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Awareness Without Access: Exploring University Students' Perceptions of SRH Education in Nepal

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Abstract

Sexual and Reproductive Health (SRH) education is a very important aspect for the overall development of students. However, in a conservative educational context like Nepal, this topic has not yet received enough attention, due to which it has become an under-addressed topic. The aim of this study was to understand the perceptions of university-level students on SRH education. A quantitative approach was used for this. Supplementary qualitative data were used only for triangulation.

A census sampling method was adopted. An online survey form was distributed to all 769 undergraduate students of the Faculty of Education. Despite several follow-ups, only 480 students responded. Thus, the response rate was 62.4%. To further enrich the findings, six students from non-health backgrounds were purposively selected. Out of them, three were male and three were female. In-depth physical interviews were conducted with them. Chi-square test was used for quantitative data analysis. Thematic analysis was adopted for data triangulation.The results showed that 87.5% of the students understood the importance of comprehensive sexuality education (CSE). Similarly, 90.6% of the students said that early intervention is needed to inform about it. However, a large gap was still seen in CSE access. Only 36.2% of students believed that their college provided adequate resources for sexuality information. Similarly, only 53.1% of students felt that a safe space was needed to discuss CSE. For female students, social stigma was a major barrier to accessing information on sexuality. Bivariate analysis showed that students who were male, older (26-35 years) and had highly educated parents, especially mothers, had more positive perceptions about SRH (sexual and reproductive health). Students have high awareness regarding SRH. However, due to

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social structures and cultural barriers, they do not have access to adequate knowledge. Therefore, colleges should include gender-sensitive and inclusive SRH education not only in health subjects but also in other subjects, which helps break the cycle of stigma and silence. Additionally, counseling services need to be provided to create a safe and supportive environment where all students can access reliable and competent health information.

Keywords: Sexual health education, Comprehensive sexuality education, Sexual and reproductive health, Stigma, Taboo

Background

Sexual and reproductive health (SRH) education is extremely important.

Especially during adolescence and young adulthood, when people begin to form relationships, understand their bodies, and explore their identities (Flanagan, 2024; Crooks et al., 2024). It teaches students how to build respectful relationships, understand consent, protect themselves from infection, and make informed decisions about their bodies and emotions. Therefore, comprehensive sexuality education (CSE) is not limited to knowledge about biology or reproduction; it also plays a significant role in the overall development and health improvement of human society (Byers et al., 2003; Simon, 2024). Although students have come to understand the need for information on sexual health, many are still unable to access accurate information due to various barriers. As a result, they are receiving incomplete or harmful information.

Many countries in South Asia, including Nepal, often prohibit talking about sexual issues in schools and communities. Cultural, religious, and social beliefs prevent open discussion, which can leave students with more questions than answers (Evans et al., 2000; Tohit & Haque,2024; Mulholland et al., 2025). Many parents feel uncomfortable talking to their children about sexual and reproductive health issues. In addition, teachers may lack the training and teaching materials needed to teach effectively. As a result, young people often obtain information about sex education from friends, social media, or online sources, especially pornography (Ezeji & Uwizeyimana, 2025; Muili et al., 2025). Getting information from the Internet is beneficial and a useful tool. However, the Internet contains a lot of misinformation, myths, and unrealistic portrayals of sex and relationships, which can lead to confusion, anxiety, and risky behavior. Therefore, it is very important to have the right guidance before accessing sex education information via the Internet.

According to the World Health Organization, approximately 20 million new cases of sexually transmitted infections (STIs) occur among adolescents worldwide each year, which has increased the need for accurate and inclusive sexual and reproductive health (SRH) education (Sinka, 2024; Zhang et al., 2022). Access to high-quality sexuality education and services can help effectively address a variety of sexual challenges. Studies have shown that students who receive appropriate CSE are more likely to delay the onset of sexual activity. Additionally, adopting safe sex practices and communicating openly with their partners about sexual relationships improves their understanding and decision-making skills (Edison et al., 2025;

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Garcia-Barba et al., 2025). Similarly, appropriate sexuality education can also help students understand consent, develop knowledge about gender equality, and emotional health.

