# EFFECTS OF CULTURE ON SEXUAL HEALTH EDUCATION IN DEVELOPING COUNTRIES

## Empowering Adolescents in Nepal

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Bachelor's thesis
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Option of Medical-Surgical Nursing

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**ABSTRACT**

Tampereen ammattikorkeakoulu
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The purpose of this thesis was to create educational sessions on sexual health to empower adolescents in Nepal. The topic emerged from the need of the working life connection. Research was conducted on the effects of culture on education, specifically surrounding sexual health, and the literature review focused on the state of sexual health education in Nepal.

Through research, this thesis aims to raise awareness of the need of cultural competence in nursing. Moreover, the research gave direction for the actualisation of the project, which consisted of several educational sessions and individual discussions. The educational sessions were video recorded, observed, and evaluated. Feedback and assessment were gathered by using qualitative methods; the project was generally well received and suggestions were given for future improvement.

The thesis brings forth the urgent need to increase and improve education for cultural competence in healthcare. Because culture has an effect on every aspect in life, cultural ignorance can be harmful. Through collaborative work, further studies can aid in the development and refinement of the knowledge and implementation of culturally competent care.

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Key words: globalisation, developing countries, culture, religion, Hinduism, education, sexuality, sexual health education, Nepal.

**TIIVISTELMÄ**

Tampereen ammattikorkeakoulu
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Voimaannuttamassa nuoria Nepalissa

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Tämän toiminnallisen opinnäytetyön tarkoituksena oli suunnitella ja toteuttaa seksuaaliterveyteen keskittyviä kasvatuksellisia ohjaustuokioita, joiden tavoitteena oli voimaannuttaa nuoria Nepalissa. Työn aihe syntyi nepalilaisen työelämän yhteistyökumppanin ehdotuksesta. Opinnäytetyön sisältämä tutkimus tarkastelee kulttuurin vaikutusta koulutukseen, erityisesti seksuaaliterveyteen liittyen, ja kirjallisuuskatsaus syventyi seksuaalikasvatuksen nykytilaan Nepalissa.

Tutkimuksen tavoitteena oli lisätä tietoisuutta kulttuurisen kompetenssin tarpeesta hoitotyössä. Opinnäytetyön toiminnallinen osuus perustui tehtyyn tutkimukseen ja koostui henkilökohtaisista keskusteluista sekä useasta kasvatuksellisesta ohjaustuokiosta. Ohjaustuokiot videoitiin arvioinnin mahdollistamiseksi. Palaute ja arviointi kerättiin laadullisia tutkimusmenetelmiä käyttäen; projektiin suhtauduttiin myönteisesti ja ehdotuksia annettiin sen edistämiseksi.

Opinnäytetyö tuo esiin tarpeen kulttuurisen kompetenssin lisäämisestä ja parantamisesta hoitotyössä. Koska kulttuuri vaikuttaa elämän jokaiseen osa-alueeseen, voi kulttuurinen tietämättömyys olla haitallista. Moniammatilliseen yhteistyöhön pohjautuva lisätutkimus voi auttaa kehittämään kulttuurisen kompetenssin ymmärrystä sekä sen toteutusta hoitotyössä.

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Asiasanat: globalisaatio, kehitysmaat, kulttuuri, uskonto, hinduismi, koulutus, seksuaalisuus, seksuaalikasvatus, Nepal

**CONTENTS**

**ABBREVIATIONS AND TERMS**

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| BMI | Body Mass Index |
| CCCET-TV | Cultural Competence Clinical Evaluation Tool - Teacher Version |
| CSES | Cultural Self Efficacy Scale |
| GNI | Gross National Income |
| HIV | Human Immunodeficiency Virus |
| MPI | Multidimensional Poverty Index |
| NGO | Non-Governmental Organisation |
| OPHI | Oxford Poverty and Human Development Initiative |
| PMS | Pre-Menstrual Syndrome |
| STI | Sexually Transmitted Infection |
| TSET | Transcultural Self-Efficacy Tool |
| UN | United Nations |
| UNDP | United Nations Poverty Index |
| WHO | World Health Organization |

# 1 INTRODUCTION

In recent years, an increasing amount of immigrants have been moving to Finland (Official Statistics of Finland 2013). The culture, which used to be very homogenous, has become more complex and diverse due to globalisation (Dale 2009, 35). Duffy (2001, 490) states that differences in cultures are decreasing and similarities are increasing due to cross cultural interaction: people are assimilating their own culture with new adopted characteristics.

Culture has a major impact on health education and nursing care (Duffy 2001, 488; Waszak, Thapa & Davey 2003, 84; Purden 2005, 227; Daniels, Lauder & Porter 2009, 7-9). Because of migration, nursing practice all over the world demands cultural acceptance – particularly because borders between countries are becoming less distinct and cultures are intertwining. However, in order to achieve quality care (a legal and moral obligation of nurses), cultural boundaries need to be respected. (Duffy 2001, 488; Marsella 2009, 126.)

The adaptation to the transformation of cultural boundaries is not progressing as fast as it needs to be. Although nursing education has evolved, it still lacks the capacity to meet the requirements of globalisation. (Duffy 2001, 488.) The teaching of culture in nursing education is still focused on the separation between *us* and *them* by pointing out the differences of cultures, which in turn causes an oversimplification of the needs of diverse patients (Duffy 2001, 488-489.) In addition, this teaching method does not provide nurses with the tools to approach culturally sensitive care nor does it meet the requirements of cultural awareness (Purden 2005, 232). Duffy (2001, 491-492) and Mixer (2008, 28) recommend using transformative cultural education, a method that focuses on cultural commonalities instead of differences.

When cultures are intertwined, or even within an individual culture, there are some elements which are harder to assimilate (Machida 2012, 429, 440-441). For example, in a great number of countries, discussing sexual matters with parents is considered to be disrespectful, and even taboo (Bott, Shah & Jejeebhoy 2003, 231; Regmi, Simkhada & van Teijlingen 2008, 66; Rawson & Liamputtong 2010, 351; Regmi, van Teijlingen, Simkhada & Acharya 2010, 619, 623; Tsakani, Davhana-Maselesele & Obi 2011, 7).

Therefore, the majority of the youth turn to the products of modernisation, such as the media, to learn about sex and sexual health (Bott et al. 2003, 231; Pokharel, Kulczycki & Shakya 2006, 158; Regmi et al. 2008, 67; Regmi et al. 2010, 623). Moreover, many societies do not provide adequate sexual health education, as it causes an uncomfortable dissonance between the generations (Bott et al. 2003, 231, 235; Pokharel et al 2006, 157).

Thus, we reviewed literature on the effects of culture on sexual health education and applied it to our endeavours in Nepal. Our project consisted of several educational sessions that covered sexual health needs, which were defined in our research. We also held individual sessions, which included health check-ups, with the adolescents. We executed the project in cooperation with a children's home, as it was also our working life connection. Our goal was to empower adolescents of the children's home through an educational process. Moreover, the process allowed us to gain insight on our own cultural competence. In order to evaluate our work, the project was video recorded and assessed. To respect the confidentiality of the adolescents, all names were kept anonymous.

## 2 PURPOSES, OBJECTIVES, AND AIMS

Our primary purpose was to prepare educational sessions on sexual health for the adolescents of a children's home in Nepal. Our secondary purpose was to create a trusting and comfortable environment to ensure open communication during the individual discussions with the adolescents.

Our objective was to pass sexual health information to the adolescents, which in turn could be spread to the community. Our ultimate goal was to empower the adolescents and future generations to acquire the tools needed in order to mature into self-sufficient adults.

The aims of the research were to raise awareness of needs for cultural sensitivity in nursing practice and to present the importance of cultural education in healthcare.

We aimed to answer the following questions through research:

1. How does culture affect sexual health education in Nepal, in representation of developing countries?
2. How is sexual health education implemented in Nepal for adolescents?
3. What are the educational needs of our target group?

# 3 THEORETICAL STARTING POINTS

## 3.1 Globalisation

Globalisation is the process of connecting countries (Machida 2012, 438). Due to the advancements of technology, the changes related to globalisation are happening fast and reaching all corners of the world (Fien 2010). World Health Organisation (2013) states that the changes of globalisation affect economics, politics, society, culture, and technology.

While some argue that globalisation is only a benefit to societies, others claim that it can be a danger as well (Machida 2012, 437). Nevertheless, the controversy lies in the impact of globalisation on cultures (Machida 2012, 436). According to Machida (2012, 436-440) and Malota (2012, 94-95), the critics of globalisation state that the dominance of American and Western culture may actually destroy the diversity of the Eastern world. Moreover, the interlacing of different cultures can lead to a "clash of civilisations" (Machida 2012, 440), which in turn can cause even greater problems than those that already exist. (Machida 2012, 436-440.)

However, there is also a concept of "hybridisation" (Machida 2012, 439) that highlights the strengths of each individual culture within a homogenised society. This concept encompasses the notion of "negotiation" (Marsella 2009, 122) and eclecticness: selecting the best of all intertwined cultures. As Machida (2012, 441) concludes, a deeper and more frequent diffusion of social globalisation reduces the culture's resistance and even mitigates its aversion towards other cultures. This is due to the fact that cultures are being exposed to one another, and in a way becoming desensitised (Machida 2012, 457).

The concept of ethnocentrism is a crucial tool when trying to grasp the effects of globalisation on cultures at an individual level. Moreover, it helps us comprehend how people cope with the impact of another culture on theirs. (Machida 2012, 440.) In some instances, the elements of a certain culture can easily find their nook in a foreign culture (Machida 2012, 429). However, there is also a substantial number of elements which cannot be dissolved without altercation (Machida 2012, 440-441). According Marsella

(2009, 131), we need to dismiss the idea of "other" and find a way to gently introduce Western culture into Eastern culture, all the while accepting that the latter is just as good as the former.

### 3.2 Developing country

There is no single, internationally recognised definition of a "developing country". However, World Bank (2012) divides developing from developed countries according to the country's Gross National Income (GNI) per capita per year. GNI is the sum value of the income of all producers and product taxes, excluding the income coming from abroad (World Bank 2012). Additionally, low income is not the only indicator of poverty, which is often associated with developing countries. Nowadays, poverty is seen to consist of multiple dimensions that are interlinked; thus, commitment and coordination are needed from various sectors on a global level to address the problem (UNDP 2010, 1). Different international methods have been formed to allow better understanding and recognition of poverty.

Alkire and Santos (2010, 1) introduce the Multidimensional Poverty Index (MPI) as a new method for determining what constitutes a developing country. MPI was developed in 2010 by the Oxford Poverty and Human Development Initiative (OPHI) in cooperation with the UN Development Programme (UNDP), and it is presented as the leading part of the UNDP's Human Development Report. Traditionally, the definition of poverty solely concentrates on the income status and ignores all other variables. However, in contrast, MPI recognises a variety of factors affecting the poverty status of a household. Thus, it is considered to be a more complex method for measuring poverty. The dimensions of MPI are health, education, and the standard of living. These dimensions in turn have several indicators. Moreover, the incidence and intensity of poverty are also calculated and considered in order to create a multidimensional profile of poverty for each developing country. (Alkire & Santos 2010, 7.)

In MPI, the dimension of health is built upon the identification of malnutrition and whether a death of a child has been experienced within a household. Therefore, the indicators for health are "child mortality" and "nutrition" (Alkire & Santos 2010, 14-15). The education dimension uses "years of schooling" and "child school attendance"

as defining factors. If at least one member of the household has attended school more than five years, the criteria of the indicator is met. In addition, if any of the school-age children are not receiving education, the whole household is considered deprived. (Alkire & Santos 2010, 13-14.) The third dimension has a broader variety of indicators. Alkire and Santos (2010, 7) have listed electricity, accessibility to drinking water, sanitation, the possibility to cook with fuel, proper flooring, and the existence of certain assets as measures for the standard of living. None of the dimensions and their indicators are considered more important than the other and all are weighed equally when measuring the household's MPI rate (Alkire & Santos 2010, 7).

According to Alkire and Aguilar (2012), MPI is used to portray the detailed status of 109 developing countries and to explore the specific indicators and their relation to one another within each country. Nepal was identified as one of the 39 "least developed countries" (Alkire & Aguilar 2012) and was also listed as a developing country for 2013 (Developing Countries 2012).

### 3.3 Culture and religion

Tylor (in Rai & Penna 2010, 3) already defined culture in 1986 as a "complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by a man as a member of society". This definition is one of the oldest and most often quoted to describe the complexity of the concept of culture (Rai & Penna 2010, 3). Bussey-Jones and Genao (2003, 733) also recognises the complex nature of culture and suggests culture to include both value and belief-based elements and more practical features like traditions and language. Leininger and McFarland (2002, 9, 47) emphasise the active role of culture in directing human thoughts, decisions, and behaviour.

