

Breaking the Silence: Sexual Behavior among Secondary Level Students of Banke**Lal Mani Acharya^{1*}**DOI: <https://doi.org/10.3126/academia.v5i2.97485>¹Department of Health, Mahendra Multiple Campus, Nepalgunj (Tribhuvan University, Nepal)*Corresponding Author: Email: lalmaniacharya@gmail.com ORCID: <https://orcid.org/0009-0000-2155-8765>

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ABSTRACT

Adolescence is one of the most important stages in physical, emotional and sexual development. Despite the potential risks of early sexual initiation, unintended pregnancies and sexually transmitted infections (STIs) faced by rural secondary school students in Nepal, limited research is available on the knowledge, attitudes, and practices (KAP) of the young people within this age group. This descriptive quantitative study was conducted to examine the KAP about sexual behavior among the 182 (109 males and 73 females) Government Secondary School students of Grade 9-12 of Baijanath Rural Municipality, Banke District, selected by convenience sampling method. Structured and pretested questionnaire was used to collect data and descriptive statistics were used to analyse it. Almost all respondents (97.8%) knew about SRH, with the primary source of information being teachers and schools (91.76%). Students expressed high knowledge on menstruation and pregnancy (98.9% correct) and the STIs (88.46% identified gonorrhoea, syphilis and HIV/AIDS). The overall attitude was positive on the issues of menstruation hygiene, delayed marriage, delayed sexual initiation, and early SRH education (59.89%). The attitudes towards masturbation and pre-marital sexuality were a blend of science and sociocultural perspectives. With respect to practices, 60.99% had experienced a romantic relationship, while 34.07% had engaged in pre-marital sex. Among sexually experienced respondents, 45.24% used no contraception at first intercourse, while 54.76% used protection (mainly condoms). To encourage safer sexual practices amongst rural Nepal adolescents, comprehensive sexuality education, increasing adolescent friendly SRH services, and correcting sociocultural misconceptions are critical.

Keywords: Adolescents, knowledge–attitude–practice, secondary school students, sexual and reproductive health

INTRODUCTION

Sexuality is a natural aspect of human growth that involves biological, psychological, social and cultural dimensions. In the adolescent age range (10-19 years), according to the World Health Organization (WHO, 2011), people undergo significant physical development, sexual arousal, and the development of intimate relationships. These developmental changes come at a time when there is increased susceptibility to sexual and reproductive

health risks such as early onset of sexual activity, unplanned pregnancy, sexually transmitted infections (STIs) and HIV infection. Adolescents globally have the highest proportion, making up a significant proportion of new HIV infections and maternal morbidity, highlighting the critical need to implement evidence-based interventions designed to support them (WHO, 2022; UNICEF, 2021). Sexuality involves more than just physical desires, it involves social scripts, emotional connections, and cultural

significance of desire, intimacy, and reproduction. As young people begin to develop sexually, the developmental tasks of adolescence (identity development, seeking autonomy, and establishing peer and romantic relationships) can either facilitate healthy developmental paths or put young people at risk of avoidable harm.

Adolescent SRH is more important in the context of public health in Nepal, due to its demographic profile. A large portion of the population is under 25, and youth live in rural areas where access to youth-friendly health services is limited, as well as where norms around sexuality are restrictive and school-based sexuality education is not well implemented (Ministry of Health and Population [MoHP] et al., 2023). However, national survey data show there is a considerable age range in the age at first sexual activity, with the median age at first sexual intercourse being 18.3 years for females aged 25-49, and 20.7 years for males aged 25-49, with a significant proportion beginning before age 15 (MoHP, et al., 2023). Teenage pregnancy rates are still high in some provinces (21% in Karnali Province) and are closely linked to lower levels of education and household wealth. Especially for girls in rural areas, the context in which they live can create a double burden of traditional norms that do not support open conversation about sexuality and heightened exposure to globalized media and peer networks that could expose them to incomplete or inaccurate information about sexual development. This creates a knowledge void, and many youths have to learn by seeing or hearing what others do in order to get the information they need.

Although there are policy changes over time such as the National Adolescent Health and Development Strategy and efforts to include comprehensive sexuality education in the school curriculum, there is limited empirical data on actual knowledge, attitudes and practices of rural secondary school students. Previous research has tended to focus on urban or peri-urban communities, college students, or high-risk sub-groups, thereby neglecting to gain an understanding of adolescents studying in government secondary schools located in the districts of Banke. This is especially significant as rural youth may face multiple challenges including: limited communication with parents regarding sexuality, sociocultural barriers to sexual education, geographic barriers to health services, and limited focus on relational, rights-based and decision-making skills in

sexuality education curricula. Comprehensive sexuality education implementation is still not uniform among provinces and type of school. Issues of teacher discomfort, limited training resources, and lingering community opposition continue to limit comprehensive and effective classroom instruction in topics of concern, including consent, contraception, and various sexual orientations and gender identities.