However, due to geographical conditions, not all students have equal access to sex education. At the school level, important topics such as contraception, sexually transmitted infection prevention, and healthy relationships are often ignored in the curriculum. Often, the curriculum focuses primarily on abstinence. Evaluations show that sexual health education lessons are likely to be omitted, especially in rural or under-resourced schools (Khau, 2012; Okoh et al., 2025). When teaching CSE in the classroom, curricula may not fully address the diverse experiences and identities of all students. LGBTQ+ youth in particular may feel marginalized or ignored when lessons are often limited to heterosexual relationships or use gendered language that does not align with their identity. In such situations, they may hesitate to ask questions or seek accurate information. (Bates et al., 2020; Harris et al., 2025). A lack of inclusive content in the curriculum can make students feel invisible or embarrassed. It makes them afraid to ask questions and creates difficulty in finding the right information.

Accessibility is not just about sex education in the classroom, but also about students having easy access to the information they need in a safe environment. This includes students being able to talk openly about sexual health issues, getting confidential counseling or health care, and having easy connections with trusted adults around them. Unfortunately, lack of access makes students afraid or uncomfortable to talk about sensitive topics like pregnancy, sexually transmitted diseases, or abusive relationships. This makes it difficult for them to get accurate information and make safe decisions (McKay et al., 2025; Diede &Holland, 2025). One study found that in some places, as many as 60% of teenagers had never talked about sexual health with a parent, teacher, or health worker. This clearly shows how serious the lack of communication is (Flanagan, 2024; Ndugga wt al., 2023).

Another major concern is how sexual and reproductive health education is being taught. The current era has become a digital age, due to which the number of students using smartphones and social media has increased. Therefore, digital platforms have become the main source of information on sexuality education (Gikas & Grant, 2013; Antala &Kariya, 2025). While apps and websites can make learning easier and more personal, they cannot guarantee that they provide accurate and relevant information. Therefore, schools should create a confidential and student-friendly environment where students can feel comfortable sharing real-life experiences. They can also act as a guide for students to determine whether what they see on the Internet is accurate or not (UNESCO, 2018; ITGSE, 2009; SEICUS, 2002).

To truly improve sexual health education, we need to understand a lot about students. What do students think about sexuality education lessons? Are they finding sexuality education information useful and accessible? Are they comfortable asking questions to teachers during class? If the school cannot answer, where do students turn for information? Only by understanding students' perspectives on CSE, teachers and policymakers can create programs that are not only informative but also respectful, inclusive, and empowering (Smith et al., 2017; Trivelli & Sita, 2025).

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Therefore, in this era, there is a need for honest, evidence-based and compassionate guidance for students. Without the right guidance, students can constantly receive mixed, incorrect and harmful informations about sexuality from social media, movies and peers, which is absolutely not right for the development of adolescents (Helmer et al., 2015). Implementing the right approach to sexuality education information not only prevents problems, but also helps young people build healthy and happy lives.

Therefore, this research examined the perceptions of postgraduate students towards sexual and reproductive health, based on their thoughts, feelings and experiences. Sexual health education is not about fear or shame; rather, it is about giving young people the knowledge and skills they need to grow, build relationships and take care of their health." Sexual health education should not be about fear or shame; it should be about giving young people the tools they need to grow, connect and take care of themselves.

Methodology

This study used a quantitative research design and included qualitative data for triangulation. A structured online survey was used to collect quantitative data. In addition, in-depth interviews were conducted with six participants in person, which helped to confirm and extend the quantitative findings. Kathmandu Valley is known as the educational, cultural and political center of Nepal, from where many scholars have emerged. Tribhuvan University, located in the same valley, is the oldest and largest educational institution in the country, which has been continuously providing higher education opportunities to students from different socio-economic, ethnic and geographical backgrounds. For this reason, the university is considered an ideal site for research on sexual and reproductive health in higher education. Quantitative data were collected online from a total of 480 students using census methods.

