which recognizes SRH as a fundamental human right (Constituent Assembly Secretariat, 2015). This approach provides young people with accurate information, encourages healthier habits, and potentially reduces risk behavior.

However, the study was conducted only in two schools within Lalitpur, and therefore, it is not generalizable to other regions or groups in Nepal (Acharya et al., 2009). The population

sample of 115 students may not adequately represent the nation's multicultural socio-cultural environment among youth. Likewise, the intervention was conducted in a single session, which may not be sufficient for long-term memory consolidation and behavior modification (Mattebo et al., 2015). Finally, using self-reported data increases the risk of bias in assessing knowledge improvement (Chinn, 2011). Despite the limitations, it offers valuable insights into the effectiveness of interventional studies and calls for large-scale applications and long-term studies to address SRHR education needs in various contexts in Nepal. Enhancing awareness of adolescent sexual and reproductive health is essential for empowering young individuals to make informed decisions regarding their health. By addressing existing gaps in knowledge through targeted educational initiatives in schools, we can contribute to improved health outcomes for adolescents while fostering a more open dialogue about these critical issues within society.

2. Materials and Methods

The study employed an interventional cross-sectional design in 2023, aiming to enhance adolescents' awareness of SRH through a structured educational program. The effectiveness of the intervention was analyzed by comparing pre-test and post-test results using paired statistical analysis, a robust method for evaluating changes in knowledge and attitudes following educational interventions (Vongxay et al., 2022). A one-time awareness-raising orientation session was conducted for eighth and ninth-grade students in two selected schools (School A and School B) in Lalitpur, Nepal. A trained SRHR facilitator delivered these sessions. Before the orientation, a pre-test was administered to assess baseline knowledge and attitudes. Then, the awareness-raising session was conducted. Seven days after the session's completion, a post-test using the same questionnaire was done with the same participants to measure changes in knowledge and attitudes resulting from the intervention (Mattebo et al., 2015).

This study targeted a total of 115 students from the selected schools, employing a non-probability purposive sampling method to ensure that only those who willingly provided informed consent were included (Acharya et al., 2009). The data collection tool was a semi-structured questionnaire designed to evaluate knowledge and attitudes on key aspects of SRH. The questionnaire's content validity was ensured through an expert review process, adhering to established guidelines for developing reliable educational assessment instruments (Chinn, 2011). Ethical considerations were rigorously maintained throughout the study. Informed consent was obtained from all participants, and the confidentiality of their responses was ensured.

2.1 The Intervention

The awareness-raising session aimed to educate and empower the students through the sharing of factual information on SRH topics such as awareness on safe sexual practices, reproductive rights, age at marriage, place of delivery, reproductive anatomy and physiology, contraceptives, abortion, STIs, HIV and AIDS, menstruation and menstrual hygiene, etc. It was aimed at fostering responsible SRH practices. Facilitations included an interactive and participatory approach in addition to the presentations, discussions, question-answer, and

interactive activities such as role-play and dramas. An inclusive learning environment was created for the active engagement of the students.

2.2 Socio-Demographic Information of Respondent

Table 1: *Socio-Demographic Information of Respondent (n=115)*

Background characteristics	Number	Percentage
Gender		
Female	78	67.8
Male	37	32.2
Age		
< 15	49	42.6
≥ 15	66	57.4
Ethnicity		
Brahmins	32	27.8
Chhetri	13	11.3
Janajati	30	26.1
Dalit	9	7.8
Newar	16	13.9
Others	15	13.0
Type of family		
Nuclear	68	59.1
Joint	34	29.6
Extended	13	11.3

The study population comprised 115 participants, primarily female (67.8%) and the rest male (32.2%). Most participants (57.4%) were aged 15 or older, while 42.6% were below 15. In terms of ethnicity, Brahmins were the largest group (27.8%), followed by Janajati (26.1%), Newar (13.9%), Chhetri (11.3%), Dalit (7.8%), and others (13.0%). Regarding family structure, most lived in nuclear families (59.1%), while 29.6% belonged to joint families and 11.3% to extended families. These characteristics provide a diverse demographic profile, contributing to the robustness of the study findings.