The anthropological point of view suggests that culture is the knowledge of humanity, a knowledge that is not natural or inborn but acquired and learned (Rai & Penna 2010, 2-3). According to Oswell (2006, 3), culture does not only describe concrete achievements or characteristics of societies, but it can also be viewed as an idea itself which, according to Leininger and McFarland (2002, 48), is the most holistic and comprehensive way to perceive and understand people. We can describe something as

"cultural" according to our experience and interpretation of the word itself. As a term, culture is broad and general, but its meaning and uses have changed and will continue to change, throughout time and place. (Oswall 2006, 3.)

Rai and Penna (2010, 3-5) present culture as an entity consisting of several features (figure 1). Altogether they list 16 features, which all provide different viewpoints for culture. Leininger and McFarland (2002, 9-10) identify similar features in their definition of culture within the theory of transcultural nursing.

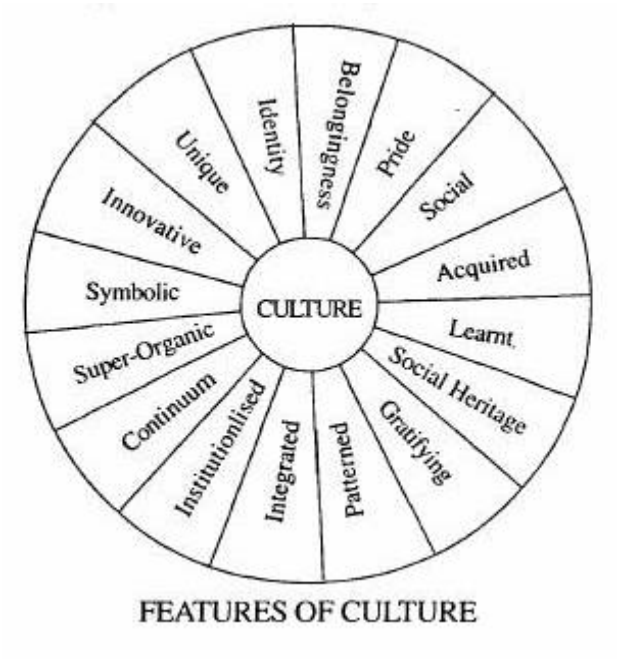


FIGURE 1. Features of culture (Rai & Penna 2010, 5).

According to Rai and Penna (2010, 3-5), every culture differs from one another; thus, cultures are "unique" by their nature and "social" as they appear within groups. Culture also provides individuals with a sense of "belongingness", "pride", and an idea of "identity". For individuals, culture is often "gratifying" as it satisfies their needs. (Rai & Penna 2010, 3-5.) As mentioned before, culture is "acquired" and "learnt", therefore considered as a "social heritage" (Rai & Penna 2010, 3-5) and is transmitted inter-generationally (Leininger & McFarland 2002, 47). Rai and Penna (2010, 3-5) suggest that culture can be viewed as a "continuum" where its basis remains the same. This existence over time and generations makes culture "super-organic", meaning that it survives regardless of the lifespan of people and societies (Rai & Penna 2010, 3-5). However, Leininger and McFarland (2002, 10), together with Rai and Penna (2010, 3-

4), point out that culture is not fixed but goes through changes over time, according to alterations made by new generations. Moreover, both authors (Rai & Penna 2010, 3-5; Leininger & McFarland 2002, 9) agree that culture is "patterned" in that its practices, ceremonies, and traditions are repeatable and recognisable. Shared ideals, values, beliefs, practices, and traditions make culture "integrated" by its nature. Several different institutions exist in different cultures and enhance the order within them, making the cultures "institutionalised". (Rai & Penna 2010, 3-5.) Rai and Penna (2010, 3-5) and Leininger and McFarland (2002, 48) describe cultures as "symbolic" because they have a wide range of symbols for the representation of material and non-material worlds. Cultures have an ability to create, and therefore Rai and Penna (2010, 3-5) describe "innovation" as the last feature of cultures. In addition, Leininger and McFarland (2002, 49) stress the existence and discuss the importance of intercultural variations between and within all cultures.

Rai and Penna (2010, 3, 40-41) define religion as part of culture and argue that it belongs in every society. Although religion is a component of society, the form varies. Faith can be spread across several deities or none whatsoever, and some have only one god that is worshipped. Nevertheless, the consistent factor found in every religion is that they focus on a world beyond the immediate experience. (Rai & Penna 2010, 41.)

Religion is a social process and has several different functions. It brings meaning for life and provides a sense of control over certain events. Religion also answers essential existential questions, and thus it empowers people during difficult times. In practice, faith is demonstrated through rituals, which vary in every religion. Such rituals may include praying, singing, dancing, eating certain foods or fasting, and much more. (Rai & Penna 2010, 41-43.)

### 3.3.1 Cultural competence in healthcare

Changes in the socio-demographic profiles of countries worldwide have raised a new challenge and need in healthcare (Duffy 2001, 488; Purden 2005, 227; Zander 2007, 50). As the world is becoming more diverse and multicultural (Mixer 2008, 23), nursing has changed accordingly (Keighley 2012, 181). Migration to Western countries is increasing due to the growing need for more workforce (Duffy 2001, 488). Thus,

healthcare providers are receiving more culturally diverse patients and the working environment itself is becoming more multicultural (Duffy 2001, 488; Mixer 2008, 23). Due to these changes, more attention has been paid to the growing demands for cultural competence and sensitivity in nursing (Dudas 2012, 320; Mixer 2008, 23). Bussey-Jones and Genao (2003, 733) state that the effects of culture must be respected in order to ensure effective and good quality care. Furthermore, Leininger developed a theory of transcultural nursing to highlight the importance of cultural aspects in nursing and healthcare (Leininger & McFarland 2002, 15), which will be covered in later sections.

Zander (2007, 50) describes cultural competence as a "highly complex phenomenon". Dudas (2012, 318) recommends to view cultural competence as a dynamic process or a journey of "becoming culturally competent rather than being culturally competent" (Campinha-Bacote 1999, 203). To become culturally competent, one must become aware and conscious of the elements of cultural competence and through practice, finally reach a state where providing culturally appropriate care happens automatically (Dudas 2012, 318). The elements of cultural competence are cultural awareness, cultural sensitivity, cultural knowledge, and cultural skills (Zander 2007, 53; Mixer 2008, 25; Dudas 2012, 320).

Cultural awareness is the first dimension of cultural competence and seen as an ongoing process where one becomes knowledgeable about the values, beliefs, attitudes, and practices related to another culture (Zander 2007, 53; Dudas 2012, 318). To enable this process, one must become receptive to cultural differences and develop an understanding of the cultural effects and influence through self-awareness (Zander 2007, 53). As Dudas (2012, 218) states, "to understand the needs of another, one must understand oneself". Zander (2007, 53) refers to cultural sensitivity as part of cultural awareness. Cultural sensitivity is the will and ability to tolerate and let cultural differences coexist, without trying to affect or change the values or beliefs that differ. In general, cultural awareness is respecting and appreciating the diversity and differences between people of different backgrounds. (Zander 2007, 53.)

Zander (2007, 51) states that due to the strides towards a multicultural environment, one can never master cultural knowledge. More importantly, the knowledge should be gathered on a personal level while recognising the individual differences, rather than relying on stereotypical descriptions received from literature. Motivation and

enthusiasm is needed as “gaining cultural knowledge is a lifelong endeavour”. (Zander 2007, 51.)

Effective communication with culturally diverse people is one of the key elements of cultural skills. Communication includes verbal competence, which is characterised by speaking several languages or using an interpreter correctly, and nonverbal communication. (Zander 2007, 51.) Dudas (2012, 319) states that language barriers may lead to the inability of recognising and meeting the needs of patients. Attention should also be paid to nonverbal communication, as the meaning of messages can vary drastically in different cultures. Cultural skills also consist of proficiency in cultural assessment, the ability to sense and recognise cultural differences, and take them into account when providing care. (Zander 2007, 51.)

Cultural competence in nursing has lately received a great deal of attention and has prompted discussion (Zander, 2007, 50; Mixer 2008, 23; Dudas 2012, 320; Keighley 2012, 181). O’Hagan (2001, 97) argues that “there is no tradition of cultural sensitivity or cultural competence in health or social care professions, neither in their literature nor their practices”. Additionally, Duffy (2001, 488) states that the current healthcare system succeeds only when addressing the needs of members from the dominant culture; thus, the care of people who differ from the mainstream in any way is inadequate. Even if cultural competence in nursing has not yet reached its full potential, the need for it has been recognised and recommendations for future practice have been suggested (Duffy 2001, 493; Purden 2005, 232; Zander 2007, 54; Dudas 2012, 320-321).

### 3.3.2 Culture in nursing education

Due to globalisation and the increase of diversity, nursing educators worldwide are faced with challenges in teaching multidimensional cultural competence for future nurses (Mixer 2008, 23-24). It is crucial that they are able to provide culturally competent care to enhance patient safety, satisfaction, and beneficence (Mixer 2008, 24). Additionally, a paramount feature in the personal and professional responsibility of nurses is to show respect and sensitivity to all cultures (Gray & Thomas 2006, 76).

As previously stated, nursing education does not effectively teach new nurses how to carry out culturally competent care. Moreover, students have low confidence in their ability to care for people of different backgrounds. This is, in part, due to the lack of working experience. (Mixer 2008, 24-25). However, the issue is in the disconnection between the values that are taught during the learning of multiculturalism and the actual fruition of proposed philosophies. While cultural competence is written in institutional values and beliefs, sometimes the commitment to teach these philosophies is not that evident in the curricula. Furthermore, the education that is provided for nursing students is typically generalised. (Mixer 2008, 29-30).

Mixer (2008, 24, 26) and Duffy (2001, 491) suggest that transcultural (transformative) nursing (Leininger & McFarland 2002, 15) education needs to be integrated throughout the curricula of all levels, worldwide. This strategy would expose students to other cultural lifestyles. It would also encourage students to thoughtfully reflect and develop their own value and belief systems in an inclusive way, and explore how they relate to those of other cultures in a "co-learning" and "co-creating" manner. (Duffy 2001, 491.) This would create a power balance between cultures. Students would be placed into clinical trainings where they would be mandated to work with people of different cultural backgrounds. For example, in one study (Mixer 2008, 23-36), a group of students took part in a two-to-three week international clinical immersion and came back with higher scores on the Cultural Self-Efficacy Scale (CSES). The students who participated in the international clinical immersion enhanced their recognition of ethnocentrism and realised the need to develop their cultural competence. In addition, the students also gained "personal growth, increased sensitivity to the needs of others and a general expansion of [their] worldview" (Mixer 2008, 28). The problem is that there are not enough qualified nursing professionals to teach transcultural nursing, as it is solely taught at masters' and doctoral levels. (Mixer 2008, 25-28).

Duffy (2001, 491) argues that one cannot learn cultural competence simply in the classroom. On an institutional level, teachers need to emphasise the importance of cultural diversity and inclusivity as a positive rather than a negative concept, and students need to have an eagerness to become more culturally competent (Duffy 2001, 491). Research (Mixer 2008, 23-36) has also found that students from a minority group were naturally more culturally competent. However, the movement towards cultural competence lies in the ability to communicate, learn, and change, rather than in the

ability to distinguish between cultures (Duffy 2001, 491). After all, cultural competence is constantly developing throughout the nursing journey, as new needs arise and old needs become outdated (Mixer 2008, 24-25, 27).

## 3.4 Education

Education is a widely discussed, studied, and even debated issue. The meaning and purpose of education has various explanations, and the practices and policies related to education are more complex than ever (Daniels et al. 2009, 1-2). Regardless, the fundamental purpose of education and its importance have been recognised for a long time. In 1948, the Universal Declaration of Human Rights already acknowledged education as a fundamental right for everyone (UN 2007, 10). Elementary education should be free of charge and further education made generally available. Furthermore, education should be "directed to the full development of the human personality" and it should aim "to promote understanding and tolerance". (UN 2007, 10.)

Fairfield (2009, 1) explains education as a transformation or a process through which an individual gains knowledge and information, ultimately reaching maturity and emancipation. According to Power (2005, 17), the family, and local community and schools affect education, and therefore they need to be strong and supportive to ensure the successfulness of this long-term process. From another viewpoint, education can also be viewed as a method of providing skills, later to be used for the economic benefit to society and nation by creating future workers (Daniels et al. 2009, 2). In addition, Dale (2009, 33) argues that education is specifically formed and designed to serve a purpose and to fulfil certain interests. This approach can create a conflict of values between the educators and the system (Daniels et al. 2009, 2).

### 3.4.1 Cultural effects on education

Globalisation and the blending of cultures greatly affect education, as it is seen as the most communal of institutions (Dale 2009, 27). Pedagogy and education are not separate or immune to their surroundings; they are affected by all levels: the classroom, school, system, and society (Alexander 2009, 11).

On the classroom level, the factors of teaching are: the characteristics, development, motivation, and needs of students; the ideas concerning learning and teaching; and finally, the curriculum (Alexander 2009, 16-17). The diversity among students includes their personal characteristics and variation in their preferred learning styles and approaches. Furthermore, these factors are built based on the background, culture, ethnicity, and origin of the students. (Wisker, Exley, Antoniou & Ridley 2008, 86-89.)