Instrument Development and Validation

Self-administered online questionnaire was used for data collection. Questionnaire was developed on Google plateforms due to several semesters were run by online classess. Questionnaire was designed based on the five-point Likert scale: strongly agree (SA), agree (A), not sure (NS), disagree (DA), and strongly disagree (SD).

The questionnaire was pre-tested with 10% of the sample population from similar educational settings outside the main sampled. Based on the responses, revisions were made to improve clarity and relevance and Cronbach's alpha was also calculated to check the internal consistency of the questions, which demonstrated acceptable internal consistency with a Cronbach's alpha of 0.70, indicating good reliability.

Physical mode was used for the qualitative information. Six students, 3 males and 3 females were purposively selected from non-health subjects. Semi-structured in-depth interviews were conducted to validate and triangulate the survey data. Interview guideline was used. Mainly focused on personal understanding of sexual health, challenges in receieving information on CSE, and perceived ability to engage in discussion or advocacy. Interviews were audio-recorded with consent, transcribed verbatim, and anonymized for analysis. Pseudonyms were also used to protect confidentiality.

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Sample and Sampling Procedure

All master's level students enrolled in the Faculty of Education from the first to the fourth semester were included in the target population. The second semester enrollment was abscent. A total of 769 students were enrolled in 16 departments of the department, namely English Education, Mathematics Education, Social Studies Education, Health and Population Education, Economics Education, Nepali Education, EPM, Curriculum and Assessment, History Education, Political Science Education, ICT, Geography Education, Physical Education, Science Education, SNE.

The survey was distributed to the entire population using the census sampling method, which ensured broad representation across departments and semesters. 769 students were contacted through email addresses provided by the university administration. After several follow-ups, 480 students completed the questionnaire, ensuring a 62.4% response rate.

For qualitative information, six non-health major students were selected using purposive sampling in the physical mode. Three male and three female students were included to ensure a diverse gender perspective.

Data Analysis Procedure

The quantitative data collected was transferred from Google Forms to Microsoft Excel and analyzed in BM SPSS (version 26). Simple statistics such as frequency, percentage, mean, and standard deviation were used to understand the background of the students and their responses. Univariate and bivariate analyses, as well as chi-square tests, were used to examine the relationship between socio-demographic variables and the value of statements related to sexual and reproductive health.

Similarly, qualitative data were analyzed using thematic analysis. The information was transcribed and coded in Nepali, and recurring themes were identified through a process of rereading, coding, categorizing, and interpreting. Direct participant quotes were also used to clearly illustrate key findings.

Quantitative and qualitative data were integrated together in the interpretation phase, which enabled triangulation and helped to understand students' perceptions of sexual and reproductive health more comprehensively and clearly.

Ethical Considerations

Ethical approval was obtained from the Review Board of Research Committee of Tribhuvan University. Participants were completely voluntary and informed consent was provided in both Nepali and English languages.

Particularly, the confidentiality and anonymity of the participants were ensured. It was clear that participants had the right to withdraw from the study at any time. The collected data was kept in a password-protected file and personally identifiable information was anonymized using coding. The study ensured a safe and respectful environment for all participants without using critical or derogatory language. In this way, the participants' dignity and safety were maintained.

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Results

Socio- demographic

Table 1. *Students' Socio-demographic Characteristics (N=480)*

Variables	categories	Number	Percentage
Sex	Male	183	38.1
	Female	297	61.9
Age	Up to 25	189	39.4
	26-35	247	51.5
	36-45	44	9.2%
Ethnicity	Brahmin/ Kshetri	303	63.1
	Other	177	36.9
Religion	Hindu	420	87.5
	Non- Hindu	60	12.5
Place ofRural		270	56.3
Residence	Urban	210	43.8
Living status	Home	138	28.8
	Hostel	42	8.8
	Rent/Room	300	62.5
Education ofIlliterate		93	19.4
father	Basic Level	162	33.8
	Secondary Level	135	28.1
	More than secondary	90	18.8
Education ofIlliterate		225	46.9
Mothers	Basic Level	192	40
	Secondary Level	54	11.3
	More than secondary	9	1.9
Father	Agriculture	333	69.4
occupation	Job	66	13.8
	Business	42	8.8
	Daily wage labor	6	1.3
	Abroad	33	6.9
Occupation ofHousewife		438	91.3
Mother	Business	18	3.8
	Job	21	4.4
	Abroad	3	0.6
Marital Status	Married	219	45.6
	Unmarried	261	54.4
Job	Yes	204	42.5
	No	276	57.5