3. Results

The comparison of pre-test and post-test knowledge on SRH among adolescents is found as follows:

Table 2: *Knowledge of SRH (n=115)*

Knowledge about SRH	Pretest		Post-test	
	Number	Percent	Number	Percent
The subject deals with sexual intercourse	18	15.7	14	12.2
The subject deals with reproductive organ	66	57.4	40	34.8
The subject deals with functions of reproductive organs	11	9.6	19	16.5

All of the above*	16	13.9	42	36.5
Do not know	4	3.5		
Ideal age of marriage for girls				
≤20	49	42.6	40	34.8
>20*	66	57.4	75	65.2
Ideal age of marriage for boys				
≤20	5	4.3	4	3.5
>20*	110	95.7	111	96.5
Ideal place for delivery				
Home	13	11.3	2	1.7
Home in the presence of a skilled birth attendant	20	17.3	13	11.3
Government hospital*	60	52,4	68	59.1
Private hospital*	22	19.1	32	27.8

*correct answer

Table 2 highlights the changes in respondents' knowledge of SRH before and after an intervention. In the pretest, 15.7% identified that reproductive health involves sexual intercourse, which slightly decreased to 12.2% in the post-test. Knowledge that the subject deals with reproductive organs dropped from 57.4% to 34.8%, while understanding of reproductive organ functions increased from 9.6% to 16.5%. Notably, the proportion of respondents who correctly recognized that reproductive health encompasses all these aspects rose significantly from 13.9% to 36.5%.

Regarding the ideal age of marriage, 57.4% of respondents initially identified the correct age for girls as above 20, which increased to 65.2% after the intervention. Similarly, knowledge of the correct age for boys (above 20) was already high at 95.7% in the pretest and slightly improved to 96.5%.

Knowledge about the ideal place for delivery also showed improvement. While 52.4% initially identified government hospitals as the correct place, this increased to 59.1% in the post-test. Preference for private hospitals also rose from 19.1% to 27.8%. On the other hand, the preference for home deliveries decreased significantly, from 11.3% to 1.7%.

Table 3: *Knowledge of Contraceptive Devices (n=115)*

Heard about contraceptives	**Pretest**		**Post-test**	
	Frequency	**Percent**	**Frequency**	**Percent**
Female Sterilization	19	16.5	35	30.7
Pills	52	45.2	68	59.6
IUCD	28	24.3	43	37.7
Condom	83	72.2	91	79.8
Implant	28	24.3	45	39.5
Injection	41	35.7	59	51.8
Male Sterilization	13	11.3	27	23.7
Calendar Method	16	13.9	37	32.5
Female Condoms	32	27.3	54	47.4

Ever seen condom				
Yes	55	47.8	115	100
No	60	52.2	0	0
Effectiveness of Condoms to Prevent Pregnancy				
Yes	29	25.2	48	41.7
No	17	14.8	25	21.7
Do not know	69	60	42	36.5

#multiple responses

Table 3 reveals notable improvements in respondents' knowledge about contraceptive devices after the intervention. Awareness of female sterilization increased from 16.5% in the pretest to 30.7% in the post-test. Similarly, knowledge of pills rose from 45.2% to 59.6%, IUCD from 24.3% to 37.7%, and condoms from an already high 72.2% to 79.8%. Awareness of less commonly known methods, such as implants and injections, also improved significantly, increasing from 24.3% to 39.5% and 35.7% to 51.8%, respectively. Knowledge of male sterilization and the calendar method demonstrated substantial growth, doubling from 11.3% to 23.7% and 13.9% to 32.5%, respectively. Awareness of female condoms increased from 27.3% to 47.4%.

Before the intervention, 52.2% of respondents reported having never seen a condom, while after the intervention, 100% had seen one. Understanding condom effectiveness in preventing pregnancy improved from 25.2% in the pretest to 41.7% in the post-test. However, the proportion of respondents who believed condoms were ineffective decreased from 14.8% to 21.7%, and those who did not know dropped from 60% to 36.5%.