In light of this, the present study aimed to fill this gap by systematically studying the knowledge, attitudes, and practices with regard to sexual behavior among Grade 9-12 students in relation to Baijanath Rural Municipality, Banke District. It seeks to provide descriptive evidence that is relevant to the context to support the design of more responsive school-based SRH programmes, inform local government planning and add to the wider body of literature on adolescent sexuality in South Asia.

In Nepal, though, there has been high awareness among young people about the need for HIV and condoms, but consistently lower rates of consistent condom use, especially with non-regular partners (Upreti et al., 2009). The same gaps between knowledge and practice have been noted throughout South Asia (UNFPA, 2021). But only a few studies have been conducted that combined the measurement of domains of knowledge, orientations and behavior within the same group of secondary school students in rural areas. If this information is not integrated, program designers don't have the detail they need to prioritize content areas and target subgroups and to measure progress.

The general objective of the study was to determine the knowledge, attitudes, and practices regarding sexual behavior among secondary school students in Baijanath Rural Municipality, Banke District. Specific objectives were:

1. To assess the knowledge of sexual behaviour and reproductive health among grade 9-12 learners.
2. To examine students' attitudes toward key aspects of sexual behavior, including menstrual hygiene, masturbation, premarital sex, ideal age of marriage and sexual initiation, and the appropriate educational level for SRH instruction.
3. To describe sexual practices of secondary school students such as romantic relationships, sexual debut, characteristics of sexual partners and use of contraceptives during first sexual intercourse.

REVIEW OF LITERATURE

Globally, about 1.2 billion young people between 10 and 19 years old are classified as adolescents, and almost half of all new HIV cases are among people aged 15-24 (UNFPA, 2021; WHO, 2022). UNICEF (2021), WHO (2022) estimates that 12 million girls aged 15-19 become mothers each year. Evaluated sexuality education programs have demonstrated to reduce sexual risk behaviors by 10-50% and increase contraceptive use by up to 60% (UNESCO, 2021). Every year, in the Asia-Pacific region, 2.1–2.3 million adolescent girls (15–19 years) get pregnant, with over 50% of those pregnancies being unintended (UNFPA, 2021). Adolescent HIV infection rates and maternal morbidity are not a mere population phenomenon, but are a reflection of underlying structural inequities in access to education, services and protective social norms. Research on outcomes of comprehensive sexuality education in various settings has shown that effective programs can postpone the first time that students are sexually active, boost condom and contraceptive use, and decrease unintended pregnancies and the spread of STIs. The world evidence base thus not only identifies the scale of the issue, but also confirms that educational interventions are effective if they are delivered in a faithful and intensive manner.

According to national statistics from the Nepal Demographic and Health Survey (MoHP et al., 2023) 80% of women and 96% of men aged 15–49 have heard of HIV/AIDS. 65% of women and 88% of men youth (15-24) feel that using a condom consistently decreases risk of HIV infection. The average age for women to marry is 18.3 years and for men 22.3 years. There are 14% of adolescent girls aged 15-19 who are pregnant. The findings of a systematic review indicate that there is generally a high level of knowledge about STIs, HIV and condoms amongst Nepali youth, but condom use with non-regular partners is still inadequate (Upreti et al., 2009). The data also highlights the need for context-specific data, with provincial differences in teenage pregnancy and contraceptive use. Located in the western Terai region, Banke District faces several of the same structural issues as other rural districts – limited access to specialized adolescent health services, seasonal migration affecting school attendance and access to services, and social and cultural norms that limit open discussions about sexuality – and has relatively greater road access

compared to more remote hill and mountain districts. Given this context, it is important to understand the KAP patterns in this context not only for designing local programs but also for the comparative literature of adolescent SRH in the Nepali Terai.

