Report on

Developing peer support for adolescent friendly sexual and reproductive health services in Rasuwa and Nuwakot districts

Prepared by

Women's rehabilitation Centre (WOREC) Nepal

Acknowledgements

This research report is written by Ms Elawati K.C, Research Coordinator from WOREC under the guidance of Dr Jill Allision, principle investigator from Memorial University of Newfoundland and Dr Laxmi Tamang, principle investigator from WOREC. Reporter got tremendous support from Ms Shweta Karna, Research Officer from WOREC in analyzing the data.

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Research team

Executive Summary

Adolescence is the period of physical, psychological, and social maturing from childhood to adulthood. Generally the term "adolescent" refers to individuals between the ages of 10 to 19 years. (WHO, 1989). There is growing recognition that because of a combination of biological, psychological and social factors adolescents face many different health risks and problem such as sexually transmitted infections including HIV/AIDS early and frequent pregnancy, accidents and violence. On the other hand adolescents are usually very energetic and curios to information that pertains to them and are anxious to become more autonomous in their decision making. Such curiosity and interest in learning offers great opportunities for improving health and development. The health of adolescents is profoundly linked to their development since their physical, psychological and social abilities help to determine their behavior. The young people of today are tomorrow's adults. It is of paramount importance that an environment be created and adequate support provided to enable adolescents to develop their full potential and to enjoy a healthy and responsible adulthood.

This study was conducted by WOREC in technical and financial support of Grand Challenge Canada (GCC) and Memorial University of Newfound land, Canada. This study sought to provide new ways of teaching and learning methods to adolescent in sexual and reproductive health so that they can be well prepared for their future life. Present study has tried to look at ways to improve ASRH (adolescent sexual and reproductive health).

Study was conducted from May 2018 to December 2019 (20 months) where intervention period was from December 2018 to September 2019 (10 months). Study was conducted in Nuwakot and Rasuwa district which was badly hit by earthquake of 2015. Study site were chosen where government has taken initiative to promote delivery of adolescent friendly service (AFS). Study design was mixed methods, explanatory and exploratory sequential approaches with peer ethnography. Survey, focus group discussion (FGD), in depth interview (IDI), gallery walk were methods used to collect data.

In the study, five site as intervention site and five site as non-intervention site from both district were chosen purposively i.e altogether 10 intervention site and ten nonintervention site were chosen. Peer education program was conducted among intervention site where teachers and students were trained on SRHR. Tablets with SRHR app called "Sahayogi" were provided to schools of intervention sites. Peers were made main focal person who taught their friends on using tablet and kept observing their behavior throughout the intervention period. After the intervention, difference between knowledge and health seeking behavior of adolescent in these two groups were compared. Study has tried to see what actually worked and what did not works with adolescent to receive safe information and seek health services. The study has tried to look at various social aspect, lack of access to education and health in a post disaster recovery context and also the effectiveness of adolescent program run by government.

Major findings of the study

- Early marriage is common in both Nuwakot and Rasuwa districts. Among Aryan community (Brahmin and Chhetri), marriage by parent's wish (arranged marriage) used

to be common, but now self-initiated marriage has become common. Whereas among Mongolian community (Tamang), self-initiated marriage is a part of culture.

- The main reasons for early marriage identified were lack of awareness, early marriage as a culture and lack of social support for inter-caste marriage.
- Very few adolescents return to school after marriage. Because of shyness they did not continue their school. There is not a welcoming environment in school and community where adolescents can come and continue their study after marriage.
- There is an awkwardness and hesitation among teachers while teaching ASRH.
- Peer education program was found to be effective program for students. Students got more knowledge on adolescent sexual and reproductive health (ASRH) which was not included in their curriculum.
- Participants stated that, sahayogi app has full information on ASRH. Students were excited to use the technology because they have not used such technology before and due to games and videos it was also fun to use.
- Topics such as masturbation, nightfall (nocturnal ejaculation) and information on LGBTQ, sexualities were completely new topic to participants.
- At the end of intervention, 66 peer educators felt that their expertise was recognized and they were in a position to be agents of change. These peer educator performed, used a variety of media such as theatre, songs and games to generate awareness and raise interest, not only amongst their peers but also at the community level.
- As an effect of peer education program, students has become less shy and they can deal with issue of ASRH comfortably. This shows peer education program is a good method of educating young adolescents on ASRH.
- In all 20 schools an Adolescent Friendly Service Corner (AFS Corner) for education were not established.
- Uptake of SRHR services by adolescents was very low. Study shows there is a lack of trust with health care provider. Only married adolescent sought ASRH service. Adolescent girls seek more services than boys.
- Out of 20 health institutions, 17 institutions do not have separate adolescent counselling corner. Some health institutions had provided counselling service by taking another room where there is privacy. Because of the earthquake most of the health institutions were in temporary buildings with insufficient space.
- Most of the health care providers think their health post is not fully adolescent friendly. They mentioned, lack of proper building and lack of staff as main challenges for establishing adolescent friendly health services. They themselves were not satisfied with the service they are delivering.
- After intervention number of students increased who gave correct answer on issue like LGBTIQ, concept of homosexuality, menstrual exclusion, causes of uterine prolapse and cybercrime.
- Study shows, parents identified the challenges they face both culturally and with regard to their own lack of knowledge in sharing information with their own children. This

shows clearly that parents are not a viable source of sexual and reproductive health information in many rural communities.

- Best way to educate adolescents on ASRH is using a multiple approach that includes both mobile technology (apps), other media such as videos, arts based media such as theatre and songs and classic educational approaches that included an updating of the curriculum. This recognizes the different needs of various learners and provides a number of opportunities for people to gain access to the information.

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Abbreviations

AFS: Adolescent Friendly Service

ANC: Ante Natal Care

ASRH: Adolescent sexual and reproductive health

FGD: Focus Group Discussion

FHD: Family Health Division

FP: Family Planning

HIV/AIDS: Human immunodeficiency virus infection/ Acquired immune deficiency syndrome

ICPD: International Conference on Population and Development

IDI: In-depth Interview

KII: Key Informant Interview

MoHP: Ministry of Health and Population

NA: Not Applied

NDHS: National Demographic Health Survey

NHRC: Nepal Health Research Council

NMICS: Nepal Multiple Indicator Cluster Survey

PHC: Primary Health Care Centre

PI: Principle Investigator

SRH: Sexual and Reproductive Health

SRHR: Sexual and Reproductive Health Rights

SPSS: Statistical Package for the Social Sciences

STI: Sexually Transmitted Infections

WOREC: Women's Rehabilitation Centre

WHO: World health organization

1. Introduction

Nepal has shown its commitment to adolescent health through being a signatory to the ICPD (International Conference on population and development) Programme of Action. Nepal was also involved when the WHO South-East Asia Regional Office (SEARO) developed the Regional Strategy for Adolescent Health and Development in 1996. Following these commitments, in 1998 ASRH was included in the National Reproductive Health Strategy. In 2000 the National Adolescent Health and Development Strategy was developed by the Family Health Division (FHD) of the Ministry of Health and Population (MoHP).

The Government of Nepal has identified Adolescent Sexual and Reproductive Health as a priority in their National Adolescent Health and Development Strategy in 2000 and again in 2015, with implementation guidelines and a communication strategy which affirm the rights of adolescents to comprehensive, non-judgmental and confidential counseling and services. There is a training initiative to promote delivery of Adolescent Friendly Service (AFS) based on standards of care and procedures with national and global evidence for good practices related to sexual and reproductive health.

The criteria of AFS include the availability of trained staff and information on adolescent sexual and reproductive health, the delivery of services in a confidential way, adolescent friendly, opening hours, the display of the AFS logo and including two adolescents as invitees to HFOMC (health facility operation management committee) meetings.

Adolescence is the period of physical, psychological, and social maturing from childhood to adulthood. Generally the term "adolescent" refers to individuals between the ages of 10 to 19 years. (WHO, 1989). There is growing recognition that because of a combination of biological, psychological and social factors adolescents face many different health risks and problem such as sexually transmitted infections including HIV/AIDS early and frequent pregnancy, accidents and violence. On the other hand adolescents are usually very energetic and respective to information that pertains to them and are anxious to become more autonomous in their decision making. Such curiosity and interest in learning offers great opportunities for improving health and development.

The health of adolescents is profoundly linked to their development since their physical, psychological and social abilities help to determine their behavior. Healthy development of adolescents is dependent upon several complex factors; their socio economic circumstances, the environment in which they live and grow, the quality of family, community and peer relationships, available opportunities for education and employment and access to health information and services.

The young people of today are tomorrow's adults. The fertility behavior of adolescents is a potential determining factors for future population growth in a country. It is of paramount importance that an environment be created and adequate support provided to enable adolescents to develop their full potential and to enjoy a healthy and responsible adulthood.

In Nepal, adolescents constitute 23% of the population according to the census of 2016. The practice of early marriage and childbearing is very common in Nepal. The median age at first

marriage for women age 25-49 is 17.9 years, compared to 21.7 years among men age 25-49. Among girls aged 15–19 years 29% are already married and 17% are already mothers or pregnant. Also, a higher percentage of girls aged 15–19 in rural areas had given birth than girls from urban areas. Seventeen percent of adolescent women age 15-19 are already mothers or pregnant with their first child. Teenage fertility is higher in rural areas (22%) than in urban areas (13%). Teenage pregnancy decreases with increased education; 33% of young women with no education have begun childbearing, compared to 7% young women with SLC and above education. Adolescent women in the three lowest wealth quintiles are more likely than those in the wealthiest households to have begun childbearing. Eleven percent of women begin sexual activity before age 15, while 51% have sex before age 18. Within 2.5 years of marriage, women are having their first birth. The median age at first birth for women is 20.4 years. One in five women give birth by age 18. (NDHS, 2016)

Only 15% of currently married women age 15-19 use a modern method of contraception. Unmet need for spacing is highest among married women age 15-19 (32%). Seventy-two percent of nonusers age 15-19 did not discuss family planning either with a health worker or female community health volunteer or at a health facility. Twenty-one percent (21%) of young women and 27% of young men age 15-24 have comprehensive knowledge of HIV. Women's experience of physical violence increases sharply with age, from 11% among women age 15-19 to 28% among women age 40-49. Violence during pregnancy among women who have ever-been pregnant is more common among women age 15-19 (10%). Ever experience of sexual violence is 3% among women age 15-19, compared with 7%-8% among women 20-39 and 10% among women age 40-49. Experience of physical or sexual violence increases sharply with age, from 12% among women age 15-19 to 29% among women age 30 and older. (NDHS, 2016)

Accurate and safe information on sexual and reproductive health can make adolescent life healthy and prosperous. Present study has tried to look at ways to improve ASRH (adolescent sexual and reproductive health). Study has tried to find out the best way to educate adolescents about ASRH. Technology is widely used these days in education. Study has also tried to test whether technology can help to raise awareness among adolescent.

In this study five intervention sites and five non-intervention or control sites were selected from Nuwakot and Rasuwa districts i.e altogether 10 intervention site and ten nonintervention site were chosen. Peer ethnography method was used where some students were selected as peer educator and were trained. Peer educators taught their friends back at school and observed their activity through the peer education program. The peer education program was introduced at school of intervention site of each districts. Two peers from each class of 7, 8 and 9 were chosen. In case of two sections, two peers from each section were chosen. Peer educators along with teachers were trained on ASRH education and use of tablet. Two Android tablets were distributed to all the intervention schools with our application called "Sahayogi" installed. Sahayogi was developed for adolescents and includes information on ASRH in an interactive format with stories, games and videos. Students were allowed to use app for 10 months. They were followed after 10 months to see what changes had occurred. Before peer intervention program, a pre survey was conducted at all the schools and health posts. After 10 months, a post survey was conducted. Variables like knowledge of students, heath seeking behavior and attitudes were compared.

2. Justification

Our project aimed to increase awareness and encourage peers to share accurate and safe information with each other. This study was unique in nature in that we combined a technological learning format with a peer education program. Our approach was to provide knowledge through different means of entertainment, like use of tablet based games, quizzes, videos of local street theatre, and to give peer educators a platform to share information about ASRH and gender equality while also learning about technology. The project was conducted in earthquake affected districts where resources were limited. We chose those study areas where government has taken initiative to promote delivery of adolescent friendly service (AFS). We took five site as intervention site and five site as non-intervention site from both district. We compared difference between knowledge and health seeking behavior of adolescent in these two groups. We have tried to see what actually works and what do not works with adolescent to receive safe information and seek health services. Moreover, we have also tried to look at various social aspects that is associated with ASRH. The project has tried to address gender inequality, lack of access to education, health in a post disaster recovery context and effectiveness of ASRH program run by government.

3. Objectives

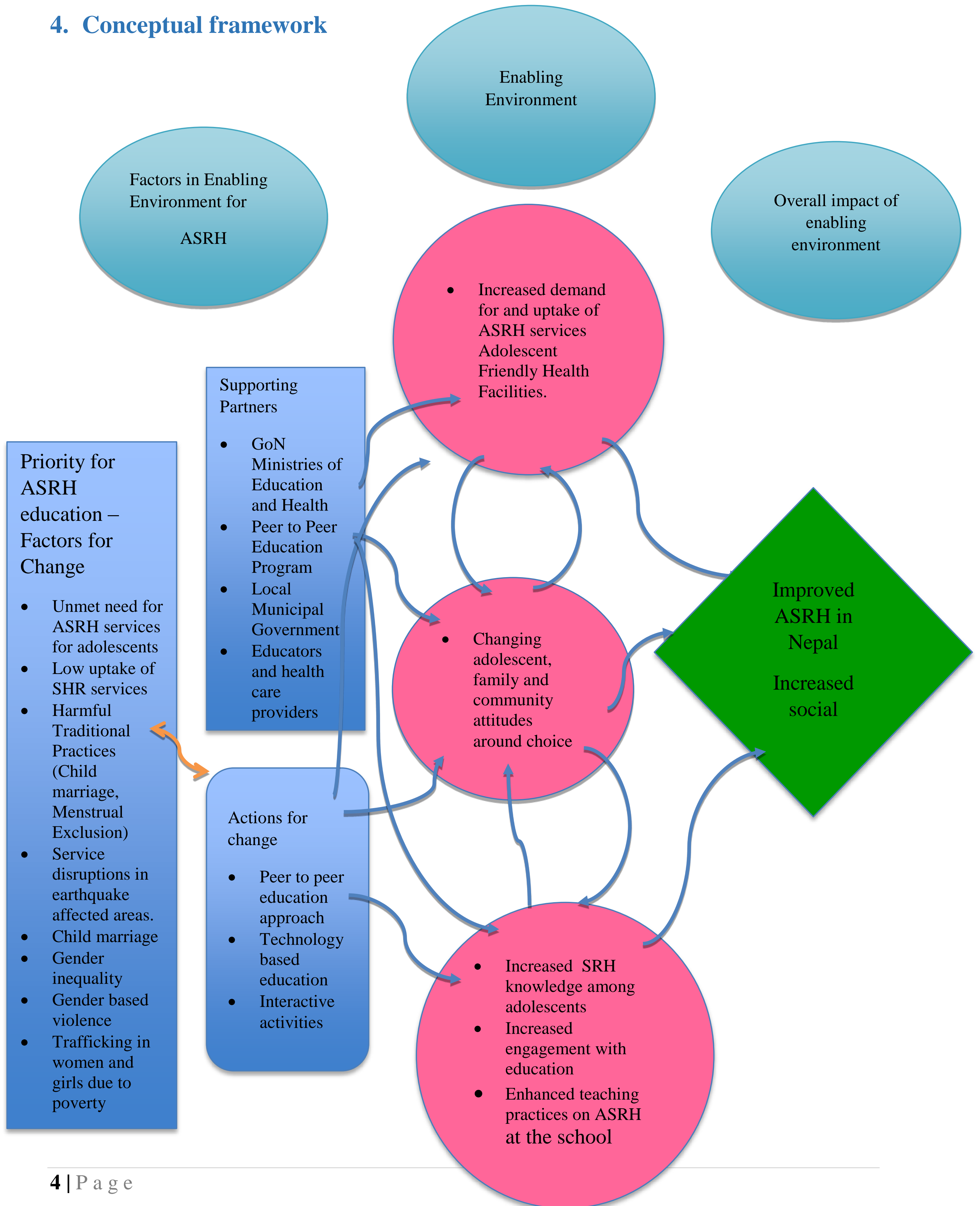
3.1 General Objective

The main purpose of our study was to find new and engaging ways teaching and learning about sexual and reproductive health for young people and change their behavior around taking care of their own health. We want to improve the well-being of young people in the community and increase safety and respect for girls.

3.2 Specific Objective

- To increase the availability of and access to quality information on adolescent health and development, and provide opportunities to build the knowledge and skills of adolescents, service providers and educators.
- To create safe and supportive environments for adolescents to improve their social and economic status.
- To create awareness on adolescence issues through use tablet based games, quizzes, videos of local street theatre and non-monetary rewards.

4. Conceptual framework



5. Methodology

5.1 Study Design

The study design was a mixed methods, explanatory and exploratory sequential approaches with peer ethnography. A quantitative survey was used to see the situation and design our technology application. Qualitative methods were used to see the in-depth understanding of situation. Peer educators were engaged as individuals who stay in the community and collect the information of other students throughout study period.

Qualitative method: Qualitative data collection methods like focus group discussion (FGD), in-depth interview (IDI) were used to assess social awareness and acceptance of adolescent SRH education by communities, educators, and health providers.

Quantitative method: Surveys were used collect quantitative data.

5.2 Data Collection Technique / Methods

Baseline survey and post intervention survey was carried out with students to assess knowledge. This was done by self-administered questionnaire.

FGD and IDI were conducted with parents, teachers and health care providers in control and intervention communities to assess levels of knowledge, behavior, attitude and acceptance of the program. IDI guideline and FGD guidelines were used to take interview and conduct FGD.

5.3 Data Collection Tools

Survey questionnaire, interview and FGD guideline

5.4 Pre-testing of the Data Collection Tools

Survey questionnaire was tested in government school of Kathmandu, whereas IDI and FGD tools were tested in Lalitpur district, in health post and nearby community.

5.5 Study Sites

The research was conducted on two districts of Nepal, Nuwakot and Rasuwa.

Map of Nepal

Nuwakot is one of the seventy seven districts in Nepal and lies in province no 3 of Nepal. Administratively it is divided into 10 rural municipality and 2 municipality. Bidur is headquarter of Nuwakot district. Tamang ethnicity represents the majority in Nuwakot (43%), followed by Brahmin (19%). The population of Nuwakot further consists of 13% Chhetris and 7% Newar followed by other caste. The literacy rate in Nuwakot is sixty percent (60%) and twenty percent (20%) of population are under poverty line.

Rasuwa is also in province no 3 of Nepal. Administratively it is divided into five rural municipality. Dhunche is the headquarters of Rasuwa district. Tamang also represent the majority ethnicity (69%) followed by Brahmin (15%). The population of Rasuwa further consists of 3% Gurung and 3% Chhetri followed by other caste. Fifty percent (50%) of the population in Rasuwa are literate and thirty two (32%) percent of population are under poverty line.

Both districts were earthquake affected districts with high incidence of girls trafficking.

Schools were selected in consultation with Ministry of Education and local government officials in each district. Approval was taken from every level of government in the District and local municipalities.

Name of rural municipality, school and health post of intervention and non-intervention site.

Rasuwa district

SN	Municipality	(Intervention) ASRH Facility	Intervention School	Municipality	Non-intervention ASRH Facility	Non-intervention School

1.	Uttargaya Rural Municipality	Laharepauwa, Bholaya Dada Health Post	Nawavijaya Higher Secondary School	Gosaikunda Rural Municpality	Dhunche, District Hospital	Rasuwa Higher Secondary School
2.	Gosaikunda Rural Municpality	Syapurbesi Health Post	Shree Syamwangfell Higher Secondary School	Parbatikunda Rural Municipality-4	Goljung Health Post	ParbatiKunda Higher Secondary School
3.	Naukunda Rural Muncipality	Samarthali, Parchyang Health Post	Gautam Buddha Higher Secondary School	Naukunda Rural Municipality	Yarsa, Lagbu Health Post	Narayan Higher Secondary School
4.	Naukunda Rural Municipality	Bhorle Health Post	Bhageshwori Higher Secondary School	Kalika Municipality, Jibjibe	Jibjibe PHC	NilkanthaNamuna Higher Secondary School
5.	Kalika Rural Municipality	Ramche, Health Post	Seti Bhumi Higher Secondary School	Uttargaya Rural Municipality	Dadagaun Health Post	Dadagaun Higher Secondary School

Nuwakot district

S.N	Municipality	(Intervention) ASRH Facility	Intervention School	Municipality	Non-intervention ASRH health facility	Non-intervention School
1.	Surya Gadhi Rural Municipality	Bhagheswori health post	Bhageshwori Higher Secondary School	Panchya Kanya Rural Municipality	Bhadratar Health post	Kundal Higher Secondary School
2.	Likhu Rural Municipality	Chaughada health post	Kshetrapal Higher Secondary School	Panchya Kanya Rural Municipality	Kabilas Health post	Rastriya Higher Secondary School

3.	Tarkeshwor Rural Municipality	Gorsyang health post	Shankhadevi Higher Secondary School	Belkotgadi Municipality	Ratme Health post	Mahadev Higher Secondary School
4.	Shivapur Rural Municipality	Likhu (Salle MaidanHealth Post) health post	Mahendra Higher Secondary School	Shivapuri Rural Municipality	Samundradevi (Gurche) Health post	Kalika Higher Secondary School
5.	Shivapur Rural Municipality	Talakhu Health post	Bhumidevi Higher Secondary School	Megan Rural Muncipality	Kimtang Health post	Sanokimtang Higher Secondary School

5.6 Sampling Methods

All the student of class 7,8 and 9 were administered the survey in both intervention and control schools. For FGD and IDI participants were purposively selected.