Table 4: *Knowledge on Abortion (n=115)*

Knowledge of Abortion	**Pretest**		**Post-test**	
	Number	**Percent**	**Number**	**Percent**
End of pregnancy*	21	18.3	43	37.4
Miscarriage	49	42.6	57	49.5
Do not know	45	39.1	15	13
Legalisation of abortion in our country				
Yes*	50	43.5	71	61.7
No	65	56.5	44	38.3

*correct answer

The findings indicate an improvement in respondents' knowledge of abortion after the intervention. The proportion correctly identifying abortion as the end of pregnancy increased from 18.3% in the pretest to 37.4% in the post-test. Those who associated it with miscarriage slightly rose from 42.6% to 49.5%, while the proportion of respondents who did not know about abortion decreased significantly from 39.1% to 13%.

Awareness of the legalization of abortion in the country also improved, with 43.5% correctly stating it was legal in the pretest, increasing to 61.7% in the post-test. Meanwhile, the proportion of respondents believing abortion was illegal decreased from 56.5% to 38.3%.

Table 5: *Knowledge of STIs (n=115)*

Knowledge of STIs	Pre-test		Post-test	
	Number	Percent	Number	Percent
Heard about STIs				
Yes	40	34.8	87	75.7
No	75	65.2	28	24.3
Cause of STI Infection				
Transmitted from sexual intercourse	36	31.3	51	44.3
Bacteria, viruses, and parasites	18	15.7	13	11.3
All of the above*	16	13.9	34	29.6
Do not know	45	39.1	17	14.8
#Heard STIs				
Gonorrhea	12	10.4	41	35.7
Syphilis	25	21.7	54	47.0
Chlamydia	3	2.6	39	33.9
HIV and AIDS	87	75.7	104	90.4
Genital herpes /sore	11	9.6	45	39.1
Do not hear any	27	23.5	18	15.7
Symptoms of STIs#				
Discharge from the genital organ	29	25.4	37	32.1
Rashes	27	23.7	25	22.1
Burning sensation while urinating	22	19.3	30	15.5
Bumps/sores/blisters on genital areas	13	11.4	28	24.8
All of the above*	16	14.0	66	58.4
None of the above	52	32.7	8	7.1
Cure of STIs				
Yes	55	47.8	66	57.4
No	60	52.2	49	42.6
Transmitted from one person to another by :				
Kissing	2	1.7	4	3.5
Touching	12	10.4	5	4.3
Sexual contact*	86	74.8	96	83.5
Huggins	4	3.5	2	1.7
Others	11	9.6	8	7.0
If any of your friends have HIV or AIDS				
End friendship	10	8.7	11	9.6
Remain as usual	50	43.5	59	51.3
Start hating	5	4.3	7	6.1
Do not know	50	43.5	38	7.0
Condom prevents STIs				
Yes*	67	58.3	74	64.3
No	23	20.0	23	20.0
Do not know	25	21.7	18	15.7

*correct answer #multiple answers

Table 5 indicates a significant improvement in respondents' knowledge about sexually transmitted infections (STIs) after the intervention. The percentage of respondents who had heard about STIs increased from 34.8% in the pretest to 75.7% in the post-test. Knowledge about the causes of STIs also improved, with 44.3% of respondents correctly identifying sexual intercourse as a cause in the post-test, compared to 31.3% pre-test. Furthermore, awareness of all causes (bacteria, viruses, parasites, and sexual transmission) rose from 13.9% to 29.6%.

In terms of specific STIs, recognition of gonorrhea increased from 10.4% to 35.7%, syphilis from 21.7% to 47.0%, and chlamydia from 2.6% to 33.9%. However, awareness of genital herpes and syphilis also grew significantly. Knowledge of symptoms also improved, with those identifying all symptoms (discharge, rashes, burning sensation, and sores) rising from 14.0% to 58.4%.