Secondly, "the system" (Alexander 2009, 16-17) and the school authorise what is taught by establishing different policies. The policies concerning the curriculum form and adjust the content and the aims of teaching. The admission of students and the qualification and training of the teachers are also based on formal policies and requirements. (Alexander 2009, 16-17.)

Alexander (2009, 16) lists culture and society as the third domain to influences pedagogy and education. Collective ideas, values, customs, and relationships shape the way society views itself and education. Individual experience of the 'self' and the ideas of human identity guide education and youth by giving them an idea of their social purpose. (Alexander 2009, 16-17.)

In addition, Räsänen (2005, 31) points out the cultural effects on education from the societal and personal levels. Education can be seen as a way of transferring something that is considered valuable and beneficial. Society strongly defines what is valuable. However, teachers have some freedom to choose and influence the material and content that is taught in concordance to their own personal assessment and values. Thus, education can be highlighted in different ways depending on the values of society, institution, and teachers. (Räsänen 2005, 31.) By exploring the interaction between the students and teachers, one may not only learn about their personal beliefs, but also receive a wider understanding of the governing values of society (Alexander 2009, 11). Regardless of the inevitable changes in the educational system brought on by globalisation, multiculturalism, and modernity, education is mostly affected by the governing culture and ideology of the specific region in which it is situated (Alexander 2009, 17; Dale 2009, 35).

### 3.4.2 Educational methods

There are many different teaching styles that an educator can use when teaching. Khurshid and Aurangzeb (2012, 19) and Alexander (2009, 21) have defined the following as the most commonly used teaching methods: Formal Authority, Expert, Facilitator, Delegator, and Personal Model. These five teaching styles are then applied to different mediums for transferring knowledge. However, effective learning is encompassed by interactive learning (Chen & Wang 2009, 273). For example, the developed cognitive strategies that derive from gameplay aid in the students' ability to connect new and old information (Cheng & Wang 2009, 275). According to Mohammed and Mohan (2009, 197), the students' affinity for absorbing new information is defined by their cultural background. Moreover, the use of humour in education can improve the learning process and retention of new information by creating more student interaction (Mohammed & Mohan 2009, 198).

Mykrä and Hätönen (2010, 41-68) explore different types of group work: small groups, cumulative group, reflective group, brainstorming, and role playing. For the purpose of our project, we expand only on some of the aforementioned types.

The benefit of small group work is that everyone is able to actively participate and share his or her thoughts. The goal of small group work is to encourage generally quiet students to participate in learning as well, whereas reflective group work promotes students to look back and try to see matters from different perspectives. Moreover, according to Hsiao (2009, 222-223), reflection encourages students to collaboratively pay attention to interactions between themselves and others, all the while taking into consideration the environment and world around them. The benefit of reflective group work is that while each person reflects on their thoughts, other group members are able to reflect on theirs and reformulate their ideas. (Mykrä & Hätönen 2010, 41-43, 46-48.)

Role playing is when the student takes on the role of another person and interacts with others. The point of role playing is to learn by trying, practicing, and observing the behaviour of others in different situations. During role play, one can learn different feelings, attitudes, and values. This type of group work is beneficial, because it teaches students different scenarios of interaction, develops one's concept of the self, and instructs how to deal with human relations. (Mykrä & Hätönen 2010, 56.)

### 3.4.3 Adolescents' educational needs

The educational needs of adolescents are complex and encompass unique features and characteristics compared to adult education (Main 2010, 82). Firstly, Main (2010, 82) suggests that the concept of adolescent education is based on particular assumptions and ideas, including the development and characteristics of adolescents. For instance, their brains are going through "dynamic" (Casey, Jones & Somerville 2011, 24) changes that cause them to process information differently. Moreover, their emotional development is also in the process of maturing. As a result, while the adolescent brain is physiologically ready to make sound choices, the delay of emotional maturation causes them to fall short, leaving their brains vulnerable. (Schwartz 2008, 86-88; Blakemore 2009, 96; Scarborough, Lewis & Kulkarni 2010, 277; Casey et al. 2011, 24.)

During this intense transition, adolescents also experience an enormous amount of pressure from their peers, family, and society (Regmi et al. 2010, 623). These interactions bombard adolescents with a mixture of positive and negative impacts (Schwartz 2008, 89). Thus, adolescents need to seek role models to help them understand and accomplish their "developmental tasks" (Khurshid & Aurangzeb 2012, 20) in a healthy manner. These tasks include emotional maturation, physical development, and defining their role in group and sexual relationships. (Khurshid & Aurangzeb 2012, 20; Homma, Saewyc, Wong & Zumbo 2013, 13).

The duties of educators, who are teaching sexual health, are to enhance, influence, and promote meaningful learning experiences so that adolescents can tackle and adjust to real life situations (Bott et al. 2003, 231, 235; Khurshid & Aurangzeb 2012, 19; Lynch 2012, 140). Furthermore, educators are a resource for adolescents during their transformation from childhood into adulthood; they need to teach and prepare adolescents to take on the role of adults and to be accountable (Khurshid & Aurangzeb 2012, 20, 27; Rajendran 2012, 690).

Further, Main (2010, 82) argues that the current system provides only half of education. "The other half" (Main 2010, 82) is an unconscious form of education where the educator's personality indirectly affects the adolescent. Through unconscious education, adolescents form their own sense of judgment and independency. Educators should be aware of not only what they do or say, but also how and who they are. The unconscious

education can also be damaging or even "mar" (Khurshid & Aurangzeb 2012, 28) the psychosocial development of adolescents if the educator unintentionally transfers his or her own unconscious problems. (Main 2010, 82-84, 91.) Therefore, it is imperative to create an educational session that stimulates and encourages the adolescent students to cultivate their developmental tasks (Khurshid & Aurangzeb 2012, 28).

However, educators also have to take into consideration that female adolescents are less aware of their developmental tasks (Khurshid & Aurangzeb 2012, 28) and more prone to risky behaviour (Regmi et al. 2010, 622; Makenzius & Larsson 2013, 23), which in turn may cause them to need more guidance. Regardless, among other expectations, Khurshid and Aurangzeb (2012, 20) state that once an adolescent reaches adulthood, one should be able to accept and maintain his/her own body, get along amicably with both genders, develop a set of values, and to become a responsible member of society.

Botts et al. (2003, 232) and Khurshid and Aurangzeb (2012, 28) recommend a compassionate, empathetic, trustworthy, and non-judgemental approach to teaching. In addition, Scarborough et al. (2010, 278) suggest that using a goal-setting technique will enhance "sociocognitive development, interpersonal relationship skills, and self-efficacy".

### 3.5 Sexual health

According to Tsakani et al. (2011, 3), sexual health is the ability to express one's sexuality within the parameters of self-respect and respect for the partner. It is affected by physical, psychological, and social factors. Moreover, it needs to be accepted within a country's social, economic, and political context (Sexual and Reproductive Health 2014). As sexuality is a "fundamental" (Regmi et al. 2010, 619) aspect of life (Makenzius & Larsson 2013, 23), Evans (2013, 55) states that ignoring sexual health needs of adolescents is essentially denying their feelings and desires as sexual beings.

During puberty, adolescents go through a series of changes. These changes should develop within a certain time frame for them to be considered healthy growth (Palo Alto Medical Foundation 2014). According to Thies and Travers (2001, 145), the physical maturation of puberty should begin between ages 10-12 and end between ages 18-20.

For example, adolescents should go through a growth spurt one to two years after the onset of their puberty. (Thies and Travers 2001, 144-145; Dowshen 2012; Palo Alto Medical Foundation 2013.)

While the physical aspects of sexual health are important, one must not leave out the value of the abstract aspects such as emotions and feelings. What one feels about love, relationships, and sexuality is essential to their sexual identity. Furthermore, these complex perspectives play an important role in the creation and modification of future intervention programmes. (de Irala, Osorio, del Burgo, Belen, de Guzman, del Carmen Calatrava & Torralba 2009, 283.)

# 4 NEPAL

Because Nepal is situated between Tibet and India, its society encompasses lifestyles and beliefs that have evolved as a result of being a principal trans-Himalayan and North-Indian trade route (Rolls & Chamberlain 2004, 176-177). The governing religion around this region is Hinduism (Aura 2008, 164).

Hinduism has several unique features and is polytheist by its nature. Hindus believe in karma, rebirth (samsara) and final release (moksha), and have faith in several deities. (Hodge 2004, 30-31; Srikanthan & Reid 2008, 133; Whaling 2009, 3.) The basic idea of karma is that the consequences following an act are similar in their nature (Srikanthan & Reid 2008, 133). By fulfilling one's ethical duties, good karma is accumulated. On the contrary, one gathers bad karma by living a selfish life. (Hodge 2004, 30.) Furthermore, karma is seen to be the element of justice in the cycle of rebirths. Therefore, a better future and form of rebirth can be achieved by gathering good karma in the life at hand. (Hodge 2004, 30-31; Srikanthan & Reid 2008, 133.)

Although Hinduism is a broadly spread religion, there is a great deal of variation within it depending on the geographical or societal location (Whaling 2009, 3). Family-centeredness and social relationships are key aspects in the Hindu religion (Hodge 2004, 26; Aura 2008, 165). The way of viewing and valuing an individual is through connectivity, communication, and the aspect of generosity and sharing. A person is defined as a part of a social group and not according to one's individual features. (Hodge 2004, 26; Aura 2008, 165.) People tend to work for the benefit of their community rather than their own (Hodge 2004, 26), within the limits set by their caste (Whaling 2009, 4).

The caste system is a centric part of Hinduism, as it directs the social involvement and behaviour of its members (Whaling 2009, 3). As mentioned before, the caste and status within it, is determined according to karma (Hodge 2004, 30; Whaling 2009, 3). The caste system has faced a great amount of critique due to the strong hierarchical inequalities. For example, the treatment and role of women and the members of the lowest caste (Dalits), have especially been questioned. (Whaling 2009, 4.) However,

Whaling (2009, 4) also points out that the caste system provides security and stability for society.

### 4.1 Sexuality in Nepali culture

Sexuality is considered a sensitive and private topic for nearly all individuals (Aura 2008, 9). Culture, religion, and personal experiences affect the way sexuality is seen and addressed (Aura 2008, 9; Regmi et al. 2008, 66; Kaufman, Harman & Shrestha 2012, 328). Throughout history, religions have typically directed and regulated the behaviour of individuals. These influences have frequently served to protect and satisfy the benefit of the religion (Aura 2008, 9).

Hinduism is a religion which values social relationships and interactions. Marriage is seen as an obligation and a necessity from both personal and social points of view. (Aura 2008, 166-167; Srikanthan & Reid 2008, 133.) The majority of Nepali women marry at a relatively young age; 60% of women aged 20-24 were married by the age of 18 (Bott & Jejeebhoy 2003, 8). Moreover, dating and love-based marriages are considered unacceptable and they rarely occur (Aura 2008, 166). In most marriages, the parents choose the partners from an appropriate caste and family (Bott & Jejeebhoy 2003, 11; Aura 2008, 166). However, the culture has become a little more tolerant, as young people now have a chance to express their opinions in the process of finding a suitable partner. Married couples are seen to depend on one another. However, in the case of divorce or death of a partner, the man is expected to remarry, whereas the woman remains alone because her first husband is seen as irreplaceable. (Aura 2008, 166-167.)

Sexual behaviour is considered to belong exclusively to married couples. However, in terms of reproduction, it becomes an openly discussed family matter, because a child is essential for the continuity of the family line (Aura 2008, 165, 167). Nevertheless, Hinduism recognises the individual experiences of sexuality and intimacy, and considers them private issues (Aura 2008, 165). Successful conception is a demonstration of the husband's manhood, as it is considered a responsibility that only belongs to the husband (Aura 2008, 167; Kaufman et al. 2012, 330). Even though the

main purpose of marriage is reproduction, marital sex itself has other meanings (Aura 2008, 166-167).

According to Aura (2008, 167), sexuality is seen as a physical need that must be satisfied for the sake of a good marriage. Srikanthan and Reid (2008, 133) describe sexual relationships as mutually experienced and enjoyed within Hinduism. Several other authors (Regmi et al. 2008, 69; Wasti, Randall, Simkhada & van Teijlingen 2011, 41; Kaufman et al. 2012, 328) present sex as a male domain and state that women have little power in sexual decisions. Denying marital duties (Aura 2008, 167; Kaufman et al. 2012, 330) or having problems such as impotence had been described as justifiable "psychological violence" in some divorce documents explored by Aura (2008, 167-168). Furthermore, men are believed to have the right to use force for their own sexual benefit (Regmi et al. 2008, 69); thus sexual abuse often happens within marriages (Bott & Jejeebhoy 2003, 14). Despite the offense, premarital sex and extramarital relationships are more common among men (Aura 2008, 168). In addition, inappropriate sexual relationships contaminate the participants, and although a man may cleanse himself through rituals, a woman cannot; thus, she will be impure from that moment onwards (Aura 2008, 170)

Because conceiving a child is the main purpose for marriage, problems with conception drive the couple to seek help. Typically, couples turn to traditional healing and alternative medicine. However, some couples lean on spiritual and religious rituals. Fertility clinics are used by urban, richer couples who belong to higher castes. Infertility is considered to be resulting from a woman's inability to fertilise. Nevertheless, men are also tested in the clinics. (Aura 2008, 169.) While some cultures create a supportive environment where sexual health information and services can be accessed, family planning services are not culturally accepted by the Nepali community (Regmi et al. 2008, 66).