5.7 Sample size

S.N	Particular	Sample size
1	Pre-survey	1777
2	Post survey	1933

IDI and FGD participant in pre survey

S.N	Particular	Intervention	Non-intervention	Total participant
1	IDI with Health care provider	5-R, 4-N	5-R, 9-N	18
3	IDI with teacher	5-R, 4-N		9
			Total participants	27

IDI and FGD participant in post survey

S.N	Particular	Intervention	Non-intervention	Total participant

1	IDI with Health care provider	3-R, 3-N	2-R, 2-N	10
3	IDI with teacher		2-N, 2-R	4
4	IDI with parents of peer educator	3-N, 3-R	NA	6
5	IDI with peer educator	3-N, 3-R	NA	6
6	IDI with student who has not taken peer educator training	3-N, 3-R	3-N, 3-R	12
7	FGD with peer educator	4 N, 4R		58
8	FGD with teacher of intervention school	1N, 1N		9
			Total participants	105

(R: Rasuwa, N: Nuwakot)

5.8 Validity and Reliability of the Study Tools:

- Validity and reliability was maintained by pretesting of questionnaire.
- Survey questionnaire and IDI and FGD guideline was translated in Nepali
- A research guide and experts were consulted for the review of the questionnaire.
- Adequate related literature review was done.

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5.9 Limitation of the Study

- Study challenge: We carried out study where most of the participants speak Tamang language as a mother tongue. Although participants speak Nepali language they were more comfortable with Tamang language. Researchers were not Tamang language speakers so in some case there might be a chance of language barrier.
- Study challenge: As research is on a sensitive topic, sometime it was difficult for participant to open up where they cannot express themselves fully.
- Due to budget limitation we could only provide two tablets in each intervention school.

5.10 Ethical consideration

Ethical clearance was taken from both Memorial University and the Nepal Health Research Council. Similarly consent was taken from each rural municipality, school and health post. Group consent was taken from head teacher for those who were below 16 years. Written and

informed consent were obtained from participants who participated in our interview and FGD. Participant's personal information is not mentioned in report. All the personal information, recording, transcription, translation are kept in secret were researcher only can have access.

6. Research Activities

Research activities were divided into three main parts.

1. Pre survey (Baseline survey)

Before the intervention, pre survey was conducted in all 20 sites of Nuwakot and Rasuwa district. Pre survey was conducted in school, health post and community of intervention and non-intervention site. From 20 schools, 1777 adolescent participated in survey whereas in FGD and IDI, 27 individual participated. Situation at pre survey is described below.

1.1 Situation of adolescent friendly health service at heath institutions

Almost all health care providers said they do not have a special program for adolescents, however they provide counselling service if adolescents come to seek this. As a part of the school health program they also conducted classes at schools on various health issues.

"We don't have a special program for adolescents, we provide them with the daily services. Here we conduct program for adolescents for 1pm to 2 pm every day during their lunch break. Sisters [nurses and ANMs] *are more focused towards that program. Sometime I take the class at school."* (Health post, Nuwakot)

As married adolescents came to seek service more frequently, service like ANC service, counselling and family planning services were delivered most often. This suggests that unmarried adolescents rarely come to seek service.

"Adolescents come to the health post rarely. Trend is a little different in our area. There is high rate of early marriage. In case of early marriage there is high chance of early pregnancy as well. We provide them ANC service, counselling and family planning services. We provide DEPO, pills, condoms. We distribute condoms time and again." (Health post, Rasuwa)

1.2 Separate corner for counselling

In most health posts there was no separate corner for counselling, however providers managed in some other room to provide counselling.

"Well, our building is small, there are limited number of rooms. There is a room for pregnant women, a separate room for PNC. We arrange counselling for FP in the available rooms that we have". (Health post Nuwakot)

1.3 Health care provider perception toward their health facility's capacity for on adolescent friendly service

Most of the health care providers think their health post is not fully adolescent friendly. Although they were told many things during training on providing adolescent services, they have not been able to do what is required. They mentioned, lack of proper building and lack of staff as main

challenges for establishing adolescent friendly health services. They themselves were not satisfied with the service they are delivering.

"This is not adolescent friendly at this moment. First of all, we do not have proper building structure. We do not have enough space. Another thing is staffing. At this time we have complete sanctioned post. Most of the time sanctioned post was vacant before. Before, I was only one ANM and health post incharge. There was scarcity of staff. Another thing is I am not satisfied with this program. Whatever we have been told in training, we are not able to do that. That is why I am not satisfied with the program" (Health post Nuwakot)

A health care provider from Rasuwa mentioned that he has tried his best to provide service to adolescent. But service he has been providing mainly focuses on married adolescent.

"Yes, I think it is a little adolescent friendly. We provide service to every adolescent who comes here. We give them our 100%. We have oral contraceptive pills as well in case of pregnancy. In case of pregnancy of more than 2 months then we don't have any facilities for them. In that case we refer them. We try our best to provide them with the facilities." (Health post-Rasuwa)

1.4 Service most frequently sought by adolescent

Health care provider revealed that adolescents mainly come to seek general health service. Most of them mentioned that girls come to ask about menstruation related problems besides general health service.

"Especially adolescents come here to seek general services. Some share their problems related to menstruation as well. They talk to the sisters about menstruation problems." (Health post-Nuwakot)

One of the health care providers from Rasuwa also mentioned that parents of disabled adolescent bring them for family planning service so that they do not get pregnant. There is concern about sexual abuse of women with intellectual and physical disabilities.

"Usually differently abled unmarried females come here to take family planning services; their parents bring them to the health post. Some parents feel that their daughters aren't safe and bring them. We have given services to these type of case as well." (Health post-Rasuwa)

1.5 Who seeks more services?

Health care providers revealed that adolescent girls seek more service than boys. Unmarried girls usually seek service when they have a problem related with menstruation and in the case of married adolescents they seek pregnancy related service and family planning service most often. This suggests that adolescent girls seek more services than boys.

"Adolescent boys don't really come here. They come here to receive first aid when they get injured. Usually adolescents come with problem of common cold, fever, they haven't come here with any serious problems." (Health post Rasuwa)

"Adolescent girls usually come up with problem on menstruation. If they are married they come up with some family planning issue and some come for atenatal care (ANC) visit." (PHC Rasuwa)

1.6 Major challenges felt by health care providers in establishing adolescent friendly health facilities.

The major challenges identified for establishing adolescent friendly health institution were lack of infrastructure, lack of IEC material, lack of staff, transfer of trained staff and lack of training/orientation to service provider.

"The main problem we have here is unavailability of separate room for adolescents, we don't have pamphlets to give, and IEC materials are unavailable. We can only provide them information verbally." (Health post-Rasuwa)

One health care provider from Rasuwa mentioned that no one from the health post has received any training on adolescent friendly service.

"At first we need training or orientation. There should be private space for counselling. We also feel discomfort to give counselling in front of others." (Health post-Rasuwa)

One male health care provider mentioned that two trained staff were already transferred, so when girls come to seek service he will not be able to provide service.

"We lack manpower to deliver services. Three of us had taken training but 2 staff have already been transferred. I am the only one in the health post who is trained so it is not possible to bring change by a single person's effort. If it was male adolescents then I will be able to solve their problem but it is girl I will not be able to solve the problem." (Health post-Nuwakot)

1.7 Suggestion from health care provider

Health care providers suggested that problems like early marriage and early pregnancy are rampant. Sexual health problems of adolescent are indicate the need for adolescent friendly program. It is interesting that many health care providers feel it is a matter of educating the adolescents when the problem of early marriage is clearly a social issue that has wider context than young people understanding the challenges posed by early marriage. The need for wider social change and support for less conservative attitudes toward safe sexual activity by young people is not mentioned.

"Well in our society people get married at young age, don't know why. They give birth to a baby at a young age too and people prefer home delivery. Few use family planning device and understand child spacing. If this type of program is launched and advocated then these problems can be reduced. There are lots of problems due to sexual disease, there is cases of hysteria, convulsive disorder in females." (Health post-Rasuwa)

"This is the time when adolescent have queries and they are vulnerable to many problems. In order to mitigate those problem adolescent should be given this services." (PHC-Rasuwa)

Training on adolescent friendly health service was not provided to all staff in spite of the importance of this issue in government health priorities.

"The training on ASHR is only given to 1 or 2 staffs, it would have been better if training was given to all the staffs because all the staffs are involved while conducting one hour session to adolescents. So, it is necessary to provide training to all the staffs." (Health post-Nuwakot)

1.8 Topics taught in school

School teacher mentioned that ASRH is a part of curriculum where different topics related to ASRH were taught.

"Under sexual and reproductive health, I teach things related to adolescents about birthing, about family planning, about child spacing, when to get pregnant, how much spacing is needed and also about menstruation, and then about marriage, I mean appropriate age of marriage. These are the things I taught to adolescents." (School-Nuwakot)

1.9 Discussion during class

Teachers revealed that student do not ask many questions during ASRH class.

"No one asks questions, even when I ask them if they have any problems" (School-Nuwakot)

Once there was class of changes on adolescent period where students need to draw figure of reproductive parts. One student asked to go to toilet and he did not return in whole period. He already passed class 10. Sometime such thing happen. But these days, this does not happen. Students feel shy but they did not leave class. (School Rasuwa)

1.10 How comfortable are teachers to deliver ASRH education curriculum?

Most of the teacher mentioned that they are comfortable to teach student on ASRH however one teacher mentioned that he cannot teach openly to girls due to gender difference.

Well, what I feel is, when I teach subject matter related to reproductive health, use of family planning I can talk and teach the boys openly but it's a little difficult to open up in front of girl students. I have requested the Public health office to manage a sister (nurse or ANM) to teach these chapters to girl. Male students ask questions like "what is sperm? Where does it come from?" Well I can answer that question easily in front of boys but I feel a little uncomfortable to explain that to girls. Because of this situation I have requested them (health care providers) to take the class. (School Rasuwa)

Another teacher mentioned that if he teaches openly about ASRH villagers might think he is behaving inappropriately.

"If someone from outside comes and finds out that school teaches students about SRH then they feel shy because I teach this kind of subject. The villagers might think I am pervert" (school Nuwakot)

1.11 Content needed to be added in curriculum

Teachers mentioned that topics in the curriculum are fine. Some additional topics on ASRH and pregnancy related topics need to be added.

"Before there wasn't enough contents in the syllabus but now students learn about HIV/AIDS since grade 4 or 5. I think there should be addition on topics like sexual and reproductive health, pregnancy related things. Apart from that everything else is fine." (School Rasuwa)

Another teacher mentioned that content on ASRH should be introduced for younger classes so that they can be more prepared.

"Girls have more problems related to reproductive health. If there was information about reproductive health for younger classes in detail it would be better." (School Nuwakot)

Another teacher mentioned that topics on violence like rape and trafficking need to be added.

"*Everything is squeezed into a single chapter. Taking one or two classes in the subject matter will not be effective. I think the chapter should be more focused, I think matters such as rape and trafficking should also be addressed*." (School- Rasuwa)

1.12 Adolescent friendly corner at school

Teachers mentioned that they have not established an adolescent friendly corner at their school. *"We haven't made adolescent friendly corner*." (School-Rasuwa)

"We haven't received any kind of information to build such a corner. We haven't received such information from any organization." (School-Nuwakot)

One of the teachers from Nuwakot mentioned that they used to have a health corner but they cannot make it sustainable due to lack of resources.

"There was a health information corner before. In that corner there used to be materials. But we haven't been able to give continuity to that program due to lack of resources." (School-Nuwakot)

7. Intervention

Peer education training

Introduction

As part of interventional research project entitled **"Developing Peer Support for Adolescent Friendly Sexual and Reproductive Health Services"** peer educator training was held from , 4 to 6 December, 2018 1st lot and 7 to 9 December, 2018 2**nd** lot in Battar, Nuwakot. Five schools from Rasuwa and five schools from Nuwakot participated in the training. Altogether, thirty five participants from Nuwakot along with 5 teachers and 41 participants from Rasuwa along with five teachers received training. Training was facilitated by Jill Allison, principle investigator of the research from Memorial University of Newfoundland, Laxmi Tamang, national principle investigator from WOREC Nepal, Abhiram Roy, program director from WOREC Nepal, CEO from AmakoMaya Rajendra Poudel, apps develor from Amako Maya Ramchandra Poudel, Anil Kharel, Bini Maharjan along with Elawati KC and Shweta Karna, researchers from WOREC Nepal. In the training, ASRH app "Sahayogi" was launched.

This research project was supported by Grand Challenge Canada with the implementing partner Memorial University of Newfoundland, WOREC Nepal and Amako Maya.

Major objective of the training

- Develop student leadership to become a peer educators in their school
- Increase knowledge of teachers and students on sexual and reproductive health and rights as the content of the training program.

- Teach students and teachers on use of tablets and its safe handling
- Clarify roles and responsibilities of students as a peer educators and teachers as a facilitator at school
- To launch ASRH app "Sahayogi" among the intervention group
- To distribute tablets to intervention schools

Training sessions

Training was conducted in two lots, first to Rasuwa group and second to Nuwakot group with the similar setting, schedule, facilitators and contents. The training session is described below , outlining the three days for both groups.

First day (4th December and 7th December, 2018)

First day training was started at 8;00 AM by welcome session. Dr Laxmi welcomed the participants and also explained the objective of the program.

Activity 1: Welcome program was followed by introduction of the participants through an ice breaker game. It was facilitated by Abhiram Roy. During the game, each participant chose one unknown friend and shared their name, address, two similarities and two dissimilarities between them. Each of the participants (including teachers) would then introduce their new friend to the group sharing the information they had learned about each other. The purpose of this exercise was to build some friendship and familiarity between participants who did not know each other prior to participation.

Activity 2: Introduction session was followed by making **ground rule session,** where participants and facilitator agreed and rules were made. Ground rules focused on respect for each other, being attentive and serious about learning, respecting the facilitators, time, and the equipment.

Activity 3: Subsequent to the introduction session, pretest was conducted. To assess the thematic knowledge a pre-test was administered with questions based on the content of the ASRH program. Participant's identity was made anonymous on paper. This was done to assess baseline knowledge of the information. This pre-test consiste of 15(??) questions taken from the content of the Sahayogi App.

Activity 4: In order to assess the level of understanding of technology, a gallery walk was conducted with questions on familiarity with apps and technology. Questions were written on newsprint and hung on wall. Participants were given a marker and invited to tick what they thought was the best answer on the newsprint.

Participants observing questions and putting a tick

Activity 5: As part of the introduction of terminology, group work was conducted. In the group work participants were divided in five groups and they were given different sets of news print. The groups listed as many body parts and terms related to sexual and reproductive health as they could think of. They shared their lists as a means of building respect, comfort with terms and an understanding of what language was common, what language was respective and what language was considered inappropriate. The objective of this activity is to build comfort and familiarity with language.

Activity 6: A second activity aimed at terminology then took place as we asked everyone to respond to the question" What do we mean by…" This activity introduced terminology related to sexuality and identity, sexual activities and other terminology. Mr Abhiram Roy facilitated the session in Nepali with words translated and printed in Nepali language.

SRHR terminologies that were discussed:

Heterosexual	**sexually transmitted disease**	**Partner**	**Gay**
Celibate (Abstain)	**Lesbian**	**Transvestite**	**Bisexual**
Snogging	**Homophobia**	**Homosexual**	**Masturbation**
Gender	**Orgasm**	**Sex**	**Rape**
Feminine	**Anal sex**	**Oral sex**	**Contraception**
Masculine	**Safer sex**	**Kissing**	**Love**

Friend	Transgender	Sexual	Sexist
Vaginal sex	Abortion	Consent	Confidentiality

Activity 7: Subsequent to the group work, body mapping game was played. In this game participants were divided in same five groups. They were asked to draw the outline of girl and boy on newsprint. During body mapping they were invited to draw and label male reproductive organ (external and internal) and female reproductive organ (external and internal) and sexual activity. Participants actively participated in the game. After that each group presented what they had drawn and discussed their images. The purpose of the this activity was get students to talk and understand the embodiment of reproductive organs and bodies, to be less shy and to encourage some respect for each other as they explained the bodies they had drawn. This activity also encouraged some fun and laughter as people shared their drawings. We were also able to gauge the level of knowledge about anatomy and physiology from this activity.

Participants drawing the outline of their friend's body

Participants drawing female reproductive organs

After they finish drawing, one male group member presented female reproductive organ and female group member presented male reproductive organ. This encouraged each to be familiar and comfortable with describing the body parts of the other sex.

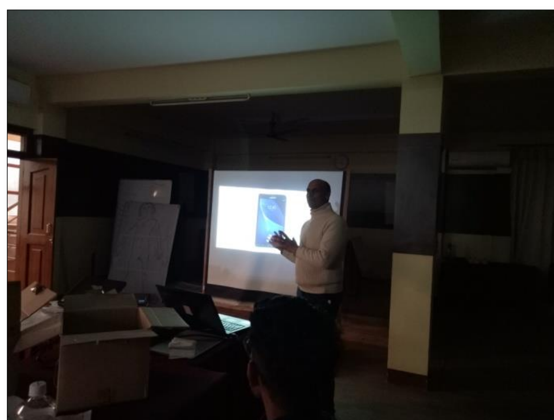
Particiapants from Rasuwa presenting male reproductive organ

Participants from Nuwakot presenting female reproductive organs

Activity 8: Discussion and Consolidation. After the game, Dr Laxmi summed up by explaining reproductive organs of male and female. She asked participants the name of reproductive organ on different local language which they use in their locality. This made participants to open up more and lessen their shyness. She also explained the way of maintaining hygiene of private parts and some disease related to reproductive organ like uterus prolapse and fistula.

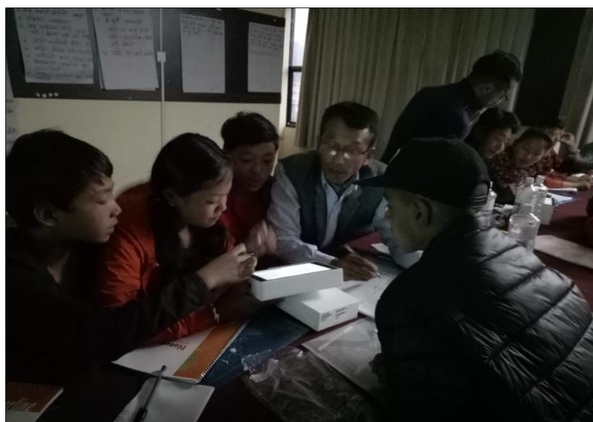
Dr Laxmi showing the way of cleaning perineal region after defecation

Second Session (afternoon Day 1) Activity 9: After lunch, session on introduction on tablet was conducted by Mr Rajendra Prasad Poudel from Amako Maya. He introduced android tablets and the way of using it. Before he reached the major part of session he also discussed the result of gallery walk. After the lecture on android tablet and its safe handling, students in a group along with their respective school teachers were given tablets and they practiced using apps on tablets.



Mr Rajendra Poudel presenting on android tablets

It was followed by practical session on using tablets.



Students with teacher practicing on using apps on tablets

Second day (5th December and 8th December, 2018)

Activity 10: Second day session began with review of day one. Review was done by passing the ball among students. Students who got the ball had to talk about what they remember from the previous day session. Students discussed multiple topics from the previous day. This activity provided a review and encouraged everyone to speak. It also provided a fair way to involve everyone in the conversation.

Activity 11: After the review, we played a game focused on masturbation. All the students were gathered at one place and they were asked to agree or disagree with the statement they heard on the subject of masturbation. The facilitator narrated different statements and students moved to one side of the room or the other or remained central based on whether they agreed or disagreed or were undecided or neutral regarding what was said based on their knowledge or opinions. The facilitator asked students to explain why they agreed or disagreed and many participants answered based on their reasons. At the end of game, facilitator gave the correct answer to all statements. Mr Abhiram Roy facilitated the session.

Participants gathering at corner and explaining why they chose the side in activity.

Activity 12: After the game, there was a lecture on adolescent and youth sexual development and sexuality by Mr Abhiram Roy. He discussed different stages of adolescence and physical and emotional changes that occur during this phase of life as well as social issues such as early marriage, early pregnancy, STI/HIV/AIDs, substance abuse and why it is necessary to avoid those problems. Information also included sexual and reproductive health rights like, consent, health, accessibility to health services and information, decision on giving birth, and decision on getting married. The main crux of giving these lectures was to make participants aware on their rights as well as their responsibilities with respect to themselves, others and society.

Mr Abhiram Roy giving lecture on adolescence, sexual health, consent and rights

Activity 13: An interactive session called "What's in the Bag" on family planning was conducted. Students were divided in nine groups. Each group was given a bag with family planning device and leaflets that explained the use, potential side effects and availability of each device. Each group was assigned a task to present to the larger group after they read the leaflets and looked at, handled and thought about the devices and medications.. The audience asked "what is inside the bag", and the presenter started explaining about thefamily planning methods in their bag. They were invited to explain who would use the device/medication, how to use, when to use, indication and contraindications.

Participants from Nuwakot reading about FP devices from leaflet

Activity 13: A video entitled "sahamati" was shown. Video was about consent for sexual relationships. The video compared sexual activity to giving someone a cup of tea. If someone is unconscious they cannot consent to drinking a cup of tea. If someone says no, they don't ant tea you should not force them to drink tea. This was followed by a discussion on sexual and reproductive health rights.

Activity 15: A series of videos on child marriage were shown and a discussion was encouraged. The videos included "From child to bride to mother" about how an adolescent girl might fall in love and decide to marry and the further consequences she would face.

Activity 16: A presentation on sexually transmitted infection (STI) was conducted. Dr Laxmi Tamang facilitated the session. STI session was followed by condom blowing game. The main objective of playing condom blowing game was to familiarize participants with condoms and lessen the shyness. The one who make the largest size of condom by blowing it was awarded with chocolate.

