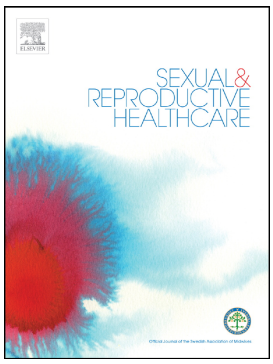

Ukrainian students' conceptualisations of sexual and reproductive health and rights within a transformative learning programme during wartime: a qualitative study

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Title: Ukrainian Students' Conceptualisations of Sexual and Reproductive Health and Rights within a Transformative Learning Programme During Wartime: A Qualitative Study

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Ukrainian Students' Conceptualisations of Sexual and Reproductive Health and Rights within a Transformative Learning Programme During Wartime: A Qualitative Study

Highlights

- The international SRHR course provided a context for reflection on SRHR in wartime Ukraine.
- Pre-course responses conceptualised SRHR mainly in biomedical and informational terms.
- Post-course focus group reflections included broader rights-based, ethical, social, and professional dimensions of SRHR.
- Participants discussed SRHR in relation to institutional responsibility, structural barriers, and youth-friendly services.
- Transformative learning in higher education related to SRHR may support professional reflection.

Abstract

Background: Sexual and reproductive health and rights (SRHR) education is particularly important in wartime Ukraine, where young people face disrupted access to services, persistent socio-cultural taboos, and increased vulnerability related to conflict. However, little is known about how Ukrainian students and future professionals understand and make sense of SRHR.

Objective: This study explored how SRHR was conceptualised in pre-course written responses and articulated in post-course focus group reflections, and how these framings related to students' future professional readiness in wartime Ukraine.

Methods: A qualitative exploratory design was used. Data comprised pre-course open-ended responses (n = 15) and post-course focus group discussions (three groups; n = 16) from voluntary participants of the same international SRHR course. The two datasets were analysed using framework analysis and treated as complementary qualitative sources rather than as matched individual-level pre-post data.

Results: Pre-course written responses showed that students mostly understood SRHR in biomedical and informational terms, focusing on reproductive health, contraception, sexually transmitted infections, and access to medical services. In post-course focus group reflections, SRHR was discussed more broadly, with attention to psychological, social, ethical, institutional, and rights-based dimensions: students reflected on professional responsibility, youth-friendly services, structural barriers, and the importance of SRHR in the context of war.

Conclusions: Transformative learning-based SRHR education provided a useful context for broader reflection on sexual and reproductive health and rights among future professionals. Integrating such courses into higher education may support professional reflection and preparedness for SRHR-related practice during war and post-war recovery in Ukraine.

Keywords: sexual and reproductive health and rights (SRHR), Ukrainian students, transformative learning, qualitative study, wartime Ukraine, higher education, professional readiness

Introduction

Sexual and reproductive health and rights (SRHR) are a key component of public health, gender equality, and social equity. They are also embedded in international human rights, public health, and sustainable development frameworks, including the right to health and non-discrimination [1]. The implementation of SRHR remains relevant across both developing and highly developed countries, although the specific challenges differ and may include early marriage, limited access to sexual, reproductive and perinatal services, and gaps in SRHR education [2, 3, 4, 5, 6].

In Ukraine, the topic of SRHR is particularly acute due to several deeply rooted socio-cultural factors [7]. Historically, attitudes towards sexuality have been strongly influenced by Christian tradition, which was hostile to its expressions [8]. Sex was considered acceptable only within legal marriage for the purpose of reproduction. This conservative foundation was further strengthened by the Soviet legacy, marked by the suppression of sexuality and the promotion of what later became known as “prudish desexualisation” and “sexless upbringing” [9]. Such a combination of historical attitudes has created an environment where open discussion of SRHR remains stigmatised [7].

The full-scale war in Ukraine has triggered a multidimensional crisis in the field of reproductive health among young people, which goes beyond purely medical and logistical problems. War is a powerful determinant of biological and behavioural changes, including the domain of reproductive health [10], while collective trauma reshapes patterns of sexual behaviour and significantly affects sexual well-being [11]. In a humanitarian crisis, adolescents and young people often become a “forgotten group”, and their SRHR needs to take a back seat. Population migration, reduced access to healthcare and contraception, and sexual violence are the most common and significant factors directly contributing to the spread of sexually transmitted infections (STIs) during armed conflicts [12]. In times of crisis, young people often turn to informal sources for information. This significantly increases the risks to their health, including the likelihood of unwanted pregnancies and STIs. The situation is further complicated by the fact that sex education in Ukrainian schools does not fully comply with UNESCO international standards, leaving young people without adequate knowledge and support [13].