Parenting is greatly valued in Hinduism and not taken for granted because of the known risks related to pregnancy and giving birth. Although miscarriages are common, abortions are discouraged (Srikanthan & Reid 2008, 133) and seen as morally unjustified (Aura 2008, 173). During pregnancy, the mother is well taken care of and the importance of good nutrition, proper rest, and a calm state of mind are recognised. Often, mothers give birth at home with the assistance of relatives or a traditional

midwife. From the beginning, the mother assumes the main responsibility of the child, all the while fulfilling the expectation to care for her husband. (Aura 2008, 170.)

As sexuality and sexual behaviour are considered private matters, (Aura 2008, 168; Wasti et al. 2011, 40) couples are publicly not allowed to demonstrate any behaviour indicating their affection towards one another. Traditionally, the wife should not address her husband or mention his name in the presence of other people. (Aura 2008, 168-169.) Similar rules of modesty and prudery concern everyone regardless of their relationship status. For example, the members of opposite sex are not to shake hands or touch each other when greeting. Clothing, especially for women, is to be modest and well covering, at least hiding the shoulders and knees. Dressing and undressing is to be done in privacy, even if one is only to add more clothing on top of the already existing pieces. (Aura 2008, 172.)

Purity and impurity are closely related to femininity and the female gender through symbolism and social organisations. The caste system, especially the higher castes, views women as the representatives of purity. Therefore, special attention is paid to maintain the pure status. Contamination may happen through soiled food, drinks or touch of a person from a lower caste. Furthermore, sexual intercourse, menstruation, and birth are considered to be defiling due to the impure nature of certain bodily fluids, for instance semen and menstrual blood. After the beginning of menstruation, young women are to pay more attention to their clothing and restrict their freedom to move publicly. During menstruation, women are not allowed to enter a Hindu temple or participate in religious rituals or pilgrimages. (Aura 2008, 171.) Impurity wanes along with age until menopause, when the symbolic risk of impurity finally fades completely. Menopause is considered relieving; afterwards, the life of women is less constrained. (Aura 2008, 172.)

Due to the strong cultural norms and modesty towards all issues related to sexuality (Aura 2008, 174; Shrestha, Otsuka, Poudel, Yasuoka, Lamichhane & Jimba 2013, 2), adolescents receive nearly no sexual health education from their parents (Aura 2008, 174; Kaufman 2012, 329-330). Asking questions and discussing sexual health matters is considered highly inappropriate for the children and youth (Bott et al. 2003, 231; Aura 2008, 174; Regmi et al. 2008, 66; Rawson & Liamputtong 2010, 351; Regmi et al. 2010, 619, 623; Tsakani et al. 2011, 7). As mentioned before, sexuality belongs only in

marriage and one is not supposed to know anything about the subject beforehand (Aura 2008, 174). According to Kaufman et al. (2012, 328, 335), information about sexuality is especially harmful for women, who can be stigmatised for being knowledgeable. Kaufman et al. (2012, 330) also states that in Nepal, adult men are more free to discuss sexual matters and prepare themselves by watching pornography or even practicing by hiring sex workers before marriage. Regardless, the first intercourse often comes as a shock especially to the girls (Aura 2008, 174; Kaufman et al. 2012, 330). However, due to modern technology, such as the media and the Internet, new ways have been created for the youth to seek information, and the adolescents spread their knowledge by word of mouth (Bott et al. 2003, 231; Pokharel et al. 2006, 158; Aura 2008, 174; Regmi et al. 2008, 67; Regmi et al. 2010, 623).

Sexually transmitted infections (STIs) are also taboo subjects within the Southern Asian culture (Aura 2008, 174; Shrestha et al. 2013, 2). Medical attention is sought only after symptoms arise or if the couple is facing infertility. STIs are a great shame for women as they are stigmatised as obscene in case of an infection. (Aura 2008, 174.) Due to the modesty and silence surrounding sexuality (Aura 2008, 174; Kaufman et al. 2012, 329-330; Shrestha et al. 2013, 2), sexual minorities are also not socially recognised or discussed. Members of sexual minorities often face strong inequality and avoidance. (Aura 2008, 175; Wasti et al. 2011, 40.)

Aura (2008, 174) argues that the social inequalities related to the caste system place women in a vulnerable position. Women from lower castes, in particular, often face sexual abuse and violence. Furthermore, they feel responsible for such occurrences. Aura (2008, 174) states that the victims of rape carry guilt and social stigma, as they are seen to be an embarrassment to themselves and their families, and they will never be in a good marriage. Despite the implementation of the hierarchical system in the societies of Southern Asia being strong, it is neither eternal nor unchangeable; new generations are challenging and transforming society and cultural norms through small actions in everyday life. (Aura 2008, 175.)

## 4.2 Sexual health education in Nepal

The concern for sexual health education of early adolescents has recently become a global issue (Regmi et al. 2010, 619), particularly in developing countries such as Nepal (Pai & Lee 2012, 1988-1989). In Nepal, the combination of changing values among the younger generation and the lack of policies focused on that group creates a society which does not provide sufficient sexual health education for the curious youth (Regmi et al. 2008, 65). However, different authorities have been developing programmes and policies on governmental and non-governmental levels to promote the knowledge of sexual health among the youth (Pokharel et al. 2006, 156; Regmi et al. 2008, 65; Acharya, van Teijlingen & Simkhada 2009, 446). Regmi et al. (2008, 65) argue that the implementation of developed programmes and strategies has not been successful and is still facing a great number of challenges.

The National Reproductive Health Strategy (1998) and the National Adolescent Health and Development Strategy (2000) identify adolescents as the most important target group for sexual health education and services. Their main focus is to increase the availability of healthcare services for the youth. (Pokharel et al. 2006, 156; Regmi et al. 2008, 65; Acharya et al. 2009, 446; Regmi et al. 2010, 620.) The Government of Nepal has introduced sexual health education as a compulsory part of the secondary school curriculum (Regmi et al. 2008, 65; Kaufman et al. 2012, 328). Despite the disagreement between the authors on what constitutes secondary school grades, the adolescents are typically around the age of 15 when receiving sexual health education for the first time (Pokharel et al. 2006, 156; Regmi et al. 2008, 65; Acharya et al. 2009, 446; Kaufman et al. 2012, 328). However, sexual health education does not reach both genders equally, as girls often terminate their education before reaching the secondary level due to the new responsibilities brought on by an early marriage, housework, and motherhood (Pokharel et al. 2006, 160; Waszak et al. 2003, 81). According to the research of Kaufman et al. (2012, 328), 75.8% of Nepali women never attend secondary school, and therefore never receive sexual health education. Pokharel et al. (2006, 160) emphasise the importance of early sexual health education and its long term benefits, as it might be the only time to receive any education on the matter, whatsoever.

Acharya et al. (2009, 446), Pokharel et al. (2006, 158) and Shrestha et al. (2013, 2, 8) state that the teachers and schools lack educational resources and rely only on one

textbook, *Health, Population and Environment* (Acharya 2010), when teaching sexual health. The textbook covers the basics of sexual health by addressing the topics of "safe motherhood, family planning, reproductive physiology, STIs/HIV, infertility, adolescent health, reproductive health problems of post-menopausal women, and reproductive rights" (Pokharel et al. 2006, 157). However, due to the lack of research on sexual health education in Nepal (Acharya et al. 2009, 445, 447; Regmi et al. 2010, 619; Shrestha et al. 2013, 2), there is no knowledge on how well these topics are covered in schools (Pokharel et al. 2006, 157). Acharya et al. (2009, 446) argue that the sexual health education in Nepal remains on a superficial level as it concentrates solely on anatomy and physiology, rather than discussing broader issues such as feelings and relationships, and life skills (Regmi et al. 2008, 69).

### 4.2.1 Benefits of sexual health education in Nepal

Acharya et al. (2009, 445) suggest that sexual health education has positive effects on more than just an individual level and that it can potentially affect the whole family, community, and healthcare system. In order to increase knowledge, decrease unplanned pregnancies, delay the first sexual experience, and decrease the number of sexual partners and the spreading of sexually transmitted diseases, education on sexual health for early adolescents is crucial (Pokharel et al. 2006, 160; Lou, Chen, Li & Yu 2011, 1696; Shrestha et al. 2013, 2). According to Acharya et al. (2009, 445), Pokharel et al. (2006, 160), and Shrestha et al. (2013, 2), there is international evidence that the necessary life skills needed for making positive sexual health decisions can be effectively acquired via proper sexual health education in school. Although sexual health education is a lifelong process, institutional programmes that provide an open and positive environment for adolescents have long term benefits (Pokharel et al. 2006, 160; Acharya et al. 2009, 448). Several studies show that individuals who have received a substantial amount of education on HIV transmission are more consistent with condom usage (Pai & Lee 2012, 1988-1989; Shrestha et al. 2013, 8). While it is believed that early adolescents, ages 12-15, are not sexually active, the truth remains that they are (Regmi et al. 2010, 619; Pai & Lee 2012, 1988-1989). However, the obstacle is that they are not properly prepared for their erotic feelings and sexual drive (Pai & Lee 2012, 1988-1989).

Pai and Lee (2012, 1995) encourage nurses to promote sexual health education and to help young adolescent girls identify their sexual self-concept and educate them in the self-evaluation of their sexual attitudes, feelings, and actions (Lou et al. 2011, 1697; Pai, Lee & Yen 2012, 47), as means to protect their sexual health development (Lou et al. 2011, 1697, 1702). Having knowledge and awareness of STIs/HIV is only one strategy to promote condom usage; access to education on contraception, negotiation skills, and gender role balance are also crucial for sexual health promotion and maintenance (Homma et al. 2013, 20).

### 4.2.2 Different perspectives

As previously discussed, Nepal's heavily integrated cultural norms prevent adolescents from raising sexual health matters with their parents (Acharya et al. 2009, 446; Aura 2008, 174; Kaufman et al. 2012, 329-330; Regmi et al. 2010, 619; Shrestha et al. 2013, 2, 8). Not only do Nepali parents believe that students are too young to learn about sexual health matters, they also view the discussion as inappropriate and that giving adolescents sexual health education will only encourage them to engage more in premarital sex (Pokharel et al. 2006, 160; Acharya et al. 2009, 445, 447; Shrestha et al. 2013, 2). According to Acharya et al. (2009, 447), in Nepal only 7% of boys and 14% of girls have been able to obtain sex and relationship guidance from their parents. Because Nepali parents have low awareness of their adolescents' education, they are also oblivious to the management and content of sexual health education (Shrestha et al. 2013, 2, 8). Despite the need for parental participation in sexual health education, Nepali parents feel that assuming responsibility for sexual health education is unthinkable and would leave them with an uncomfortable burden (Acharya et al. 2009, 447). There is also a generational conflict regarding attitudes towards sexuality and sexual health education (Regmi et al. 2008, 67). While sexual health education remains universal, Nepali parents want their children to learn about the moral aspects of it (Acharya et al. 2009, 446). As mentioned before, parents are also hesitant to have their daughters learn about sexual health (Acharya et al. 2009, 448).

Pokharel et al. (2006, 156-161) interviewed eight teachers responsible of sexual health education in public schools of Western Nepal. The teachers highlighted the following as problems related to sexual health education: lack of resources and knowledge, cultural

restrictions, and the attitudes of students. They also admitted to having prejudices of their own towards the topic and felt uncomfortable teaching it. (Pokharel et al. 2006, 157-158.) Beyond the textbook, teachers have no other aids to use when discussing the matters of sexual health. For example, audio-visual material would be considered useful (Pokharel et al. 2006, 158; Acharya et al. 2009, 446; Shrestha et al. 2013, 8). Other researchers (Acharya et al. 2009, 446; Regmi et al. 2010, 620; Shrestha et al. 2013, 2, 8) have landed on similar findings when studying the effectiveness of school-based sexual health education in Nepal.

The main challenge for sexual health education in Nepal is the teachers' lack of confidence (Acharya et al. 2009, 446) and reluctance to discuss the topic with students (Pokharel et al. 2006, 157; Shrestha et al. 2013, 8). Many consider students to be too young for such information (Acharya et al. 2009, 446). Lack of confidence and knowledge in teachers lead to ineffective education (Acharya et al. 2009, 446; Shrestha et al. 2013, 8), and the teachers lose credibility in the eyes of their students (Acharya et al. 2009, 446). Some teachers even suggested that "students should be left to learn these things by themselves" (Pokharel et al. 2006, 157). Teachers also fear criticism and censorship from their colleagues and school (Pokharel et al. 2006, 157) as well as the parents of their students and the whole society (Shrestha et al. 2013, 8).

