ISSN: 2091-2889 (online)
2091-2412 (print)

Received: 12 Oct 2025
Accepted: 21 Jan 2026
Published: 28 Feb 2026

DOI: 10.54530/jcmc.1830

OPEN ACCESS

Knowledge and attitude regarding reproductive health and sex education among school teachers of Dhading, Nepal

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Peer reviewed

Abstract

Introduction: Reproductive health and sex education (RHSE) is essential for adolescent development. Teachers are key facilitators, yet their preparedness in Nepal is understudied. This study assessed the knowledge and attitude regarding RHSE among school teachers in Dhading, Nepal.

Method: A cross-sectional study was conducted from Feb to Apr 2023 among teachers from six secondary schools in Benighat Rorang Rural Municipality, Dhading, Nepal. Ethical approval was obtained. A census method was used. Data were collected via a pretested, structured, self-administered questionnaire. Knowledge and attitude scores were categorized using Bloom's and Boom's cut-off points, respectively. Descriptive statistics, chi-square tests, and Spearman's correlation were used for analysis in IBM SPSS version 21, with a significance level of $p \leq 0.05$.

Result: Among 104 teachers, the mean age was 34.98±10.37 years. More than half had an average level of knowledge (54.8%, n=57), and the majority showed a neutral attitude (64.4%, n=67). A significant association was found between sex and knowledge level (p=0.020), with a higher proportion of males having good knowledge. A weak positive correlation between knowledge and attitude was observed (r=0.015, p=0.82).

Conclusion: The study indicates that selected teachers in Dhading possess average knowledge and a neutral attitude toward RHSE. Knowledge is associated with sex, and improved knowledge may foster a more positive attitude. Mandatory, culturally sensitive training programs are recommended to enhance teachers' capacity to deliver effective RHSE.

How to cite

Tuladhar JB, Barakoti Y, Sakha R, Khanal A, Khanal P. Knowledge and attitude regarding reproductive health and sex education among school. Journal of Chitwan Medical College. 2026;16(57):59-72.

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Introduction

Sex education is a lifelong process encompassing learning about puberty, sexual behaviour, reproductive health, interpersonal relationships, and gender roles.[1,2] It aims to promote healthy relationships, reduce risks such as unintended pregnancies and sexually transmitted infections (STIs), and empower young people to make informed decisions.[1]

In Nepal, adolescence is marked by limited access to accurate sexual health information due to socio-cultural taboos. Risky sexual behaviours among adolescents can lead to severe consequences, including early pregnancy, unsafe abortion, and STIs, contributing to long-term health and socioeconomic challenges.[3] Teachers are pivotal in bridging this information gap and shaping positive attitudes among students.[4,5]

However, the effectiveness of teachers depends largely on their own knowledge and attitudes toward reproductive health and sex education (RHSE). In rural areas like Dhading, where resources and training are often scarce, assessing these factors is crucial. This study aimed to assess the knowledge and attitude regarding RHSE among school teachers in Dhading district, Nepal.

In Nepal, particularly in rural areas like Dhading, there is limited research on teachers' preparedness to deliver sex education. This study was conducted to fill this gap and assess the knowledge and attitude regarding reproductive health and sex education among school teachers in Dhading district, Nepal.

Method

A cross-sectional descriptive study was conducted to assess the knowledge and attitude regarding reproductive and sex education among teachers from six government and private schools of ward no. 3, Benighat Rorang Rural Municipality, Dhading district, Nepal. A non-probability purposive sampling technique was used to select schools, and census method was applied to include all teachers from these schools, yielding a sample of 104 participants.

Ethical approval was obtained from the Institutional Review Committee of Kathmandu Medical College Public Limited (Ref: 2312202201). Written informed consent was obtained from all respondents prior to data collection. Data were collected between Feb to Apr 2023 using a structured, self-administered questionnaire. The tool was pretested among 10% of the total sample to ensure clarity, adequacy, and feasibility. Reliability was established with a Cronbach's alpha of 0.72. The questionnaire was prepared in English and translated into Nepali before administration.

The instrument consisted of three parts:

Part I: Socio-demographic information (age, sex, marital status, religion, ethnicity, education level, subject group, teaching experience, training, years of teaching, and sources of information on reproductive health and sex education).

