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Beyond Lecture Halls: Exploring Barriers to Sexual and Reproductive Health Services among students in South African Higher Education institutions

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Clayton Hazvinei Vhumbunu
Research Fellow in International Relations, School of Social Sciences, University of KwaZulu-Natal (UKZN), Durban; South Africa
Email: cvhumbunu@gmail.com

Abstract

Despite progressive policy frameworks aimed at safeguarding young people's sexual and reproductive health and rights (SRHR), students studying in the 26 public universities and around 138 private higher education institutions (HEIs) in South Africa continue to encounter multifaceted barriers that undermine their ability to access essential SRHR services. This study interrogates the persistent challenges of accessing SRHR services faced by students in South African HEIs by moving beyond conventional analyses of service utilisation to critically examine the structural, institutional, socio-cultural, and individual-level constraints embedded within higher education environments. It uses a variety of media reports and variegated secondary data sources, with qualitative content analysis utilized to identify key themes and patterns, through a qualitative research approach. Urie Bronfenbrenner (1977)'s *Social Ecological Model (SEM)* provides a theoretical framework of analysis. The study reveals how infrastructural limitations, fragmented institutional mandates, stigma, gendered power dynamics, and inadequate knowledge ecosystems intersect to shape students' SRHR trajectories. The findings demonstrate that while South African HEIs are uniquely positioned to support students' wellbeing, entrenched organisational cultures, insufficient resource allocation, and inconsistent policy implementation create a disconnect between policy intent and lived realities. By illuminating these hidden and overlapping barriers, the article argues for a reimagined, student-centred SRHR approach that integrates rights-based, context-responsive, and intersectional interventions into the core functioning of

higher education institutions. The study contributes to broader debates on youth health equity particularly in South Africa, and generally in the Global South, and underscores the imperative for transformative institutional reforms capable of advancing holistic SRHR access for diverse student populations.

Key Words: *Sexual and Reproductive Health Rights (SRHR), Youth Health Equity, Higher Education Institutions, South Africa.*

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Introduction

Despite being one of the fundamental women's rights, quality, adequate and comprehensive sexual and reproductive health and rights (SRHR) remains inaccessible to many South African women. Whilst there has been reports on SRHR access barriers across South Africa, there has not been many studies that have focused on the availability, accessibility, acceptability, and quality standards in South African higher education institutions (HEIs). This study used a variety of media reports and variegated secondary data sources to interrogate the persistent challenges of accessing SRHR services faced by students in the 26 public universities and around 138 private in South Africa, utilizing Urie Bronfenbrenner (1977)'s *Social Ecological Model (SEM)* as a theoretical framework of analysis.

Background and Rationale to Students' Access to Sexual and Reproductive Health and Rights (SRHR)

The Constitution of the Republic of South Africa (1996) guarantees the right to access healthcare services, inclusive of SRHR services.

Specifically, this This constitutional guarantee, which forms the foundational human-rights basis for SRHR in South Africa, is expressed under Section 27 of the Constitution (under the right to health care services), which confers individuals - including students - with the right to access reproductive health care as part of general health services. In addition to the following legislations exist: the Children's Act, 2005 (Act No. 38 of 2005), the Choice on Termination of Pregnancy Act, 1996 (as amended), and the National Guideline for Implementation of the Choice on Termination of Pregnancy Act (2019). A number of policies and strategies have also been formulated, including the Sexually Transmitted Infections Management Guidelines (2015), the National Integrated Sexual and Reproductive Health and Rights Policy (NISRH) of 2019, National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (ASRHR Framework) of 2014–2019, National Adolescent and Youth Health Policy (AYHP) of 2017, the National HIV Testing Services (HTS) Policy, the National Strategic Plan for HIV, TB and STIs (NSP HIV, TB & STIs 2017-2022), the Department of Basic Education National Policy on HIV, STIs and TB & Policy on the Prevention and Management of Learner Pregnancy in Schools, the National Guideline on the Management of Post-Exposure Prophylaxis (PEP) (2019), and the National Clinical Guideline for Contraception (2019). These policies implore the state and other actors – through a multi-level and multi-sectoral approach - to provide adequate, quality, accessible and comprehensive SRHR services.