Furthermore, students also have some prejudice towards sexual health education (Pokharel et al. 2006, 158). There is also a difference in the reception of sexual health education: males tend to react more negatively than females (Acharya et al. 2009, 446). The leading cause for the aforementioned issues is that there is poor communication between teachers and students: only 57% of students felt that their questions were answered and 2% of students were not even sure if they had been given sexual health education (Pokharel et al. 2006, 158). Students feel their teachers either only focus on the physical aspects of reproduction or avoid the lecture altogether (Pokharel et al. 2006, 158). In fact, they are interested in life skill-based sex education (Acharya et al. 2009, 446). Moreover, students believe that their teachers are not able to effectively teach sexual health and do not create an atmosphere for open discussion (Pokharel et al. 2006, 158-159, Shrestha et al 2013, 8). However, students are also hesitant to ask questions because they feel that the relationship between a teacher and a student resembles that of a parent and a child; resulting in the repetition of impeding discomfort when sexual health matters are discussed (Pokharel et al. 2006, 159).

According to a study done by Shrestha et al. (2013, 5-8), students report that they receive very little support and involvement from their parents, and that the information that they do receive is inadequate at emphasising life skills, emotions, relationship issues, and sexual health facilities. Some other issues that are highlighted in the study are: students feel that the principals of the schools are not committed to improving sexual health education, and teaching aids and time allocated for sex education were limited. (Shrestha et al. 2013, 8.)

### 4.2.3 Recommendations for sexual health education

There are controversies on what adolescents should know regarding sexual health and who should teach the material (Bott et al. 2003, 231). Moreover, there is a disconnection between the expectations of parents, teachers, and students (Pokharel et al. 2006, 158; Acharya et al. 2009, 446). It has been suggested that sexual health education should be provided by visiting healthcare professionals as they are thought to be more qualified, informative, and comfortable discussing such a sensitive topic (Pokharel et al. 2006, 158; Acharya et al. 2009, 447, 449). Nevertheless, Acharya et al. (2009, 449) argue that healthcare professionals may not necessarily be competent in teaching, thus they might not be able to meet the educational needs of the students. Nevertheless, adolescents themselves prefer trained outsiders to teach sexual health education as it would decrease discomfort between teachers and students since an ongoing relationship would not have to be maintained. (Acharya et al. 2009, 447.)

Acharya et al. (2009, 448) and Pokharel et al. (2006, 150) recommend a less formal approach in a more interactive environment. As suggested by Regmi et al. (2010, 624), the education should be given in the form of peer-education. Confidentiality is also a major concern for adolescents, as they fear the sharing of their sexual health needs with their friends and families (Regmi et al. 2010, 621).

According to Bott et al. (2003, 231), the following factors must be taken into consideration when educating adolescents on sexual health: collaborating with parents and people within the community; using a curriculum that is culturally appropriate; safeguarding sensitivity in the perspective of the adolescents; and acknowledging the

topics and skills that adolescents value. (Pokharel et al. 2006, 160, Acharya et al. 2009, 448.)

According to research, the sexual health needs for our target group include the risk of HIV, high risk behaviour, and high adolescent fertility (Regmi et al. 2008, 64; Bott et al. 2003, 229). However, in order to guide adolescents away from risky sexual behaviour, they need to develop their negotiation and decision making skills (Regmi et al. 2010, 623). In addition, Acharya et al. (2009, 448) emphasise the importance of teaching adolescents personal and interpersonal life skills. Assertiveness, communication, and decision making are among some of the most crucial components of healthy relationships (Acharya et al. 2009, 448). As previously mentioned, the students want knowledge on the emotional aspects of sexuality (Acharya et al. 2009, 448).

According Regmi et al. (2010, 621), Nepali people are embarrassed to talk about sexual health in front of the opposite sex, and therefore it is recommended to teach these topics separately for boys and girls (Acharya et al. 2009, 447; Pokharel et al. 2006, 158, 160; Homma et al. 2013, 21). In addition, adolescents claim that receiving sexual health education from younger service providers of the same gender as themselves would be more comfortable (Regmi et al. 2010, 622).

Teachers need better training and skills to be able to teach sexual health effectively (Acharya et al. 2009, 446). Teaching methods of institutions are insufficient and too traditional (Pokharel et al. 2006, 156, 158; Shrestha et al. 2013, 8). As mentioned in earlier sections, the information that the students are receiving is mixed, and sometimes wrong, depending on which sources they are able to access (Regmi et al. 2010, 623). Acharya et al. (2009, 447) and Regmi et al. (2008, 64) suggest using diversity when implementing the methods for giving sexual health education. Finally, providing essential materials such as condoms and educational leaflets would encourage adolescents to use sexual health services (Regmi et al. 2010, 624).

# 5 METHODOLOGY

We approached this topic in a functional way. According to Vilkka (2006, 76), a functional thesis aims to deepen the professional skills and knowledge by using different research methods. Vilkka and Airaksinen (2003, 9) present functional theses as an alternative to theoretical theses. A functional thesis combines theoretical and functional methods; the process includes conducting research, preparing a product, and writing a report (Vilkka & Airaksinen 2003, 9). Our methodological starting points separately discuss theoretical research and the functional part of our thesis, which includes the planning, reporting, and evaluation.

## 5.1 Theoretical methodology

As mentioned before, a functional thesis is a process which starts with conducting research and obtaining a strong theoretical background for the work (Vilkka & Airaksinen 2003, 9). According to Polit and Beck (2012, 95), the importance of literature reviews is to provide a summary of existing evidence in the field in question. In addition, it establishes a basis from which new research can be conducted (Polit & Beck 2012, 95). We focused our study on the theoretical concepts of our thesis. The information was gathered from several reliable sources such as WHO, UN, UNESCO, and World Bank. All of the literature used was valid and up-to-date. Moreover, we conducted a literature review on the status of sexual health education in Nepal and how the culture affects sexuality. The databases that we used were: CINAHL, PubMed, and Nepal Journals Online. Our search words included: sexual health, sexuality, culture, religion, taboo, myth, perspective, belief, globalisation, society, Nepal, and developing country.

In order to "own" (Polit & Beck 2012, 95) our literature review, we approached our research altogether in a critical way, thus enhancing the validity of our thesis. (Polit & Beck 2012, 236-237, 336.) We chose specific articles (see Appendix 1) based on our inclusion criteria: the literature had to include our target group (adolescents of ages 10-15); cultural beliefs or attitudes people have towards sexual health; and the cultural effects on education. We also had Hinduism as our religious inclusion criterion and

Southeast Asia as our regional inclusion criterion. All the articles had to be peer-reviewed. Many articles were not chosen for our literature review, because they did not meet the requirements; for example, the age group was out of range or the geographic location was beyond our focus. We also excluded articles that were older than 2004 or the education described in them did not cover the topic of sexual health. However, some articles, which did not meet all the inclusion criteria, were used as supporting references.

## 5.2 Functional methodology

As previously acknowledged, a functional thesis consists of two parts; the product and the report (Vilkka & Airaksinen 2003, 26). Our product was a series of educational sessions, which covered important aspects of sexual health. These topics were defined, and the whole plan (Appendix 2) was prepared by following the recommendations found in our research.

The individual sessions consisted of private conversations and health check-ups which included the measurement of height, weight, and vision. To measure vision, we used a letter eye chart developed by Snellen and Donders (Precision Vision 2014), in order to define whether the adolescents had normal visual acuity. Based on height and weight, we defined the adolescents' Body Mass Index (BMI) by using a tool (Body Mass Index 2014) that took the gender and the age of the adolescents into consideration. Moreover, the BMI gave us an indication of the nutritional status of the adolescents. From our research and recommendations, and together with the working life connection, we defined topics and formed open-ended questions (see Appendix 3) to guide the individual discussions. We created further questions for the older adolescents that were based more on sexuality. However, the questions were formed in a closed manner due to the sensitive nature of the topic, as we did not want be intrusive. Depending on the reaction of the adolescent, we either proceeded with the questions or we went more in depth on a certain topic. The discussions were in the form of a semi-structured interview.

We used observation as a method of collecting information during the educational sessions and individual discussions, and the report was written accordingly. Vilkka

(2006, 37) presents observation as one of the core methods in qualitative studies. She suggests observation to be suitable especially when the study aims to explore the behaviour and communication between individuals. Observation is an active and conscious method that aims to understand phenomena. (Vilkka 2006, 37-38.)

Polit and Beck (2012, 533) raise important issues in collecting data for qualitative studies. For example, we needed to keep in mind the Hawthorne effect, a phenomenon where the subjects alter their behaviour due to conscious observation (Denscombe 2010, 68-69). In addition, considering the fact that we have video recorded our educational sessions, we had to also establish trust between us and our target group. One of the key issues was creating a comfortable metaphorical space between us and our target group: on one hand, we had to adapt to the target group and the situation. On the other hand, we had to also maintain an appropriate distance to be able to remain objective in our analysis. (Polit & Beck 2012, 533-534.)

While Polit and Beck (2012, 534) highlight the benefits of video recording, they also stress the ethical considerations behind storing videos. For example, the video recordings should be carefully labelled and the storage area must be safeguarded.

Evaluation is an important part of functional theses and the beneficence of feedback in the process of the assessment is evident (Vilkka & Airaksinen 2003, 154, 157). Furthermore, Bott et al. (2003, 231) suggest that the educational sessions themselves need to be rigorously evaluated. Therefore, we created an assessment tool for our project (see Appendix 4). We gathered feedback from the adults who observed the educational sessions and from the participating adolescents by using qualitative methods. The observers evaluated our cultural competence by watching the video recordings of the educational sessions. Moreover, the feedback from the observers was in the form of a questionnaire, which they were to fill out in privacy. Afterwards, we held semi-structured interviews to collect more thorough feedback. From the adolescents, we gathered feedback during the closing session, where they were allowed to write and draw their feelings and thoughts towards the project.

# 6 EMPOWERING ADOLESCENTS IN NEPAL

## 6.1 Planning

We planned our educational sessions based on the recommendations found through our literature review on Nepal's status in regards to sexual health education. All of the educational sessions and individual discussions were held in English, as it was the only verbal language we shared with the adolescents.

As there have been disconnected expectations between parents, teachers, and students (Pokharel et al. 2006, 158; Acharya et al. 2009, 446), we decided to focus on the topics that the students were interested to learn about, as they represent the future generation. We held the educational sessions instead of creating teaching material for someone else to use; firstly, because Pokharel et al. (2006, 158) and Acharya et al. (2009, 447, 449) recommend that having a visiting healthcare professional or guest lecturers to discuss the sensitive topics with the adolescents could be more effective, and secondly, because Regmi et al. (2010, 624) suggest adolescents to benefit from peer-education.

Pokharel et al. (2006, 159-160), Acharya et al. (2009, 448), and Shrestha et al. (2013, 2) emphasise the importance of creating an open and positive environment for discussing sexual health matters. In addition, in the Pokharel et al.'s (2006, 159) study, students felt that they were not able to freely talk about sexuality due to the fact that the environment was not made suitable by the teachers. Therefore, our project begun with two introductory sessions where we aimed to build trust amongst each other, created an open and friendly environment, and became familiar with each other.

In order to respect the limitations of what the adolescents are supposed to know at different stages of life, we consulted the textbook *Health, Population and Environment* (Acharya 2010, 149-188), which is used in schools to teach the students about sexual health. As previously mentioned in the recommendations section, collaboration with the community and creating a culturally appropriate curriculum is very important. In order to safeguard sensitivity, we also reviewed the topics we covered with the working life connection. We did this to obtain the opinion of the working life connection on the appropriateness in regards to topics and age limitations. While taking these aspects into

consideration, we also tried our best to emphasise the topics and skills valued by students. Again, according to the recommendations, students themselves also preferred the emotional aspects of sexuality.

As requested by our working life connection, we chose to focus on physical and emotional changes of puberty. They also emphasised the need for life skills and how to relate to others in a healthy manner. The findings of Acharya et al. (2009, 446) and Regmi et al. (2008, 69) also support the need for life skills and information regarding feelings and relationships rather than focusing exclusively on anatomical and physiological aspects.

From the recommendations (Pokharel et al. 2006, 150, 158, 160; Acharya et al. 2009, 447; Homma et al. 2013, 21), the educational sessions were delivered separately for boys and girls. The focus of the first educational session was on the physical changes during puberty. The second educational session focused on the emotional changes of puberty. The information was based on Palo Alto Medical Foundation's (2014) material. Appendix 2 provides a more detailed description of the project.

The topics discussed with the adolescents were based on information gathered through research; sexuality in schools and the sexual aspect of bullying (Lehtonen 2003, 134-166), bullying and reasons behind it (Wang & Iannotti 2012, 3; Cooper & Nickerson 2013, 526-540), the effects of bullying (Yang, Stewart, Kim, Kim, Shin, Dewey, Maskey & Yoon 2013, 309-318), the physical and emotional changes of puberty (Palo Alto Medical Foundation 2014), the social development of adolescents (Khurshid & Aurangzeb 2012, 20), and life skills (Regmi et al. 2008, 69). It was also crucial that we had correct information, because the information that students receive may not always be reliable or up-to-date (Regmi et al. 2010, 623).