Participants playing condom blowing game

Activity 17: A subsequent session to practice on tablets and the use apps was conducted.

Third day (6th December and 9th December, 2018)

Third day session began with review of previous day.

Activity 18: Review session was followed by, roles and responsibilities of the teachers and peer educator. After going back to school what will teachers and students need to do was explained in the session.

Activity 19: Post-test to assess change in level of knowledge.

Activity 20: Reflection session was held to invite participants to share their thoughts about the training session. After that training was closed by closing remarks and vote of thanks. Jill Allison, principle investigator gave thanks to all participants for joining and making this project successful. All the teachers, one male and one female students also gave thanks to the organizer

for providing them opportunity to be a part of research. Tablets were distributed to the schools. Two tablets were given to each school. Students were also given record file and diary to keep the record of their work in school.

Innovation in Workshop Methodology

Throughout the workshop we endeavored to keep things interactive, fun and challenging. The students and teachers came to expect the unexpected. While the students and teachers were surprised by the level of frankness and openness of our teaching style, they also participated fully. We also used the opportunity to consult with the adolescents who participated about the situation in their own communities. They were regularly given opportunities to share their perspectives and experiences in a non-threatening and supportive learning environment. When it came to the opportunity to learn about the contents of the application students contributed many stories about situations that happened in their own communities. We took those stories and incorporated them, where possible, into the program in real time. This way they saw their own contributions to the information being built into the program. These stories included incidences of early marriage, sexual harassment, LGBTQ identities and health issues linked to pregnancy and childbirth.

Result of pretest and post

For pretest and posttest participants were given a questionnaire of 20 questions. We categorized three types of score.

Less than 11-low marks-red color

11-15-average-yelllow color

Above 15-highest mark-green color

In pretest for Rasuwa group, three participants scored lowest mark below 10, whereas 8 participants scored highest mark from 16 to 20.

In posttest, five participants scored average mark from 11 to 15. Remaining thirty participants scored highest mark above 15. None of the participant scored less than 10. This shows that participant's level of knowledge has been increased after training.

Rasuwa

Pre test result

Scored obtained/20	Number of Participants	Total Percent
9	2	45
10	1	50
11	4	55
12	4	60
13	4	65
14	7	70

Post test result

Scored obtained/20	Number of Participants	Total Percent
12	1	60
14	1	70
15	3	75
16	3	80
17	9	85
18	10	90

15	5	75
16	4	80
17	3	85
18	1	90
Total	**35**	

19	6	95
20	2	100
Total	**35**	

Result of Nuwakot,

In pretest for Nuwakot group, eight participants scored lowest mark below 11, whereas eight participants got highest mark above 15.

In posttest, one participant got lowest marks below 11 and 39 participants got highest marks above 15. This also shows that participant's knowledge has been increased.

Result of pre test

Scored obtained	Number of Participants	Total Percent
9	6	45
10	2	50
11	4	55
12	7	60
13	5	65
14	8	70
15	6	75
16	2	80
Total	**40**	(1 participant were absent)

Result of post test

Scored obtained	No of Participants	Total Percent (%)
10	1	50
13	1	65
16	2	80
17	7	85
18	11	90
19	14	95
20	5	100
Total	41	

8. Monitoring

After the peer education training, peers and teachers taught other students on what they have learned during training and about use of tablet. Researchers along with technicians also reviewed with students the use of the app, the login procedure and care of tablets. Three monitoring visits were undertaken over the course of the 10 months to see how they were engaged in this program.

<table>
<tr><td> </td><td> </td></tr>
<tr><td>Students learning to register their account in app</td><td>Researcher showing students about the procedure to login and play different game</td></tr>
<tr><td> </td><td> </td></tr>
<tr><td>App developer showing students, how to use tablet and play game</td><td>App developer showing students, how to use tablet and play game</td></tr>
</table>

Students learning to use app	Students using tablet

9. Post survey

Post survey was also conducted in 20 sites of Nuwakot and Rasuwa district. Like the pre survey, post survey was conducted in school, health post and community of intervention and non-intervention site. From 20 schools 1,933 adolescent participated in survey. One day workshop was conducted for each district, where participatory approach like FGD, gallery walk theater role play and group discussion were also conducted.

Results of post survey

Qualitative result

1. **Early Marriage**

Early marriage is common in both districts. Among Aryan community (Brahmin and Chhetri), marriage by parent's wish (arranged marriage) used to be common, but now self-initiated marriage has become common. Whereas among Mongolian community (Tamang), self-initiated marriage is part of culture. At first the couple "runs away" together. After sometime there is ceremony called "tolchyang" where both girl's and boy's family come together for an agreement. After a year of tolchyang, the couple gets married. Through this process the couple can stay together even before they get married. It is not uncommon for couples to run away during major festivals Lhosar, the Tibetan New Year celebration.

"They (adolescents) get married, there are many students who left school while studying. When the guardian of class 1 and 2 come to school. I observe them, they are not more than 19 or 20 years. That means… they have got early marriage." (FGD participant, Male, 25, Dalit, Hindu)

One of the participant shared that, every year 5/6 students run away from school and they discontinue their study too.

"I want to take example of school than community. In this school there is early marriage. Last year, no last year of last year, (2 years ago), there were 75 studenst in class 9, and out of 75 studenst, 5 or 6 students did early marriage." (IDI, Female, 16, Janajati, Student, Budhhist)

"They run away directly from the school….,it is prevalent. Yes, it is seen occasionally. Student run away despite the fact that we warn them. It is like a trend now. In the past, it was more like forced marriage but now they run away of their own will." (IDI participant, Female, 23, Janajati, Budhhist.)

"I actually belong to "Uttargaya" municipality. I mean that is my home town and child marriage is prevalent there. If not to lie, then my own sister ran away at just 15 years of age and she is in "Rukum" now. Similarly, my uncle's daughter and my cousin sister, and my maternal uncle's daughter they all ran away before 20 years of age." (IDI student, Male 16, Janajati, Budhhist)

"Yes! Actually, in our "Tamang" community, there is a ceremony called "Tolchyang". After "Tolchyang" normally family agrees. But that is not a marriage; in our tradition marriage happens after a certain period of "Tolchyang". In "Tolchyang" we also ask questions to boys about his plans, we ask them how they fell for each other, we ask them whether they both liked each other, both agreed to stay together or it was by pressure and all. There is a small meeting between the two families. Questions are asked and of the couple satisfyingly answer then they are allowed to stay together. After the "Tolchyang" procedure it's like giving the daughter to her in-laws family. They then take the responsibility of their daughter-in-law."(IDI student, Male 16, Janajati, Budhhist)

2. **Reason of early marriage**

The main reasons for early marriage identified were lack of awareness, early marriage as a culture and lack of social support for inter-caste marriage.

Participants believe that early marriage is happening due to lack of education among adolescents and parents. And in some community early marriage is well accepted.

Yeah, due to lack of education and also due to the influence of friends and other reason. It is also due to the lack of awareness and education in parents. (IDI participant, Male, 52, Brahmin, Hindu)

"Yes! It is prevalent here. More immensely… adolescents themselves are responsible for this. It's not their parents who force them, it is because of adolescents themselves. It might be due to lack of education but even the culture of this community is like that. They get married early and then settle according to that. " (IDI participant, Female 27, Brahmin, Hindu)

One of the participant described the association between early marriage and Lhosar which is celebrated in the Tamang community.

"Usually people run in Lhosar." (IDI, Female, 16, Janajati, Student, Budhhist)

Participants also described how young people in the community run away run away if they fell in love with someone who is not from their caste. They think that their parents will not allow them to marry so they run away.

"Girl was from high caste and boy was from lower caste. In such case they run to marry. I think, they might feel that if they do not get married at that time, their family might create obstacles. They might think that in future they may not be together." (IDI participant, Female 16, Janajati, Hindu)

"In my community (Tamang community) parents agree for marriage. Brahmin and chhteri are upper caste so they do not want their children to marry lower caste." (Female, Janajati, Age 16, Unmarried, Hindu)

One mother talked about her fear that her other daughter would run away with someone from another cast like her elder daughter did. So, she initiated an arranged marriage for her other two daughters even thought they were not yet 20 years of age. .

There is saying, "ban ko bagh le khaos nakhaos, man ko bagh le khancha" (a tiger (fear) in your mind is likely to devour you more than the real tiger in the jungle. My elder daughter ran away, then I should give my other daughters when proposal comes. Isn't it? (IDI participant, Female, 50, Janajati, Budhhist)

3. Returning to school after early marriage

Very few adolescents return to school after marriage. Because of shyness they did not continue their school. There is not a welcoming environment in school and community where adolescents can come and continue their study. However, in few case they have come back and studied too.

Self-initiated marriage has decreased as compared to before. But some of them run away. My mitini (best friend) ran away and after marrying, her husband brought her back to school for continuing her education but our teachers didn't agreed to provide her education saying that other students will imitate or follow her and it will spoil the study environment."

(IDI participant, Male 15, Janajati, Budhhist)

4. Right age of marriage to parents

Parents we spoke with felt that the right age of marriage is after 20 years.

"Right age of marriage is 30 years for guy and 25 years for girl. In that age one will be economically independent. If girl and guy want to marry too soon, is that good? No, it's not." (IDI participant, Female, 50, Janajati, Budhhist)

"After 20 years and after completion of her study if they guy comes to me with the proposal to marry my daughter I will allow. That is the practice …I cannot stop them … I cannot give them dowry …. But if they will run away before 20 years I will try to separate them and then convince my daughter that it is not good … if they will follow me its good and if not I can neither scold them nor beat them." (IDI participant, Female, 40, Janajati, Christian)

"I think the appropriate age is when they have completed their education. In our village, people mostly get married after 16 years and some in 20 years of age. Even my brother's daughters got married in 16/17 years of age. Main thing is they should complete their education, age doesn't matter. Mostly they complete their bachelor and start their masters after 20 years of age." (IDI participant, male, 52, Brahmin, Hindu)

5. Parent's choice of marriage

Many parents seemed to prefer arranged marriage between same caste. They were okay, if they fall in love and get married within the same caste. But they did not mention that they will be happy if their children get married with another caste. However, parents from Tamang community said if their children married people from other castes then they do not have another option except accepting them.

"My two daughters have done arranged marriage. Now I have a younger daughter. She can love and later that can be changed into arranged marriage. I have said this to her as well." (IDI participant, male, 52, Brahmin, Hindu)

"I wish they marry as per our wish, but if they wish to marry whoever we have to accept as son in law or daughter in law. What we can do?" (Female, 50, Janajati, Budhhist)

"I don't know what to say … how will I react …. The thing is if your children prefer other religion like Brahmin or chhetri … you have to go with them … we have to accept the decision." (IDI participant, Male 32, Janajati, Buddhist)

6. Perception on pre-marital sex

Participants also felt that adolescents should not be involved in sexual relation before marriage.

"*Yes. Adolescents below 20 years should not have sexual relation."* (IDI participant, Female, 15, Janajati, Hindu)

"No! It is not appropriate, the girl is allowed to enter in-laws house only when she is married … before marriage she stays with her own parents … it's not appropriate… If such adolescent meet me I will advise them not to sleep before marriage, it is bad practice. I will also suggest them to use FP devices … use injection … before having sex." (IDI participant, Female 40, Janajati, Christian)

7. Teaching of ASRH class

Participants shared that teachers did not explain well while teaching ASRH class. They made students read themselves.

"Even now there are teachers who don't teach ASRH issues in the class … they say like we are mature enough to read those things … even in my school they don't teach us." (FGD participant, Female 16, Janajati, Buddhist)

They just say us to read and ask them if there is anything that we didn't understand.-(FGD participant, Female, 16, Janajati, Budhhist)

8. Parents Perceptions of ASRH knowledge and need for education.

Several parents highlighted the value of ASRH. There was a significant difference between how women and men engaged with us about this subject and with regard to their participation in the education of their children. Women tended to be brief, identify their own lack of awareness and suggest they were not in a position to provide education to their children. Men tended to speak with more of a sense of confidence about the topic and sometimes identified the responsibility for education children as parental whereas mothers suggested it was an education system responsibility. Mothers stated that they did not provide their daughters with any information even about menstruation.

R: *In our Tamang culture we do not know about each-others menstruation. Neither I know about my daughter's menstruation nor does she know about me. If we knew about each other we feel shy … (Smiling). We don't have practice of sharing about it in our Tamang community.*
I: *Oh! When you see blood you feel ashamed?…*
R: *Yes! So we don't show to anyone. We take care of it ourselves.*
I: *Don't they share when they menstruate for the first time?*
R: *No! They don't. No one says …*
I: *Ok! So if you don't teach them who will teach them when they menstruate for the first time … like they need to use cloth or pads and that is why they need information about that … who informs them?*
R: *I just leave her random … I don't interfere about menstruation in her life … she might have friends … friends might teach them about these things … even I have my friends and they teach me too. But we don't have practice of asking our daughter whether she menstruates or not.*
I: *What your daughter did in her first period?*
R: *She might have consulted with her friends and her sisters …* (Tamang, Mother, 40, Homemaker, Christian)

Mothers often linked their own lack of awareness on sexual and reproductive health with hardship and lack of education. While they supported the idea of education they were unclear what their children were learning at school.

> *Yes, I have suffered because I did know anything. But I do not want to see my children suffering. Whether its son or daughter I wish good thing happens to them. …Yes, I think my children should not walk ups and downs like me. I wish they will not have a high number children like me. They may have less children. They may have one son and one daughter. They may get good facilities. I wish they should not carry heavy weight like me. I wish they will not have hardship like me. I think so.* (Mother Tamang, Janajati, house manager, age: 50, No education, Married, Budhhist)

In the following exchange we see a mother describe how she does not go out and does not know much but is being taught about sexual and reproductive health by her daughters who are in school.

> *R: I do not know anything, I do not go out much, so I do not know anything.*
> *I: Do you know about menstruation? About reproductive health? About pregnancy…related things?*

R: I know cleanliness should be maintained. We need to maintain personal hygiene.
I: Have you suggested your children to maintain hygiene?
R: They have told me so
I: Did you tell your children or your children told you?
*R: My daughters teach me these things, to maintain hygiene, to maintain cleanliness, otherwise disease will infect you. (*Tamang, Janajati, Female, House manager, No education, Married, Bushhist)

In the following exchange a father speaks candidly and at length about the need for ASRH education and services. Unlike the mothers we spoke with, he goes on at length and provides examples of situations. He is asked if access to contraception to both married and unmarried adolescents will have a negative social impact.

R: No, it won't ruin the society but will improve the society.
I: Safe abortion is also one of the issued being heard, do you think safe abortion is necessary?
R: yes it is. According to my perspective, the laws should have formed far before. While talking about this topic, my two daughters are already married and I have a younger daughter left in my home, it might create other effects in her child psychology. But these things are really important. You and I have seen the statistics, before safe abortion policy many women have lost their lives in young age. Taking unsafe medicines to abort their baby… let me tell you about the incident here: a girl from lower cast got pregnant and she drank kerosene after that. We couldn't save her. If safe abortion was legal then she would not have lost her life. **(Father, 52 yrs, Brahmin, Hindu)**

The following conversation with a mother suggests her reluctance to discuss what she shares with her children regarding sexual activity.

I: Do you have talk on topic like adolescent should not have sexual relation at young age?
R: No we do not talk on such topic. (Tamang, Janajati, Female, House manager, No education, Married, Bushhist)

In the following exchange a father is emphatic that children should be taught about sexual and reproductive health but is unable to articulate why. His wife is invited to answer instead pointing out again, the lack of education and the importance of knowledge in improving their lives.

R (father): Yes! It is very important and even we parents should educate them about these things … to our son and daughter.
***I:** Why do you think it is important? Why they should know about these things?*
*R (father) **:** I don't know what to say …. (Talking in tamang language)*
I: Will you say Didi (Pointing towards wife) why do you think children should be taught about ASRH … why should they participate in the training?
*R (mother)**:**I think it is important for them …. During our time we didn't know much about these things so we were left untaught … so I want at least my children's to know about this thing… It makes me happier …*

9. Perception about peer education training

Participants mentioned that peer education program was effective program for them. Adolescents were able to learn many new things which were not taught in their school. Students got more knowledge on adolescent sexual and reproductive health (ASRH) which was not included in their curriculum.

"We came to know so many things by all of you. Initially we didn't have much knowledge. We were taught just the things which were in the syllabus. Even in heath subject we were not taught much about sexual health. So coming here, training has improved our knowledge in all aspects." (FGD, Female, 17, Janajati, Budhhist)

Some participants also felt that training could have an impact in mitigating child marriage prevailing in society and also to overcome misconceptions about ASRH.

"*We got to learn about things that we didn't know before. Those who got to read Sahayogi app in school got to know that child marriage is so much prevalent. And this awareness has highly prevented child marriage."* (FGD, Male, 14, Brahmin, Hindu)

*"Program which you have introduced on sexual and reproductive health is very relevant. Why this is relevant, because, students can learn through tablets themselves. They can also practice in tablet which is very nice. This is also the matter of their concern. This program is successful to mitigate misconception of students on sexual and reproductive health."-(*FGD, Male, 37, Janajati, Budhhist)

10. Perception on Sahayogi App

Participants of FGD and IDI have revealed that sahayogi app has full information on ASRH. Students were excited to use the technology because they have not used such technology before and due to games and videos it was also fun to use.

"Yes, this program is nice, student has learned many things. Regarding this tablet, my students were very excited to use it. They also look some other educational video on it. They are using it. Students seemed to be excited to use it" (FGD, Female teacher, 35, Brahmin, Hindu).

"Tablet is very informative. It is useful to adolescents. There is information on adolescent sexual and reproductive health. There is also information on how to solve the different problem during adolescent period. Overall, app is very nice." (IDI participant, female, 15, Janajati, Budhhist)

One teacher even mentioned that it has made it easier to conduct ASRH class and change the behavior of students.

"After using apps, it has made it easy to facilitate ASRH class. We used to hesitate to pronounce some words, before training. Now, we have become more open. We have a huge class, of 70/80 students. In such case what we do is, we take the tablet in class, we also take help of peer educator to facilitate the class. We make group in class, and give tablet to have discussion. So, in this way it has help us facilitate ASRH class while teaching health subject. We are also been able to change behavior of students." (FGD participant, Female, 34, Brahmin, Teacher, Hindu)

11. New things learned from this program

Most of the participants shared that topics such as masturbation, nightfall (nocturnal ejaculation) and information on LGBTQ sexualities were new to them.

"I came to know about masturbation, before that I have never heard that term. When I listened here for the first time, I was so surprised." (FGD participant, Female, 16, Janajati, Student, Budhhist)

"I had known little about gay and lesbian before but bisexual, transgender were new things to me." (FGD participant, Male, 13, Brahmin, Student, Hindu)

Participants also explained that while topics like sexual and reproductive health were in health curriculum, such topics were not discussed much in class.

"We came to know so many things by all of you. Initially we didn't have much knowledge. We were taught just the things which were in the syllabus. Even in heath subject we were not taught much about sexual and reproductive health. So, coming here improved our knowledge in all aspects." (FGD participant, Female, 15, Janajati, Budhhist)

12. Activities and Initiative taken by peers

Many peers told us they felt empowered and had taken initiative and conducted various activities in their school. Early marriage is one of the major social problems identified in both districts. Peers have taken major initiative for prevention of early marriage. In addition, overall ASRH issues were discussed through sharing and discussion programs.

"We conducted a quiz contest by using the questionnaire of apps. I just listed down the questionnaire from the app and used that in our program." (FGD participant, Female, 15, Janajati, Students, Budhhist)

In several schools, students also organized a dramas on early marriage. They were also invited by local ward and municipal officials to perform in the community.

"We organized street drama in the issue of early marriage… even kalikasthan called us for that … In Ramche, after a long time such inspirational drama was conducted … after so long … it was very good and we were appreciated by ward officer and also by municipal officer." (FGD participant, Male, 15, Student, Budhhist)

I wrote the script about early marriage and about how we can lose our lives if we get married and get pregnant in young age. And in our drama we showed the suffering of girl during a labour and we also showed the death of girl and boy under a bad influence (Kulatma faseko)…and how a boy tricks a girl by saying that he loves her a lot, sahayogi app helped me to write such scripts, there was story related to that in the app (IDI participant, Janajati, Female, 16, Student, Budhhist)

Some peers conducted a role play on family planning (FP) devices during the festival of Tihar, during bhailo and deusi program. Tihar is one of the festivals of Nepal, where people celebrate by singing and dancing.

"During tihar we conducted a program and in that we conducted a role play like we did here in the training … it was about FP devices" (FGD participant, female, 15, Brahmin, Hindu)

Some peers also conducted drama and performed songs during Teej. Teej is a festival of women where women celebrate by singing and dancing.

"During "Teej" also we conducted a program, after the training we conducted so many small dramas around on early marriage." (FGD participant, Female, 16, Janajati, Budhhist)

Students taught all other students to use the app and how to login it.

"We have taught everyone to use app and provide information by putting them together in the same room." (FGD participant, Male, 14, Brahmin, Student, Hindu)

Some students taught other students about the Sahayogi booklet, that was provided in training and also they taught about app.

"First two to three days, we conducted sessions in our respective classes. We were in class 8, we had book that has picture in one side and information on the other side (sahayogi booklet), we took that and showed it, we taught them to use tab as well. We took the notes we made in the training and teach them all the things written in the note" (FGD participant, Male, 13, Brahmin, Hindu)

Some peers educators told us about initating teaching to other classes on topics they were taught during peer education training.

"After receiving training, myself with my friend who went to take training with me, we went to take class to all the classes even junior classes, when teachers were absent. We taught them what you have taught during peer education training. We also showed them all the pictures and chart paper, poster you have provided to us. I taught about masturbation, uterine prolapse, contraceptive device, abortion, what causes abortion, I taught everything about it." (IDI, Female, 16, Janajati, Student, Budhhist)

There some challenges for peer educators as well. Some also mentioned that when they were teaching on ASRH other friends felt shy and called them immodest.