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Socio-demographic analysis shows some significant trends related to students' sexual health literacy. The student body is more female (61.9%), which may affect class participation and literacy-related behaviors. In terms of age, 51.5% of students fall into the 26–35 age group, which is consistent with the normal distribution of master level students. In terms of ethnicity, the sample is more Hindu (63.1%), and the Brahmin/Chhetri group is represented by 87.5%. In terms of residence, students from rural areas (56.3%) are slightly more likely to be in urban areas (43.8%), which may impact access to educational resources and health services. In terms of housing, many students live in rented rooms (62.5%), and a slight majority of students are single (54.4%). Regarding employment status, about 57.5% of students are unemployed, which may impact their time and resource management. The level of education of parents also plays an important role; 46.9% of mothers are illiterate while the majority of fathers (33.8%) have basic education. In addition, 69.4% of fathers are involved in agriculture and the majority of mothers are housewives (91.3%). These social and family background data indicate that students' sexual health literacy, access to and guidance from home have an impact.

Students Understanding Towards Sexual And Reproductive Health

Table 2. *Students' Perceptions of Sexual and Reproductive Health*

Statements	SA	A	NS	DA	SD
I feel that societal stigma makes it difficult to open a discussion	120 (25%)	240 (50%)	72 (15%)	36 (7.5%)	12 (2.5%)
CSE is essential for all students	225 (46.9%)	195 (40.6%)	36 (7.5%)	12 (2.5%)	12 (2.5%)
Parents should be involved in their children's sexual health education	183 (38.1%)	219 (45.6%)	60 (12.5%)	3 (0.6%)	15 (3.1%)
My college provides enough resources for sex health education	27 (5.6%)	147 (30.6%)	138 (28.8%)	117 (24.4%)	51 (10.6%)
I am satisfied with the sexual health education I have received	63 (13.1%)	207 (43.1%)	102 (21.3%)	93 (19.4%)	15 (3.1%)
Colleges provide more sexual health resources	168 (35%)	225 (46.9%)	54 (11.3%)	18 (3.8%)	15 (3.1%)
Talking about sexual health openly is important	99 (20.6%)	186 (38.8%)	33 (6.9%)	36 (7.5%)	126 (26.3%)
Sexual health education should start at an early age	164 (34.4%)	252 (52.5%)	27 (5.6%)	30 (6.3%)	6 (1.3%)
I believe sexual health education reduces rates of STIs	192 (40%)	243 (50.6%)	18 (3.8%)	12 (2.5%)	15 (3.1%)
I believe boys and girls should receive the same level of sexual health education	195 (40.6%)	222 (46.3%)	36 (7.5%)	18 (3.8%)	9 (1.9%)

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My college provides safe spaces for students to discuss sexual health concerns	51 (10.6%)	204 (42.5%)	102 (21.3%)	87 (18.1%)	36 (7.5%)
Access to contraception should be available to all students	102 (21.3%)	213 (44.4%)	99 (20.6%)	51 (10.6%)	15 (3.1%)
I feel confident in my knowledge about sexual health	96 (20 %)	276 (57.5%)	78 (16.3%)	21 (4.4%)	9 (1.9%)
Composite mean and SD= 3.79 ±0.49					

This study assessed the attitudes of master level students of the Central Department of Education towards sexual and reproductive health (SRH). Qualitative insights were collected from six students from different regions and disciplines in Nepal along with 480 quantitative responses. These quantitative participants were three men and three women, and their personal experiences added meaning to the survey findings.