Over and above these national legislative and policy frameworks, various pieces of international human rights legal frameworks also recognize the fundamentality of SRHR services globally. These include the International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966, the International Covenant on Civil and Political Rights (ICCPR) of 1966, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979, and Convention on the Rights of the Child (CRC) of 1989, among others, are all an acknowledgement of the importance of SRHR services for women and girls in South Africa.

Thus, SRHR services are fundamentally anchored in the recognition of human dignity, autonomy, and the ethical imperative of self-determination. The denial of SRHR services to students constitutes not merely a breach of health policy but an infringement upon the intrinsic moral agency of students as marginalized and vulnerable populations whose bodily autonomy has always been subordinated to social, political, or economic forces. Framing SRHR services as a human right asserts

that access to comprehensive SRHR services - including information, contraception, safe abortion, and maternal care – as inseparable from the pursuit of justice, equality, and freedom. Therefore, SRHR embodies the intersection of deontological and consequentialist ethics as it is a moral duty of HEIs to uphold these rights, while the practical consequences - reduced mortality, enhanced gender equality, and social empowerment - further validate their moral and societal necessity. In essence, the protection and promotion of SRHR by HEIs reflect a commitment to recognizing every student as a moral subject capable of shaping their own life and flourishing within a framework of equality and respect for human dignity whilst also creating conducive conditions for student learning and productivity.

Study Methodological Approach

This article adopted a qualitative multi-source research design that systematically analysed a wide corpus of media reports and diverse secondary data to interrogate the persistent challenges that students in South African HEIs face in accessing SRHR services. These included peer-reviewed journal articles, government and policy reports, NGO publications, and media reports, which were purposively selected based on their relevance to student access to SRHR services in South African HE, as well as recency and credibility. Anchored in Urie Bronfenbrenner's (1977) Social Ecological Model, the analysis moved deliberately beyond conventional accounts of service utilisation to reveal how structural, institutional, socio-cultural, and individual-level constraints coalesce within university environments to shape SRHR access (Bronfenbrenner, 1977; Bronfenbrenner, 2013). Data were subjected to a rigorous interpretive thematic analysis that traced the interplay of micro-level, meso-level, exo-level, and macro-level forces embedded in public discourse and institutional documentation (Nowell *et al,* 2017). Methodological credibility was enhanced through systematic triangulation across data types, iterative analytic memoing, and reflexive engagement with the positionalities informing the interpretive process (Donkoh and Mensah, 2023; Olmos-Vega *et al,* 2023).

Higher Education Students' Access to Sexual and Reproductive Health Services: Literature Review and Theoretical Framework

Conceptualizing SRHR in higher education contexts requires situating students' embodied experiences within broader socio-cultural, institutional, and policy ecologies that shape their agency, vulnerability, and capacity to access comprehensive SRH services. In this milieu, SRH emerges not merely as a set of clinical interventions but as a multidimensional construct embedded in questions of equity, power, identity, and pedagogical responsibility, demanding that universities cultivate environments that safeguard students' rights, well-being, and autonomy (Lifuka and Chanda, 2023; Pokharel, 2025).

Whilst scholars have conceptualized SRHR differences, with variations in terms of scope, breath and theoretical orientation; most scholars consider SRHR as comprehensive set of entitlements and freedoms that ensure all individuals can make informed, autonomous decisions about their sexual lives, reproductive choices, and bodily integrity without discrimination, coercion, or violence (Kok *et al,* 2025; Mlotshwa *et al,* 2025). To the World Health Organization (2025), SRHR services encompasses family planning and contraception, maternal health services, safe abortion and post-abortion care, sexually transmitted infections (STIs) prevention and treatment, adolescent and youth-friendly SRHR services, comprehensive sexuality education, infertility and reproductive health services, gender-based violence (GBV) support and counselling, menstrual health management, counselling and psychosocial support. Thus, as argued by the WHO (2025), comprehensive SRHR encompasses access to accurate SRHR information, quality SRHR healthcare services as well as the legal, social, and structural conditions necessary for exercising these SRH rights with dignity and equality.