"After the training I and "Lakpa" (another peer, name changed) went to our class to take some sessions … there when we start talking about ASRH all of our friends were so shy … some hide their faces, some started laughing.. Some feel ashamed … some turned back … they even shouted at us and called us immodest. (FGD participants, Female, 15, Student, Christian)

13. Change in behavior of students

After the training one major thing both teacher and students revealed regarding the change in behavior is, students have become less shy and they can deal with issue of ASRH comfortably.

One of the teacher during FGD mentioned that, after training boys started coming to ask sanitary pad for his friend. And she believed, it is a great change.

"I have not noticed everything, but what I have noticed is, we have sanitary pad in our staff room. When girls has period they used to feel shy and send one girl all the time to take sanitary pad. But after training, even boys came to ask sanitary pad. Isn't that a great change? I think one boy from here (peer educator) and another boy from school (who is not peer educator), they came in staff room full of teachers and they ask for sanitary pad for girl of their class, 3 or 4 times. Boys coming to ask for pad, I think this is a change." (FGD participant, Female 26, Janajati, Teacher, Budhhist)

Another teacher mentioned that, there was a provision of sanitary pad but girls were hesitant to ask for it and they used to send on girl all the time to ask for sanitary pad. After training, many girls started coming to ask for sanitary pad. They were also insisting their teacher to conduct some awareness program at school.

"We have a provision of sanitary pad at our school, before few student used to come and ask for pad. Now everyone comes and ask. They have been open in this regard, everyone is open. Now after using tablet, student are keep saying me these days to do some program on awareness like drama, poem competition or singing. I have told them, we will do it. Student are saying to do in between dashain and tihar. Students want to do some program what they have learned from tablet. They have been open." (FGD participant, Female, 35, Teacher, Hindu)

One of the teacher mentioned that, students were very shy at first and felt that they were asked bad question (chada chada prana sodeko thiyo) during pre-survey. But later, after training they realized everyone should understand these things and convinced their friends that we should not feel shy. Chada is a Nepali term used to say when people used unsocial, vulgar word.

"*There are many changes. When WOREC staff did their first survey…After completion of survey, students started saying that we were asked such a vulgar question (chada chada prasna sodeko thiyo). We felt so shy to read and answer. Later on when WOREC did their first training and distributed tablet and had interaction with students, then student started realizing that these are the things we should learn, we should not feel shy. Though we were not there, but students were trying to convince other students in such regard. I think that is a change."*(FGD participant, Female 21, Janajati, Bhudhhist)

Students revealed that they feel less shy and can talk in these issue more comfortably than before.

I liked it (Sahayogi app). Before, we used to feel shy and uncomfortable to talk about sexual health but after we learnt from Sahayogi app we don't feel shy anymore. (FGD, boys, 14, Chhetri, student, Hindu)

In class 8 once I tore all the pages of female reproductive parts stuck in my class due to shyness but now I am not shy (FGD participant, Male 15, Janajati, student, Budhhist)

"Initially I used to feel shy to talk about ASRH issues with my family, still I cannot talk to my father about that … but its bit easy now to talk with my mother." (FGD participant, Female 16, Janajati, Students, Budhhist)

"Initially, I used to not change my underwear daily … but in the training you said us that wearing same underwear for long may cause fungal infection and other diseases and now I change my underwear daily." (FGD participant, Female 15, Janajati, students, Budhhist)

Yes. There is change in my son's behavior. If somebody get married before 20, he always says this is wrong. My elder daughter is 16 years old, we were talking like, when our daughter completes her 12th grade, we should get her married, though we were not serious. Then my 13 year old son said, if you do that, this is against the law. Police will come and arrest you.(IDI participant, Male, 52, Brahmin, Hindu)

One peer shared that he felt he was successful in stopping the early marriage of his sister by counselling her.

"One of my sisters… who is around 20 years now… she had a contact with one boy… and that boy has proposed a marriage to my sister….. but her mom was little strict type……. but her father didn't deny it… so the marriage nearly get fixed… then I knew about that and advised her to not to get married, so till now she is continuing her study." (FGD participant, Male, 14, Janajati, Students, Budhhist)

One peer shared that, although there was a provision of sanitary pad at her school, girls did not come to ask for them due to shyness. She then oriented girls regarding the provision and encouraged them not to feel shy. Then girls started asking sanitary pad when they had their period.

"Recently ma'am from WOREC visited our school; I shared her that we have pad facilities in our school, but the students don't go and ask teacher for that … She then suggested to conduct an orientation program. The very next day I conducted a program and all the girls from 7, 8, 9 and 10 were invited. I oriented them and after that they started feeling free to ask pads from a teacher". (Female 16, Janajati, Student, Budhhist).

One of the peer educators shared that he felt he was successful in convincing one of his friends to continue his study. His friend almost left school but he was able to persuade him to continue his study and at the moment he is doing pretty well.

"after taking this peer educator training … its 6 months before ...one of my friends dropped the school, I convinced him so much to join the classes again, I told him that if we will drop the school we will have so many problems in our life … I also told him that our ancestors weren't so lucky to get the opportunity to read but we are lucky at least and we should continue our study. I told him about the different facilities available at our school … about technology and tablet … I told him our ancestors read through chalk and board only but now we have new facilities we have projector and tablets … he was then convinced with me and he decided to join the school, I then informed him about sahayogi app and also taught him the ways to play games… quiz… he didn't show his interest much initially but later he was so much interested in the app and he

continued his study and is doing good now" (FGD participant, Male, 12, Brahmin, Student, Hindu)

14. Adolescent Friendly Corner

In all 20 schools an Adolescent Friendly Corner for education (AFS Corner) was not established. Most of the teachers said their building had collapsed during earthquake and their new building is still under construction.

"We do not have separate corner at our school. We already have scarcity of class room. In such situation we do not have separate corner." (FGD participant, Male 37 Teacher, Janajati, Budhhist)

"We have separated adolescent's corner in the ANC room because we don't have enough rooms. Anyway we have made corner for every services, we have tried but it's not systematic." (Female 23 Teacher, Janajati, Budhhist)

One teacher mentioned that although their new building is ready an AFS corner is not going to be established because no one has raised the need of AFS corner.

"Though we have building, I do not think, we are going to have those infrastructure… looking at the present scenario." (FGD participant, Female, 34, Brahmin, Teacher, Hindu)

15. Health seeking behavior of adolescent

All the adolescents told us that they visit the health post if they get sick but none of them visited the heath institution to ask about anything related with ASRH.

"We visit health post if we got sick. I haven't gone there with the issue of adolescence. We have not felt any needs and we all are aware on it (on ASRH)." (IDI, Male 16, Brahmin, Student, Hindu)

"Yes, we visit the health post when we had stomach pain. My sisters in our home also visit the health post when they had stomach pain." (IDI, Brahmin, Female, Student, Hindu)

"Sometime if I get sick, then I visit health post. Not much…I do not have much free time. I am busy on my study. I have a free time only on Saturday. So, I do not go much." (Female, 16, janajati, Student, Budhhist)

The main reasons for not visiting the health institution identified were first, adolescents do not have information that their health institution will provide adolescent friendly service. Second is gender issue, and third is they do not trust heath care providers not to share their personal information.

Participants also told us they have not felt need to visit a health institution. Although they have a curiosity they solve it by asking their teachers and family. If not then they read books. Adolescents did not identify that health post as a place to seek information about sexual and reproductive health because they are not aware that it is a place to do that. There is a tendency to ask each other for information before going to a health care provider.

"We have teachers at first to ask, we can also ask it in family. If the question is solved within ourselves, there is no need to go there. I will search in book and other related material. Those curiosities are solved on my own. If not then friends are there. They also know about things that I don't know. They also have curiosity just like me. So we share with each other." (Male 16, Brahmin, student, Hindu)

One female participant shared that because the service provider in her Health Post is male she cannot visit there and that she cannot trust them. She had a fear that her privacy can be breached.

I do not feel comfortable to ask on such matter. Moreover, there is a sir (male staff), with whom I hesitate to talk on these issues. I have never gone there. I just feel awkward to go there. I know it something, I want to learn more but I just cannot go there….everyone is not like us, they may not keep things secret. So I cannot trust them. (IDI participant, Female 16, Janajati, Budhhist)

Health care providers shared that adolescents who visit health institution come for other service than SRH. They are hesitant to ask questions and that could be due to lack of space in health post.

Students come but I do not know why they do not express anything to us. It is because of lack of space may be. Very few students share their problem. Not everyone wants to share, they might feel shy to share with us. (IDI participant, Health care provider, Brahmin, Female, 40 yrs, Hindu)

Participants also mentioned that older staff were not friendly as compared to young staff. Younger staff were friendly and they provide a more supportive environment.

"Some are not friendly, but those who are new are very friendly, they check up very nicely. Older staff, they did not provide us medicine, they might get irritated with children I guess." (Female, Janajati, Age 16, Unmarried, Hindu)

16. Adolescent friendly health service at health institution

Out of 20 health institutions, 17 institutions do not have separate adolescent counselling corner. Some health institutions provide counselling service by taking another room where there is privacy. Because of the earthquake most of the health institutions were in temporary buildings with insufficient space.

"We don't have separate place for counseling but we have a separate room for family planning service. We provide counseling to adolescents in that room separately without keeping people around." (Sah, Madhesi, Male, Health care provider, 56 years, Health assistant, Married, Hindu.)

"We lack space and our building is also like this. Actually, adolescent friendly…. It's like this, for maintaining privacy….. It's because of rooms… it's always because of the condition of the building… but we are ready to provide services and we have been providing the services as well. But we lack enough rooms." (Tamang, Janajati, Female, Education: ANM, Age 23, Unmarried, Budhhist.)

17. Accessibility of family planning method

Adolescent participants shared their mixed perceptions on the accessibility of family planning measures. Some said information on family planning service should be provided but

contraceptives themselves should not be made accessible because they think this will promote adolescent sexual activity if family planning measures are in easily accessible.

"Yes, they should be given information but they should not be given opportunity to use family planning device. Because, they might mis- utilize it." (IDI participant, Female, 15, Janajati, Hindu)

Other adolescents thought that contraceptives should be made accessible and that providers should be gender friendly.

"*Yes, I think it should be accessible to adolescents. Also, I think there should be such a person where adolescents feel comfort to ask for contraceptive otherwise they feel hesitation to ask. It should be available in health post. I think it is also available in medical shops (pharmacies)."* (IDI participant, Female 16, Janajati, Buddhist)

One parent shared that family planning measures should not only be available in health post but it should also be available in retail shops.

"Temporary family planning methods are available only in health office and pharmacies. It should be available in all retail shops (kirana pasal) for eg; in medicals if there is boy working then it will be difficult for a girls to ask. There can't be female staff in every medical shop. But in kirana pasal, either mother or father or son or daughter in law will be there. However the process of implementation should be, it should be free and available in all types of shops." (IDI participant, Male, 52, Brahmin, Hindu)

18. Use of the tablet based apps

Participants revealed that girls were more interested in using app than boys. Boys were more interested in playing outdoor game when they have leisure time.

"Yes! Most of them, actually girls get more opportunity as boys were busy playing football games." (FGD participant, Female 16, Janajati, Budhhist)

"*Boys weren't interested but girls were interested and were influenced to learn (prabhabit) and practiced in their behavior as well."* (FGD participant, male 16, Janajati, Budhhist)

19. Challenge faced during program

The major challenge of program identified were limited number of tablets, misuse of tablet, and less cooperation by teachers.

Participants noted that since the number of tablet were only two students had to wait to get chance to use tablet. This sometimes caused arguments among students.

"This program has not reached to all the students. Because all the students cannot have access to tablets. Number of tablet is less and student number is high. We have to wait for a time." (FGD participant, Male 37, Teacher, Janajati, Buddhist)

"Since we have only two tablet, sometime girls keep on watching, then boys come and snatch it from their hand. Though I monitor, sometime there occurs such incidents." (FGD participant Male 42, Teacher, Chhteri, Hindu)

"*We didn't get much chance to explore all the contents. There are so many friends in queue. So we just took at a glance and then pass it to our other friends."* (FGD participant, Female, 16, Janajati, Buddhist)

Participants also revealed that, there used to be misuse by staff of school.

"Misuse mean, our accountant sir is Tamang, head master is also Tamang. He (head master) has been recently been our head master. Accountant used to think that I am more expert than headmaster, because head master was quite young. Then accountant took the tablet in his home and take his personal photo during holi …like that." (FGD participant Male 32, Teacher, Brahmin, Hindu)

"Sometimes they (teachers) take tablets to their own houses and don't give us when we demand. That is why we could not use it very often; they used to carry it with themselves and used to click their personal photos. It was more like their materials. That is why we could not use more." (Female 15, Janajati, Budhhist)

"Another tablet is used by our teacher. He keeps it with himself inside his house." (FGD participant, Female 15, Janajati, Hindu)

Participants mentioned that teachers did not let them to use tablet and they became passive.

"Initially, we used a lot but later on teachers were not much active and they didn't let us use the tablet." (FGD participant, Female, 16, Janajati, Buddhist)

Initially he was so motivating, he used to tell us to use tablets but later on he did nothing. Even didn't give us tablet whenever we ask them. (FGD participant, Male 16, Janajati, Buddhist)

20. Suggestions for improving the program

Participants revealed that, number of tablet was low as compare to number of students. They have suggested to increase the number of tablet.

"I think number of tablet has to be increased. I do not know what is your plan and your capacity. Because of the tablet there was an argument. We just saw role play of students, where we saw there was an argument." (FGD participant, Male 37, janajati, Budhhist)

Participants suggested to install sahayogi app in other mobile phone and tablets, making it open source. .

"Everyone told about the limited number of tablet. I think if it can be installed in our laptop and our mobile phone then we can resolve the problem of limited number of mobile. I would like to ask, why that app is only functional in this tablet, why not in our mobile phone." Mingdolma (FGD participant, Female 26, Janajati, Teacher, Budhhist)

Participant suggested to continue this program for more years in order to lessen social problems.

"If this program is continued for 3 or 4 more years more, I think 75% of problem will be reduced. When will be 100%, after getting feedback from this program… as per the feedback if

we can conduct program then we can reach 100%."-Subhadra Lama (FGD participant, Female 38, Janajati, Teacher, Budhhist)

Participants also suggested that there should be more content in present syllabus in the text book and it should start from early class like 4/5 grade so adolescent will be more prepared and feel less hesitant talk about ASRH.

"I hope they add some more content there. I hope organization also coordinate with curriculum designer. I think things of ASRH should be included before the adolescent period starts, like from 4/5 class. If they are taught from that beginning then their behavior can be changed. When we try to change behavior after they reach to adolescent period then it becomes difficult to change behavior, their shyness" (FGD participant, Female 34, Brahmin, Hindu)

Participants also suggested that awareness programs should be conducted at community level. If awareness program is conducted to parents as well this will have an impact.

*"Yeah it is also necessary to educate parents. Just like the program you did on adolescents, you should provide education to selected parents. You should do this through planning on which group of parents should be provided with orientation that will make an impact in the society. For example if we provide trainings to parents like us (laugh). I'm just giving example. I am called to attend in various programs, like health education programs and I can share what I know in a mass. That's why, providing education to school children is effective. You have provided 2 days training to the children because they haven't developed their learning capabilities yet but if you provide education to the selected parents let's say only for a day or for 2-4 hours than it will be easier for your program."***(IDI, Father, 52 yrs, Brahmin, Hindu)**

21. Best way to educate adolescent

Participants recognized that different people have different taste; some of them said technology like the application based program will be effective, whereas some said not everyone has this interest. Some participants suggested other media as a means of sharing information.

Through projector, if we can show in each class, I think that will also be effective

(IDI participant, Female 15, Janajati, Student, Hindu)

For those who don't use mobile I think drama is suitable. They will watch with friends. Drama will be appropriate. (IDI participant, Female 16, Janajati, Student, Hindu)

"You should adopt training as well as use other methods like showing documentary. It (documentary) will provide different type (more effective) of messages. When trainers speak from the stage, children as well as people of our age group attention might get lost. So, if you show them the videos then you can grab the attention of audience. Moreover, what happens in most of the cases is that people tend to remember things you say only for a short period of time but remember they see for a longer period of time. Therefore, if you adopt the picture method in trainings then I think that would be more effective." (IDI, Father, 52, Brahmin, Hindu)

22. Difference between the ethnicity

There are a number of assumptions around on how different ethnicities act, particularly with respect to sexuality and reproduction. Some of our participants spoke about these assumptions with regard to how the peer educators and other students behaved. There is an assumption that Tamang were more open and they were more vocal as compare to Brahmin, Chhetri and Newar in terms of speaking on ASRH. One of the teachers mentioned that the Tamang are brought up in an open culture where parents do not impose much restriction whereas children of Brahmin/Chhteri were just taught to be modest and speak less.

"In Tamang ethnicity, they speak like a friend with their parents. They even speak bad words (chada bolchan), they have no tension. But, in our ethnicity (Brahmin and Chhteri), what we are taught is, we cannot speak with elders with eye contact. Moreover age also makes them shy. All this reason makes them (children of Brahmin/chhetri) such a person. I want to give you one example, one girl (girl who belongs to Brahmin/chhetri) from class nine, she is first girl among 71 students. She knows everything. But here when she has to speak on ASRH, she speaks slowly. Another girl (girl who belongs to Tamang community) from class ten, she keeps on saying that, sir today we need to teach this topic to this class, she takes the lead in school and she is very commanding too." (FGD participant, Male 32, Brahmin, Hindu)

23. Module of choice

During the final monitoring workshop a gallery walk was conducted to know the choices and ideas of the peer educators with respect to the program. Only students took part in the session. The eight different modules from our Sahayogi program were drawn on poster paper and stuck on the wall and the participants were asked to rank the modules according to their importance. They were asked to rank 5 top modules.

The result of both the districts is as follows:

S.N	Name of the modules	Rasuwa	Nuwakot	Remarks
1	Relationship	15	23	
2	Sexuality and Sexual Behaviour	15	20	
3	Staying healthy, sexual health	**26**	19	Highest
4	Violence and Safety	19	23	
5	Human Body and Development	10	**7**	Lowest
6	Family planning and women’s health	20	**28**	Highest
7	Sexual and Reproductive Health and rights and gender equality	**8**	22	Lowest
8	Healthy decision making and skills	15	19	

The participants from Rasuwa found staying healthy and sexual health as the most important module and Sexual and Reproductive health as the least important. The participants from Nuwakot found Family planning and women’s health as the most important module and Human body and Development as the least one.

24. Knowledge on SRHR

Participants were asked to write about their knowledge of sexual and reproductive health. They were given the task to write about family planning, menstruation and how easy it was for them to talk on SRHR issues after Peer friendly programs. The different groups were made and later they presented their work. They were given certain questions to answers.

Below given are the answers by different district.

S.N	Question	Rasuwa	Nuwakot
1	**Understanding on SRHR**	-SRHR means safe sexual activities between adolescent boys and girls. It means to take care of our reproductive parts and to have knowledge of safety measures. -SRHR means the cleanliness of reproductive organs. -SRHR includes the reproductive organs and their cleanliness. It includes delivery of the child, menstruation and postpartum period.	-Sexual and reproductive health is a subject that gives us information about sexual activities between boys and girls and their safety measures. -It includes all the procedures from pregnancy to delivery, reproductive organs and all other things related to adolescents. -It also includes nightfall, attraction etc.
2	**Easy to talk about SRHR issues**	-After the training we can talk about SRHR issues freely. -SRHR issues are the issues for adolescents and we must not feel hesitant to talk about that.	-We can easily talk about SRHR issues now, we are much aware now. -Initially we were afraid to talk about these things with our family members and now we can talk freely.
3	**Rights for adolescent on SRHR**	-Every adolescent should have SRHR right. -We have the right not to involve in sexual activity forcefully. -The right to love marriage and deliver the child. -The right to consent to both partners while having sex.	-Right to information about reproductive organs and parts. -Right to freedom from sexual abuse -Right for medical treatment of reproductive parts. -To not show the private parts to others by their coercion. -Right to family planning devices

4	**Family planning and its types**	-Permanent methods of family planning for males are vasectomy and temporary is condom. -Permanent methods of family planning for females is Minilap and temporary is cooper-T, pills, Implant, Injectable, Femi Dom.	-In female copper –T is placed in their uterus for 5 years. -The implant is kept in the arms of the women by simple surgery. -An injection is taken by women in every 3 months. -Pills are taken by women every day. -Male uses the condom during sexual activity. It is used just once -Vasectomy is a permanent method of family planning for males.
5	**Menstruation and its procedure**	-Menstruation is the process in which girls bleeds through their vagina. -It usually starts from 10 to 15 years. -Menstruating girls should intake fresh healthy foods and fruits. -One should maintain the cleanliness of the body. -One should maintain hygiene and dispose the pads at the proper place. -One should not lift heavy loads.	-Menstruation is natural process. -It occurs from 15 to 49 years of age. -It occurs in every 28 days. -When Ovum and sperm do not meet, they bleed through vagina.

25. Which is best? Technology or Non-technology

Discussion was held with the adolescents on the topic technology vs non technology. Participants shared their opinion. They were asked question which method they prefer more. Participants shared following view.

- Learning through tablets should be increased now as we are in the modern world.
- Learning through books does not have videos but in tablet we have audio-visual adds, games and many such things.
- Colorful pictures in the app really took our attention and we are much interested to learn through apps and tablets.
- You tube should be promoted for education.

26. What happened at school after distribution of tablet?
Theater role play was conducted to see what actually happened in school after they get tablet. Different groups were made from different schools and they were asked to role-play the scenario of their school. They were invited to act the way they are directly and indirectly related to tablets.