As can be seen in the table, despite the positive awareness among the students, challenges still remain. Three fifth of the students (75%) agreed that it is difficult to discuss sexual health openly due to social stigma. A female participant from Kanchanpur shared her experience that "if a girl asks about menstruation or safety, she is labeled." This shows how stigma hinders communication among female students.

More than four-fifth (87.5%) of the students agreed with the importance of CSE, and 46.9% strongly agreed. This highlighted that the need to provide formal and structured education. Concerning gender equality in health knowledge, more than four-fifth (86.7%) of the students believed that both boys and girls should receive equal SRH education.

But, disparities in resources and access were still evident. Only more than one- third (36.2%) of students believed that their college provided adequate resources. A male student from Rolpa said, "We have no counselor, no pamphlets, nothing. If we have questions, we have to go to a friend or Google." Students from rural backgrounds experienced this sentiment more strongly.

There was also a lack of access to safe discussion spaces. Only 53.1% of students believed that their college provided a safe space for SRH discussions. Overall, more than half (56.2%) expressed confidence and satisfaction with SRH education and found moderate which was indicated by total mean and SD (3.79 ± 0.49).

On the positive side, 90.5% of students believed that SRH education helps reduce the risk of STIs and 90.6% agreed that it should be started early. A science student from Kathmandu said, "If we had received education about consent and safety in school, many of my friends would not have had to experience unwanted pregnancies or emotional trauma."

83.7% of students supported parental involvement, although some reported experiencing opposition or disagreement at home. An ICT student from Jhapa said, "Our parents still believe that sex education will encourage us to have sex." This shows a difference in generational attitudes and understanding.

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Students' confidence in their own knowledge remained limited; only 31.9% felt fully competent. 78.8% felt somewhat confident. Access to birth control also remained a topic of debate, with 65.7% supporting availability for all but 15.7% disagreeing or strongly disagreeing.

Ultimately, this study shows that there is a large gap between perception and practice. Lack of resources, social stigma, lack of adequate safe spaces, and inconsistent curricula limit students' real access. Therefore, inclusive, accessible, and culturally sensitive sexual and reproductive health education is needed, which extends beyond the classroom to help educate students in a safe and supportive environment.

Table 3. Bivariate Analysis (Chi-Square Significant) of Students Perceptions on Sexual and Reproductive Health N=480

Variables	Categories	Below/Average N	%	Above Average N	%	p-value
Sex	Male	66	36.1	117	63.9	0.004*
	Female	147	49.5	150	50.5	
Age	Up to 25	102	53.9	87	46.1	0.003*
	26–35	93	37.7	154	62.3	
	36–45	18	40.9	24	59.1	
Ethnicity	Brahmin/Kshetri	138	45.5	165	54.5	0.500
	Other	75	42.4	102	57.6	
Religion	Hindu	189	45	231	55	0.466
	Non-Hindu	24	40	36	60	
Place of Residence	Rural	114	42.2	156	57.8	0.282
	Urban	99	47.1	111	52.9	
Living Status	Home	54	39.1	84	60.9	0.113
	Hostel	24	57.1	18	42.9	
	Rent/Room	135	45	165	55	
Father's Education	Illiterate	45	48.4	48	51.6	0.026*
	Basic Level	84	51.9	78	48.1	
	Secondary Level	48	35.6	87	64.4	
	More than Secondary	36	40	54	60	
Mother's Education	Illiterate	108	48	117	52	0.001*
	Basic Level	93	48.4	99	51.6	
	Secondary Level	9	16.7	45	83.3	
	More than Secondary					

**Indicate that the statistically significant.*

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Bivariate analysis using the chi-square test (Table 3) shows significant relationships between students' sexual and reproductive health (SRH) perceptions and socio-demographic variables such as gender, age, and parental education. Gender was found statistically significant ($p = 0.004$). Male students were more likely to have above average perceptions (63.9%) than female students (50.5%). This result suggests something. Male students have easier access to SRH-related information through peer groups or informal sources. As a result, they appear to be more active on such topics. They are also more confident in participating in discussions. For example, a male mathematics student said: "In the hostel, we discuss relationships and sex. It is not formal, but we learn from each other." In contrast, a female English student from Kanchanpur said: "Girls do not discuss such topics openly even with close friends. There is always a fear of being judged." These stories show that gender influences access and comfort in SRH discussions.