According to Acharya et al.'s (2009, 448) recommendations, we approached the project in an interactive way to promote the adolescents' engagement and active learning. The methods we chose to use were based upon tactics found in Laino (2010, 160-181). As found in our research (Acharya et al. 2009, 446; Pokharel et al. 2006, 158; Shrestha et al. 2013, 2, 8), methods used by the schools are insufficient and too traditional, and therefore using diverse methods of teaching is recommended (Acharya et al. 2009, 447; Regmi et al. 2008, 64).

As confidentiality is a huge issue for adolescents (Regmi et al. 2010, 621), the sensitive nature of our topics, and the social restrictions of the Nepali culture, we chose to videotape our project rather than having observers present. However, to respect the confidentiality of the adolescents, we also informed them about the filming beforehand and received their consent. Before we arrived, our working life connection had already notified the adolescents about the project. Upon arrival, we reiterated the plans.

## 6.2 Reporting

### 6.2.1 Introductory sessions

The introductory sessions were held outside to ensure adequate space. As planned, we began by informing the adolescents that they will be filmed, but their responses to any questions and comments would not be evaluated. After that, we introduced ourselves, the nature of the project, and what they could expect in the next following weeks. The beginning of the session was more formal and the adolescents appeared reserved.

The sessions continued with games to familiarise everybody with each other and to create a less formal atmosphere. We also participated in the games, which focused on team building, aimed to promote trust amongst each other, and ensured open communication and a comfortable environment. During the games, the adolescents became more comfortable, relaxed, and active; they began to seek and became more willing to receive physical contact. By the end of the introductory sessions, the atmosphere was evidently trusting and open.

To acquaint the adolescents with the project, we created a calendar together. The adolescents became very creative with stickers and colours. They also wrote welcoming and positive phrases about the sessions onto the calendar.

As we held the introductory sessions after school and homework time, some of the adolescents grew restless towards the end of the sessions. Therefore, we did not complete all of the planned activities. Due to environmental restrictions, the workers of the children’s home were able to interfere. In addition, some technical problems

occurred due to the lack of electricity and equipment. Regardless, filming the sessions was successful as the adolescents paid no attention to and behaved naturally in front of the camera.

### 6.2.2 Sessions on physical changes during puberty

The sessions concerning physical changes during puberty were held separately for boys and girls to strengthen the comfortable and open atmosphere. Based on a request of our working life connection, we also decided to divide the boys into two groups according to their age: younger boys between the ages nine and eleven, and older boys aged 12-15. Therefore, we had three groups of four adolescents during the day.

In the beginning of each session, we became acquainted with the adolescents' previous knowledge through questions and discussion. For the most part, the adolescents seemed to be comfortable enough to ask questions, clarify misconceptions they had heard, and open up about their own experiences. For example, when asked what kind of physical changes occur during puberty, an adolescent responded that they had heard nails and eyelashes grow. After that, we explored the topics with the adolescents by drawing and painting. We concentrated on the physical changes of the gender at hand and briefly brought up the changes of the opposite sex. Nevertheless, with the younger boys, we restricted the information by not including female changes due to the cultural age limitations.

The younger boys received us rather as educators than females and thus seemed comfortable discussing the topic with us, whereas the older boys appeared more uncomfortable or modest. For example, when mapping out the physical changes during puberty, the younger boys pointed out the growth of pubic hair and painted a penis for their model. However, the older boys immediately began to laugh the moment we explored the changes of the pubic area. In light of this reaction, we did not push the topic further in depth. Altogether, the younger boys showed more interest in the activities during the session and the discussions remained shorter. The older boys appeared more quiet and seemed more reluctant to participate in the discussion or to share their experiences.

With the girls we discussed menstruation in more detail, presented sanitary pads and tampons, and demonstrated how to use them. In the beginning, the girls appeared shy and modest, but they became more open and active when the session proceeded. The girls showed interest in the topic by sharing their experiences, asking questions, and playing around with the products. We also became familiar with practices related to menstruation and methods to relieve the symptoms of Pre-Menstrual Syndrome (PMS). In general, the girls had no previous knowledge from reliable sources but had discussed some of the matters amongst themselves.

All the sessions were held in the rooms of the respective gender. The space was also restricted during the sessions. The physical sessions were also videotaped with the permission of the adolescents. Each session was concluded with a reflection of what the adolescents had learned, liked or disliked. During the reflection, each adolescent pointed out positive things they had learnt, regardless how active they appeared during the session.

### 6.2.3 Sessions on emotional changes during puberty

We began the session on emotional changes during puberty by reflecting on what was discussed during the previous session. We asked if the adolescents had any thoughts or feelings regarding the physical changes of puberty. Once questions and thoughts were clarified, we began exploring the emotional changes and how they can fluctuate throughout the day. We used role playing to identify these emotions. All of the adolescents participated and were able to express the identified emotions. After that, we held an open discussion on healthy methods to manage different emotions. The adolescents also shared their approaches.

The next topic we explored was bullying according to the wishes of our working life connection. First, we introduced the different types and forms of bullying. Then we shared experiences of times when we were bullied or had been a bully. The participation of the adolescents was voluntary in this part. Afterwards, we moved on to the topic of friendship and respect. We discussed what friendship means and the importance of friendship. To conclude the topic of friendship, the adolescents wrote positive phrases about each other.

Aiming to raise self-awareness and acceptance towards oneself and others, we played an interactive game using statements. The adolescents expressed themselves by moving across a spectrum of “absolutely yes” and “absolutely no”. During the game, we briefly discussed their placements. To highlight the importance of respect, we presented a poem and asked the adolescents to explain the meaning of the poem in their own words.

The sessions were held in an environment similar to the previous sessions and we reflected at the end of the sessions in the same manner as before. Similarly to the previous sessions, these were videotaped with the adolescents’ permission as well. The adolescents were divided into groups in the same manner as before.

The younger boys seemed interested and were participating well throughout the session. They shared their experiences openly during the discussions and engaged actively especially in the games and activities. In contrast, the older boys seemed more shy and held back. Nevertheless, they participated in all the activities and discussions, and seemed to open up in the course of the session. The girls appeared less participative than in the previous session too. Regardless, all of the adolescents participated in the sessions and the planned topics were covered. Moreover, many shared personal experiences and everyone engaged in the discussions, sharing and receiving valuable knowledge from each other.

### 6.2.4 Individual discussions

The individual discussions were held during the week after the emotional sessions. This allowed the adolescents time to process the previously given information. In the beginning, we ensured the adolescents that the discussions were not to be videotaped and would remain completely confidential. Moreover, the environment was neutral and isolated from the other adolescents and the workers to ensure privacy.

First, we measured the height, weight, and vision of each adolescent. After that, we inquired about their thoughts and feelings towards the previously discussed topics before moving forward with the discussion. We approached the session through a semi-structured interview. The interview included open-ended questions regarding their

feelings towards living at the children's home, their relationships with the other adolescents and the workers, as well as their thoughts about school and friendships. We approached the topic of sexuality through questions related to self-esteem and the adolescents' own perception of growing up.

With the adolescents over 14 years of age, we gauged their previous knowledge of sex and sexual relationships. If the adolescent was not interested or did not have any background knowledge, we did not proceed with the rest of the questions. However, if the individual had previous knowledge and curiosity towards the topics, we explored the concept of sexuality more in depth. We discussed the meaning of sex on a general level and gave the adolescent a chance to share his or her experiences. We highlighted the importance of safe sex and demonstrated the use of condoms, all the while allowing the adolescent to practice and familiarise him- or herself with the product as well. After that, we also discussed briefly the STIs in the context of protection. Furthermore, with the older boys we mentioned wet dreams and emphasised it as a part of normal and healthy growth. To conclude the session, we encouraged them to ask questions or give comments on the topics discussed.

The adolescents seemed comfortable during the discussions; they answered our questions, asked for more information themselves, and shared their own thoughts and experiences openly. Considering the sensitive nature of the topic, the older adolescents appeared curious towards the topic of sex and sexuality while demonstrating modesty, for example by looking down when discussing the topics in order to not seem too eager.

### 6.2.5 Closing session

The closing session was held in the study room of the children's home. In the beginning, the adolescents had a chance to ask further questions or comment on the sessions. They were then provided paper and markers to write and draw their feedback for the project. Some feedback was written anonymously and other was identifiable. The feedback consisted of the aspects of the sessions that the adolescents had liked, disliked, and learned.

Unlike the other sessions, this session was not videotaped. In addition, the adolescents were not separated as they were in the previous sessions. The facilities were closed from the workers of the children's home, and therefore only the adolescents were present.

### 6.3 Assessment and feedback

As mentioned before, we created an assessment tool in order to obtain feedback on our cultural competence from the observers. Our assessment was adapted from the Transcultural Self-Efficacy Tool (TSET), the Teacher Version of the Cultural Competence Clinical Evaluation Tool (CCCET-TV), and the Cultural Self Efficacy Scale (CSES) (Bernae & Froman 1987, 201-203; Jeffreys 2010, 11-15, 26-30).

The TSET is a self-assessment questionnaire consisting of 83 items and is used in nursing to identify the level of confidence in transcultural care (Jeffreys 2010, 11). We chose to use this tool, because it has been considered valid and reliable (Jeffreys 2010, 5). It encompasses features of the influence of cultural factors in nursing care; acknowledges the cultural background of clients; and identifies how well one recognises, accepts, and appreciates different impacts of culture (Jeffreys 2010, 13-15).

The CCCET-TV is a modified version of the TSET that aids teachers in the assessment of students' cultural competence. It is also in the form of an 83-item questionnaire. This tool was useful to us, because it emphasises cultural recognition, awareness, and advocacy. Additionally, it focuses on the assessment of another rather than the self. (Jeffreys 2010, 26-30.)

The CSES is a 30-item self-efficacy assessment tool. It is used to evaluate the capability of caring for clients of different cultural backgrounds. In addition, the CSES identifies the nurse's knowledge of cultural concepts and patterns. (Bernae & Froman 1987, 201-203; Loftin, Hartin, Branson & Reyes 2013, 3.)

### 6.3.1 Assessment and feedback from the observers

The observers' role was to assess our cultural competence by evaluating four different areas of focus: verbal and non-verbal communication skills; the culturally sensitive approach; social aspects; and the content and methods of the educational sessions. The questionnaire that was used as a basis for the semi-structured interview can be found as Appendix 3.

In the Communications category, our observers believed that the language we used during the educational sessions was comprehensible. However, some of the vocabulary may have been too advanced for the age group. It was suggested by our observers to have translations for some of the more complicated words beforehand. All of the observers agreed that our terminology and non-verbal communication was culturally appropriate. Moreover, we were given feedback that our non-verbal communication enhanced the adolescents' understanding. The observers also agreed that we respected the cultural limitations of the personal space and touch.

Our observers agreed that we were aware of the educational background of the adolescents and took it into consideration when implementing the educational sessions. However, the observers felt that our awareness of their religious background was not as evident. According to the feedback, the adolescents' world views were respected and we did not impose our world views onto the adolescents. Two of the observers strongly agreed that we were flexible in adapting to the new environment while one observer was neutral.

According to the observers, despite gender sensitivity being taken into consideration, our awareness of the adolescents' cultural and social expectations could have been developed more. Nevertheless, all the observers strongly agreed that we respected the societal age limitations well.

All of the observers gave similar feedback concerning the Practical Aspects. They either agreed or strongly agreed that our topics, methods, and materials were culturally appropriate. The observers agreed that our topics were relevant for the target group and the teaching methods were effective. However, it was suggested by an observer that we could have expanded on certain topics.

In general, our educational sessions were well received by our observers. One observer showed excitement towards our project and expressed the national need for this kind of education. We also received positive feedback regarding the open and trusting atmosphere that we were able to create and maintain.

### 6.3.2 Feedback from the adolescents

As mentioned before, the adolescents were given the opportunity to verbally and artistically express their feedback. All twelve adolescents responded through drawing and writing. We also received feedback at the end of each educational session when the adolescents reflected on their learning and informed us about their likes and dislikes regarding the session. Another form of indirect feedback we received during the month of being around the adolescents was how they behaved towards us in between the sessions. Altogether, we did not receive any negative feedback from the adolescents. They expressed gratitude towards the opportunity to learn and some of them were actually able to recall specific topics. For example:

> *They teach about when man will be adult they grow up and hair grow, skin grow, muscels grow etc.*
>
> *I learn many thing. I know what I do when I grow up, when we are sad, happy.*

The adolescents' happiness regarding the educational sessions was evident in nearly all of the feedbacks. Especially learning about the physical changes during puberty was pleasant for many of the adolescents. Some also stated that they understood what had been taught and one had felt curiosity towards the subject beforehand.