Students mainly showed following side;

Positive side:

- Some students thoroughly read the contents of the tablet.
- Teachers were helpful and provided tablet whenever asked.
- Peers and non-peers discussed the contents with each other.
- They conducted role play and other competition in their schools using the contents of the app.
- They used you tube to learn about various other things.

Negative side:

- Lack of tablets sometimes caused dispute among the students.
- One teacher took one tablet to his home and didn't return back to school.
- Some students played Pub-g and other games in the tablet.
- Some watched movies and serials through you tube.

Quantitative Result
Quantitative method of data collection was used, which included base-line and end-line survey. After the intervention end-line survey was conducted just after 10 months of period.

Instruments used were questionnaires which were applied in both baseline survey and end-line to enable a comparison. No additional questions in questionnaire were added during the end-line survey. Data form the survey was analyzed using statistical package for social science (SPSS), version 25. Percentage of respondent who gave right answer in pre survey and post survey was compared in intervention and non-intervention group.

Sample size of survey is shown below;

Sample size of Pre-Survey

District	*intervention*	*Non intervention*	*Total*
Rasuwa	**370**	**420**	**790**
Nuwakot	**613**	**374**	**987**
Total	**983**	**794**	**1777**

Sample size of Post-Survey

District	*intervention*	*Non intervention*	*Total*
Rasuwa	**412**	**425**	**837**
Nuwakot	**667**	**429**	**1096**
Total	**1079**	**854**	**1933**

1. During menstruation girls should do all of these except:

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Use clean clothes or pads to stay comfortable	102	27.6	103	16.9	112	26.73	47	12.6	57	13.8	97	14.5	82	19.3	48	11.2
2	Do all the activities that they normally do	49	13.2	81	13.3	51	12.17	42	11.36	22	5.3	59	8.8	60	14.1	58	13.5
3	Rest and take pain relief medication for period pain	17	4.6	75	12.3	40	9.55	38	10.19	22	5.3	61	9.1	34	8	25	5.8
4	Eat green vegetables, fruits, milk and other nutritious food	27	7.3	56	9.2	29	6.92	24	6.43	24	5.8	31	4.6	17	4	23	5.4
5	**Stay excluded**	**175**	**47.3**	**295**	**48.4**	**187**	**44.63**	**222**	**59.52**	**283**	**68.7**	**408**	**61.2**	**219**	**51.5**	**274**	**63.9**
	Missing system	0	0	3		1	0.2	1	0.3	4	1	11	1.6	13	3.1	1	0.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

2. During a woman's menstrual cycle the blood and fluid come from the vagina which is:

		Case				Control				Case				Control			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	The same as the place where urine comes out	235	63.7	412	67.54	277	65.95	215	57.49	196	47.6	421	63.1	272	64	264	61.5

2	**A different place than where urine comes from**	**134**	**36.3**	**198**	**32.46**	**136**	**32.38**	**154**	**41.18**	**213**	**51.7**	**241**	**36.1**	**137**	**32.2**	**162**	**37.8**
3	Missing system	1		3		7	1.7	0.80	3	3	0.7	5	0.7	16	3.8	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374 100**		**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

3. **Night fall is normal and healthy among boys/men;**

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%		%	F	%	F	%	F	%	F	%	F	%	F	%
1	Yes	210	56.9	326	54.0	263	63	239	63.90	311	75.5	402	60.3	263	61.9	277	64.6
2	No	159	43.1	278	46.0	154	37	134	35.83	98	23.8	254	38.1	149	35.1	147	34.3
3	Missing system	1	100	9		2	0.5	1	0.3	3	0.7	11	1.6	13	3.1	5	1.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

4. **All of these are signs of puberty except:**

S.N	Variable	Intervention				Non Intervention				Intervention				Non Intervention			
		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	A boy's body begins to change	26	7.1	67	11.1	36	8.59	22	5.90	16	3.9	27	4	34	8	22	5.1
2	A girl's body begins to change	30	8.2	60	10.0	44	10.50	11	2.95	38	9.2	51	7.6	28	6.6	18	4.2
3	Boys' voices get deeper and they begin to grow pubic and facial hair	94	25.5	129	21.5	88	21.00	74	19.84	73	17.7	149	22.3	100	23.5	93	21.7
4	Girls develop breasts	22	6.0	26	4.3	23	5.49	20	5.36	17	4.1	21	3.1	25	5.9	8	1.9
5	Weakness, tiredness and headache	196	53.3	319	53.1	228	54.42	246	65.95	259	62.9	404	60.6	223	52.5	285	66.4
6	Missing system	2		12		1	o.2	1	0.3	9	2.2	15	2.2	15	3.5	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

5. **Girls and boys have the same level of intelligence and ability;**

S.N	**Variable**	Intervention				Non Intervention				Intervention				Non Intervention			
		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Yes	213	57.9	340	56.30	247	58.81	190	50.80	197	47.8	330	49.5	225	52.9	228	53.1
2	No	155	42.1	265	43.70	173	41.19	182	48.66	214	51.9	328	49.2	188	44.2	196	45.7
3	Missing system	2		8		0	0	2	0.5	1	0.2	9	1.3	12	2.8	5	1.2
	Total	**370**		**613**		**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

6. **After puberty boy/mans' bodies produce sperm;**

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	All the time	59	16.0	102	16.97	86	20.72	43	11.62	57	13.8	87	13	74	17.4	67	15.6
2	Only when they are sexually active	128	34.7	207	34.44	137	33.01	124	33.51	162	39.3	214	32.1	139	32.7	143	33.3
3	Only when they are married	21	5.7	49	8.15	27	6.51	20	5.41	12	2.9	52	7.8	31	7.3	10	2.3
4	Between the ages of 12 and 50	161	43.6	243	40.44	164	39.52	181	48.92	180	43.7	310	46.5	154	36.2	207	48.3
	Missing system	1		12		5	0.24	4	0.54	1	0.2	4	0.6	27	6.4	2	0.5
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

7. **A girl/woman is most likely to become pregnant if she has unprotected intercourse;**

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%

1	Just before her menstrual cycle begins	77	20.9	76	12.6	76	18.40	67	18.01	94	22.8	101	15.1	72	16.9	92	21.4
2	Just after her menstrual cycle ends	87	23.6	186	30.8	116	28.09	106	28.49	74	18	182	27.3	144	33.9	137	31.9
3	At the time of menstrual cycle	106	28.8	190	31.5	137	33.17	102	27.42	102	24.8	181	27.1	115	27.1	107	24.9
4	In between the cycle between the cycle	58	15.8	100	16.6	52	12.59	65	17.47	111	26.9	154	23.1	44	10.4	68	15.9
5	There is no chance of pregnancy	40	10.9	51	8.5	32	7.75	32	8.60	23	5.6	38	5.7	32	7.5	22	5.1
	Missing system	2		10		7	1.7	2	0.5	8	1.9	11	1.6	18	4.2	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

8. A healthy woman on an average is pregnant for;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	6 months	18	4.9	17	2.8	21	5.01	7	1.88	1	0.2	6	0.9	12	2.8	2	0.5
2	8 months	5	1.4	16	2.6	5	1.19	1	0.27	2	0.5	6	0.9	3	0.7	4	0.9
3	9 months	320	86.7	544	88.9	351	83.77	352	94.62	402	97.6	639	95.8	384	90.4	419	97.7
4	12 months	26	7.0	35	5.7	42	10.02	12	3.23	6	1.5	14	2.1	21	4.9	4	0.9
	Missing system	1		1		1	0.2	2	0.5	1	0.2	2	0.3	5	1.2	0	0

	Total	370	100	613	100	420	100	374	100	412	100	667	100	425	100	429	100

9. When a woman is pregnant she needs to see her healthcare provider at least;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	4 times	199	53.8	380	62.1	239	57.31	240	65.22	336	81.6	464	69.6	279	65.6	291	67.8
2	2 times	45	12.2	46	7.5	46	11.03	14	3.80	17	4.1	47	7	34	8	26	6.1
3	9 times	114	30.8	168	27.5	114	27.34	103	27.90	54	13.1	144	21.6	93	21.9	107	24.9
4	Only one time	12	3.2	18	2.9	18	4.32	11	2.99	4	1	11	1.6	9	2.1	4	0.9
	Missing system	0		1		3	0.7	6	1.6	1	0.2	1	0.1	10	2.4	1	0.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

10. The appropriate age of women to get pregnant is;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	At any age	17	4.6	30	4.96	16	3.81	6	1.60	15	3.6	11	1.6	18	4.2	19	4.4
2	After the age of 16	36	9.7	37	6.10	49	11.67	18	4.81	8	1.9	20	3	42	9.9	19	4.4
3	Before the age of 19	6	1.6	15	2.47	10	2.38	3	0.80	3	0.7	13	1.9	9	2.1	5	1.2
4	After the age of 20	311	84.1	524	86.47	345	82.14	347	92.78	385	93.4	622	93.3	352	82.8	383	89.3

	Missing system	0		7		0	0	0		1	0.2	1	0.1	4	0.9	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

11. Girls/Women who are pregnant should take regular rest and avoid;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Eat fruits and vegetables	19	5.1	28	4.6	25	5.95	6	1.61	11	2.7	13	1.9	18	4.2	10	2.3
2	Lifting and carrying heavy items	281	75.9	457	74.7	318	75.71	328	87.94	368	89.3	565	84.7	342	80.5	373	86.9
3	Touching others and cooking foods	32	8.6	26	4.2	31	7.38	13	3.49	12	2.9	11	1.6	20	4.7	6	1.4
4	Seeing a health care provider until the end of the pregnancy	14	3.8	32	5.2	22	5.24	5	1.34	7	1.7	23	3.4	15	3.5	6	1.4
5	Going to the temple	24	6.5	69	11.3	24	5.71	21	5.63	12	2.9	50	7.5	18	4.2	32	7.5
	Missing system			1		0	0	1	0.3	2	0.5	5	0.7	12	2.8	2	0.5
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

12. **A woman cannot get pregnant if;**

	Intervention	**Non Intervention**	**Intervention**	**Non Intervention**

S.N	Variable	Rasuwa	Nuwakot			Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	She bathes immediately after she has sexual intercourse	44	12	49	8.1	58	13.98	30	8.06	20	4.9	45	6.7	46	10.8	26	6.1
2	She uses contraception methods correctly	172	46.7	311	51.6	202	48.67	240	64.52	285	69.2	419	62.8	224	52.7	324	75.5
3	It is her first time to have intercourse	51	13.9	71	11.8	59	14.22	36	9.68	26	6.3	57	8.5	36	8.5	23	5.4
4	She knows exactly when her menstrual cycle occurs	59	16.0	88	14.6	58	13.98	33	8.87	43	10.4	55	8.2	59	13.9	24	5.6
5	She is having special food	42	11.4	84	13.9	38	9.16	33	8.87	28	6.8	82	12.3	44	10.4	27	6.3
	Missing system	2		10		5	1.2	2	0.5	10	2.4	9	1.3	16	3.8	5	1.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

13. It is a crime if husband/boyfriend beats or uses bad words to their wife/girlfriend;

S.N	Variable	Intervention				Non Intervention				Intervention				Non Intervention			
		Rasuwa		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Yes	326	88.83	545	89.50	349	83.10	354	94.65	382	92.7	633	94.9	384	90.4	396	92.3
2	No	41	11.17	64	10.50	70	16.67	20	5.35	28	6.8	30	4.5	39	9.2	32	7.5
3	Missing system	3		4		1	0.2	1	0.3	2	0.5	4	0.6	2	0.5	1	0.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

14. If husband has forceful sex with his wife is it considered a marital rape;

		Intervention				Non Intervention				Intervention				Non Intervention			
S. N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Yes	264	71.5	442	72.3	298	70.95	285	76.20	322	78.2	510	76.5	311	73.2	334	77.9
2	No	105	28.5	169	27.7	119	28.37	88	23.53	89	21.6	149	22.3	105	24.7	92	21.4
3	Missing system	1		2		3	0.71	1	0.3	1	0.2	8	1.2	9	2.1	3	0.7
	Total	**370**		**613**		**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

15. Only a husband can decide to have a sex or not, when to become pregnant, how many children to deliver, when to deliver;

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		NUwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	True	101	27.56	178	29.62	136	32.38	53	74.06	44	10.7	119	17.8	118	27.8	54	12.6
2	False	265	72.44	423	70.38	281	66.90	277	14.17	366	88.8	539	80.8	299	70.4	372	86.7
3	Missing system	4		12		3	0.7	44	11.76	2	0.5	9	1.3	8	1.9	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

16. Household chores like cooking, washing, taking care of children, taking care of in mother in law and father in law is the responsibility of women;

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%

1	True	56	15.22	71	11.68	78	18.57	13	85	19	4.6	39	5.8	61	14.4	23	5.4
2	False	312	84.78	537	88.32	339	80.71	317	12	392	95.1	623	93.4	359	84.5	402	93.7
3	Missing system	2		5		2	0.48	3		1	0.2	5	0.7	5	1.2	4	0.9
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

17. If someone tries to physically harass you, you should;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Stay silent because one who wants to harass you is elder than you.	12	3.2	20	3.23	25	5.95	4	1.2	7	1.7	5	0.7	16	3.8	0	0
2	Stay silent because one who harass you is your own relative	15	4.1	11	1.81	27	6.43	20	3	4	1	7	1	10	2.4	4	0.9
3	Tell the person with whom you feel comfortable	314	84.9	514	84.2	321	76.4	307	92.7	391	94.9	636	95.4	359	84.5	407	94.9
4	Nothing can be done because this is your own bad fortune. If someone knows it your family reputation will be spoiled.	29	7.8	65	10.65	46	10.95	20	3	10	2.4	17	2.5	35	8.2	17	4.0
	Missing system	0		3		1	0.24	0	0	0	0	2	0.3	5	1.2	1	0.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

18. Which of the following stage is not considered as rape?

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	If man has sexual intercourse with women without her consent	88	23.8	99	16.2	62	14.80	39	11.75	55	13.3	62	9.3	56	13.2	52	12.1
2	If man has sexual intercourse with a girl less than 18 year without her consent	34	9.2	47	7.7	50	11.9	29	8.73	25	6.1	44	6.6	29	6.8	24	5.6
3	If man has sexual intercourse with a girl less than 18 year with her consent	40	10.8	47	7.7	139	9.31	23	6.93	38	9.2	49	7.3	40	9.4	21	4.9
4	If man has sexual intercourse with women above 18 with her consent	208	56.2	418	68.4	268	63.96	241	72.59	291	70.6	508	76.2	291	68.5	330	76.9
	Missing system	0		2		1	0.2	43	11.2	3	0.7	4	0.6	9	2.1	2	0.5
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

19. Boys can force girls to have sex if;

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%

1	The girl goes out for a walk or to a movie with them	50	13.6	44	7.2	68	16.39	17	5.14	35	8.5	42	6.3	50	11.8	22	5.1
2	If a girl go for outing and watch cinema for a male friends	9	2.4	6	1.0	12	2.89	3	0.91	5	1.2	14	2.1	13	3.1	6	1.4
3	They know her family	27	7.3	21	3.4	19	4.58	3	0.91	15	3.6	12	1.8	12	2.8	3	0.7
4	Never – it is never okay to force someone to have sex	76	20.6	186	30.5	105	25.30	137	41.39	160	38.8	269	40.3	129	30.4	209	48.7
5	If they offer to marry them	207	56.1	353	57.9	211	50.84	171	51.66	194	47.1	322	48.3	214	50.4	187	43.6
	Missing system	1		3		5	1.2	43	11.5	3	0.7	8	1.2	7	1.6	2	0.5
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

20. If someone is raped? Who is guilty?

		Intervention		**Non Intervention**		**Intervention**		**Non Intervention**	
S. N	Variable	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**

		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	One who is raped because she has encouraged perpetrator to rape	94	25.5	104	17.02	108	25.84	65	17.38	64	15.5	117	17.5	106	24.9	93	21.7
2	One who rape	275	74.5	507	82.98	305	72.97	267	71.39	347	84.2	544	81.6	312	73.4	331	77.2
	Missing system	1		2		2	0.5	42	11.23	1	0.2	6	0.9	7	1.6	5	1.2
	Total	**370**		**163**		**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

21. If a boy/man wants to have sexual relations with a girl/woman he must;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S. N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Ask her father	29	7.9	58	9.5	36	8.63	9	2.71	11	2.7	32	4.8	23	5.4	6	1.4
2	Ask his brother	7	1.9	12	2.0	8	1.92	2	0.60	4	1	6	0.9	4	0.9	8	1.9
3	Demand it forcefully	33	9.0	50	8.2	43	10.31	21	6.33	11	2.7	49	7.3	35	8.2	14	3.3

4	Ask for her consent and ensure it is agreed	26 9	73.1	43 6	71.4	2888	69.06	276	83.13	369	89.6	524	78.6	309	72.7	370	86. 2
5	Tell his friends so they can help him	30	8.2	55	9.0	42	10.07	24	7.23	17	4.1	50	7.5	45	10.6	29	6.8
6	Missing system	2		2		3	0.7	42	11.2	0	0	6	0.9	9	2.1	2	0.5
	Total	**37 0**		**61 3**		**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

22. When a pregnancy happens and it is ended with the help of a healthcare provider by pills or surgery it is called;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Miscarriage	56	15.3	95	15.6	56	13.43	38	11.52	27	6.6	54	8.1	49	11.5	33	7.7
2	Abortion	150	40.9	313	51.3	197	47.24	194	58.79	260	63.1	400	60	207	48.7	301	70.2
3	A secret	62	16.9	54	8.9	67	16.07	39	11.82	40	9.7	71	10.6	68	16	46	10.7
4	None of the above	99	27.0	148	24.3	97	23.26	59	17.88	83	20.1	134	20.1	93	21.9	45	10.5
5	Missing system	3		3		3	0.7	44	11.8	2	0.5	8	1.2	8	1.9	4	0.9
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

23. If a woman is pregnant and she does not want to have baby what can she do?

		Intervention				Non Intervention				Intervention				Non Intervention			
S. N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Keep the pregnancy secret and abort it	31	8.4	79	12.9	53	12.77	23	6.95	24	5.8	34	5.1	43	10.1	19	4.4
2	Consult traditional healer	13	3.5	12	2.0	10	2.41	5	1.51	1	0.2	9	1.3	7	1.6	6	1.4
3	Visit health institution to get counselling on safe abortion	306	82.9	498	81.4	336	80.96	293	88.52	380	92.2	606	90.9	361	84.9	392	91.4
4	Nothing can be done	19	5.1	23	3.8	16	3.86	10	3.02	7	1.7	15	2.2	9	2.1	11	2.6
	Missing system	1		1		5	1.2	43	11.5	0	0	3	0.4	5	1.2	1	0.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

24. It is NOT legal in Nepal to have an abortion because;

		Intervention				Non Intervention				Intervention				Non Intervention			
S. N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	The mother chooses	74	20.11	137	22.4	96	23.13	83	25.08	109	26.5	98	14.7	106	24.9	110	25.6

2	The fetus is abnormal	74	20.11	76	12.4	53	12.77	32	9.67	32	7.8	91	13.6	47	11.1	43	10
3	The mother is not healthy	133	36.14	223	36.4	139	33.49	98	29.61	133	32.3	251	37.6	128	30.1	130	30.3
4	The fetus is a girl	87	23.64	175	28.6	127	30.60	118	35.65	135	32.8	220	33	134	31.5	141	32.9
	Missing system	2		1		5	1.2	43	11.5	3	0.7	7	1	10	2.4	5	1.2
	Total	**370**		**613**		**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

25. Uterine prolapse is a condition where the uterus begins to fall down inside the woman's body. It can be caused by all except;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S. N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Not being allowed to get good health care during pregnancy and when the baby is born	60	16.3	89	14.6	75	18.07	38	11.48	30	7.3	46	6.9	61	14.4	26	6.1
2	Carrying too much heavy load while pregnant or	62	16.8	140	22.9	67	16.14	73	22.05	55	13.3	131	19.6	60	14.1	96	22.4

	right after the baby is born																
3	Prolong labour during delivery	27	7.3	56	9.2	44	10.60	44	13.29	33	8	55	8.2	32	7.5	48	11.2
4	Early marriage and frequent pregnancy	124	33.6	220	36.0	143	34.46	116	35.05	129	31.3	226	33.9	149	35.1	160	37.3
5	Unsafe sex	96	26.0	106	17.3	86	20.72	60	18.13	164	39.8	199	29.8	109	25.6	98	22.8
	Missing system	1		2		5	1.2	43	11.5	1	0.2	10	1.5	14	3.3	1	0.2
	Total	**370**		**613**		**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

26. A woman who has uterine prolapse should

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Keep it a secret from her family	24	6.56	24	3.9	18	4.31	4	1.20	11	2.7	12	1.8	11	2.6	6	1.4
2	Go to the doctor because it can be cured	271	74.04	479	78.1	298	71.29	271	81.63	350	85	566	84.9	333	78.4	374	87.2

3	Be divorced by her husband because she can't have more children	59	16.12	95	15.5	80	19.14	51	15.36	41	10	72	10.8	64	15.1	44	10.3
4	Stay in the house because it is very embarrassing	12	3.28	15	2.4	22	5.26	6	1.81	9	2.2	12	1.8	12	2.8	2	0.5
	Missing system	4		0		22	5.26	42	11.2	1	0.2	5	0.7	5	1.2	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

27. Adolescent girl and boy need to have equal sexual and reproductive rights. Is this statement true or false?

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	True	292	79.8	486	79.3	324	78	313	83.7	348	84.5	579	86.8	349	82.1	389	90.7
2	False	60	16.39	87	14.2	66	16	12	3.2	42	10.2	64	9.6	54	12.7	30	7.0
3	Depends upon community	14	3.83	40	6.5	27	6.5	7	1.9	19	4.6	23	3.4	16	3.8	9	2.1
	Missing system	4		0		2	0.5	42	11.2	3	0.7	1	0.1	6	1.4	1	0.2
	Total	**370**	**100**	**613**	**100**	**200**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