Age also found statistically significant ($p = 0.003$). Students in the 26–35 age group showed above-average perceptions (62.3%), while students under 25 had the lowest (46.1%). This statistically significant may be related to their life experience, exposure to different perspectives, and personal relevance of SRH issues. A science student said: "As you get older, friends start getting involved in relationships, unplanned pregnancies, and STIs become more common. Then you start to realize the importance of this issue." Parental education was also a key factor determining SRH perceptions. Both father's education ($p = 0.026$) and mother's education ($p = 0.001$) were significant. Children of mothers with secondary or higher education demonstrated above-average perceptions (83.3% and 52%, respectively). Only 52% of children of illiterate mothers showed above-average perceptions. This highlights the importance of maternal education. A male student from Jhapa recalled: "My mother gave me pamphlets about menstruation and hygiene. It felt normal to talk about it at home." In contrast, a science student said: "My parents never taught me such things. I didn't even know what an STI was until I heard it from a friend."

No statistically significant associations were found for variables such as ethnicity, religion, place of residence, and residential status ($p > 0.05$), suggesting that individual and family factors determine SRH perceptions more than cultural or geographical background. However, qualitative data show subtle differences. A rural female student from Kanchanpur said: "Talking about sex is still taboo in our community. It is not comfortable to ask questions even in college." An urban male student from Kavre said: "There is a lot of information online, but not all of it is reliable. The college should provide clear sources."

In terms of quality of life, students living at home (60.9%) showed slightly higher perceptions than students living in hostels (42.9%), possibly due to family support or a stable environment. However, as hostel life encourages peer-based learning, informal networks act as a buffer in the absence of formal education.

According to this study, positive perceptions of SRH were mainly associated with male students, older age groups, and highly educated parents, especially mothers. Qualitative results showed that students studying non-health subjects reported gaining more knowledge

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from friends, family, and their own experiences than from formal courses. This highlights the need for inclusive and age-appropriate SRH education at the university level, especially for young students and children from less educated family backgrounds.

Discussion

The results of this study show that university students' perceptions of SRH are determined by a complex interplay of awareness, access, and socio-cultural factors. Although CSE has been given substantial theoretical support by the ITGSE, 2018, there are still clear gaps in knowledge, institutional support, and access among students. These gaps appear to be shaped primarily by factors such as parental education, gender, and age.

Nearly three-quarters (75%) of students agreed that social stigma prevents open and frank discussions on SRH issues, a striking finding. This is also consistent with global evidence that cultural taboos, particularly those related to female sexuality, can stifle SRH discourse and encourage the spread of misinformation (Tohit and Haque, 2024; Dimitrov et al., 2022). The experience of a female English student from Kanchanpur further illustrates this reality: in a conservative environment, young women face constant social pressure and stigma when seeking SRH knowledge, which further reinforces gender inequality.

Despite the obstacles, students clearly acknowledge the importance of SRH education. 90.6% of students believe that CSE should be started immediately, while 87.5% respond that it is very necessary. With early and age-appropriate SRH education available, students are more likely to delay sexual intercourse, encourage condom use, and reduce the risk of STIs and unwanted pregnancies (Ramaswamy, 2021; Lehn & Chahboun, 2025). Science student said, "If only we had learned about consent and safety earlier…," which is consistent with recent studies. These studies show that young people who receive SRH education late or not at all may be at risk during critical years of development (Chandra-Mouli et al., 2020; Okoh et al., 2025).