Part II: Knowledge-related questions covering anatomy and physiology, pubertal changes, marriage, pregnancy, family planning, childbirth, abortion, STIs, and sexual health. Each correct response was scored as "1", and incorrect as "0". Knowledge levels were categorized based on Bloom's Cut-off: >80%=good, 60–79%=average, and <60%=poor.[6]

Part III: Attitude-related questions measured on a 5-point Likert scale (1=strongly disagree to 5=strongly agree), with reverse scoring applied where necessary. Attitude was classified as >80%=positive attitude, 60–79%=neutral, and <60%=negative, according to Boom's criteria.[6]

Data were checked daily for completeness, entered, coded, and analysed using SPSS version 21. Descriptive statistics (frequency, percentage, mean, standard deviation and Spearman correlation) and inferential statistics (chi-square test) were used. A 5% significance level ($p \leq 0.05$) and 95% confidence interval were considered for statistical tests.

Result

The study found majority (69.2%) were in the age group of 19–39 years, with a mean age of 34.98±10.37 years. Slightly more than half were female (51.9%), while 48.1% were male. Most of the respondents were married (76.9%), and the predominant religion was Hinduism (94.2%). By ethnicity, 65.4% were Brahmin, followed by Janajati (22.1%), Chettri (11.5%), and Madhesi (1%). Regarding educational qualification, 43.3% had completed a Master's degree, 33.7% a Bachelor's degree, 22.1% higher secondary level, and one respondent (1%) had completed a PhD, Table 1.

We found that respondents taught a range of subjects including English, Nepali, Mathematics, Science, Health and Physical Education, Social Studies, Accountancy, Economics, and Computer Science. The highest proportion taught Nepali (22.1%), while the lowest taught Computer Science (1.9%).

More than half of the respondents (57.7%) had less than 10 years of teaching experience, whereas 42.3% had more than 10 years. School-level textbooks were reported as the main source of knowledge on sex education (70.2%), followed by the internet and other books (9.6%).

A large majority (89.4%) had not received any formal training on sex education, and only 10.6% reported attending training. Similarly, most respondents (78.8%) had no prior experience teaching sex education, while 21.2% had such experience, Table 2.

Table 1. Socio-demographic variables of school teachers, n=104

Variables	Categories	n(%)
Age (years)	19–39	72(69.2)
	40–60	32(30.8)
Sex	Male	50(48.1)
	Female	54(51.9)
Marital status	Married	80(76.9)
	Unmarried	24(23.1)
Religion	Hindu	98(94.2)
	Buddhist	4(3.8)
	Muslim	2(1.9)
Ethnicity	Brahmin	68(65.4)
	Chettri	12(11.5)
	Janajati	23(22.1)
	Madhesi	1(1.0)
Education	Higher Secondary	23(22.1)
	Bachelor’s Degree	35(33.7)
	Master’s Degree	45(43.3)
	PhD	1(1.0)

We found that more than half of the teachers (54.8%) demonstrated an average level of knowledge, 40.4% had good level of knowledge, and only 4.8% had poor knowledge, Table 3.

The majority of respondents (64.4%) demonstrated a neutral attitude, 34.6% had a positive attitude, while only 1% expressed a negative attitude, Table 4.

A statistically significant association was observed ($p<0.05$), male teachers were more likely to have good and average level of knowledge, while greater proportion of female

teachers demonstrated an average level of knowledge, Table 5.

We found there was no statistically significant association between teachers' level of attitude and any of the sociodemographic or professional variables, including age, sex, marital status, religion, ethnicity, educational status, years of teaching, teaching experience, source of knowledge, and training on sex education. For all variables, the p-value was greater than 0.05, Table 6.

We found a weak but statistically significant positive correlation between knowledge and attitude scores (Spearman's rho=0.015, p=0.82), indicating that an increase in knowledge level was associated with a corresponding improvement in attitude towards reproductive health and sex education.

Table 2. Teaching-related characteristics of school teachers, n=104

Variables	Categories	n(%)
Teaching subject	English	21(20.2)
	Nepali	23(22.1)
	Mathematics	18(17.3)
	Science	16(15.4)
	Social Studies	15(14.4)
	Accountancy/Economics	9(8.6)
	Computer Science	2(1.9)
Years of teaching	<10 years	60(57.7)
	≥10 years	44(42.3)
Source of knowledge on sex education	Television	9(8.7)
	School-level textbooks	73(70.2)
	Internet	10(9.6)
	Other books	10(9.6)
	Other personnel	2(1.9)
Training on sex education	Yes	11(10.6)
	No	93(89.4)
Experience on teaching sex education	Yes	22(21.2)
	No	82(78.8)

Table 3. Level of knowledge regarding reproductive health and sex education, n=104