The critical role of SRH services in supporting student well-being, retention, and academic success has been explored by a number of studies. Castleton *et al* (2024) and Yillah *et al* (2025), for instance, underscore the importance of HEIs as key delivery points for youth SRH services. The authors highlight that HEIs – which function as integrated social ecosystems—combining academic, residential, and extracurricular environments - occupy a strategic position in delivering SRHR services because they congregate large populations of young adults at a formative stage of psychosocial and sexual development, providing a concentrated platform for both preventive and curative interventions (Castleton *et al*, 2024; Yillah *et al,* 2025). The access to comprehensive SRHR services

mitigates health-related stressors that can compromise the cognitive focus, scholarly productivity, engagement and psychosocial stability of HEIs students; hence the requirement that HEIs meet the salient SRHR needs in a confidential, accessible, quality and youth-sensitive manner (Bolarinwa *et al,* 2024; Meherali, 2025).

Global and regional trends and patterns of university students' SRHR service needs, access and utilization among university students reveal several challenges in sub-Saharan Africa whilst comparative insights show how African HEIs differ from global institutions in SRHR service availability (Bolarinwa *et al,* 2024; Meherali, 2025; Castleton *et al*, 2024; Yillah *et al,* 2025). In Africa, and generally in developing countries, there are several structural, socio-economic and institutional barriers to students access of SRHR services, with challenges relating to functionality of campus clinics, health promotion units, and referral systems due to institutional capacity constraint, staffing inadequacies, resource shortages, university governance limitations, policy implementation gaps, and variability between historically advantaged and disadvantaged institutions (Lifuka and Chanda, 2023; Chekol *et al*, 2023; Worke *et al,* 2024). The studies identify a multitude of sociocultural and gendered barriers facing HEIs students in accessing SRHR services in the form of stigma, cultural expectations, gender norms, and moral judgements within university communities whilst LGBTQ+ students, international students, and other vulnerable groups continue to be confronted with unique challenges as social norms shape perceptions of SRH service delivery in HEIs (Bolarinwa *et al,* 2024; Lifuka and Chanda, 2023; Meherali, 2025; Chekol *et al*, 2023; Worke *et al,* 2024; Yillah *et al,* 2025; Castleton *et al*, 2024). The prevalence of interpersonal and psychosocial factors continue to affect access to quality and comprehensive SRHR services in HEIs as factors such as peer influence, intimate partner dynamics, and fear of judgement by staff or fellow students, mental health issues and SRH literacy remain serious barriers (Meherali, 2025; Chekol *et al*, 2023; Worke *et al,* 2024; Yillah *et al,* 2025)

Urie Bronfenbrenner's (1977) Social Ecological Model (SEM) provided a nuanced theoretical lens to examine the multi-layered factors influencing HEIs students' access to SRHR services. Recognizing that student health behaviors and service utilization are embedded within complex social systems, the SEM facilitated a holistic interrogation of barriers spanning individual, relational, institutional, and broader societal dimensions. At the microsystem level, the framework illuminated how personal knowledge, attitudes, and health literacy intersect with peer and

familial influences to shape SRHR decision-making (Bronfenbrenner, 1977; Bronfenbrenner, 2013). The mesosystem perspective allowed for exploration of the interplay between academic environments, student support structures, and community health resources, emphasizing the relational dynamics that either enable or constrain access. Simultaneously, exosystemic factors, such as institutional policies, service availability, and healthcare infrastructure, were considered for their indirect yet consequential impact on student SRH engagement (Bronfenbrenner, 1977; Bronfenbrenner, 2013). At the macrosystem level, the framework foregrounded the socio-cultural, legal, and normative contexts, including gendered expectations and national SRHR policies, which collectively govern the structural accessibility and acceptability of services within higher education institutions (Bronfenbrenner, 1977; Bronfenbrenner, 2013).