Regarding the transmission of STIs, 83.5% of respondents correctly identified sexual contact as the primary mode of transmission in the post-test, up from 74.8% pre-test. The percentage of respondents who knew that condoms can prevent STIs also rose from 58.3% to 64.3%. Additionally, more respondents indicated they would remain as usual with a friend who had HIV/AIDS, increasing from 43.5% to 51.3%.

Table 6: *Knowledge of Menstruation*

Knowledge of menstruation	**Pretest**		**Post-test**	
	Number	Percent	Number	Percent
Menstruation				
Physiological Process	100	87	107	93
Curse of god	6	5.2	4	3.5
Caused by sin	5	4.3	1	0.9
Caused by diseases	4	3.5	3	2.6
The organ from which blood comes				
Vagina	82	71.3	102	88.7
Anus	19	16.5	7	8.1
Do not know	14	12.2	6	5.2
Absorbent is ideally used during menstruation				
Sanitary pad	91	79.1	91	79.1
Pieces of cloth	17	14.8	19	16.5
Others	7	6.1	5	4.3
For Females only (n=78)				
Menstrual hygiene	**Pretest**		**Post-test**	
	Number	Percent	Number	Percent
Water only*	59	75.64	66	84.6
Soap and water	13	16.6	10	12.8
Others	6	7.6	2	2.6
The disposal method of used absorbents				
Washcloth kept in sunlight and reused*	49	42.6	49	42.6
Burn used one	21	18.3	5	4.3
Throw on dustbin*	3	2.6	22	19.1

Kept in a place where nobody sees and reused	5	4.3	2	1.7

*correct answer

The findings indicate an overall improvement in respondents' knowledge of menstruation after the intervention. The understanding of menstruation as a physiological process increased slightly from 87% in the pretest to 93% in the post-test, while misconceptions about menstruation being a curse of God or caused by sin significantly decreased. Regarding the source of menstrual blood, the percentage of respondents identifying the vagina as the correct organ increased from 71.3% to 88.7%. In comparison, those incorrectly identifying the anus as the source decreased from 16.5% to 8.1%.

Knowledge about menstrual hygiene practices also improved. The percentage of respondents using water only for hygiene increased from 75.6% to 84.6%, while the use of soap and water remained stable. Additionally, there was an increase in respondents correctly identifying throwing used absorbents in the dustbin as the proper disposal method, rising from 2.6% to 19.1%.

Table 7: *Comparison of Mean Knowledge Scores on Reproductive Health Before and After Educational Intervention*

	Mean score	**Std. Deviation**	**Std. Error Mean**	***p*-value**
Pre-test	8.18	2.47	.23060	
Post-test	10.91	2.78	.25925	.0001*

**significant at 1% level*

The results of the pretest and post-test scores indicate a significant improvement in respondents' knowledge. The mean score for the pretest was 8.18 (SD = 2.47), while the mean score for the post-test increased to 10.91 (SD = 2.78). The standard error for the pretest was 0.23, and for the post-test, it was 0.26. The p-value of 0.000 indicates that the difference between the pretest and post-test scores is statistically significant at the 1% level. This suggests that the intervention led to a meaningful increase in the respondents' knowledge.

4. Discussion

The study indicates a mixed response in understanding reproductive health. Notably, knowledge that reproductive health involves sexual intercourse decreased from 15.7% to 12.2%, while awareness of reproductive organ functions increased from 9.6% to 16.5%. The recognition that reproductive health encompasses multiple aspects rose significantly from 13.9% to 36.5% (Başar et al., 2021). This suggests that while some foundational concepts may not have been effectively communicated, there is potential for growth in comprehensive understanding when educational strategies are employed.

Previous research supports the notion that targeted reproductive health education can significantly enhance knowledge. For instance, a quasi-experimental study found that adolescents who received structured reproductive health education demonstrated higher knowledge levels than those who did not (Mishra & Levitt-Dayal, 2003). This reinforces the need for comprehensive curricula addressing various reproductive health dimensions.