28. The type of female contraception place in uterus and lasts for 12 years is;

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	IUCD	148	40.4	225	37.0	157	37.83	165	49.70	262	63.6	347	52	182	42.8	225	52.4
2	Norplant	51	13.9	108	17.8	103	24.82	68	20.48	64	15.5	83	12.4	115	27.1	93	21.7
3	Depo-provera	52	14.2	122	20.1	88	21.20	47	14.16	42	10.2	90	13.5	58	13.6	67	15.6
4	Ligation	36	9.8	58	9.5	26	6.27	20	6.02	5	1.2	39	5.8	16	3.8	9	2.1
5	None of the above	79	21.6	95	15.6	41	9.88	32	9.64	34	8.3	101	15.1	37	8.7	32	7.5
	Missing system	4		5		5	1.2	42	11.2	5	1.2	7	1	17	4	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

29. The birth control pill is a good form of contraception if;

		Intervention				Non Intervention				Intervention				Non Intervention			
S. N	Variable	**Rasuwa**	**Nuwakot**			**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	If it is taken every day at the same time	90	24.7	144	23.7	103	24.88	94	28.57	98	23.8	192	28.8	124	29.2	141	32.9
2	The women is married already	74	20.3	120	19.8	92	22.22	55	16.72	87	21.1	87	13	92	21.6	72	16.8

3	The woman wants to keep the contraception method a secret	86	23.2	164	27.0	113	27.29	99	30.09	109	26.5	187	28	79	18.6	132	30.8
4	The woman does not want to get health advice about contraception	115	31.1	179	29.5	106	25.60	81	24.62	113	27.4	191	28.6	108	25.4	83	19.3
	Missing system	5		6		6	1.4	42	11.2	5	1.2	10	1.5	22	5.2	1	0.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

30. It is girl/woman responsibility to use contraception;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Yes	60	16.30	78	12.72	58	14	26	7	29	7	61	9.1	48	11.3	40	9.3
2	No	308	83.70	535	87.28	357	85	81	300	380	92.2	605	90.7	369	86.8	387	90.2
	Missing system	2		0		3	0.1	43	11.5	3	0.7	1	0.1	8	1.9	2	0.5
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

31. Planning a family means except;

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S. N	**Variable**	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Raswua**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Using family planning methods	82	22.2	126	20.7	111	26.56	43	13.07	93	22.6	92	13.8	98	23.1	98	22.8

	until you are ready to become a parent																
2	Talking with your partner and deciding when and how many children you want to have	66	17.9	130	21.3	88	21.05	84	25.53	82	19.9	131	19.6	106	24.9	98	22.8
3	Talking to a health care provider about the best way to prevent pregnancy until you are ready and knowing what methods of family planning are available and safe for you	107	29.0	134	22.0	88	21.05	47	14.29	75	18.2	117	17.5	77	18.1	82	19.1
4	Having regular health checkups and asking your health care provider lots of questions about pregnancy and childbirth	26	7.0	53	8.7	25	5.98	14	4.26	16	3.9	23	3.4	24	5.6	9	2.1
5	All the above	88	23.8	166	27.3	106	25.36	141	42.86	144	35.1	297	44.5	113	26.6	137	31.9
	Missing system	1		4		2	0.5	45	12	2		7	1	7	1.6	5	1.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

32. Some people cannot be identified as either men or women, is this statement true?

S.N	Variable	Intervention				Non Intervention				Intervention				Non Intervention			
		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Yes	60	16.30	78	12.72	256	61	238	63.64	276	67	490	73.5	267	62.8	321	74.8
2	No	308	83.70	535	87.28	164	39	93	24.87	132	32	172	25.8	155	36.5	106	24.7
	Missing system	2		0		0	0	43	11.5	4	1	5	0.7	3	0.7	2	0.5
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

33. Boy/men who prefer to have sex with other men are:

S.N	Variable	Intervention				Non Intervention				Intervention				Non Intervention			
		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Normal sexuality	91	24.80	126	20.90	130	31.18	50	15.06	59	14.3	117	17.5	107	25.2	62	14.5
2	Homosexual	203	55.31	382	63.34	238	57.07	263	79.22	331	80.3	501	75.1	268	63.1	348	81.1
3	Normal human being	73	19.89	95	15.76	49	11.75	18	5.42	19	4.6	41	6.1	41	9.6	12	2.8
	Missing system	3		10		3	0.7	42	0.3	3	0.7	8	1.2	9	2.1	7	1.6
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

34. A person can be a female who has a male body or a male who has a female body. These people are:

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Gay	153	41.8	259	43.4	208	49.88	190	57.40	165	40	342	51.3	237	55.8	215	50.1
2	Heterosexual	116	31.7	226	37.8	133	31.89	105	31.72	80	19.4	154	23.1	109	25.6	136	31.7
3	Transgender	97	26.5	112	8	76	18.23	36	10.88	161	39.1	158	23.7	65	15.3	66	15.4
	Missing system	4		16		3	0.7	43	11.5	6	1.5	13	1.9	14	3.3	12	2.8
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

35. It is a result of bad work or pre life to be minor in sexuality (third gender). Is this statement right or wrong?

		Intervention				Non Intervention				Intervention				Non Intervention			
S.N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Right	104	28.34	136	22.37	112	40	28	7.49	37	9	66	9.9	101	23.8	49	11.4
2	Wrong	263	71.66	472	77.63	305	60	308	82.35	374	90.8	597	89.5	315	74.1	375	87.4
	Missing system	3	0	5	0.1	3	0.7	38	10.16	1	0.2	4	0.6	9	2.1	5	1.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

36. If some boy asks a girl to send her photo in Facebook/ messenger/viber, what a girl should do?

		Intervention				Non Intervention				Intervention				Non Intervention			
S. N	Variable	Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot		Rasuwa		Nuwakot	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%

1	She should do according to boy if that is her boyfriend, he has all right to on her photo	50	13.6	85	13.9	67	15.95	24	7.16	28	6.8	52	7.8	46	10.8	41	9.6
2	She should not send photo to that boy because he might misuse the photo	299	81.0	474	77.7	329	78.33	297	88.66	375	91	601	90.1	347	81.6	378	88.1
3	She should be happy as boy has asked her to send photo and she should quickly send the photo	20	5.4	51	8.4	24	5.71	13	3.88	9	2.2	7	1	26	6.1	7	1.6
	Missing system	1		3		0	0	39	10.4	0	0	7	1	6	1.4	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

37. Posting pictures of your friends on Facebook that they would not want to share (like in the bathroom or bathing) is:

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S. N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%

1	A funny joke and nobody should be angry about it	31	8.37	42	6.9	42	10.05	10	2.97	11	2.7	23	3.4	43	10.1	17	4
2	Dangerous because the photos break privacy and could cause harm	292	78.9	496	81.3	313	74.88	301	89.32	371	90	592	88.8	319	75.1	371	86.5
3	Okay because nobody will know who they are.	30	8.1	38	6.2	38	9.09	10	2.97	21	5.1	21	3.1	32	7.5	31	7.2
4	This is fine because till date no harm has happened	16	4.3	34	5.6	25	5.98	16	4.75	7	1.7	22	3.3	19	4.5	6	1.4
	Missing system	1	0	4		2	0.5	37	9.9	2	0.5	9	1.3	12	2.8	4	0.9
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

38. What type of effect does smoking and tobacco will cause to our body?

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	It makes us like hero/heroine of a cinema	14	3.81	11	1.81	15	3.57	4	1.19	2	0.5	5	0.7	5	1.2	12	2.8
2	It help to reduce stress	15	4.1	25	4.11	24	5.71	6	1.78	2	0.5	11	1.6	26	6.1	9	2.1
3	It help to socialize you in your friend circle	11	3.0	20	3.23	13	3.10	5	1.48	5	1.2	5	0.7	10	2.4	11	2.6

4	It will have negative impact on your health	327	89.0	551	90.85	367	87.38	320	94.96	400	97.1	645	96.7	378	88.9	395	92.1
	Missing system	3		6		1	0.2	37	9.9	3	0.7	1	0.1	6	1.4	2	0.5
	Total	**370**	**100**	**613**	**100**	**400**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

39. Itching, foul vaginal or penile discharges are the symptoms of?

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S. N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Sexually transmitted infections	105	28.7	205	33.83	138	33.01	146	43.32	171	41.5	257	38.5	148	34.8	194	45.2
2	Healthy body	27	7.4	39	6.43	34	8.13	5	1.48	19	4.6	16	2.4	30	7.1	16	3.7
3	Poor hygienic condition	233	63.7	362	59.74	244	58.37	185	54.90	214	51.9	389	58.3	235	55.3	216	50.3
	Missing system	5	0.3	7		2	0.24	37	9.9	8	1.9	5	0.7	12	2.8	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

40. Which method of contraception is best for prevention of HIV?

		Intervention		**Non Intervention**		**Intervention**		**Non Intervention**	
S.N	Variable	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**

		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Pills	29	4.4	27	7.9	24	5.80	5	1.49	11	2.7	23	3.4	20	4.7	13	3.0
2	Injection	33	17.4	106	8.9	39	9.42	25	7.44	13	3.2	70	10.5	30	7.1	11	2.6
3	Condom	264	60.0	365	71.5	285	68.84	268	79.76	363	88.1	516	77.4	331	77.9	383	89.3
4	Implants	17	8.9	54	4.6	33	7.97	23	6.85	12	2.9	25	3.7	17	4	15	3.5
5	Sterilization	26	9.2	56	7.0	33	7.97	15	4.46	13	3.2	26	3.9	18	4.2	6	1.4
	Missing system	1		5	1	6	1.4	38	10.21	0	0	7	1	9	2.1	1	0.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

41. Can HIV infected person look healthy?

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Yes	82	22.16	128	21.08	68	21.2	76	20	141	34.2	218	32.7	80	18.8	143	33.3
2	No	288	77.83	479	78.92	329	78.3	259	70	265	64.3	446	66.7	334	78.6	284	66.2
	Missing system	0	0	6	0.4	3	0.03	37	9.9	6	1.5	3	0.4	11	2.6	2	0.5
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

42. Is HIV transmitted by the bite of mosquito?

		Intervention		**Non Intervention**		**Intervention**		**Non Intervention**	
S.N	Variable	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**

		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Yes	235	38.46	402	66.45	280	67	209	56	284	68.9	461	69.1	315	74.1	287	66.9
2	No	133	21.76	203	33.55	132	32	123	33	122	29.6	196	29.4	99	23.3	139	32.4
	Missing system	2		8		5	1	39	10.4	6	1.5	10	1.5	11	2.6	3	0.7
	Total	613		370		420	100	374	100	412	100	667	100	425	100	429	100

43. Up to how many sexual partners one should have?

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	2	24	6.5	31	5.1	34	8.11	9	2.67	14	3.4	22	3.3	16	3.8	13	3
2	3	9	2.4	13	2.1	9	2.15	8	2.37	5	1.2	7	1	3	0.7	4	0.9
3	5	16	4.3	19	3.1	20	4.77	8	2.37	6	1.5	10	1.5	14	3.3	9	2.1
4	1	305	82.4	499	82.1	328	78.28	303	89.91	367	89.1	594	89.1	364	85.6	379	88.3
5	Whatever number does not matter	16	4.3	46	7.6	28	6.68	9	2.67	18	4.4	33	4.9	22	5.2	23	5.4
	Missing system	0		5		1	0.2	37	9.9	2	0.5	1	0.1	6	1.4	1	0.2
	Total	**613**	**100**	**370**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

44. If a guy and a girl truly love each other they can have sexual relationship?

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Yes	139	37.77	219	36.14	196	46.67	115	30.75	105	25.5	198	29.7	160	37.6	139	32.4
2	No	229	62.23	387	63.86	223	53.10	223	59.63	305	74	467	70	258	60.7	285	66.4

3	Missing system	2		7		1	0.24	36	9.6	2	0.5	2	0.3	7	1.6	5	1.2
4	Total	370		613		420	100	374	100	412	100	667	100	425	100	429	100

45. Running away to get married when you are less than 18 years old is:

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S. N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	This is the best way to escape from arrange marriage	29	7.9	45	7.4	34	8.11	14	4.15	15	3.6	32	4.8	33	7.8	26	6.1
2	This the bad because this increases the possibility of early pregnancy which can affect mothers	293	79.81	466	76.4	302	72.08	299	88.72	368	89.3	595	89.2	321	75.5	377	87.9
3	This is good if couple is getting chance to go school	17	4.5	38	6.2	32	7.64	14	4.15	15	3.6	15	2.2	27	6.4	17	4.0
4	This is the better way for love marriage	18	4.8	33	5.4	32	7.64	7	2.08	11	2.7	7	1	21	4.9	5	1.2
5	This is not big deal in Nepal	13	3.5	28	4.6	19	4.53	3	0.89	2	0.5	4	0.6	14	3.3	0	0
	Missing system	0		3		1	0.2	37	9.9	1	0.2	14	2.1	9	2.1	4	0.9
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

46. Attraction between adolescent girl and boy is :

		Intervention		**Non Intervention**		**Intervention**		**Non Intervention**	
S.N	Variable	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**	**Rasuwa**	**Nuwakot**

		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	This is sign of deep love between adolescent girl and boy.	151	40.80	228	37.2	133	31.67	141	41.8	137	33.3	214	32.1	126	29.6	124	28.9
2	This is a symptom of spoiled children	158	42.70	267	43.6	212	50.48	92	27.3	103	25	255	38.2	211	49.6	153	35.7
3	This is normal	61	16.50	118	19.2	75	17.86	104	27.8	168	40.8	190	28.5	85	20	147	34.3
3	Missing system	0	0	0	0	0	0	37	9.9	4	1	8	1.2	3	0.7	5	1.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

47. Adolescent rush to get married after being in love because they think that they are in deep love which can be simply an attraction. Is attraction and love the same thing?

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	This is a different thing	276	74.8	432	70.6	286	68.1	250	74.2	297	72.1	511	76.6	322	75.8	329	76.7
2	This is a same thing	93	25.2	180	29.4	130	31.0	87	25.8	112	27.2	147	22	96	22.6	96	22.4
3	Missing system	1		1		4	1.0	37	9.9	3	0.7	9	1.3	7	1.6	4	0.9
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

48. In Nepal, adolescent get married at 16 and within a year they get divorced. This is is increasing yearly, what could be the reason behind this?

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Misuse of social media	86	23.2	107	17.5	86	20.72	65	19.23	57	13.8	128	19.2	86	20.2	90	21
2	Lack of proper sexual and reproductive education	183	49.5	361	58.9	200	48.19	231	2.37	244	59.2	404	60.6	212	49.9	263	61.3
3	Influence of movie	22	5.9	32	5.2	31	7.47	8		23	5.6	32	4.8	8	1.9	24	5.6
4	Peer influence	79	21.4	113	18.4	98	23.61	34	10.06	86	20.9	101	15.1	105	24.7	47	11
	Missing system	0	0	0	0	5	1.2	36	9.6	2	0.5	2	0.3	14	3.3	5	1.2
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

49. If you go to the Health Post to ask for information about your reproductive health, the health care provider will:

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S.N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1	Tell your parents you were there and what you talked about	58	15.7	100	16.3	60	14.32	31	9.2	16	3.9	98	14.7	49	11.5	41	9.6

2	Tell you to go away because you are too young to ask about this topic	56	15.1	103	16.8	58	13.84	65	19.2	57	13.8	103	15.4	80	18.8	60	14
3	Provide you with safe care and respect your privacy	144	38.9	239	39.0	136	32.46	147	43.5	205	49.8	254	38.1	164	38.6	216	50.3
4	Tell you what to do or force you to take treatment without giving you a choice	86	23.2	133	21.7	117	27.92	83	24.6	104	25.2	171	25.6	88	20.7	95	22.1
5	They will forcefully give you a treatment by their own decision	26	7	37	6.0	48	11.46	36	9.6	26	6.3	36	5.4	35	8.2	15	3.5
	Missing system	0		1		1	0.2	36	9.6	4	1	5	0.7	9	2.1	2	0.5
	Total	**370**		**613**		**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

50. Why it is necessary to have sexual and reproductive health education?

		Intervention				**Non Intervention**				**Intervention**				**Non Intervention**			
S. N	Variable	**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**		**Rasuwa**		**Nuwakot**	
		F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%

1	It helps on our personal life as well as helps to be responsible toward society and family	263	71.1	382	62.3	262	62.53	249	73.67	324	78.6	509	76.3	265	62.4	323	75.3
2	Because this education is kept on our curriculum and we must learn it	47	12.7	108	17.6	73	17.42	37	10.95	43	10.4	97	14.5	89	20.9	52	12.1
3	If someone ask then I have to answer	31	8.4	47	7.7	24	5.73	15	4.44	15	3.6	8	1.2	24	5.6	14	3.3
4	This education will help person to handle his life in a better way	29	7.8	76	12.4	60	14.32	37	10.95	26	6.3	52	7.8	38	8.9	37	8.6
	Missing system	0		0		1	0.2	36	9.6	4	1	1	0.1	9	2.1	3	0.7
	Total	**370**	**100**	**613**	**100**	**420**	**100**	**374**	**100**	**412**	**100**	**667**	**100**	**425**	**100**	**429**	**100**

Discussion.

The quantitative survey results indicate some interesting differences in a few key questions. On some attitudinal questions regarding LGBTIQ sexualities there were some appreciable differences in the pre and post answers and the intervention and control schools. With respect to defining homosexuality the intervention schools showed an increase in correct answers of 25% in Rasuwa and 12% in Nuwakot (compared with 6% and 2% in the control schools). With regard to understanding the meaning of transgender there was a 13% and 15% increase in correct answers to the survey questions in Rasuwa and Nuwakot respectively (compared to a decrease of 3% and increase of 5% respectively in control schools). Another key attitudinal question was with respect ot menstrual exclusion. Here we saw students answer correctly that girls should not be excluded with an increase of 21% in Rasuwa and 12% in Nuwakot (compared to 6% and 4% in control schools). This is an important issue in Nepali society where forms of menstrual exclusion are both rooted in and perpetuate gender inequities. Other questions that suggest increased knowledge among our intervention schools included ones on access to abortion counselling, the causes of uterine prolapse and the dangers associated with inappropriate sharing of photos on the internet.

Overall, comparative analysis shows the number of students who gave the correct answer after intervention has not been increased significantly. There are a number of possible reasons including that the student population is somewhat mobile in these government schools and because the survey was anonymous we could not track how many students did not do the pre-survey or participate fully in the program. We also observed that the students have a fear of failing and in spite of the survey being anonymous (no names were attached) and being asked to answer the survey for themselves they were frequently seen sharing their answers and asking one another. The percentage of students who gave right answer in non-intervention sites has also been increased in some cases, particularly around basic information on puberty, reproductive biology and contraception. This may be due to the fact that they had studied the regular curriculum during the intervention period and gained sufficient knowledge to answer correctly. We also noted that since Nepal is a country with numerous NGOs aimed at sexual and reproductive health, we could not control who the schools engaged with over the intervention period. A few of the schools in both the intervention and control communities reported that other organizations had come in primarily to teach menstrual management and this was likely a factor affecting out results.

Thus, while the quantitative data do not necessarily indicate a proof of concept, we believe that our qualitative data indicate significant benefits of our approach. Our interviews, focus groups and observations indicate that among the peer educators there was, in most cases, a sense of having expertise to share and a platform for taking control of sharing information on sexual and reproductive health. Young people performed, used a variety of media such as theatre, songs and games to generate awareness and raise interest, not only amongst their peers but also at the community level. The young people took advantage of key events like public holidays and festivals to bring messages to people in their communities. Our data suggest that many of the 66 peer educators felt that their expertise was recognized and that they were in a position to be agents of change. They used the Sahayogi program as a spring board for other creative activities and said that they gained inspiration for scripts for plays and street theatre from our stories. Many of the stories were their stories, collected and included in the development of the app.

Our qualitative data also highlight the change in behavior amongst students in the intervention schools as there was a widely reported reduction in shyness and a willingness to speak more openly about sexual and reproductive health. This was often reflected in a willingness to acknowledge menstruation as a normal event and seek out hygiene products such as pads that were made available at school. This was true of both boys and girls as reported in our findings. A number of teachers spoke about the difference in attitude amongst their students during the implementation of our program and commented on the reduction in shyness and increased engagement around the material. There were also challenges as teachers spoke about the difficulty they faced in administering the curriculum in schools. They were afraid that their own values would be called into question if they spoke too opening about sexual and reproductive health, particularly in a mixed classroom. One teacher and a few peer educators reported that students felt that the questionnaire was "vulgar" when we administered it as a pre-test. They felt less uncomfortable after participating in the educational program. During our peer educator training workshop one teacher told us she felt she might have to "boycott" as the material presented was too direct and the methods non-conventional. By the end of the 3-day workshop she came to us to say she understood what we were trying to accomplish and was fully supportive of the program.

Parents identified the challenges they face both culturally and with regard to their own lack of knowledge in sharing information with their own children. Clearly parents are not a viable source of sexual and reproductive health information in many rural communities. The inability to discuss topics as basic as menstruation with adolescent daughters presents a high risk of young women not having access to appropriate hygiene, emotional supports and knowledge about their own bodies.

We also found the perspectives of both adolescents and teachers and parents on how best to teach ASRH compelling. There were many suggestions on using a multiple approach that includes both mobile technology (apps), other media such as videos, arts based media such as theatre and songs and classic educational approaches that included an updating of the curriculum. This recognizes the different needs of various learners and provides a number of opportunities for people to gain access to the information.

Our participants also emphasized the importance of support from the teachers and school system in enabling the environment for both teaching and learning. We learned about the challenges the peer educators faced when the atmosphere at school was not conducive to their efforts or when teachers took control of the tablets provided. We recognize the importance of working closely with teachers and principals but we also acknowledge that some things are beyond control. Teachers often felt that the mainstream curriculum was their priority and the success of students on various exams was more important than the ASHR program.