Employing Bronfenbrenner's SEM also facilitated a rigorous interpretive methodology by providing an organizing schema through which emergent themes could be systematically situated within layered ecological contexts. This theoretical scaffolding allowed for the identification of both proximal and distal determinants of SRHR service utilization, thereby illuminating how seemingly individual-level behaviors are shaped by broader systemic forces (Bronfenbrenner, 1977; Bronfenbrenner, 2013). However, it has to be stated that while Urie Bronfenbrenner's Social Ecological Model provides a useful framework, some of its assumptions may be considered outdated given recent developments in social and educational research. For instance, contemporary research emphasizes fluid, rapidly changing, and globalized contexts which is no longer stable and structured. In addition to this, the Social Ecological Model does not fully account for newer perspectives such as intersectionality, power dynamics, and more complex forms of inequality – which are all key in the SRHR discourse. Notwithstanding this, by anchoring the analysis in SEM, the study was able to trace the complex interplay of micro-, meso-, exo-, and macro-level influences, demonstrating that interventions targeting student SRHR require multi-tiered strategies that transcend individual behavior change and address institutional, community, and policy-level levers (Bronfenbrenner, 1977; Bronfenbrenner, 2013). Consequently, SEM not only guided data interpretation but also underscored the necessity for contextually sensitive, integrated approaches to improving SRHR access and equity in South African HEIs settings.

Barriers to Sexual and Reproductive Health Services Among Students in South African Higher Education Institutions

This analysis identified six major barriers faced by students enrolled in South African HEIs in accessing quality and comprehensive SRHR services. These barriers are discussed in detail below, and they include; *limited awareness and knowledge of SRHR; stigma, discrimination, gender and social norms-related barriers; insufficient SRHR youth-friendly services; and financial, policy and structural barriers.* The themes emerged through an inductive qualitative content analysis of the secondary data, whereby recurrent patterns and issues identified across multiple sources were systematically categorized into themes. This ensured a transparent analytic linkage between the empirical evidence in the literature and the resulting themes.

1. Limited Awareness and Knowledge of SRHR

Whilst awareness and knowledge of SRHR is pivotal for students in HEIs, as this constitute not merely instruments of personal health management but profound enablers of autonomous decision-making, ethical self-governance, and the cultivation of holistic well-being, several students in South African HEIs lack adequate information about the available SRHR services, their scope, and how these can be accessed which has often resulted in the underutilization of SRHR services HEIs campuses. Mwamba *et al* (2022)'s study which focused on SRHR knowledge of postgraduate students at the University of Cape Town in South Africa found out that the students often exhibit limited awareness and knowledge SRHR services due to the confluence of fragmented institutional communication, socio-cultural stigmas surrounding sexuality, and insufficient integration of comprehensive SRHR education within academic curricula. Likewise, a joint study by the Department of Higher Education and Training (DHET), Universities South Africa (USAf) and the Commission for Gender Equality (CGE) (2025) revealed SRHR service access challenges arising from lecturer-student relationships, peer relationships, sex for marks/grades, sex bartered for accommodation, rape, stigmatisation, physical abuse of the LGBTQIA+ community, among others. A recent survey by Mutinta (2022) indicated that unplanned pregnancy prevalence rate was around 13 percent for unmarried female students at the Nelson Mandela University (NMU) in South Africa's Eastern Cape Province. Relatedly, Mokgatle *et al* (2021)'s cross-sectional survey of partner notification among young people in

general, and university students in South Africa in particular, focusing on self-reported STIs and partner notification practice, intentions, and preferences among university students as well as students' STI knowledge and risky sexual behaviour in relation to STIs revealed that students in South African universities engaged in risky sexual behaviours but had a low perception of the risks of acquiring STIs despite being at high risk of acquiring STIs and HIV due to an early age of sexual debut and inconsistent condom use.