Level of Knowledge	n(%)
Mean±SD 75.88±9.22	
Good (>80%)	42(40.4)
Average (60–79%)	57(54.8)
Poor (<60%)	5(4.8)

Table 4. Level of attitude regarding reproductive health and sex education, n=104

Level of Attitude	n(%)
Mean±S 77.32±8.32	
Positive (>80%)	36(34.6)
Neutral (60–79%)	67(64.4)
Negative (<60%)	1(1.0)

Table 5. Association between level of knowledge and independent variables, n=104

Variables		Good	Average	Poor	p-value
Age (years)	19–39	29(40.3)	39(54.2)	4(5.6)	1.000
	40–60	13(40.6)	18(56.3)	1(3.1)	
Sex	Male	25(50.0)	25(50.0)	0	0.020
	Female	17(31.5)	32(59.3)	5(9.3)	
Marital Status	Married	30(37.5)	47(58.8)	3(3.8)	0.230
	Unmarried	12(50.0)	10(41.7)	2(8.3)	
Religion	Hindu	39(39.8)	55(56.1)	4(4.1)	0.240
	Others	3(50.0)	2(33.3)	1(16.7)	
Ethnicity	Brahmin	25(36.8)	39(57.4)	4(5.9)	0.600
	Others	17(47.2)	18(50.0)	1(2.8)	
Education	≤Bachelor's	21(36.2)	32(55.2)	5(8.6)	0.100
	>Bachelor's	21(45.7)	25(54.3)	0	
Teaching experience on sex education	Yes	12(54.5)	10(45.5)	0	0.230
	No	30(36.6)	47(57.3)	5(6.1)	
Training on sex education	Yes	4(36.4)	7(63.6)	0	0.860
	No	38(40.9)	50(53.8)	5(5.4)	

Table 6. Association between level of attitude and independent variables, n=104

Variables		Positive	Neutral	Negative	p-value
Age (years)	19–39	21(29.2)	50(69.4)	1(1.4)	0.160
	40–60	15(46.9)	17(53.1)	0	
Sex	Male	18(36.0)	32(64.0)	0	0.910
	Female	18(33.3)	35(64.8)	1(1.9)	
Marital Status	Married	27(33.8)	52(65.0)	1(1.3)	0.850
	Unmarried	9(37.5)	15(62.5)	0	
Religion	Hindu	34(34.7)	63(64.3)	1(1.0)	1.000
	Others	4(66.7)	4(66.7)	0	
Ethnicity	Brahmin	23(33.8)	45(66.2)	0	0.410
	Others	13(36.1)	22(61.1)	1(2.8)	
Education	≤Bachelor's	21(36.2)	36(62.1)	1(1.7)	0.820
	>Bachelor's	15(32.6)	31(67.4)	0	
Teaching experience on sex education	Yes	6(27.3)	16(72.7)	0	0.570
	No	30(36.6)	51(62.2)	1(1.2)	
Training on sex education	Yes	4(36.4)	7(63.6)	0	1.000
	No	32(34.4)	60(64.5)	1(1.1)	

Discussion

In the present study, more than half of the teachers (54.8%) demonstrated an average level of knowledge regarding reproductive health and sex education. The finding contrasts with the study conducted in Haryana, where the majority (62.9%) of teachers had average knowledge.[7] Similarly, a study from Nigeria reported that only 23.0% teachers possessed adequate knowledge regarding sex education, whereas another Nigerian study revealed that 64.53% of teachers had a high level of knowledge.[1,5] In Sri Lanka, 73.34% of teachers were found to have good knowledge of sex education.[8] Differences in findings across studies may be attributed to factors such as teacher's sex, prior training, and experience related to reproductive health and sex education.

In the present study 64.4% of teachers expressed a neutral attitude whereas 34.6% had positive attitude and only 1% showed negative attitude towards reproductive health and sex education. These findings contradict a study

conducted in India, where majority of teachers (71.4%) demonstrated a moderately favourable attitude.[7] Similarly, a study from Nigeria reported a much higher proportion (86.9%) of teachers with a positive attitude.[9] Consistently, another study documented a generally positive attitude among secondary school teachers towards the teaching of sex education.[10]

Another study reported a positive attitude among 38.39% teachers, which is comparable to the findings of the present study.[8] In contrast, a study from India revealed that more than half of the teachers (52%) had a high attitude towards sex education, while 48% had a low attitude.[11] Similarly, other studies have also highlighted a positive attitude among teachers towards teaching sex education in schools.[12] A study conducted by Maria Hellen and colleagues further confirmed the presence of a favourable attitude among teachers toward sex education.[13]

A study conducted by Bibina and colleagues reported that the majority of the instructors (58%) had negative attitude towards sex education which contrasts with the present study where only 1% of teachers demonstrated a negative attitude.[14] Similarly, a study from India revealed that many teachers avoided discussions about sexuality, with only 10% reporting that they had ever discussed the topic with their students.[4] This finding also stands in contrast to the results of the current study.