Our data do not indicate any increase in the uptake of adolescent health services at health facilities in the intervention community. This was an optimistic indicator on our part and it is probably only after a couple of years of providing education in collaboration with health facilities that we would expect to see any change in uptake of services. Given that one of main reason for not going to the Health Post with questions and concerns about sexual and reproductive health was a lack of trust of the providers, it will take some time before there will be a change and the health care providers themselves have some work to do in this regard. There is evidence of a conservative approach toward adolescent sexual behavior in clinical care and only married adolescents were provided

services. Our questionnaire reflected the curriculum which promotes monogamy and marriage as the normative practice for sexual activities. Most of our informants, both young people and adults, reflected this belief even while acknowledging that this perspective is contributing to early marriage. It is widely recognized that adolescents who want to have intimate relationships "run away" to get married rather than seek contraception. The fact that a couple of our peer educators suggested that masturbation was a solution to the issue of sexual desire in young couples is particularly interesting.

Early marriage was a focus of much of discussion partly because the research partners in Nepal were attentive to the issue and partly because it is a less challenging subject to talk about than providing adolescents with sexual and reproductive health care generally. While this is a social issue linked to ASRH, it is one that people seem to think is a matter of education rather than altering deeply held social values around sex and marriage.

Conclusions

1. Situation in health institutions: Health institutions in both districts are not adolescent friendly, adolescents usually seek general service and married adolescents seek more services as compared to unmarried adolescents. There is evidence in our interviews that health care providers are more willing to provide non-judgmental SRH services to married adolescents. Frequency of girls seeking health service is higher than boys.
2. Situation in schools: Schools teach the curriculum on ASRH but students do not interact with teachers due to hesitation. Schools do not have adolescent friendly corners for providing information and increasing comfort with inquiries and self-learning. Teachers suggested that the subject of ASRH should be introduced from junior class so that adolescents will be prepared from early age.
3. Early marriage: Early marriage is common in both districts. Self-initiated marriage is increasing in trend as compared to forced or arranged marriage by parents. In Tamang community early and self-initiated marriage is a more common part of culture. The main reasons identified for early marriage are lack of awareness, culture, and lack of acceptance of inter caste marriage. Most of the adolescents who marry early do not continue school because of shyness and lack of support from schools.
4. Parent know the right of age of marriage and they prefer their children to marry in their own ethnicity.
5. Participants identified that they were able to learn a number of new concepts from peer education training and tablet-based program - Sahayogi. Many of these new concepts are not in their curriculum. After the training peer educators and other students took many initiatives in their school to increase awareness on sexual and reproductive health, gender based violence, prevention of child marriage and menstrual management.
6. Best way to educate adolescents: Mixed type of teaching and interactive methods are found to be effective to teach ASRH. Mobile app, showing video, documentary show, street drama are methods that can be used to educate adolescents.
7. Major challenges of program: The major challenges of program identified were limited access to material on tablets, misuse of tablets and lack of cooperation by teachers.

10.ANNEXES

ANNEX 1
Questionnaire

"Developing peer support for adolescent friendly sexual and reproductive health services in Nuwakot and Rasuwa district"

Questionnaire

Date:

Name of school **Sex: Ma[ ]** **Fem[ ]** **Age:**

1. During menstruation girls should do all these except:
   a. Use clean clothes or pads to stay comfortable
   b. Do all the activities that they normally do
   c. Rest and take pain relief medication for period pain
   d. Eat green healthy foods including vegetables, milk and fruits
   e. Stay excluded

2. During a woman's menstrual cycle the blood and fluid come from the vagina which is:
   a. The same as the place where urine comes out
   b. A different place than where urine comes from

3. Night fall is normal and healthy among boys/men
   a. True
   b. False

4. All of these are signs of puberty except
   a. A boy body begins to change
   b. A girl's body begins to change
   c. Boys' voices get deeper and they begin to grow pubic and facial hair
   d. Girls develop breasts
   e. Weakness, tiredness and headache

5. Girls and boys have the same level of intelligence and ability to be leaders
   a. True
   b. False

6. After puberty boy/mans' bodies produce sperm:
   a. All the time
   b. Only when they are sexually active
   c. Only when they are married

   d. Between the ages of 12 and 50

7. A girl/woman is most likely to become pregnant if she has unprotected intercourse:
   a. Just before her menstrual cycle begins
   b. Just after her menstrual cycle ends
   c. During her menstrual cycle
   d. In the midway point between menstrual cycles
   e. There is no chance of pregnancy

8. A healthy woman on an average is pregnant for how many months?
   a. 6 months
   b. 8 months
   c. 9 months
   d. 12 months

9. When a woman is pregnant she needs to see her healthcare provider at least how many times?
   a. 4
   b. 2
   c. 9
   d. 3

10. The appropriate age of women to get pregnant is:
    a. Any age
    b. After 16 years
    c. Before 19 years
    d. After 20 years

11. Girls/Women who are pregnant should take regular rest and avoid
    a. Eating fruits and vegetables
    b. Lifting and carrying heavy items
    c. Touching others and cooking foods
    d. Seeing a health care provider until the end of the pregnancy
    e. Going to the temple

12. A woman cannot get pregnant if :
    a. She bathes immediately after she has sexual intercourse
    b. She uses contraception methods correctly
    c. It is her first time to have intercourse
    d. She knows exactly when her menstrual cycle occurs
    e. She is having special food

13. Is it a crime if husband/boyfriend beats or use bad words to their wife/girl friend?
    a. Yes, it is a crime
    b. B. No, it is not a crime

14. If husband has forceful sex with his wife is it considered a marital rape?
    a. Yes
    b. No

15. Only a husband can decide to have a sex or not, when to become pregnant, how many children to deliver, when to deliver. Is this statement true or false?
    a. True
    b. False

16. Household chores like cooking, washing, taking care of children, taking care of in mother in law and father in law is the responsibility of women. Is this statement true or false?
    a. True
    b. False

17. If someone wants to physically harass you what should you do?
    a. Stay silent because one who wants to harass you is elder than you.
    b. Stay silent because one who harass you is your own relative
    c. Tell with the person whom you feel comfortable
    d. Nothing can be done because this is your own bad fortune. If someone knows it your family reputation will be spoiled.

18. Which following stage is not considered as rape?
    a. If man has sexual intercourse with women without her consent
    b. If man has sexual intercourse with a girl less than 18 year without her consent
    c. If man has sexual intercourse with a girl less than 18 year with her consent
    d. If man has sexual intercourse with women above 20 with her consent

19. Boys can force girls to have sex if:
    a. The girl goes out for a walk or to a movie with them
    b. If a girl go for outing and watch cinema for a male friends
    c. They know her family
    d. Never – it is never okay to force someone to have sex
    e. If they offer to marry them

20. If someone raped? Who is guilty?

a. One who is raped because she has encouraged perpetrator to rape
b. One who rape

21. If a boy/man wants to have sexual relations with a girl/woman he must:
    a. Ask her father
    b. Ask her brother
    c. Demand it forcefully from her
    d. Ask for her consent and ensure it is agreed and relation of couple must be legally approved by law of Nepal
    e. Tell his friends so they can help him

22. When a pregnancy happens and it is ended with the help of a healthcare provider by pills or surgery it is called
    a. Miscarriage
    b. Abortion
    c. A secret
    d. None of the above

23. If women is pregnant and she does not want to have baby what she can do?
    a. Keep the pregnancy secret and abort it
    b. Consult traditional healer
    c. Visit health institution where you can get counselling on safe abortion.
    d. Nothing can be done

24. It is NOT legal in Nepal to have an abortion because:
    a. The mother chooses
    b. The fetus is abnormal
    c. The mother is not healthy
    d. The fetus is a girl

25. Uterine prolapse is a condition where the uterus begins to fall down inside the woman's body. It can be caused by all except:
    a. Not being allowed to get good health care during pregnancy and when the baby is born
    b. Carrying too much heavy load while pregnant or right after the baby is born
    c. Prolong labor
    d. Having babies too close together or having a baby when the mother is very young
    e. Having frequent sexual intercourse

26. A woman who has uterine prolapse should

a. Keep it a secret from husband and family
b. Go to the doctor because it can be fixed
c. Be divorced by her husband because she can't have more children
d. Stay in the house because it is very embarrassing

27. Adolescent girl and boy need to have equal sexual and reproductive rights. Is this statement true or false?
    a. True
    b. False
    c. Depends on situation

28. The type of female contraception place in uterus and lasts for 12 years is:
    a. IUD
    b. Norplant
    c. Depo-Provera
    d. Ligation

29. The birth control pill is a good form of contraception if :
    a. It is taken every day at the same time
    b. The woman is married already
    c. The woman wants to keep the contraception method a secret
    d. The woman does not want to get health advice about contraception

30. It is girl/woman responsibility to use contraception.
    a. True
    b. False

31. Planning a family means except:
    a. Using family planning methods until you are ready to become a parent
    b. Talking to your partner and deciding when and how many children you want to have
    c. Talking to a health care provider about the best way to prevent pregnancy until you are ready and knowing what methods of family planning are available and safe for you
    d. Having regular health checkups and asking your health care provider lots of questions about pregnancy and childbirth
    e. All of the above

32. Some people do not identify as either men or women
    a. True

b. False

33. Boy/men who prefer to have sex with other men are:
    a. Normal sexuality
    b. Homosexual
    c. Normal human being

34. A person can be a girl/woman who has a male body or a body/man who has a female body. These people are:
    a. Gay
    b. Heterosexual
    c. Transgender

35. It is a result of bad work of pre life to be minor in sexuality (third gender). Is this statement right or wrong?
    a. Right
    b. Wrong

36. If some boy ask a girl to send her photo in facebook/ messenger/viber, what a girl should do?
    a. She should do according to boy if that is her boyfriend, he has all right to on her photo
    b. She should not send photo to that boy because he might misuse the photo
    c. She should be happy as boy has asked her to send photo and she should quickly send the photo

37. Posting pictures of your friends on Facebook that they would not want to share (like in the bathroom or bathing) is:
    a. A funny joke and nobody should be angry about it
    b. Dangerous because the photos break privacy and could cause harm
    c. Okay because nobody will know who they are.
    d. This is fine because till date no harm has happened

38. What type of effect does smoking and tobacco will cause to our body?
    a. It makes us like hero/heroine of a cinema
    b. It help to reduce stress
    c. It help to socialize you in your friend circle
    d. It will have negative impact on your health

39. Itching, foul vaginal or penile discharge are the symptoms of?
    a. Sexually transmitted infections

b. Healthy body
c. Poor hygienic condition

40. Which method of contraception is best for prevention of HIV?
    a. Pills
    b. Injection
    c. Condom
    d. Implants
    e. Sterilization

41. Can HIV infected person can look healthy?
    a. Yes
    b. No

42. Can HIV is transmitted by bite of mosquito?
    a. Yes
    b. No

43. Up to how many sexual partner one should have?
    a. 2
    b. 3
    c. 5
    d. 1
    e. Whatever number does not matter

44. If a guy and a girl truly loves each other they can have sexual relationship?
    a. Yes
    b. No

45. Running away to get married when you are less than 18 years old is:
    a. A good strategy to avoid an arranged marriage
    b. Can lead to pregnancy and having a baby before your body and mind are ready
    c. Is okay as long as you stay in school
    d. Is the best way to have a love marriage
    e. This is not problem in Nepal

46. Attraction between adolescent girl and boy is which of the following statement?
    a. This is sign of deep love between adolescent girl and boy.
    b. This is sign of spoiled girl and boy
    c. This is a normal phenomena

47. Adolescent rush to get married after being in love because they think that they are in deep love which can be simply an attraction. Is attraction and love is same thing?
    a. Yes it is a same thing
    b. These are different thing

48. In Nepal, adolescent get married at 16 and within one and two year they are getting divorce. Such incident is increasing yearly, what could be the reason for that?
    a. Misuse of social media
    b. Lack of proper sexual and reproductive education
    c. Influence of movie
    d. Peer influence

49. If you go to the Health Post to ask for information about your reproductive health the health care provider will:
    a. Tell your parents you were there and what you talked about
    b. Tell you to go away because you are too young to ask about this topic
    c. Provide you with safe care and respect your privacy
    d. They will refer to another health care provider whom you do not feel comfortable (for example, for male-female and for female-male)
    e. Tell you what to do or force you to take treatment without giving you a choice

50. Why it is necessary to have sexual and reproductive health education?
    a. It helps on our personal life as well as helps to be responsible toward society and family
    b. Because this education is kept on our curriculum and we must learn it
    c. If someone ask then I have to answer
    d. This education will help person to handle his life in a better way

IDI/FGD guideline

A. IDI for Health care provider

1. Can you tell me, what are the services that are available at this health facility for adolescents? How adolescents are accessing those health services in your health post? Is there any change in adolescent health seeking behavior in last six months (after the interview we took last time)? If yes, what are the changes?
2. Have you participated in any kinds of training in last 6 months? Have you received any training or orientation on adolescent friendly services in last 6 months (after we took interview)?
3. Have you received any kind of support either material or non-material from any other agencies for adolescent sexual and reproductive health in last 6 months?
4. Are there any changes in number of adolescent visiting health post in last six months (after our intervention)? Do adolescents from school visit HP and seek adolescent sexual and reproductive health service?
5. What is the situation with early marriage in this area? What are the main factors that contribute to early marriage in this area? Since we last spoke are there any changes in early marriage trend in this community? If Yes, why do you think this is happening? What needs to change in order to stop early marriage?
6. Do you think young adolescents need to have access of contraceptive? Why/Why not?
7. What will you do if adolescents who are less than 18 years come to you for contraceptives or abortion? (probe)
8. What contraceptive services do you have available in the HP right now? Do you have all the family planning options available that you are supposed to have? (If not why not)
9. Would you like to add anything in addition to what you have already mentioned?
10. How many of the following services were provided to adolescents in last one year?

    (Refer HMIS) (September to September)

Variables	2018/2019
Counseling (numbers)	
Emergency contraceptive pill (Number)	
Pills(number)	
Injectable (number)	
IUCDs (number)	
Implants (number)	
First ANC visit as per protocol (number)	
Four ANC visit as per protocol (number)	
Medical safe abortion (number)	

Delivery (number)	

	2013/2014
No of adolescent (male)	
No of adolescent (female)	
Total	

11. How was trend different from last one year? (Refer to HMIS)

B. IDI with parents of peer educator

1. Your child recently participated in training to be a peer educator training on SRHR. Do you know what the training was about? How do you feel about it? What did your child share about his/her experience in that training?
2. Do you think it is necessary to teach adolescents on SRHR matter? If yes why, if not why?
3. In your opinion what are the different ways that adolescent get knowledge on ASRH? Which one is the best medium? Can you tell us what the school's role is in providing ASRH education? Do you talk about ASRH with your children? Both sons and daughters? If yes, what are the topics you discuss with your daughter? What are the topics you discuss with your son??
4. Did you find any changes in your children after they received the SRHR training? If yes, can you describe about the changes? (Probe Attitude? Behavior? Knowledge?)
5. What did s/he share within family related to SRHR?
6. What do you think are the most important things for young people to learn about SRHR? Why?
7. In your opinion, what could be the best way of promoting adolescent health in regard of sexual and reproductive health?
8. In villages in this area how often are unmarried adolescents who are less than 20 involved in sexual activity? How does the community generally feel about this? Do you think they should use contraceptive or they should get married before age 20? What is your opinion in it?
9. What do think is the appropriate age of marriage? At what age do you want your child to get married? Why? Which marriage do you prefer (arranged or love)? What you will do if your child choses inter-caste marriage?
10. How people around your community get married before the age of 20? Which type marriage is prevalent here? What is the context of early marriage?

11. Would you like to add anything in addition to what you have already mentioned?

C. IDI with peer educator

1. How are you? How is your study going on?
2. Do you like the program of peer education that has been conducted at your school?
3. What activities did you conduct at your school after receiving the training?
4. What did you learn from this program (peer educator training and Sahayogi app)?
5. How satisfied you are with the learning from peer educator training and Sahayogi app?
6. What did you like most in this program and what are the things you did not like at all? Can you/all names the different modules? Which module you find most interesting? Is there anything that you/all think should not have included in training or app??
7. How helpful did you find the contents of sahayogi app? Did you find it enough for learning?
8. Were you able to engage your friends to use app? How often did they use the app? Did you maintain log book?
9. Do all the students get opportunity to use tablet/play game? What did they read mostly in the app? Which game did they play most?
10. What is the most interesting thing you find in the app? What you like the least in app?
11. Does this program change your idea/value? (For example, is there anything you thought wrong, now you think right or vice versa)? Have you came to know about any important SRHR issues?
12. What do you understand by sexual harassment? Are there any cases of sexual harassment in your class? Do students talk about it at school or outside school? Do any students come to you to talk about it? What would you tell students to do if they came to talk to you about sexual harassment?
13. Have you heard that any students have started visiting health post to seek SRHR service? Do you know about it or do you visit health post to seek SRHR service? (for change in attitude) Have any students asked you about where to get SRH services?
14. Some adolescent run away to get married before 20 years? Why do they do so? Do you have any idea? (this could be interesting to know from peer educator) Have any of your friends married before 20, why they have done so, do you have any idea?
15. Present the situation, if a girl and boy wanted to have sexual relationship before 20, what they should do? Where could they get contraceptives? Or should they get married? If they get pregnant before marriage, what they should do? What are their choices?
16. In your opinion, what should be done to stop early marriage?
17. Would you like to add anything in addition to what you have already mentioned?

D. IDI with students (who are not peer educator but from case school)

1. Do you know about SRHR program that is implemented in your school? How often did you use the tablets? Can you name the app? What do you know about sahayogi app?

2. Can you name the modules? What you like most about sahayogi app? Which content you find most interesting? Did peer educator teach you how to use app? (probe, did you read all story, play games etc..) Which game did you find interesting?
3. How was your relationship with peer educator? Do you like him/her?
4. Are the contents of sahayogi app helpful/appropriate and enough for learning?
5. How this program has changed your way of thinking, any idea/value? (For example, is there anything you thought wrong, now you think right or vice versa)
6. Present the situation, if a girl and boy wanted to have sexual relationship before 20, what they should do? Where can they get contraceptives? Should they get married? If they get pregnant before marriage, what they should do? What are their options?
7. In your opinion what could be the appropriate way to educate young adolescent like you about SRHR? How technology is useful for adolescent to teach these things? or some other way should be introduced?
8. How often do you visit health post to seek SRHR services? What are the services you seek for? How do the health care providers treat you? Do your peer friends go with you to HP?
9. Would you like to add anything in addition to what you have already mentioned?

E. Interview guideline for school teachers for control school:

1. Tell us something about SRH course in the school curriculum? What are the different topics in the school curriculum that address adolescent sexual and reproductive health?
2. How are these topics taught in your school? Could you please share your experiences teaching this course in the school?

   Probing:
   - How you feel about teaching these topics?
   - Do you think that SRH topics should be taught in the school?
   - How does the discussion between teacher and students?
   - Are there any topics you don't feel comfortable teaching?
   - How do you deal with the issues raised in the class?
   - Do students regularly attend sexual and reproductive health classes?
3. What other topics do you think should be covered in adolescent sexual and reproductive health?
4. Are you aware of any differences in absenteeism in school between boys and girls? If yes, why do you think that happens? Does anyone ask the girls about their absence? Do you think there is absenteeism in the class due to issues with menstruation?
5. Do you have the facility for providing sanitary pads at your school? Are there separate toilet facilities for girls? If the teacher does not talk about issues with menstruation, probe:
6. Do you know about AFS (adolescent friendly service) corner? If yes, is there establishment of AFS corner at your school? If yes, what are the services they provide to the students? Do the students come to seek services at AFS corner? Is there any particular teacher or student responsible to provide information and services from these AFS corner?
7. If no, do you think AFS corner is essential at school? If yes, why? If no, why?
8. What are the major challenges you have faced to implement ASRH education program in your school?
9. What are your recommendations to overcome those challenges?

10. Would you like to add anything in addition to what you have already mentioned?

F. Interview guideline for students for control school:

1. Have you heard the term ASRH? If yes, what do you know about ASRH?
2. What are the courses included in your curriculum of health? What are the topics related to ASRH in your school curriculum?
3. How comfortable do you feel while learning about ASRH? What are the different ways your teacher teaches about ASRH? Do you ask the questions if you don't understand? Is there any topic you feel uncomfortable while learning?
4. Which is your best topic in ASRH? Do you think there should be extra content? If yes, what?
5. What do you do during your menstruation? Do you attend class? If no, why? **(For girls only)** What are the facilities given by school for adolescent and menstruating girls?
6. Have you ever participated in any kinds of training? If yes, what was the training about? Has anyone from outside come at school any taught about SRHR? If yes, what they taught? Did you find it helpful?
7. Is there establishment of AFS (adolescent friendly service) corner at your school? If yes, what are the services they provide to the students? If no, do you think it is important to have AFS corner?
8. In your opinion what could be the appropriate way to educate young adolescents like you about SRHR? How technology like mobile app is useful for adolescent to teach these things? Or some other way should be introduced? (explain about mobile app, if interviewee do not understand)
9. Is there early marriage at your community/school? Why you think they get married early?
10. Present the situation, if a girl and boy wanted to have sexual relationship before 20, what they should do? Where can they get contraceptives? Should they get married? If they get pregnant before marriage, what they should do? What are their options?
11. How often do you visit health post to seek SRHR services? What are the services you seek for? How do the health care providers treat you? How easy is for young people in your community to get advice on contraceptives or other SHR services?