The intervention led to a positive shift in awareness regarding the ideal marriage age, with correct identification for girls increasing from 57.4% to 65.2% and for boys from 95.7%

to 96.5% (Salam et al., 2016). This finding aligns with other studies indicating that educational interventions can influence attitudes toward marriage and family planning among adolescents, fostering a more informed perspective on age-appropriate marriage (Titiloye & Ajuwon, 2017).

Improvements were also noted in knowledge about delivery locations, with government hospital identification rising from 52.4% to 59.1% and private hospital preference increasing from 19.1% to 27.8%. The significant decrease in home delivery preference (from 11.3% to 1.7%) highlights a shift toward recognizing institutional healthcare as a safer option for childbirth (Prajapati et al., 2024). This trend is consistent with findings from other studies advocating for increased awareness of healthcare facilities among adolescents to improve maternal and child health outcomes (Vincent & Krishnakumar, 2022).

The intervention resulted in notable improvements in contraceptive knowledge, with awareness of female sterilization increasing from 16.5% to 30.7% and knowledge of contraceptive pills rising from 45.2% to 59.6% (Başar et al., 2021). The increase in exposure to condoms from a concerning 52.2% having never seen one to complete awareness post-intervention demonstrates the effectiveness of educational outreach in promoting contraceptive use (Mishra & Levitt-Dayal, 2003). Comprehensive sexual education has been shown to enhance contraceptive knowledge and reduce risky behaviors among adolescents, underscoring the necessity of such programs (Salam et al., 2016).

Significant advancements were observed in abortion knowledge, with correct identification rising from 18.3% to 37.4%. Awareness of its legal status also improved markedly, suggesting that education can play a crucial role in dispelling myths surrounding abortion (Prajapati et al., 2024). Similarly, STI awareness surged from 34.8% to 75.7%, with substantial increases in knowledge about specific STIs and their transmission routes (Vincent & Krishnakumar, 2022). These findings echo previous research indicating that effective sexual health education can lead to improved understanding and attitudes toward STIs among adolescents (Titiloye & Ajuwon, 2017).

The intervention positively impacted respondents' understanding of menstruation, with recognition as a physiological process increasing from 87% to 93%. Misconceptions about menstrual blood sources were also corrected significantly, indicating effective educational strategies (Başar et al., 2021). Studies have shown that comprehensive menstrual health education reduces stigma and improves adolescent hygiene practices (Mishra & Levitt-Dayal, 2003).

The overall improvement in respondents' knowledge was statistically significant, with pretest mean scores rising from 8.188.18 (SD = 2.472.47) to 10.9110.91 (SD = 2.782.78), confirming the effectiveness of the intervention at the 1%1% significance level (Salam et al., 2016). This aligns with other studies demonstrating that structured educational programs can increase adolescent knowledge retention.

5. Conclusion

The intervention was found to effectively enhance the respondents' knowledge across various aspects of reproductive health, highlighting its critical role in educating adolescents about essential health issues. While some areas showed improvement, persistent misconceptions on some aspects indicate the need for continued educational efforts and

targeted interventions to foster comprehensive understanding and behavioral change in reproductive health practices among young people. Future initiatives should aim for holistic approaches that address both knowledge gaps and cultural barriers adolescents face in accessing reproductive health information and services. Students are usually not taught properly in the classes regarding SRH in Nepal. This one-shot intervention was also highly effective in this regard, showing a need for continued intrusion for positive behavior change among adolescent students.

SRHR knowledge needs to expand among more schools and reach all adolescents, increasing schools to make informed decisions about SRHR. The programs should focus on reinforcing accurate information, addressing specific misconceptions, and employing strategies to improve long-term knowledge retention in school and out of school. Efforts need to be made to give adolescents access to information and knowledge of contraceptives, prevent unintended pregnancies, and prevent the infection of STIs, as well as abortion and sexual and reproductive rights. This includes providing practical demonstrations and dispelling myths surrounding contraceptive use. Future studies can be focused on evaluating the sustainability of the knowledge gained from the intervention, incorporating follow-up studies at multiple time points. Also, these studies can explore the impact of integrating culturally tailored SRH education programs that address local norms and beliefs.

6. Declaration

Conflicts of Interest

None.

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None.

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