The body of work to date has been mostly sampling urban or college populations. There is still limited research on rural secondary school students. Very rarely, has there been an investigation which has captured multidimensional knowledge and nuanced attitudes and concrete behavioral indicators simultaneously. The present study was proposed and planned to overcome these deficiencies using primary data in a rural municipality of Banke District. The lack of attention given to the secondary school students in rural areas is particularly concerning since secondary school students make up a large proportion of the adolescent population in Nepal and because rural areas are likely to have fewer alternatives for reliable and accurate information about SRH. Research conducted with rural samples often combines them with urban samples, masking patterns. The findings of the present investigation, therefore, not only add to the substantive findings but also add to the methodological demonstration of the fact that sensitive data can be collected ethically and efficiently in rural government schools.

METHOD

Research design

A descriptive quantitative survey design was employed. The design was chosen because the main purpose was to explain the prevalence of knowledge, attitudes and practices in a specific adolescent population and not to test causal hypotheses. Descriptive designs are well suited to the situation where the research objective is to determine prevalence rates that can be used as baseline figures in the programme planning phase and as a yardstick for evaluating the future. This is reflected in the lack of inferential statistics in the present analysis, with larger probability samples in future studies potentially allowing associations between knowledge domains and attitudinal orientations as well as knowledge domains and behavioral outcomes to be tested.

Study setting and population

The study was carried out in Baijanath rural municipality in Banke district of Lumbini province in Nepal. Banke is a multi-ethnic predominantly rural district in the Terai. Three government secondary schools of Shree Bageshowary Secondary School, Prabhat Secondary School and Gyanodaya Model Secondary School were selected by convenience sampling. All students in Grades 9–12 from these three schools (N = 907) were the target population.

Sample size and sampling procedure

A sample of 182 students was taken in total population of 20% of the students. A 3:2 ratio of male to female students (60% male and 40% female) was used within each school to ensure gender representation. Students who volunteered and gave informed consent, and who filled out the questionnaire, were retained. The sampling of some one-fifth of the enrolled population was determined by practical considerations of time, resources, and the desire to have reasonable estimates that would not disrupt the regular school program, but would nevertheless give estimates that could be used for descriptive purposes with reasonable precision.

Table 1
Sample Distribution by School and Sex

School	Universe	Male (60%)	Female (40%)	Total
Shree Bageshowary Secondary School	285	34	23	57
Prabhat Secondary School	274	33	22	55
Gyanodaya Model Secondary School	348	42	28	70
Total	907	109	73	182 (20%)

Note: Respondents were selected using a 3:2 male-to-female ratios from each school.

Table 1 indicates that the total sample of 182 students, comprising 109 male and 73 female students, is 20 percent of the student population in the three schools. Proportional allocation resulted in equal representation based on institution and sex.

Data collection instrument and procedure

A structured questionnaire was prepared, content validated and pre tested with 20 students from similar

schools. The instrument has been prepared in both English and Nepali language. After administrative clearance, questionnaires were filled out in separate rooms, confidentially, by gender. Descriptive statistics (frequencies and percentages) were used to analyze the data, stratified by sex, if applicable.

Ethical considerations

All participation was voluntary. Students were told that they could withdraw from the study at any time. Participation was kept anonymous and confidential throughout. To collect valid data on sexual behavior of adolescents in conservative sociocultural settings, the proper ethical considerations and a non-judgemental environment are key requirements.

RESULTS

Knowledge of sexual and reproductive health

Nearly all respondents (97.8%; 178 of 182) reported having heard of sexual and reproductive health. Awareness was comparably high among males (97.25%) and females (98.63%).

Table 2
Distribution of Respondents Having Knowledge of SRH

Heard of SRH	Male n (%)	Female n (%)	Total n (%)
Yes	106 (97.25)	72 (98.63)	178 (97.80)
No	3 (2.75)	1 (1.37)	4 (2.20)
Total	109 (100)	73 (100)	182 (100)

Note: Percentages are calculated within each sex column.

As shown in Table 2, awareness of SRH was nearly universal. When asked to specify familiar domains, the most frequently cited areas were family planning (16.85%), practicing safe sex (14.61%), and menstrual health and hygiene (14.61%). Knowledge of consent and healthy relationships was the least frequently mentioned domain (8.99%), indicating a relative gap in relational and rights-based components of SRH.

Table 3
Primary Source of Information on SRH

Source of Information	Number	Percent
School/Teacher	167	91.76
Friends/Peers	9	4.94
Parents/Relatives	4	2.20
Magazine/Newspaper	2	1.10
Total	182	100

Note: Only one primary source was recorded per respondent.

Table 3 confirms that schools and teachers constituted by far the dominant source of SRH information (91.76%). Family and media sources contributed minimally, underscoring both the centrality of formal education and the limited role of parental communication in this rural setting.