In the present study, the majority of respondents (69.2%) were in the age group of 19–39 years, with a mean age of 34.98±10.37 years. This finding is comparable to a study conducted in Nigeria where the respondents' ages ranged from 25–60 years, with a mean of 38.17 years.[5] No significant association was found between age and level of knowledge (p=1.00), which is consistent with the findings of a study conducted in Portugal that also reported no significant association (p>0.05).[13]

With respect to sex, 51.9% of respondents were female, similar to the study in Nigerian Secondary school where 53% were female. A significant association was observed between sex and level of knowledge (p=0.020), which aligns with findings from a Nigerian study (p=0.04).[12] Moreover, a study conducted in Enugu reported that male teachers had better knowledge than female counterparts.[1]

In this study 76.9% respondents were married which is comparable to a study conducted in Nigeria where 64.7% were married.[12] No significant association was found between marital status and level of knowledge (p=0.23), which is consistent with the study from Enugu (p=0.25).[1] Similarly, no significant association was observed between level of knowledge and religion (p=0.238) and ethnicity (p=0.60). To the best of our knowledge, no previous studies have specifically examined the association between religion, ethnicity, and level of knowledge.

Furthermore, no significant association was found between educational status and level of knowledge (p=0.10), which is consistent with the findings of a study conducted in Enugu (p=0.11).[1]

In this study 89.4% of respondents had not attended any training program, and no significant association was found between training and level of knowledge. In fact, many respondents without training demonstrated average or moderate level of knowledge. This contrasts with the study conducted in Portugal, where 77.6% of respondents had not received training but still showed good perception on sex education. Similarly, no significant association was observed between teaching experience in sex education and level of knowledge (p=0.23); even respondents without such experience demonstrated moderate knowledge level.[15]

In this study, no significant association was found between age and attitude (p=0.16) which is consistent with the study conducted in Enugu, where younger respondents tended to have more positive attitude compared to older age group.[1] Similarly, sex was not significantly associated with attitude (p=0.91), indicating that male and female respondents had comparable attitudes towards reproductive health and sex education. This finding aligns with a study in Nigeria, but contrasts with the

studies from Ludhiana, Punjab (p=0.01), Portugal (p=0.006), and India which reported significant gender difference in attitude, with male or female showing more favourable attitudes depending on the context.[3,5,12,16]

No significant association was observed between marital status and attitude (p=0.85), as more unmarried respondents demonstrated a neutral attitude compared to married respondents. This contrasts with findings from Nigeria, where married individuals tended to have a more positive attitude and were better positioned to provide sex education.[17] Similarly, training related to sex education was not significantly associated with attitude (p=1.00); respondents without training generally exhibited a neutral attitude. This is in contrast to the study among Portuguese teachers, which found a significant positive association between training and attitude (p=0.005).[5]

Furthermore, teaching experience in sex education was not significantly associated with attitude (p=0.57), as respondents without such experience still demonstrated neutral or moderate attitudes, which is in contrast to the study conducted in Portuguese teachers that revealed significant association between teaching experience and attitude (p=0.00) which showed those with previous experience showed more positive attitude.[15]

Finally, a statistically weak but positive correlation was observed between knowledge and attitude (r=0.015), suggesting higher knowledge levels were associated with slightly more positive attitudes. This finding contrasts with the study by Aakanksha and colleagues, which reported a mild negative but non-significant correlation (r=-0.21, p=0.862), but aligns with another study that found a significant positive correlation (r=0.30, n=163, p<0.0001) between knowledge and attitude towards sex education.[7,13]

The study has some limitations that should be considered when interpreting the findings. The cross-sectional design limits the ability to establish causal relationships. The study was conducted in one rural municipality of Dhading district, which may affect the generalizability of results to other settings. Self-reported data may be subject to social desirability bias, particularly for attitude-related questions. Additionally, the purposive sampling of schools may limit the representativeness of the sample. Despite these limitations, the study provides insights into the current state of teacher preparedness for reproductive health and sex education in rural Nepal.