Similarly, Mazibuko *et al* (2023)'s study which explored factors influencing non-use of SRHR services by students at Mangosuthu University of Technology in South Africa (MUT) found out that many sexually active university students engage in several risky behaviours, including sex with multiple sexual partners, low condom use, and low contraceptive use due to newfound freedom and lack of adequate knowledge of SRHR services notwithstanding the implementation of campus-based health education programmes, government-sponsored condom distribution programmes, as well as HIV and STI-prevention intervention programmes for university students. It is therefore important for HEIs students to be constantly acquainted with multi-dimensional SRHR knowledge relating to their legal and ethical rights regarding SRHR, contraception and pregnancy prevention, STIs and HIV/AIDS transmission, prevention and treatment options, healthy relationships, accessing SRHR, knowledge of consent and communication, as well as mental and psychosocial dimensions of SRHR.

2. Stigma, discrimination, gender and Social Norms-related Barriers

Stigma, discrimination, and entrenched gendered and social norms coalesce into a subtle yet profoundly disciplinary matrix that not only polices students' bodies and desires, but also circumscribes the moral legitimacy of seeking SRHR services. Within HEIs - spaces ostensibly dedicated to emancipation and critical inquiry - these normative forces reproduce hierarchies of respectability and vulnerability, rendering SRHR engagement an arena where students must navigate the tensions between institutional ideals of autonomy and the socio-cultural architectures of judgment that delimit their lived possibilities (Worke *et al,* 2024; Chekol *et al*, 2023). Thus, stigma, discrimination, gender and social norms-related barriers present barriers to SRHR services access for students in HEIs in South Africa by creating an environment and atmosphere of surveillance

and shame that deters students from openly seeking SRHR services even when such services are readily available in the form of enacted stigma, ridicule or public shaming of students who use contraception, seek STI testing, or disclose sexual activity; stigma attached to specific SRHR services such as abortion, Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis (PEP/PrEP) and sexuality and HIV-related stigma which instil fear in students of being labelled 'promiscuous' or HIV-positive if seen at SRHR services (Meyer *et al,* 2023). A study by Tyabazeka *et al* (2024) on HIV self-management perceptions and experiences of students at a selected university in South Africa showed that students in HEIs encountered HIV-related stigma as they attempted to seek HIV-related SRHR services which frequently resulted in elevated stress levels.

In addition to the above, students in HEIs also face provider discrimination in the form of judgmental attitudes or refusal of care by clinic staff or campus nurses. There is also institutional discrimination arising from university policies and/or practices as manifested through restrictive administrative rules, lack of youth-sensitive opening hours, and inaccessible SRHR service locations (Bohren *et al,* 2022; Akhurst *et al,* 2019; Hanass-Hancock *et al,* 2024). Further, the absence of confidential services on campus, peer discrimination and social exclusion as well as intersectional discrimination in the form of race-based exclusion, disregard of students living with disabilities, foreign nationals and in some cases survivors of sexual violence whilst tendencies of heteronormativity and invisibility of LGBTQI+ needs also persist in some HEIs (Bohren *et al,* 2022; Akhurst *et al,* 2019; Hanass-Hancock *et al,* 2024). There are well-documented studies that have revealed the prevalence of masculinity norms that discourage SRHR service-seeking by male students as they are considered 'weak', with commonplace religious and cultural norms that disapprove the use of contraceptives, abortion, sexual autonomy and shun sexuality education; with some social norms stigmatizing pregnancy/parenting students in HEIs thereby discouraging students from seeking related SRHR services such as safe abortion, post-abortion care, contraceptives (Bohren *et al,* 2022; Akhurst *et al,* 2019; Hanass-Hancock *et al,* 2024). Even some members of special populations in South African HEIs are also subjected to additional stigmas and norms that amplify barriers. For instance, there is rampant stigmatization, moral judgement and criminalization of sex workers and transactional sex in most South African HEIs which reduces students' willingness to disclose and access targeted SRHR services whilst students living with disabilities are often excluded based on assumptions about

asexuality and inadequate SRHR clinic accessibility (*see* Durden *et al,* 2025). The above normative forces do not only delegitimize students' sexual autonomy but also embed inequitable power relations within institutional cultures, thereby transforming SRHR access into a socially risky act marked by fear of judgement, reputational harm, and socio-cultural sanction within South African HEIs.