Knowledge of menarche, pregnancy, and fertile period

All respondents reported knowledge of menarche and menstruation. Approximately half (49.45%) correctly identified 11–13 years as a typical age range for menarche.

Table 4
Knowledge of the Process of Pregnancy

Knowledge of Pregnancy	Male n (%)	Female n (%)	Total n (%)
After sperm meets ovum	107 (98.17)	73 (100)	180 (98.90)
Only after frequent intercourse	2 (1.83)	0 (0)	2 (1.10)
Total	109 (100)	73 (100)	182 (100)

Note: Female respondents demonstrated complete accuracy on this item.

Table 4 shows that virtually all respondents (98.9%) correctly understood the biological process of pregnancy. Only 1.1% (all male) held the misconception that pregnancy requires frequent intercourse.

Table 5
Knowledge of High-Risk Period for Pregnancy

High-Risk Period	Male n (%)	Female n (%)	Total n (%)
Around ovulation (fertile window)	63 (57.80)	44 (60.27)	107 (58.79)
Immediately after menstruation	22 (20.18)	16 (21.92)	38 (20.88)
One week before menstruation	20 (18.35)	11 (15.07)	31 (17.03)
During menstruation	4 (3.67)	2 (2.74)	6 (3.30)
Total	109 (100)	73 (100)	182 (100)

Note: Correct response is “Around ovulation (fertile window).”

Table 5 indicates that only 58.79% of respondents correctly identified the fertile window as the highest-risk period for conception. More than two-fifths held misconceptions, revealing incomplete fertility-awareness education.

Knowledge of masturbation, STIs, and safe sex

Table 6
Awareness of Masturbation and Primary Source of Information

Variable	Male n (%)	Female n (%)	Total n (%)
Heard of masturbation: Yes	109 (100)	72 (98.63)	181 (99.45)
Heard of masturbation: No	0 (0)	1 (1.37)	1 (0.55)
Source: Own self	98 (89.91)	24 (33.33)	122 (67.40)
Source: Internet	6 (5.51)	10 (13.89)	16 (8.84)
Source: School/Books	2 (1.83)	13 (18.05)	15 (8.29)
Source: Radio/TV	1 (0.92)	12 (16.67)	13 (7.18)
Source: Friends/Peers	2 (1.83)	10 (13.89)	12 (6.63)

Note: Source percentages are among those who had heard of masturbation (n = 181).

Table 6 shows near-universal awareness of masturbation (99.45%). Males predominantly learned through self-discovery (89.91%), whereas females more frequently cited external educational and media sources. Formal curricula appear to address this topic only minimally.

Table 7
Knowledge of STIs/STDs and Safe Sex Practices

Variable	Male n (%)	Female n (%)	Total n (%)
Know all (gonorrhea, syphilis, HIV/AIDS)	97 (88.99)	64 (87.67)	161 (88.46)
Know HIV/AIDS only	9 (8.26)	7 (9.59)	16 (8.79)
Know about safe sex: Yes	100 (91.74)	67 (91.78)	167 (91.76)
Safe sex = condom use	66 (66.00)	49 (73.14)	115 (68.86)
Safe sex = birth control pills	17 (17.00)	8 (11.94)	25 (14.97)
Safe sex = cleaning after sex	11 (11.00)	5 (7.46)	16 (9.58)

Note. Safe-sex practice percentages are among those who reported knowing about safe sex (n = 167).

As presented in Table 7, 88.46% of respondents correctly identified all three major STIs. Knowledge of safe sex was high (91.76%), and condom use was the most frequently recognized protective practice (68.86%). However, 9.58% still endorsed the misconception that cleaning after sex constitutes safe sex.

Attitudes toward sexual behavior

Table 8
Attitudes Toward Masturbation

Attitude	Number	Percent
Sometimes good	67	36.81
Keeps a person healthy	49	26.92
Bad	42	23.08
Makes a person tired/weak	24	13.19
Total	182	100

Note: Respondents selected a single primary attitude.

Table 8 reveals heterogeneous attitudes toward masturbation. The largest proportion (36.81%) regarded it as “sometimes good,” while 23.08% considered it “bad” and 13.19% believed it causes physical weakness. This distribution reflects the coexistence of emerging scientific understanding and residual sociocultural stigma.

Table 9
Attitudes Toward Ideal Age of Marriage

Ideal Age	For Male n (%)	For Female n (%)
<16 years	0 (0)	5 (2.75)
16–19 years	24 (13.19)	36 (19.78)
20–24 years	98 (53.85)	114 (62.64)
25–29 years	48 (26.37)	25 (13.73)
≥30 years	12 (6.59)	2 (1.10)
Total	182 (100)	182 (100)

Note: Each respondent indicated an ideal age for both males and females.