Conclusion

This study concludes that school teachers in Benighat Rorang, Dhading, possess average knowledge and a neutral attitude regarding reproductive health and sex education. Knowledge was linked to the teacher's sex, the attitude remained uninfluenced by common socio-demographic or professional factors. A weak, positive link between knowledge and attitude suggests a pathway for intervention and training by educational authorities and policymakers for empowering teachers.

Author contribution

Concept design: JBT, YB; Literature search JBT, YB; Data collection: YB; Data analysis: JBT, YB; Draft manuscript: JBT, YB; Final manuscript and accountability: All

Acknowledgement

The author sincerely thanks the participating schools and all the teachers for their valuable cooperation and support during data collection.

Conflict of Interest

None

Funding

None

Supplementary material

The data and supplementary material that support the findings of this study are available

from the corresponding author upon reasonable request.

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Tools/Questionnaire

Part I (Socio-demographic questionnaire)

For each item, circle the option that best represents your view.

1. Age ……
2. Sex …….
3. Marital status

a. Married
b. Divorced
c. Widow
d. Unmarried

4. Religion

a. Hindu
b. Buddhism
c. Christian
d. Muslim
e. If others, specify ……

5. Ethnicity

a. Brahmin
b. Chhetri
c. Janajati
d. Dalit
e. Madhesi
f. If others, specify ……

6. Level of education

a. Secondary level (+2 level)
b. Bachelor level
c. Master degree
d. PhD

7. Teaching subject ……
8. Years of teaching ……
9. What is the source of knowledge of sex education?

a. Television
b. Internet
c. Books and magazines
d. School level books
e. Other personnel

10. Any training regarding sex education?

a. Yes
b. No

11. Experience of teaching regarding sex education?

a. Yes
b. No

Part II – Knowledge related questionnaire
For each item, circle the option that best represents your view and fill the blank space.

Reproductive system related questions:

1. What do you understand by reproductive health?
   a. Social health
   b. Psychological and emotional health
   c. Physical health
   d. All of above

2. How many components are there in reproductive health? (More than one answer)
   a. Safe motherhood
   b. Family planning
   c. Child health
   d. Prevention and management of complications of abortion
   e. STI/HIV/AIDS
   f. Prevention and management of sub fertility
   g. Adolescence reproductive health
   h. Problems of elderly women
   i. Gender based violence

3. Which of the following are the parts of female reproductive organs? (More than one answer)
   a. Cervix
   b. Uterus
   c. Urethra
   d. Scrotum
   e. Vagina
   f. Prostate
   g. Ovaries
   h. Testes

4. Which of the following are the parts of male reproductive organs? (More than one answer)
   a. Ovaries
   b. Uterus
   c. Urethra
   d. Scrotum
   e. Vagina
   f. Prostate
   g. Testes

Puberty related questions:

5. According to WHO, period of adolescence is:
   a. 12-19 years
   b. 10-19 years
   c. 12-16 years
   d. 10-16 years

6. What is the cause of pubertal change in adolescence?
   a. Hormonal change
   b. Mental problem
   c. Physical illness
   d. Don't know

7. What pubertal changes occur in male adolescents? (More than one answer)
   a. Change in voice
   b. Growth of sex organs
   c. Ejaculation
   d. Increase in height and weight
   e. Increase in hip size

8. What pubertal changes occur in female adolescents? (More than one answer)
   a. Onset of menstruation
   b. Pubic and axillary hair growth
   c. Breast enlargement
   d. Nocturnal emission

9. What is the first sign of puberty in females?
   a. Increase in height and weight
   b. Breast enlargement
   c. Acne
   d. Onset of menstruation

10. What is the first sign of puberty in male?
   a. Increase in height and weight
   b. Acne
   c. Axillary hair growth
   d. Enlargement of scrotum and testes

11. Generally, menstruation in girls start at the age of?
   a. 12 years
   b. 15 years
   c. 18 years
   d. 10 years

Marriage, child birth, family planning and abortion related questions:

12. What is the eligible age of marriage for boys and girls according to the law of Nepal?
   a. 18 years
   b. 20 years
   c. 22 years
   d. 24 years

13. Pregnancy at a lower age can be the risk for?
   a. Health of baby only
   b. Health of mother only
   c. Health of both mother and baby
   d. No one

14. What is the appropriate age of childbirth?
   a. Below 20 years
   b. 20-25 years
   c. 25-30 years
   d. Above 30 years