3. Insufficient SRHR Youth-friendly services

SRHR youth-friendly services are considered to be those that are deliberately designed to align clinical quality with developmental sensitivity, ensuring that adolescents and young adults encounter care environments that are confidential, non-judgmental, equitable, and attuned to their evolving psychosocial realities (Kihwele *et al,* 2025; Lynch *et al,* 2025; Nyirarukundo *et al,* 2025). Youth-friendly SRHR services have to integrate accessibility, cultural responsiveness, and relational trust-building to remove structural and interpersonal barriers, thereby enabling young people to exercise autonomy and make informed decisions about their sexual and reproductive well-being (Lynch *et al,* 2025; Nyirarukundo *et al,* 2025; Kihwele *et al,* 2025).

Whilst SRHR youth-friendly services are critical in empowering HEIs students to make informed decisions, fostering holistic well-being and enabling optimal cognitive, emotional, and social functioning within the HE environment; students in South African HEIs are facing challenges as some campus clinics are providing youth-unfriendly SRHR services. Studies on SRHR services provision in South African HEIs by Gillespie *et al* (2022) and Mashamba *et al* (2024) have shown that several universities and colleges' campus clinics provide youth-unfriendly SRHR services as they lack confidentiality and privacy; staffed by judgmental or untrained health service providers with negative attitudes; operate inconveniently as their service hours are only during school hours; are guided by complex procedures characterized by lengthy registration, bureaucratic processes, or adult-centric communication can alienate younger clients whilst some are physical inaccessibility as they are located far from students' residences with absence of peer or supportive networks; very inadequate accompanying SRHR information, education and communication services; and lack of student participation in design of SRHR systems and service packages.

On the basis of the above challenges, scholars such as Mashamba *et al* (2024), Sanyang *et al* (2025) and Mwamba *et al* (2022) have suggested that HEIs need to establish private SRHR consultation spaces for students,

implement strict data protection and confidentiality policies, train and build capacity of campus clinic staff on adolescent and youth-sensitive approaches, emphasize understanding of diverse identities such as LGBTQ+ students, students with disabilities, and other marginalized populations to eliminate stigma, and offer flexible SRHR service hours outside the usual and normal lecture and exam schedules. In addition to this, it has also been suggested that HEIs shift to online SRHR services and telehealth or digital SRHR consultations to reach students discreetly, provide a full range of comprehensive and integrated SRHR services, meaningfully engage students in planning, monitoring, and evaluation of SRHR services, target students in aggressive awareness and education campaigns on available SRHR services, and implement sensitization programs to reduce stigma surrounding SRHR services (Sanyang *et al*, 2025; Mwamba *et al,* 2022; Mashamba *et al,* 2024).

4. Financial, Policy and Structural Barriers

Financial, policy, and structural barriers converge to produce a multilayered architecture of exclusion that subtly, yet powerfully, constrains the capacity of HEIs students' to access comprehensive SRHR services. Such barriers – which are structurally rooted and entrenched in institutional resource inequalities, regulatory ambiguities, and systemic governance limitations - shape the everyday realities of students' SRHR service-seeking behaviours, ultimately reinforcing persistent gaps in SRHR equity within HEIs spaces (Wube *et al,* 2025; Ogedegbe *et al,* 2025; Chavula *et al,* 2023). In South African HEIs, whilst some SRHR services may be free, students sometimes face costs for contraception, medications, or transport, limiting access (Sanyang *et al,* 2025; Holtman *et al,* 2024). Studies by Sanyang *et al* (2025) and Holtman *et al* (2024) reveal that several students end up failing to access SRHR services due to their financial inability to afford consultation fees for SRHR services at clinics, private providers, or university health centres; high cost of contraceptives that may not be fully subsidized; exorbitant costs of pregnancy-related services; high price of menstrual health products which has often resulted in what has been termed as "period poverty"; out-of-pocket payments for STI/HIV testing and treatment or any other SRHR-related medications; and financial burden of transportation to external clinics or hospitals when campus services are limited or unavailable.