Table 9 shows that a clear majority identified 20–24 years as the ideal age for marriage for both males (53.85%) and females (62.64%). Respondents generally preferred a slightly older marriage age for males, and very few supported marriages below the legal minimum age of 20 years.

Table 10
Attitudes Toward Premarital Sex

Attitude	Male n (%)	Female n (%)	Total n (%)
Acceptable if practiced safely	46 (42.20)	30 (41.09)	76 (41.76)
Bad in terms of culture	29 (26.61)	22 (30.14)	51 (28.02)
No problem due to biological needs	31 (28.44)	17 (23.29)	48 (26.37)
No response	3 (2.75)	4 (5.48)	7 (3.85)
Total	109 (100)	73 (100)	182 (100)

Note: Percentages are calculated within each sex column.

Table 10 indicates mixed attitudes toward premarital sex. The largest single group (41.76%) regarded it as acceptable if practiced safely, while 28.02% considered it culturally unacceptable. These patterns illustrate the simultaneous presence of pragmatic health-oriented and traditional cultural frames.

Additionally, 59.89% of respondents believed that SRH education should begin at the basic education level, and 67.03% considered daily bathing during menstruation appropriate. Attitudes toward menstrual hygiene were generally positive, with 59.89% endorsing the comprehensive view that hygiene maintains cleanliness, prevents odor, and prevents infections.

Practices related to Sexual Behavior

Table 11

Experience of Romantic Relationships

Variable	Male (%)	n	Female n (%)	Total n (%)
Ever been in love: Yes	69 (63.30)	42	(57.53)	111 (60.99)
Ever been in love: No	40 (36.70)	31	(42.47)	71 (39.01)
Age at first love: 13–15 years	13 (18.84)	9	(21.43)	22 (19.82)
Age at first love: 16–18 years	51 (73.91)	30	(71.43)	81 (72.97)
Age at first love: 19–22 years	5 (7.25)	3	(7.14)	8 (7.21)
Current love affair: Yes	60 (55.05)	36	(49.32)	96 (52.75)

Note: Age-at-first-love percentages are among those who had ever been in love (n = 111).

Table 11 shows that 60.99% of respondents had experienced being in love, most commonly first falling in love between ages 16 and 18 (72.97%). At the time of the survey, 52.75% reported a current romantic relationship.

Table 12

Premarital Sexual Behavior and Motivating Factors

Variable	Male n (%)	Female n (%)	Total n (%)
Premarital sex: Yes	36 (33.03)	26 (35.62)	62 (34.07)
Premarital sex: No	73 (66.97)	47 (64.38)	120 (65.93)
Motive: Relationship commitment	19 (52.78)	18 (69.23)	37 (59.68)
Motive: Own wish	11 (30.55)	3 (11.54)	14 (22.58)
Motive: Friends/peer influence	6 (16.67)	3 (11.54)	9 (14.52)

Note: Motive percentages are among those who reported premarital sex (n = 62).

As shown in Table 12, approximately one-third of respondents (34.07%) reported involvement in premarital sexual activity, with similar proportions among males and females. Relationship commitment was the dominant motivating factor (59.68%), cited more frequently by females (69.23%) than males (52.78%).

Table 13

Contraceptive Use at First Sexual Intercourse

Variable	Male (%)	n	Female n (%)	Total n (%)
Used contraceptive: Yes	23 (53.49)	23	(56.10)	46 (54.76)
Used contraceptive: No	20 (46.51)	18	(43.90)	38 (45.24)
Method: Condom	19 (82.61)	15	(65.22)	34 (73.91)
Method: Emergency pills (ECP)	0 (0)	7	(30.43)	7 (15.22)
Method: Other (withdrawal/injectable)	4 (17.39)	1	(4.35)	5 (10.87)

Note: Method percentages are among those who used contraception at first sex (n = 46). Base for use/non-use is sexually experienced respondents (n = 84).

Table 13 reveals a critical finding: although 54.76% of sexually experienced respondents used a contraceptive method at first intercourse, 45.24% used none. Among users, condoms predominated (73.91%). The substantial proportion of non-use at sexual debut constitutes a clear risk indicator for both unintended pregnancy and STI transmission.