1. Would you like to add anything in addition to what you have already

G. FGD with peer educator

2. How are you all? How is your study going on?
3. Do you like the program of peer educator that has been conducted at your school?
4. What activities did you conduct at your school after receiving the training?
5. What did you learn from this program (peer educator training and Sahayogi app)?
6. How satisfied you are with the learning from peer educator training and Sahayogi app?
7. What did you like most in this program and what are the things you did not like at all? Can you/all names the different modules? Which module you find most interesting? Is there anything that you/all think should not have included in training or app??
8. How helpful do you/all find the contents of sahayogi app? Did you find it enough for learning?
9. Were you able to engage your friends to use app? How often did they use the app? Did you maintain log book? If not why?

10. Do all the students get opportunity to use tablet/play game? What did they read mostly in the app? Which game did they play most?
11. Does this program change your idea/value? (For example, is there anything you thought wrong, now you think right or vice versa)? Have you came to know about any important SRHR issues?
12. What do you understand by sexual harassment? Are there any cases of sexual harassment in your class? Does any students come to you to talk about it? What would you tell them if they came to talk to you about sexual harassment?
13. Is there any students who have started visiting health post to seek SRHR service, do you know about it or do you visit health post to seek SRHR service? (For change in attitude). Have you demanded health post staff to provide ASRH friendly service?
14. In your opinion what could be the appropriate way to educate young adolescent like you about SRHR? How technology is useful for adolescent to teach these things? Do you think use of technology might be useful or some other ways should be introduced?
15. Did you get the support from your teacher for using tablet and conducting SRHR program at your school? Were your peers enthusiastic to learn through tablet? What kind of relationship you share with your peers?
16. Some adolescent run to get married before 20 years? Why do they do so? Do you have any idea? (this could be interesting to know from peer educator) Have any of your friend married before 20, why?
17. Present the situation, if a girl and boy wanted to have sexual relationship before 20, what they should do? Where can they get contraceptives? (probe if they think the health post would provide them and whether they think young people can get services from the health post. We want to know about judgment and discrimination) Should they get married? What will change in their lives if they get married? If they get pregnant before marriage, what they should do? What are their options?
18. Would you like to add anything in addition to what you have already mentioned?

H. FGD with school teacher-Intervention school

1. Please tell us, how students used tablets in your school? Do all the students get chance to get engaged with tablets?
2. Did you find the content of the training appropriate for adolescent? How did you feel about the content of app?(probe)
3. Has your school has created space for an adolescent friendly learning corner?
4. Did you find any changes after intervention (after we gave training) in school students about the issue of SRHR?
    a. How openly did they discuss the issue now?
    b. Did they ask any questions regarding the issue?
    c. Did they come to share any problems related with SRHR?
    d. Were there any changes in attitudes about any topics?
    e. Were there any changes in behavior between girls and boys? (like respecting each other, not making fun of friend, helping each other)
5. Can you describe how you feel about teaching adolescents about SRHR?

a. How did you feel about teaching ASRH after you received training from WOREC?
b. Did you intervene any activities in school related with SRHR? What kind of activities you intervened? If not why?
c. Were you able to support students to use tablet?

6. Do you feel changes in ASRH education than past? If you have not experienced any changes what could be the reason for that?
7. In your opinion, what could be the best way of promoting adolescent sexual and reproductive health education?
8. Would you like to add anything in addition to what you have already mentioned?

Annex 2
Training manual- Peer education training-ASRH

Introduction

As part of interventional research project entitled **"Developing Peer Support for Adolescent Friendly Sexual and Reproductive Health Services in Nuwakot and Rasuwa district"** peer education training is going to held from , 4 to 6 December, 2018 1st lot and 7 to 9 December, 2018 2nd lot in Battar, Nuwakot. Training will be facilitated by Dr Jill Allison, Dr laxmi Tamang, Abhiram Roy, Rajendra Poudel, Elawati K.C and Shweta Karna.

Major objective of training

- Develop student's leadership to become a peer educator in their school
- Increase knowledge of teachers and students on sexual and reproductive health and rights
- Teach students and teachers on use of tablets and its safe handling
- Clarify roles and responsibilities of students as a peer educator and teachers as a facilitator at school
- To launch ASRH app "Sahayogi" among the intervention group
- To distribute tablets to intervention schools

Following session will be held on day 1

1. **Introduction of participants**

All Participant will be mixed along with facilitator. And then, they will be choose one unknown partner. After that, they will introduce their partner by telling his/her name, where s/he come from, what s/he does, two similarities between them and two dissimilarities between them.

2. **Gallery Walk**

In gallery walk, different questions related to apps and technology will be written down and hung on wall. Three different statement will be written below question.

a. I agree
b. I don't agree
c. I do not know

Then participants will put a tick on one of the statement or as per the question there will be choice to put a tick mark.

Questions on technology and apps are;

1. Nothing happens to android tablet even if it is drop in water. Do you agree with the statement?
2. Nothing happens to android tablet if it is keep closer to fire. Do you agree with the statement?

3. Nothing happens to android tablet if you seat above it or you put heavy substance over it. Do you agree with the statement?
4. How long android tablet should be charged? 10%, 50%, 70%, 90%
5. You can touch with the pointed pen/pencil on screen of android tablet. Do you agree with the statement?
6. How long android tablet can be used if it's charge get drop to…10%, 20%, 70%, till it gets completely off
7. Which app you have used in android tablet?
8. Have you ever used android tablet?
9. After using android tablet instead of keeping it safely it should be given to children to play. Do you agree with the statement?
10. Tablet should be charged whole night. Do you agree with the statement?

3. Sessions on SRHR

By the end of training participants will be able to know the meaning of following terminologies.

Heterosexual: Heterosexuality is romantic attraction, sexual attraction or sexual behavior between persons of the opposite sex or gender. Someone who is heterosexual is commonly referred to as straight.

Homosexual: Homosexuality is romantic attraction, sexual attraction, or sexual behavior between members of the same sex or gender. As a sexual orientation, homosexuality is "an enduring pattern of emotional, romantic, and/or sexual attractions" to people of the same sex.

Sexually transmitted disease: Sexually transmitted diseases (STDs) are infections that are passed from one person to another through sexual contact. The causes of STDs are bacteria, parasites, and viruses. There are more than 20 types of STDs, including Chlamydia, Genital herpes, Gonorrhea, HIV/AIDS, HPV, Syphilis, Trichomoniasis

Partner: Sexual partners are people who engage in sexual activity together. The sexual partners can be of any number, sex, gender, or sexual orientation. The sexual partners may be in a committed relationship, either on an exclusive basis or not, or engage in the sexual activity on a casual basis. They may be on intimate terms (in which case they are often referred to as "lovers") or anonymous, as in the case of sex with a stranger, a one-night stand, or a prostitute.

Gay: Gay is a term that primarily refers to a homosexual person or the trait of being homosexual. The term was originally used to mean "carefree", "cheerful", or "bright and showy"

Celibate (Abstain): Celibacy is the state of voluntarily being unmarried, sexually abstinent, or both, usually for religious reasons. Mostly used in terms of abstaining from sexual relations.

Lesbian: A lesbian is a homosexual woman. The word lesbian is also used for women in relation to their sexual identity or sexual behavior, regardless of sexual orientation, or as an adjective to characterize or associate nouns with female homosexuality or same-sex attraction.

Transvestism: Transvestism is the practice of dressing and acting in a style or manner traditionally associated with the opposite sex. In some cultures, transvestism is practiced for religious, traditional, or ceremonial reasons. The term is rarely applied to women.

Bisexual: Bisexuality is romantic attraction, sexual attraction, or sexual behavior toward both males and females, or to more than one sex or gender. It may also be defined as romantic or sexual attraction to people of any sex or gender identity, which is also known as pan sexuality.

Snogging: Snogging means kissing and cuddling

Homophobia: Homophobia encompasses a range of negative attitudes and feelings toward homosexuality or people who are identified or perceived as being lesbian, gay, bisexual or transgender (LGBTIQ)

Heterosexism: Sometimes, even if individual people are not bigots or homophobes, institutions and cultural norms may be discriminatory or even oppressive by favoring heterosexual people at the expense of non-heterosexual people. Such institutions and norms are heterosexist, and people who do not protest against them or resist them also may be said to be heterosexist. Not all heterosexists are homophobic, but all homophobes are heterosexist.

Masturbation: Masturbation is the sexual stimulation of one's own genitals for sexual arousal or other sexual pleasure, usually to the point of orgasm. The stimulation may involve hands, fingers, everyday objects, sex toys such as vibrators, or combinations of these.

Gender: Gender is the range of characteristics pertaining to, and differentiating between, masculinity and femininity. Depending on the context, these characteristics may include biological sex (i.e., the state of being male, female, or an intersex variation), sex-based social structures (i.e., gender roles), or gender identity.

Orgasm: The orgasm is widely regarded as the peak of sexual excitement. It is a powerful feeling of physical pleasure and sensation, which includes a discharge of accumulated erotic tension.

Sex: In general terms, "sex" refers to the biological differences between males and females, such as the genitalia and genetic differences.

Gender is more difficult to define, but it can refer to the role of a male or female in society, known as a gender role, or an individual's concept of themselves, or gender identity.

Contraception: Birth control, also known as contraception and fertility control, is a method or device used to prevent pregnancy

Masculine: Masculinity (also called manhood or manliness) is a set of attributes, behaviors, and roles associated with boys and men. Although masculinity is socially constructed, some research indicates that some behaviors considered masculine are biologically influenced.

Safe sex: Safe sex is sexual activity using methods or devices (such as condoms) to reduce the risk of transmitting or acquiring sexually transmitted infections.

Kissing: A kiss is the touch or pressing of one's lips against another person or an object. Cultural connotations of kissing vary widely.

Love: Love encompasses a range of strong and positive emotional and mental states, from the most sublime virtue or good habit, the deepest interpersonal affection and to the simplest pleasure.

Friend: Friendship is a relationship of mutual affection between people.

Transgender: Transgender people have a gender identity or gender expression that differs from their sex assigned at birth. Some transgender people who desire medical assistance to transition from one sex to another identify as transsexual

Vaginal sex: Sexual intercourse (or coitus or copulation) is sexual activity typically involving the insertion and thrusting of the penis into the vagina for sexual pleasure, reproduction, or both

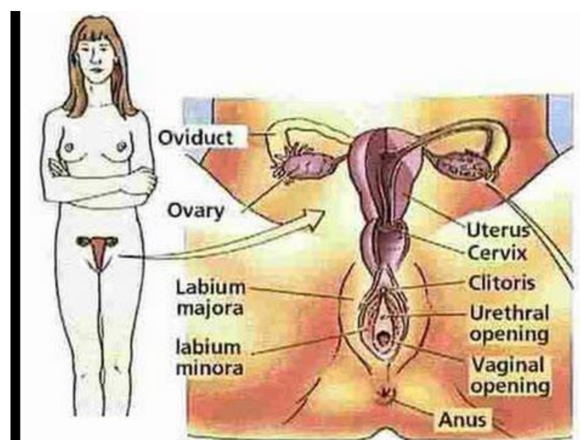
Abortion: Abortion is the ending of a pregnancy by removal or expulsion of an embryo or fetus before it can survive outside the uterus.

Consent: Consent occurs when one person voluntarily agrees to the proposal or desires of another

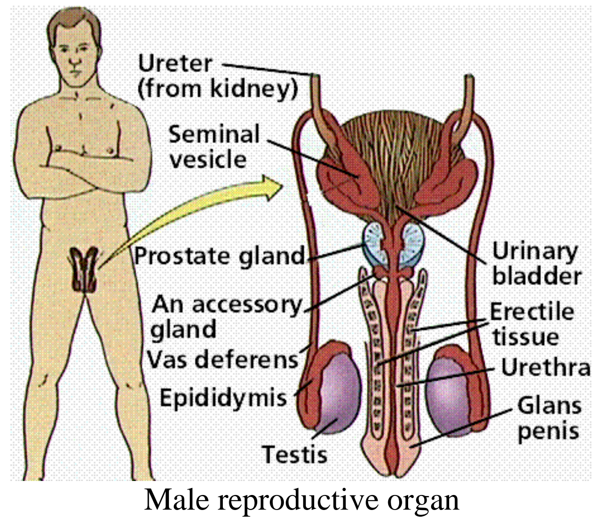
Confidentiality: Confidentiality involves a set of rules or a promise usually executed through confidentiality agreements that limits access or places restrictions on certain types of information.

4. **Body mapping game**

In this game participants will be divided into 5 groups. After that, one male and one female member of group will lie on white paper, while other member will draw out line of body on white paper. After that, one who is lying on paper will leave and all the members will draw male and female reproductive organ and name it.



Female reproductive organ



Male reproductive organ

5. Introduction to android tablet
   In this session participants will be given answer of questions that was asked during gallery walk and they will be introduced with the android tablet and about its safe handling. After that students will be provided with androind tablet to use.

Following session will be held on Day 2

1. Review of day 1

Review of day one will be conducted where participants will be given a ball. They have to tell what they learn from day 1. Then they have to pass the ball to another participants. In this way, all the participants have to tell at least one important learning from day 1.

2. Masturbation game

In this game different opinion on masturbation will be told to participants. Two side of room, one myth and one fact will be named. Then participants will told to take a side of myth or fact, and they will be asked why they chose that side.
Opinion on masturbation are;

1. Masturbation will increase the sexual desire of person
2. Masturbation is normal activity
3. Masturbation will not cause any disease
4. Masturbation is done by married person only
5. Masturbation will reduce the number of sperm
6. Masturbation do not cause any harm
7. Masturbation makes people blind
8. Masturbation can cause infertile
9. Female cannot do masturbation
10. Masturbation gives pleasure
11. Masturbation will grow hair on hand
12. Every individual can get pleasure by masturbation

13. Masturbation makes person weak
14. Masturbation will affect married life of couple
15. Masturbation is done by bad person

3. Session on adolescent, changes during adolescent, main problem of adolescent, ASRH rights

By the end of session participants will be able to understand following content,

- Adolescent is the transitional period between childhood and adulthood. It is considered as the period from10 to 19 years.
- Many changes occurs in adolescent period like;

Girls

- Girls may begin to develop breast buds as early as 8 years old. Breasts develop fully between ages 12 and 18.
- Pubic hair, armpit and leg hair usually begin to grow at about age 9 or 10, and reach adult patterns at about 13 to 14 years.
- Menarche (the beginning of menstrual periods) typically occurs about 2 years after early breast and pubic hair appear. It may occur as early as age 9, or as late as age 16. The average age of menstruation in the United States is about 12 years.
- Girls growth spurt peaks around age 11.5 and slows around age 16.

Boys:

- Boys may begin to notice that their testicles and scrotum grow as early as age 9. Soon, the penis begins to lengthen. By age 17 or 18, their genitals are usually at their adult size and shape.
- Pubic hair growth, as well as armpit, leg, chest, and facial hair, begins in boys at about age 12, and reaches adult patterns at about 17 to 18 years.
- Boys do not start puberty with a sudden incident, like the beginning of menstrual periods in girls. Having regular nocturnal emissions (wet dreams) marks the beginning of puberty in boys. Wet dreams typically start between ages 13 and 17. The average age is about 14 and a half years.
- Boys' voices change at the same time as the penis grows. Nocturnal emissions occur with the peak of the height spurt.
- Boys' growth spurt peaks around age 13 and a half and slows around age 18.

- The sudden and rapid physical changes that adolescents go through make adolescents very self-conscious. They are sensitive, and worried about their own body changes. They may make painful comparisons about themselves with their peers.
- Physical changes may not occur in a smooth, regular schedule. Therefore, adolescents may go through awkward stages, both in their appearance and physical coordination.

Girls may be anxious if they are not ready for the beginning of their menstrual periods. Boys may worry if they do not know about nocturnal emissions.

- During adolescence, it is normal for young people to begin to separate from their parents and make their own identity. In some cases, this may occur without a problem from their parents and other family members. However, this may lead to conflict in some families as the parents try to keep control.

Main problem during adolescent

- Early marriage
- Early pregnancy, unsafe abortion
- Mortality and morbidity related to reproductive health
- Vulnerability toward STD and HIV/AIDS
- Substance abuse
- Girls trafficking
- Sexual abuse
- Menstrual related problem
- Night fall
- Misconception on masturbation

Sexual and reproductive rights

Adolescent should know following rights;

- My body my rights
- Right to have access of information and health service
- Right to choose how many children to give birth
- Right to choose life partner, when to marry or not marry
- Access to family planning service, safe abortion, safe motherhood
- Right to have quality service
- Right to live without sexual harassment, rape, unwanted pregnancy, and unsafe abortion

Responsibility of adolescent

- Understanding the culture and belief system of society and family in a right way and try to explain family and society about good aspect
- Be sensitive toward family and society
- Try to control the sexual impulse
- Be responsible for your sexual desire
- Be engaged in creative work, and stay away from wrong thought

Responsibility of parents

- Accept the changes of adolescent children, take it normal and be positive toward the change
- Have a conversation with your children
- Share your learning from your experience
- Assure your children that you are equally serious of your children future.

Responsibility of society and policy maker

Provide appropriate education, counselling service and create favorable environment for adolescent which lead them in positive way.

4. **Session on family planning**

In this session participants are divided in 7/8 groups. They will be provided with family planning device along with its written description in leaflet. Then they will be told to describe about the device which their group get, about its use, side effects, who use this.

Key message to deliver

- Every girl/woman has the right to determine when, how often and if at all she would like to become pregnant.
- Adolescents have the right to information on and to select the contraceptives of their choice!
- Health service providers and FCHV should equip you with detailed information and contraceptives.
- There are several safe and free contraceptives available in Nepal to prevent or space pregnancies. Contraceptives do not affect women's childbearing capacity. Fertility returns when a woman stops taking contraceptives.
- The condom is special: it prevents both from becoming pregnant and getting infected
-

5. **Video show**

    1. Consent & Tea (Nepali version)

(https://www.youtube.com/watch?v=pYMG6Epv81U)

    2. From child, to bride, to mother: Child marriage in Nepal

https://www.youtube.com/watch?v=Q6brZfwf1lw

6. **Session on sexually transmitted disease**

Key message to deliver

- Sexually transmitted diseases (STDs) are infections that pass from one person to another through sexual contact.
- Some STDs can spread through the use of unsterilized drug needles, from mother to infant during childbirth or breast-feeding, and blood transfusions.

- The genital areas are generally moist and warm environments, ideal for the growth of yeasts, viruses, and bacteria.
- People can transmit microorganisms that inhabit the skin or mucous membranes of the genitals. Infectious organisms can also move between people in semen, vaginal secretions, or blood during sexual intercourse.
- Human immunodeficiency virus (HIV) attacks the immune system, leaving its host much more vulnerable to infections and diseases. If the virus is left untreated, the susceptibility to infection worsens.
- HIV can be found in semen, blood, breast milk, and vaginal and rectal fluids. HIV can be transmitted through blood-to-blood contact, sexual contact, breast-feeding, childbirth, the sharing of equipment to inject drugs, such as needles and syringes, and, in rare instances, blood transfusions.
- HIV is not transmitted by the bite of mosquito
- STDs can be prevented by the use of condom and keeping one faithful sexual partner.

7. **Condom blowing game**

In this game participants will be given with condom and they will told to blow it. Partcipants will be rewarded with chocolate after blowing condom. This game will help to reduce shyness of participants.

Following session will be held on Day 3

1. **Review of day one**

Participants will be told to say the learning of previous day.

2. **Session on Roles and responsibilities of peer and school teacher**

Key message to be deliver;

For peer educator

- Establishment of adolescent corner with the help of teacher and school management team
- Keeping the tablet in safe place after the use
- Registering the name of friends who have come to use tablet (name, class, gender, age)
- Helping other friends to learn tablet and use app
- Engaging all the friends to use tablet and app
- Maintaining logbook on what friends ask you about ASRH, what problem they have faced and discussion they do on ASRH
- Using tablet only at adolescent corner and school. Do not take tablet out of the school premise

For teacher

- Facilitate to establish adolescent corner
- Facilitate to open corner as per the schedule
- Ensure the safety of tablet

- Ensure that students has maintain registration and logbook
- Ensure all the students have used tablet
- Facilitate peer educator to take class on ASRH in their class.

Training schedule

Day-1

Time	Activities	Responsibility
7:30-8:00	Breakfast	
9 AM-9:15 AM	Welcome remark	Laxmi & Elawati
9:15 AM-10 AM	Ice break game & Ground rule /Group division/Role division	Jill & Abhiram
10 AM-11 AM	Pre testing session & Gallery walk	
11 AM-11:15 AM	Tea break	
11:15 AM-12 PM	Introduction to SRHR language	Jill & Abhiram
12PM- 1 PM	Body Mapping game	Jill & Laxmi
1PM-1:45 PM	Lunch	
1:45 PM-2:30 PM	Introduction of technical session/Apps introduction	Rajendra and team
2:30 PM- 4:00 PM	Practical session on Apps	Rajendra and team
4:00PM-4:15PM	Hi tea	
4:30PM-5:00 PM	Masturbation game	Jill, Elawati, Shweta, Abhiram
8:00 PM	Dinner	

Day-2

Time	Activities	Responsibility
7:30AM-8:00 AM	Breakfast	
8 AM-8:30 AM	Recap	Abhiram/ Laxmi

8:30 AM-10 AM	Masturbation game	Jill & Abhiram
10 AM-11 AM	Session on Sexuality, relationship, Safety, Consent	Jill/ Laxmi
11 AM-11:15 AM	Tea break	
11:15 AM-1 PM	SRHR rights	Abhiram
1PM-1:45 PM	Lunch	
1:45 PM-2:30 PM	Review on Apps	Ramchandra
2:30 PM- 4:00 PM	Session on STI	Jill/Laxmi
4:00 PM-4:15 PM	Hi Tea	
4:15-5:00	Practical session	Ramchandra
8:00 PM	Dinner	

Day 3

Time	**Activities**	**Responsibility**
7:30AM-8:00 AM	Breakfast	
8:00 AM-9:00 AM	Post test	Jill & Laxmi
9:00 AM-11:00 AM	Roles and responsibility of peer educator and school teacher	Abhiram & Elawati
11: 00	Lunch	