But perceptions and practices do not always match. Only 53.1% of students felt that they had a safe place to talk about concerns or SRH issues. Similarly, only 36.2% of students believed that their college confidently provided adequate SRH resources. Given that many students are starting their independent lives at university, such institutional neglect is particularly worrying. According to a male student in the mathematics department, informal peer networks have now become a major source of information, which sometimes increases reliance on unreliable data. Research shows that in the absence of structured guidance, students often rely on peer or internet-based sources, which often contain inaccurate or harmful information (Glazkova et al., 2025; Amigud & Pell, 2025).

Male students showed more positive SRH attitudes (63.9%) than female students (50.5%) and this gender difference was statistically significant. A male student's experience shows that in informal or casual settings, men are able to talk more freely about sexual and reproductive health (SRH) issues. They seem more confident in their (albeit inadequate) knowledge, while women remain more cautious due to fear of social consequences. Research in South Asia has

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shown that patriarchal norms perpetuate gender inequalities in discussions about sex, which is consistent with this finding (Bhopal, 2019; Simon & Hasan, 2025).

Another important factor is age. Students aged 26–35 years showed greater awareness of SRH. This suggests that even in the absence of formal education, experiences such as STIs or unwanted pregnancies among peers can serve as practical teachers. The experience of a male student illustrates that SRH knowledge is more relevant when it is personally related to real-life outcomes. This is consistent with longitudinal studies, which show that experiential learning can bridge the gaps created by weak curricula (Bood & Eriksen, 2025; Kudare, 2024).

Parental education, especially maternal education, plays a major role in SRH awareness. Mothers with secondary or higher education were significantly more likely (83.3%) to have above-average SRH awareness. The experience of a female student who easily received pamphlets and information about sexual and reproductive health at home from her mother, who was herself a teacher, shows that educated mothers can help normalize this topic at home. International studies have also identified maternal education as a key indicator of adolescent health literacy (Naigada et al., 2015; UNICEF, UNESCO, 2018). On the other hand, the experience of a male student from Rukum shows how silence at home can pass on stigma from generation to generation. This suggests that such social barriers need to be addressed through community-level awareness programs.

Interestingly, ethnicity, religion, and place of residence were not statistically significant. This suggests that perceptions of SRH in this group are more influenced by personal experiences and family background, rather than by general cultural identity. Qualitative data, such as information from a man from Kavre and a woman from Kanchanpur, show that rural-urban differences in terms of accessibility and comfort are still evident, although they are not clearly reflected in the total score. This confirms that quantitative data alone cannot capture the true complexity and the need for a multi-method approach.

Although Nepali university students support SRH education, their access and confidence are still limited due to structural and cultural barriers. The study data and the students' personal experiences show that there is a need to include comprehensive and gender-sensitive SRH education in non-health subject curricula, provide mentors, create safe discussion spaces, and specifically involve mothers. Various studies from around the world have also shown that young people have access to SRH education, which has positive social, educational, and health-related impacts (Sidamo et al., 2025; UNESCO, 2018). Universities must become places of empowerment where all students, regardless of gender, background, or discipline, can access the information they need to succeed, overcoming stigma and silence.

Conclusion

This study shows that master level students strongly support SRH education. However, significant gaps in its access remain due to social stigma, gender norms, and lack of budget. Many students rely on informal and often unreliable sources, but awareness is high, especially among older students and educated parents, especially mothers. In addition to the lack of safe

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spaces and organized programs on campus, female students face significant social barriers. The results show that all students can access accurate, private, and inclusive sexual health information. Therefore, comprehensive and gender-sensitive SRH education needs to be included in the curricula of all non-health departments. This should be coupled with counseling services and active parental involvement.

Limitations

Although the study methodology was rigorous, there are some limitations. The participants provided self-reported data, which may have introduced social desirability bias. In addition, the 62.4% response rate may limit the generalizability of the results. As data on second-semester enrolled students were not available, the semester included in the analysis may have influenced the representativeness. However, the complementary qualitative approach and the inclusion of participants from diverse subject backgrounds strengthened the depth and credibility of the results.

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