> *I learn many things about our body (outside body and inside body)*
>
> *I am very happy because Ida and Lin teach us. They teach all things like our body and brain. I am very glad to know our body of human beings.*

The adolescents participated well in the activities through which the topics were covered. We received positive feedback from the adolescents during and in between the educational sessions regarding the used teaching methods. During the reflections at the

end of the educational sessions, the adolescents also commented on the methods in a positive manner. Below are some examples from the feedbacks:

> *Ida and Lin teach very nice and good. They also teach creative things and playing, dancing, singing with us*
>
> *They teach us many good and properly It was very good.*

With the exception of one person, most of the adolescents did not bring up the individual discussions in their feedbacks. However, the adolescents remained comfortable with us throughout the project, which indicates that we did not cross a personal or cultural boundary during the educational sessions or individual discussions. Finally, all of the adolescents took active roles throughout the project regardless of their voluntary participation.

# 7 ETHICAL CONSIDERATIONS

The ethics of our thesis was carefully considered for several reasons. According to Gajjar (2013, 8), the primary reasons for ethical considerations are to promote honesty and to avoid error. For us it was crucial to consider ethics from a concrete point of view, because we were researching a topic that delved into moral and social values. These aspects of our work needed to be approached with Gajjar's (2013, 9) essential ethical standards: trust, mutual respect, and fairness.

Gajjar (2013, 9-10) states that honesty, objectivity, integrity, carefulness, openness, confidentiality, responsible mentoring, social responsibility, non-discrimination, competence, and legality are some ethical principles for research. In order to respect these premises, we received formal permission from the organisation in charge of the children's home to complete the functional part of our thesis. Our social responsibility was taken into consideration by respecting the need for sensitivity when discussing about certain topics. In tribute to our professional competence, we strived to educate the adolescents with the most up-to-date information available. Finally, we honoured confidentiality by maintaining anonymity with the names of the adolescents and their home; which in turn protected their identities.

As researchers and professionals, we were compelled to abide by Polit and Beck's (2012, 154) concept of respecting human dignity by acting according to Gajjar's (2013, 9) concept of integrity. For example, we followed through with our agreements by keeping in contact with our working life connection throughout the process, openly sharing our information, and informing them of our plans for reporting. Moreover, Vilkka (2006, 57) states that research data is not to be collected without permission from the subjects. Therefore, the adolescents were informed of the nature of our research, the video recording, and how we planned to use the information gathered. We also informed the adolescents that they had the right to self-determination and could refuse to participate in our study had they wished so. To honour Polit and Beck's (2012, 156) concept of right to privacy, we notified the adolescents that they had the right to not answer any questions they deemed too personal or did not feel comfortable answering. Furthermore, it was our duty to protect the exploitation of the information

that the adolescents share with us. Gajjar (2013, 13) supports this notion of safeguarding in his discussion of limitations in regards to confidentiality and integrity.

## 7.1 Trustworthiness

Lincoln and Guba's (Lincoln & Guba 1985, according to Polit & Beck 2012, 583) criteria suggest we must work in a trustworthy and valid manner to establish our credibility as researchers. While trustworthiness does not ensure rigour in itself, it sets a standard to which research can be evaluated. Lincoln and Guba's framework around trustworthiness can be broken into five co-dependent criteria: credibility, dependability, confirmability, transferability, and authenticity. (Polit & Beck 2012, 583.)

Credibility is the certainty we can have that the research holds true to reality. Moreover, it implies that the findings are appropriate and enhances the plausibility in the context of our study. (Polit & Beck 2012, 584-585.) As Nepal is the focus country of our study, we decided to execute the functional part of our thesis there. This increased the credibility of our research, because we were able to experience, first hand, the situation in Nepal.

Polit and Beck (2012, 584-585) explain dependability as the degree to which the results of research would remain the same if the study was executed within a similar context and similar participants. As our target group has had a vast amount of contact with Westerners, the dependability of our study may have been compromised. This is due to the fact that we are not able to assess the congruence between the culture of our target group and the generalised culture of adolescents in Nepal.

Confirmability is very similar to dependability. However, the difference lies in the idea of objectivity: two independent studies, which are researching the same topic, can agree on the relevance and value of the results. (Polit & Beck 2012, 584-585.) The confirmability of our literature review on the status of sexual health education in Nepal was established upon interacting with our target group and other people within the community.

Transferability refers to the notion that the same results can be produced within a different setting. It also assigns us, as researchers, the duty to provide ample

information in a way that other researchers could assess the transferability of our results. (Polit & Beck 2012, 584-585.) The applicability of our research is difficult to assess, because the focus of our study was limited to Nepali culture. Therefore, we have no means to gauge the results of our findings in a different culture. However, our theoretical background was more broad on its' focus.

According to Polit and Beck (2012, 584-585), authenticity is the transparency to which we display our results. We have reported our functional part as accurately as possible considering the confidentiality limitations; thus, we are transparent in our documentation of results. Moreover, the ethics that we have considered establishes a grounds for reasons in which some topics could not be reported. The importance of these five criteria surround the idea that our readers can receive our research and the results in the truest form at which they are produced.

### 7.2 Moral dilemmas

Vilkka (2006, 56) states that qualitative research always has an effect on the lives of the study subjects and is considered as an intervention. This raises ethical questions when weighing the possible effects of the intervention. For example, Vilkka (2006, 58) recommends researchers to consider whether there is a limit one cannot cross when interfering with the personal lives of the study subjects.

Polit and Beck (2012, 152-153) highlight the importance of beneficence in nursing research. Vilkka (2006, 58) also argues that the interventions and interference related to qualitative research are often justified in the name of common good. Our obligations as researchers were to minimise maleficence and to magnify welfare. In order to do so, Vilkka (2006, 57) advises researchers to be constantly aware of the effects and the possible consequences that the process and the product itself may have on the lives of the subjects. In the context of our thesis, we needed to be wary of the fact that we are outsiders coming into their territory and exploring their psyche on extremely personal matters.

Due to the nature of our thesis, we also had to consider ethical questions related to internationalisation and globalisation. Asgary and Junck (2012, 1-5) and Räsänen (2005,

16) raise specific ethical questions associated with international co-operation. Some of these questions can be applied to our thesis and we took them into consideration throughout the process. For example, Räsänen (2005, 16) questions whether we, as representatives of the Western culture, have a right to interfere with any other culture and the related customs. Asgary and Junck (2012, 1-5) also discuss the possible damage caused by interfering with other cultures. Räsänen (2005, 16) contemplates whether the whole ethical discussion is Western-biased if it is based on Western ideals. Altogether, it is questionable: is it even possible to combine the general ethical principles with specific cultural values or can international co-operation be harmful regardless how well those principles are followed? These questions are difficult or even impossible to answer as we are still lacking universal value basis and global ethical guidelines. (Räsänen 2005, 16-17, 21.) Regardless, Räsänen (2005, 21) suggests that the Golden Rule of ethics is evident in different religions and philosophies, making it an appropriate representation of an unestablished universal code of ethics.

# 8 DISCUSSION

Our discussion uses Jasper's (2006, 91) SWOT method as a framework to evaluate our professional development and critical thinking (Jasper 2006, 100, 103) throughout the project. SWOT is an acronym for strength, weaknesses, opportunities, and threats (Jasper 2006, 91). It also serves as a medium through which we reflect upon our success in fulfilling the recommendations suggested by our research. The analysis of the project covers the strengths and weaknesses, whereas the threats are represented as our limitations. However, defining the separation between the weaknesses and the limitations was difficult; thus, they are interchangeable. Finally, the opportunities are suggested in the conclusion.

## 8.1 Analysis of the project

The strengths of our project were evident in how the adolescents responded to the educational sessions. The adolescents participated in all the sessions and did not refuse to answer any questions or to discuss any topics. This indicated that the adolescents were comfortable in the environment that was created. For example, the girls openly and spontaneously shared their experiences with menstruation.

The reactions and responses of the adolescents were consistent with their natural tendencies outside of the project. Active participation during the sessions revealed their interest and curiosity towards the topics, which was also visible during the individual discussions as they felt confident in asking more personal questions. The adolescents also came to ask for advice in between the sessions.

Although the sessions were recorded, the adolescents quickly became used to the video camera, and thus we believe that the Hawthorne effect was not evident. The activities seemed to keep the adolescents busy throughout the sessions, as they did not pay attention to the camera. As the reactions of the adolescents were so uninhibited, at the end of some sessions they displayed some regret for their actions and concerns about who would view the recordings. In response, we reminded them that the sole purpose of

video recordings was to evaluate our cultural competence and that they would not be publicly viewed, which relieved their concerns.

Jasper (2006, 91) presents the identification of weaknesses as a component of analytical strategies. As mentioned before, our working life connection requested last minute changes in the groups which we had predesigned. Due to this late request, we did not have enough time to rearrange the groups appropriately according to the maturation of the adolescents. As a result, during two sessions, certain adolescents seemed less comfortable within their assigned groups. However, the issue resolved on its own as the adolescents interacted more with each other.

Another weakness we were not able to avoid was the fact that the adolescents are not native English speakers; the language barrier was evident during the sessions. At times, the older adolescents interpreted some of the taught facts. During those moments, we were not able to confirm whether the translation was a true representation of what we were teaching. However, during the semi-structured interviews with the observers, we learnt the translations; the older adolescents had moulded the information into more culturally and colloquially understandable language for the younger adolescents.

## 8.2 Limitations

As evident in our ethics section, doing a study with human subjects brings forth many limitations. First and foremost, according to Khurshid and Aurangzeb (2012, 28), adolescents are more receptive to education guidance from educators with higher academic and professional qualifications; thus, our effectiveness may have been compromised. However, trained peer educators are suggested to be effective in increasing the adolescents' knowledge of sexual and reproductive health (Regmi et al. 2010, 624).

Another limitation is that the adolescents of our target group have been living under the influence of Western cultures. They are associated with a Western NGO that helps maintain financial stability. Therefore, our results cannot be generalised to all Nepali adolescents.

One possible influential limitation is that we are Western females teaching Nepali adolescent males. This is regarded as a limitation because of the fact that Nepali people are uncomfortable with the idea of discussing sexual health topics in front of the opposite sex (Pokharel et al. 2006, 158, 160; Acharya et al. 2009, 447; Homma et al. 2013, 21).

As suggested by our working life connection, we divided the adolescent males into two groups according to their age to respect cultural norms and provide the possibility of adjusting the material appropriately. Some of them were subjectively placed into the older age group based solely on our working life connection's and our perception of their maturity.

A very significant limitation was the fact that we have no knowledge on the community's perception of the adolescents; for example, whether they are considered privileged or underprivileged. Our initial objective was to empower the adolescents with knowledge so that they could create a domino effect by spreading the information to their peers. However, we cannot gauge how their knowledge and advice will be viewed within the community later on.

Finally, the major threat of our project is the lack of a follow-up plan. At the moment, we do not have the means to do supplementary research. Therefore, we cannot fully gauge the long term effects our project will possibly inflict on the adolescents and the future generations.

### 8.3 Reflection

Donald Schön (in Jasper 2006, 46) presents a conscious, retrospective approach to reflection called "reflection on action". We have decided to use the aforementioned method in combination with the three-a-day technique (Jasper 2006, 93) as a base to reflect on our experience throughout our thesis process. The technique promotes a reflection based on identifying three meaningful factors (Jasper 2006, 93).

What made the process enjoyable was the fact that the topic was very personal to us as we both are very curious about different cultures. The time spent for researching was

pleasant for us, because it was as if we were exploring a new value system. Being able to combine our shared passion of travelling with the project made our thesis so gratifying. Moreover, we really enjoyed being able to interact with the adolescents, because it brought out a sense of youthfulness in us. Despite hardships, our motivation was driven by the fact that the adolescents were eager to connect and reach out to us throughout the entire process.

In retrospection, we felt that the research became overwhelming. At times, it was hard to find the boundaries of our project. At the beginning of the process, it was very difficult to establish a permanent working life connection. Due to this, we felt that we did not receive enough feedback in regards to the parameters of our research and planned project until we were physically in Nepal. It was only once we were able to directly meet our working life connection in Nepal that we were given guidance and our plan could be finalised. We were also hesitant about overstepping our boundaries as outsiders, because we felt responsible for our actions and how they would affect the lives of the adolescents. In addition, due to the fact that we lived with the adolescents, it was sometimes hard to define our roles as educators.

During the thesis process, we learned that we are intuitive people: we were constantly observing and analysing situations, and tried our best to adapt accordingly. Before our departure, the content of our literature review felt very two-dimensional. However, our time in Nepal truly opened our eyes to the challenges that sexual health education really faces. Suddenly, the research we had done became three-dimensional and very realistic. Our project also deepened our awareness of the fact that the movement towards cultural competence is not so simple. Rather, it is a very abstract and subjective process that has the capacity to change between people within the same culture. Moreover, we also learned that the process of creating educational sessions, which are effective in transferring information, is profoundly influenced by the individual's learning style, life experiences, and thus culture in its entirety. This further made us realise how much cultural competence and individualised care are intertwined.

At some point, we came to realise that our thesis, which started out as a simple idea, quickly became a very complex and challenging project that examined ethical and moral controversies. Throughout the process, we kept questioning ourselves and if our motives were justified. How could we assume that they would benefit from our knowledge?