In some cases, HEIs students have inadequate medical aid or insurance coverage which ultimately leaves students unable to pay for essential SRHR services such as hormonal therapies or post-exposure prophylaxis (PEP), high SRHR service administrative costs such as travel costs, legal documentation, private counselling and digital data for accessing to tele-SRHR services or online SRHR information at a time when many students are financially dependent on parents/guardians, or National Student Financial Aid Scheme (NSFAS) bursaries (Mwamba *et al,* 2022; Musakwa *et al,* 2021). Most of the NSFAS-funded students are financially struggling, with a combined annual household income threshold not exceeding R350 000 (around US$20 500), and in the year 2023, NSFAS funded around 66 percent of students enrolled in public universities in South Africa and 34 percent of students enrolled in Technical and Vocational Education and Training (TVET) colleges (NSFAS, 2025). Moreover, NSFAS funding often covers accommodation, food, transport, data, and textbooks costs leaving meagre funds for healthcare-related expenses, with studies having revealed that NSFAS funds are often fraught with payment problems, eligibility disputes, and under-coverage; hence the suggestion that NSFAS may need to introduce SRHR vouchers for HEIs students (Mwamba *et al*, 2022).

Over and above financial barriers to SRHR service access, HEIs students in South Africa are also affected by institutional policy limitations. Specifically, institutional policies, bureaucratic procedures, or unclear referral systems in various HEIs often delay or prevent students access to SRHR services. Mathabela *et al* (2024) implore institutional and policy-related constraints within HEIs settings which create environments in which SRHR services are fragmented, delayed, or inaccessible, whilst rigid institutional policies, such as formalised consent requirements, limited service mandates within campus clinics, and inconsistent implementation of national SRHR guidelines, often restrict timely access for students who require confidential or immediate care. The above constraints are further exacerbated by bureaucratic procedures, including lengthy administrative processes, unclear referral pathways to external health facilities, and poor coordination between campus health units and the public health system (Mathabela *et al,* 2024). Additionally, there may be gaps in integrating SRHR services within student health programs. Thus, an interplay of rigid institutional regulations, opaque administrative pathways, and inadequately integrated health systems all produce an entrenched architecture of exclusion that

subtly yet systematically constrains the timely and equitable access to comprehensive SRHR services by students in HEIs.

Conclusion and Recommendations

This article study reveals how the pursuit of higher education in South Africa unfolds within institutional landscapes marked by profound inequities in SRHR services access. The findings illuminate not only the persistence of financial, socio-cultural, policy, and structural barriers, but also the subtle ways in which these forces converge to delimit the autonomy of students in South African HEIs, their wellbeing, and full participation in academic spaces. Ultimately, addressing these entrenched obstacles demands a transformative, multisectoral reimagining of university health ecosystems - one that centres student agency, equity, and justice as foundational to the future of South African higher education.

Based on the findings that emerged from the analysis, the article makes five key suggestions. First, HEIs are encouraged to embark on institutional policy reform to streamline access to SRHR services and minimize bureaucratic impediments and ensuring clear referral pathways for students. Second, HEIs should integrate SRHR services into existing student health programs, emphasizing holistic care that addresses prevention, treatment, and counselling while remaining sensitive to students' diverse cultural and social contexts. Third, HEIs have to make financial accessibility interventions through targeted financial support mechanisms, including subsidized SRHR services and include SRHR packages as part of student health insurance, to mitigate financial barriers that disproportionately affect marginalized student populations. Fourth, HEIs must ensure the provision of youth-friendly service specialized training to ensure that SRHR services are nonjudgmental, confidential, culturally competent, and attuned to the developmental and psychosocial needs of students. Lastly, there should be campus-based stigma reduction and awareness campaigns in HEIs to actively challenge stigma, discrimination, and restrictive gender norms surrounding SRHR service delivery so as to foster an environment of inclusivity and informed decision-making within HEIs.

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