15. Who is responsible for determination of child' sex?
    a. Male
    b. Female
    c. Both male and female
    d. Don't know

16. Which of the following are natural methods of contraception? (More than one answer)
    a. Vasectomy
    b. Abstinence
    c. Intrauterine device
    d. Condom
    e. Withdrawal or pulling out method

17. The contraceptive method that can prevent both pregnancy and STIs?
    a. Norplant
    b. Copper-T
    c. Pills
    d. Condom

18. Which among the following is not a long acting reversible contraceptive (LARC) ?
    a. Intrauterine device
    b. Norplant
    c. Pills
    d. Depo-Provera

19. Safe abortion means termination of pregnancy by trained health care provider without risk of women's health.
    a. Yes
    b. No
    c. Don't know

20. Legalized abortion is done up to?
    a. 12 weeks
    b. 18 weeks
    c. 20 weeks
    d. 22 weeks

STIs related questions:

21. What do you understand by Sexually Transmitted Infections (STIs)?
    a. It is a simple disease that doesn't need to be treated
    b. Infection transmitted from one infected person to another through sexual contact
    c. Disease caused due to improper hygiene of external genital organs
    d. Infection due to poor lifestyle

22. Which of the following are the signs and symptoms of STIs? (More than one answer)
    a. Foul smelling vaginal discharge
    b. Swelling of genitalia
    c. Cough and cold
    d. Painful sexual intercourse
    e. Blister/ulceration around genitalia
    f. Cramping legs and hands

23. How STIs can be prevented? (More than one answer)
    a. Having single sex partner
    b. Abstaining from sexual activity
    c. Having sexual relationship with same sex
    d. Using condom

Sexual health related questions:

24. What do you understand by sex education?
    a. Education provided to have early safe sex
    b. Basic education about reproductive and sexual health, sexuality and life skills
    c. Knowledge necessary for only married person
    d. Something that shouldn't be taught and is learned from social life

25. Noctural ejaculation in male adolescence is?
    a. Normal
    b. Abnormal
    c. Don't know

26. Which of the following statement is correct?
    a. Only boys do masturbation
    b. Masturbation cause infertility
    c. Masturbation decreases visual capacity
    d. Masturbation is natural process

27. Safe sexual behaviour includes? (more than one answer)
    a. Abstinence
    b. Masturbation
    c. Use of condom
    d. Sexual relationship with multiple partners

28. Which of the following is appropriate for sexuality?
    a. Marrying at appropriate age
    b. Using condom
    c. Abstinence
    d. Masturbation

29. Is it important to provide sex education to students?
    a. Yes
    b. No

30. When is the right age to start providing sex education to student?
    a. 10 years
    b. 15 years
    c. 18 years
    d. 21 years

31. Which of the following is not the element of sex education?
    a. Sexual rights
    b. Sexual variety
    c. Sex behaviour
    d. Sexual violence

32. Which of the following indicates the importance of sex education?
    a. Encouraging teenagers for safe sexual behaviour
    b. Treating STIs
    c. Teaching sexual intercourse livelihood skill
    d. Teaching sexual behaviour to children since young age

33. Who is appropriate person for teaching sex education?
    a. Parents
    b. Teacher

c. Health personnel
d. None

Part III (Attitude related questionnaire)

Following statements concerned with how you feel and think about the sex education. Depending upon your feelings and thinking related to each of the following items, mark on the space provided in each option whether you 'strongly disagree', 'disagree', 'neutral', 'agree' or 'strongly agree'.

S.N	Statements	Strongly disagree	disagree	Neutral	Agree	Strongly agree
1.	Sex education at school is very important to children and adolescents.					
2.	Most appropriate place to provide sex education is school.					
3.	Sex education is equally necessary for both boys and girls.					
4.	Sex education should be provided by same sex teacher.					
5.	Sex education should be provided by science teacher only.					
6.	Sex education shouldn't be taught at school.					
7.	It can be learnt through internet and other social sites.					
8.	Sex education should be provided by parents not teachers.					
9.	Providing sex education to school students encourages early sexual behaviour.					
10.	Adequate knowledge and training about sex education are necessary for teachers before educating students about it.					
11.	Irresponsible sexual activities, teenage pregnancy, various STIs can be minimized through proper sex education.					
12.	Narrow thinking towards sexuality can be imparted through proper sex education in school.					
13.	A well informed student can motivate the opponent of sex education with the help of logical arguments.					
14.	School teacher has an efficient role in providing sex education.					
15.	Proper sex education benefits an individual, family and society.					