Among female respondents, sanitary pads were the most common menstrual absorbent used at menarche (57.53%), followed by new or clean cloth (23.29%) and old cloth (15.07%). Sexual debut occurred predominantly between ages 16 and 19 (72.62%), with 22.62% reporting debut before age 16. The most common locations were a private room (35.72%) or hotel (33.33%).

DISCUSSION

This study gives a detailed description of knowledge, attitude, and practices of secondary school students in the Banke District of the rural community with regard to sexual behavior.

Awareness of SRH is almost universally high (97.8%) and the spread of information through schools and teachers is high (91.76%) are positive results of the continuing growth of school-based health education in Nepal. The figures are in line with the national survey data (MoHP et al., 2023), and the previous reviews (Upreti et al., 2009). In parallel, the low spontaneous mentions of consent and healthy relationships (8.99%) and lack of understanding regarding the fertile window (58.79% incorrect) indicate that most of the work that is currently being done in education is focused on the biological aspect

and disease prevention and not on relational competency and fertile window awareness. Such a high level of awareness is a prerequisite but not a sufficient condition for protective behaviours. The Health Belief Model reminds us that knowledge will not lead to consistent protective action until there is perceived susceptibility, perceived severity, and a favorable balance between the benefits of taking the action and barriers to taking the action. Additionally, subjective norms, which can be shaped by peer education and skills training in school settings, and perceived behavioral control, which can be fostered by supportive classroom climates, are other key determinants in the Theory of Planned Behavior that can be targeted by school-based programs.

The general attitudes on menstrual hygiene and the desired age for marriage and first sexual experience were fairly pro- and consistent with the national legal framework. The majority preference of SRH education at the basic level (59.89%) indicates adolescents' readiness to be taught at an earlier age. Interestingly, however, attitudes about masturbation and about having sex before marriage were very different from each other, and showed great variation, indicating both transmission and interaction of biomedical information and traditional moral values.

The most significant of findings is that of a high level of knowledge with an incomplete level of protective practice. Despite the high percentage of people who knew about safe sex (91.76%), 45.24% of all sexually experienced respondents did not use any method of contraception at the time of their first sexual intercourse. This is similar to previous Nepali and regional research (Upreti et al., 2009; UNFPA, 2021) and can be explained using the Health Belief Model and Theory of Planned Behavior: perceived barriers, lack of self-efficacy in negotiation, and subjective norms can outweigh the cognitive perception of risk. To close this gap, moving beyond the transfer of didactic information to interactive, skill-based pedagogy that fosters self-efficacy in condom negotiation, partner communication and refusal of unwanted sexual advances is required. When men and women students are involved in joint discussion around issues of mutual responsibility, programs may be especially successful in altering the relationship where one partner is currently doing more than the other. International technical guidance on sexuality education underscores the sequential and age-appropriate nature of sexuality education to start in early adolescence and proceed through secondary

school. The majority opinion in this study about introducing SRH education at the basic level is in line with this guidance and offers a student-centred justification for the need to integrate SRH education earlier in the curriculum. Teacher preparation is a vital constraint, as even an effective curriculum, if poorly prepared and inadequately delivered will be poorly adapted, or even delivered with an uncomfortable finish which the student will immediately recognise.

CONCLUSION

This study, consisting of 182 students from secondary schools in Baijanath Rural Municipality, Banke District concludes that rural Nepali adolescents have overall high knowledge on SRH which is reported to be gained mainly through school and teachers with general positive perceptions around menstrual practices & delayed marriage. However, there are ongoing knowledge gaps surrounding consent and healthy relationships as well as fertility awareness; meanwhile attitudes towards masturbation and premarital sex continue to be inconsistent. Most importantly, 45.24% of students who had experience of sexual intercourse did not use any contraception when first having sex with a person: this reflects a large and enduring gap from knowledge to protective behaviour. Despite its limitations of a cross-sectional and non-sampling design, this finding offers an adequate empirical justification for targeted immediate action at the school level and local government.

These results give support to the importance of schools in SRH education but suggests an urgent need for a shift from transmission of information toward comprehensive, skills-based and gender-responsive sexuality education that addresses consent, relationships and contraceptive decision-making. Key priorities are systematic teacher training, early introduction of content that is age-appropriate; particularly around pregnancy prevention and management and in sanitary products; enhanced school-adolescent friendly health service linkages together with greater access to contraceptives. Future studies should use larger probability sampling, multi-site approaches with mixed-method and longitudinal designs to determine sociocultural drivers of the knowledge–practice gap in rural Banke or similar districts; assess intervention effectiveness over time across various socio-

ecological circumstances associated with particular populations; and measure clinical outcomes.

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