There were times when we did not know how to move forwards due to the fear of meddling with and violating their perception of life. During those times, we felt slightly inadequate in our ability to provide culturally competent educational sessions.

In all, we felt that our educational sessions were designed as appropriately as we could manage, considering how we gauged and interpreted the recommendations from our research. There were defining moments during our study that made us conscious of our capability in creating an open and comfortable atmosphere between the adolescents and ourselves. Those were the raw, unanticipated moments when we felt that we accomplished something.

# 9 CONCLUSION

In hopes of reaching the community and future generations, the ultimate goal of our project was to equip the adolescents with means to empower themselves during their journey towards adulthood. Due to the nature of our project, the long term effects cannot be determined yet. Nevertheless, the response from the adolescents confirmed their acquired capacity to deal with the changes during maturation. By giving insight into the obstacles of providing more culturally competent care, we were able to raise awareness and promote cultural understanding amongst nurses, thus meeting our aims. Our thesis also brought forth the complexities behind the power shifts between cultures. Providing culturally appropriate care involves more than just identifying superficial differences; it is digging deeper into, and trying to understand the needs of another individual who has been brought up within a society of different value systems. Through our theoretical starting points and literature review, our thesis answered our research questions.

The implications of our thesis for clinical practice surround the notion of being aware and sensitive to the individualised needs of patients in order to maintain our professional responsibility. We, as nurses, must not make assumptions, judge nor impose our beliefs onto those of the patient. Furthermore, we must not make a patient feel that their values and beliefs are inferior, even when we do not agree with them.

Upon completing our thesis, we realised that there is an urgent need to increase and improve education for cultural competence in healthcare. Moreover, it is imperative for future nurses to be able to find similarities and understanding for their patients, so that the nurse-patient relationship encompasses respect. However, more research has to be done in order to develop and refine the knowledge and implementation of culturally competent care. Finally, collaborative work between healthcare professionals and patients from different cultural backgrounds will be essential in the expansion of this body of knowledge.

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# APPENDICES

Appendix 1. Table of literature review articles

| **Authors, year, and country** | **Purpose of the study** | **Results** | **Recommendations** |
|---|---|---|---|
| Pokharel et al. 2006 Nepal | To examine the effectiveness and affecting factors of sexual health education given in schools in Western Nepal | Adolescents felt uncomfortable and did not get enough information, and most teachers were reluctant and some lacked the skills to teach the topic of sexual health | In order for effective sexual health education to reach all Nepali youth, teachers need culturally appropriate theory and practical training, classes should be separate for each gender in a less formal atmosphere, and teaching material should be more effective. |
| Regmi et al. 2008 Nepal | To outline the sexual and reproductive health status of Nepali adolescents | A combination of factors cause an increase in risky behaviors surrounding sexual health in Nepali youth | Peer education programmes and accessible youth friendly services, and development of more effective materials and curricula for sexual health education could improve the sexual health status of Nepali youth |
| Acharya et al. 2009 Nepal | To identify and address challenges to and opportunities for sexual health education in Nepali schools | Identified limitations included: lack of life skill-based approach and appropriate teaching aids, reliance on conventional methods, non-existent community support, and lack of research and evaluation of sex education | Diverse methodology, peer education, better involvement of parents and external agencies, and access to support and service organisation, and research and evaluation in sex education were suggested |
| Shrestha et al. 2013 Nepal | To gain insight into students' perception and attitude of school-based sexual health education and their intentions for safe sex. | School-based education is not on par with the expectations of students regarding HIV and sexual health education. | Responsible sexual behaviour among students' can be enhanced with adequate sexual health education and the support and involvement of teachers and parents. |

Appendix 2. The plan for empowering adolescents in Nepal

Day 1 - Opening Session 1 (6)

Everyone

| Objective | Content | Methods |
|---|---|---|
| Get to know each other | Introduction of ourselves to one another | Name games (individual and team games) |
| Create open, trusting, and comfortable atmosphere | N/A | Other games (Broken phone, Human knot, etc. ) |

Day 2 - Introduction

Everyone

| Objective | Content | Methods |
|---|---|---|
| Familiarise the adolescents with the project | Introducing the project, topics, and timetable in more detail | Create a schedule together with the adolescents |
| Build trust | N/A | Trust games (Wind in the willows) |
| Ensure open communication | N/A | Trust games (Wind in the willows) |

(continues)

Day 3 – Physical Changes during Puberty 2 (6)

Boys

| Objective | Content | Methods |
|---|---|---|
| Learn the physical changes of puberty for males | Body hair, height, and muscle growth, voice change, genitalia changes, increased sweating, wet dreams, and acne | Mapping physical changes through drawing<br>Discussion |
| Learn the physical changes of puberty for females | Breast development, body hair and height growth, acne, increased sweating, and menstruation | Discussion |
| Raise self-awareness of the physical changes<br><br>Develop awareness and understanding towards other people | Individuality of the physical changes and previous topics | Previous methods<br>Discussion |
| Reflect on day's activities, thoughts and feelings | N/A | Reflection circle<br>Discussion |

(continues)

Day 3 (7.6.) - Physical Changes during Puberty 3 (6)

Girls

| Objective | Content | Methods |
|---|---|---|
| Learn the physical changes of puberty for females | Breast development, body hair and height growth, increased sweating, and acne | Mapping physical changes through drawing<br>Discussion |
| Learn about the menstruation and related practices | Menstruation, including the menstrual cycle, PMS and emotional changes, cramps, headache, acne, and bloating<br><br>Hygiene and feminine products<br><br>Means to deal with PMS, including exercise, rest, painkillers | Ask own experiences<br><br>Timeline of menstrual cycle and drawing of the reproductive tract<br><br>Showing pads and tampons, and how to use them<br><br>Discussion, yoga |
| Learn the physical changes of puberty for males | Body hair, height, and muscle growth, voice change, genitalia changes, increased sweating, wet dreams, and acne | Discussion |
| Raise self-awareness of the physical changes<br><br>Develop awareness and understanding towards other people | Individuality of the physical changes and previous topics | Previous methods<br>Discussion |
| Reflect on day's activities and thoughts and feelings | N/A | Reflection circle<br>Discussion |

(continues)

Day 4 - Emotional Changes during Puberty 4 (6)

Boys

| Objective | Content | Methods |
|---|---|---|
| Learn emotional changes of puberty<br><br>Identify different emotions | Emotional changes during puberty.<br><br>Different emotions (sadness, anger, happiness, tiredness, jealousy, etc.)<br>Curiosity towards opposite gender | Introduction and discussion<br><br>Mood walk |
| Raise awareness towards the problems related to bullying<br><br>Decrease the possible occurrence of bullying | Types (physical, verbal, relational, sexual) and forms (conscious and unconscious)<br><br>Reasons<br><br>Effects<br>(direct and long-term) | Introduction of the topic<br><br>Sharing experiences<br><br>Discussion |
| Learn the importance of friendship and respect for others | Responsibility<br>Peer-support and friendship<br>Social skills | Discussion<br><br>Positive phrases about each other (on stars) |
| Raise self-awareness and acceptance of the emotional and behavioural changes<br><br>Develop awareness and understanding towards other people | Self-awareness, self-esteem, body image, life values and attitudes<br><br>Respect towards oneself and others | Line game (mapping life values)<br><br>Analysing a poem |
| Reflect on day's activities and thoughts and feelings | N/A | Reflection circle<br>Discussion |

(continues)

Day 4 - Emotional Changes during Puberty 5 (6)

Girls

| Objective | Content | Methods |
|---|---|---|
| Learn emotional changes of puberty<br><br>Identify different emotions | Emotional changes during puberty.<br><br>Different emotions (sadness, anger, happiness, tiredness, jealousy, etc.)<br>Curiosity towards opposite gender | Introduction and discussion<br><br>Mood walk |
| Raise awareness towards the problems related to bullying<br><br>Decrease the possible occurrence of bullying | Types (physical, verbal, relational, sexual) and forms (conscious and unconscious)<br><br>Reasons<br><br>Effects<br>(direct and long-term) | Introduction of the topic<br><br>Sharing experiences<br><br>Discussion |
| Learn the importance of friendship and respect for others | Responsibility<br>Peer-support and friendship<br>Social skills | Discussion<br><br>Positive phrases about each other (on stars) |
| Raise self-awareness and acceptance of the emotional and behavioural changes<br><br>Develop awareness and understanding towards other people | Self-awareness, self-esteem, body image, life values and attitudes<br><br>Respect towards oneself and others | Line game (mapping life values)<br><br>Analysing a poem |
| Reflect on day's activities and thoughts and feelings | N/A | Reflection circle<br>Discussion |

(continues)

Day 5 (21.6.) - Closing Session 6 (6)

Everyone

| Objective | Content | Methods |
|---|---|---|
| Allow reflection on the discussed topics | N/A | Discussion |
| Receive feedback to develop ourselves | N/A | Drawing and writing |

Individual Discussions

Everyone

| Objective | Content | Methods |
|---|---|---|
| Physical measurements | Height, weight, vision | Measuring tools |
| Allow reflection on the discussed topics<br><br>Offer a chance for more information | Thoughts, feelings, questions on the subjects of living at the children's home, relationships, self-esteem, and school and education. | Semi-structured interview<br>Discussion |

Everyone 14 + years

| Objective | Content | Methods |
|---|---|---|
| Physical measurements | Height, weight, vision | Measuring tools |
| Allow reflection on the discussed topics | Thoughts, feelings, questions on the subjects of living at the children's home, relationships, self-esteem, and school and education. | Semi-structured interview<br>Discussion |
| Offer a chance for more information according to the personal interests and readiness | Sexuality, sexual relationships, protection and contraception, and STIs | Samples and demonstration (condom usage)<br>Discussion |

Appendix 3. Individual Discussion Questions

**Questions regarding the children's home**

1. How do you feel living at the children's home?
2. How do you feel about the workers and the volunteers?
3. How do you feel about the other children?
4. Do you have someone you can trust?
5. How much do you know about why you were brought here?

**Questions regarding school and education**

1. How do you feel about school?
2. How do you think you are doing in school?
3. What subjects do you like?
4. What do you want to be when you grow up?
5. Who are your friends at school?

**Questions regarding sexuality** (for all of the adolescents)

1. How do you feel about growing up?
2. How do you feel about yourself?

**Questions regarding sexuality** (for the older adolescents)

1. Do you like anyone?
2. Have you began having menstruation/wet dreams?
    a. How do you feel about that?
3. Have you heard about sex?
    a. Are you curious about sex?
    b. Do you know what sex is for?
4. Have you heard about safe sex?
    a. Do you know any methods of safe sex?
    b. Do you know why safe sex is important?
5. Do you know what a condom is?
    a. Would you like to learn how to use a condom?

Do you have any questions you would like to ask?

Appendix 4. Assessment tool for cultural competence

**Description** 1 (4)

This assessment consist of 17 items. It was adapted from the Transcultural Self-Efficacy Tool (TSET), Cultural Competence Clinical Evaluation Tool – Teacher Version (CCCET-TV), and Cultural Self Efficacy Scale (CSES). This assessment is divided into four categories: (1) Communication, (2) Cultural aspects, (3) Social aspects, and (4) Practical aspects. Each category is composed of several statements which aid in the determination of the students' cultural competence.

The objective of the project was to empower adolescents by passing information in a culturally sensitive manner. The purpose of this assessment tool is to measure the cultural awareness of the students during the execution of their project.

**Instructions**

Number each statement on a scale from 1 to 5, strongly disagree to strongly agree, respectively. Mark an "x" in the box that best represents your opinion based on observation.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Strongly Disagree | | | | Strongly Agree |

This assessment includes an open feedback section for supplementary comments.

(continues)

Part 1 - **Communication** 2 (4)

| Statement | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| The language of the students was comprehensible. (vocabulary, sentence structure) | | | | | |
| The language of the students was culturally appropriate. (terminology) | | | | | |
| The students used appropriate non-verbal communication. (gestures, eye contact, tone of voice, posture) | | | | | |
| The students took culturally acceptable personal space and touch into consideration. | | | | | |

1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree

Part 2 - **Cultural aspects**

| Statement | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| The students were aware of and took the educational background of the adolescents into consideration. | | | | | |
| The students were aware of and took the religious background of the adolescents into consideration. | | | | | |
| The students respected the adolescents' world view. | | | | | |
| The students did not impose their world views onto the adolescents. | | | | | |
| The students were flexible with moulding into the new environment. | | | | | |

1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree

(continues)

Part 3 - **Social aspects** 3 (4)

| Statement | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| The students covered the topics while taking gender sensitivity into consideration. | | | | | |
| The students were aware of the social expectations of adolescents in their culture. | | | | | |
| The students took societal age limitations into consideration. | | | | | |

1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree

Part 4 - **Practical aspects**

| Statement | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| The topics were culturally appropriate. | | | | | |
| The material was culturally appropriate. | | | | | |
| The methods were culturally appropriate. | | | | | |
| The topics were relevant for the target group. | | | | | |
| The teaching methods were effective. | | | | | |

1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree

(continues)

Part 5 - **Open feedback** 4 (4)