In Ukraine, SRHR education and awareness are promoted by both international agencies, notably the UNFPA, and non-governmental organisations, as well as the Ministries of Health, Education and Science [7, 14, 15]. The new State Standard for secondary education mandates the development of competencies in reproductive health and responsible sexual behaviour among

high school students, which, in turn, requires training qualified specialists and developing appropriate educational programs. However, due to the long-standing taboo surrounding SRHR topics, comprehensive educational initiatives remain limited. This highlights the need to integrate SRHR into higher education to train competent professionals, including doctors, psychologists, sociologists, and social workers. However, less is known about how students themselves make sense of SRHR when participating in such educational initiatives, especially in the context of war, where professional responsibility, rights-based approaches, and access to care become particularly salient.

The aim of this study was to explore how SRHR was conceptualised in pre-course written responses and articulated in post-course focus group reflections from participants in the same international SRHR course. The study also examined how these framings related to students' reflections on future professional readiness in the wartime Ukrainian context.

Methods

Study context and educational programme

To address gaps in SRHR education, the international Swedish–Ukrainian project "Sexual and Reproductive Health and Rights of Youth in Wartime and the Post-War Future: Education and Promotion of Online Youth and Young Adult Consultations" was implemented with funding from the Swedish Institute through the SI Baltic Sea Neighbourhood Programme. The project was carried out by Dalarna University in cooperation with three Ukrainian universities and aimed to strengthen SRHR education and train specialists through a peer-to-peer approach [16, 17, 18]. The project drew on the Swedish rights-based and value-based approach to SRHR, which has been described as grounded in human rights, solidarity, equity, and gender equality [19]. **In the present project, this approach was used as an educational reference point for discussing SRHR in wartime Ukraine, particularly in relation to autonomy, bodily integrity, non-discrimination, ethical and social responsibility, accessibility of care, and professional sensitivity to crisis-related SRHR needs.**

As part of the project, the course "SRHR of Adolescents and Young People in Ukraine" was held from April to November 2024. Its aim was to equip future specialists in medicine, psychology, sociology, and social work with the knowledge and skills to support patients and clients in SRHR-related consultations. Forty students and ten teachers from Lviv Polytechnic National University, Ivan Franko National University of Lviv, and Odesa National Medical University participated in online seminars and lectures delivered by Dalarna University faculty. After

completing the course, the course participants conducted peer-to-peer seminars for younger students under the guidance of their lecturers (these younger students were not participants in the present study).

Methodological basis of the training programme

The theoretical basis of the course curriculum was transformative learning theory proposed by J. Mezirow [20]. The main assumption of this theory is that people perceive the world through "perspectives of meaning," that is, mental structures that shape their worldview. These deep-rooted beliefs can be challenged **through critical reflection,** particularly in response to a crisis or a "disorienting dilemma" [21]. Transformative learning extends beyond simple knowledge accumulation and focuses on reconsidering **established meaning perspectives,** which is **particularly relevant** for future professionals in SRHR.

The principles of transformative learning were implemented by involving participants in analysing Sweden's experience in SRHR and comparing it with the Ukrainian context. This approach, based on the study of "contrasting" models**, created opportunities for critical reflection on established ideas and sociocultural norms related to SRHR. The wartime Ukrainian context provided an additional basis for reflection, linking course content to professional responsibility, ethical sensitivity, and rights-based approaches to SRHR in crisis conditions.**

The educational intervention was a 7.5 ECTS course, structured into thematic modules combining national and international perspectives on SRHR, including sexuality and consent, reproductive health, andrology and gynaecology, gender and identity, perspectives of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and others (LGBTQ+), relationships, risk behaviours, mental health, violence, and the impact of war and conflict. Teaching followed a flipped classroom model, utilising pre-recorded lectures, course literature, and digital resources via the course platform, complemented by interactive online seminars that focused on discussion, applied tasks, and peer learning. An integral component of the programme pedagogics was an individual self-reflection logbook, in which students documented reflections on course materials, seminar discussions, and evolving perspectives on SRHR throughout the training.

Research design

A qualitative two-stage exploratory design was used to examine students' conceptualisations and reflections on SRHR through pre-course written responses and post-course focus group discussions conducted within the same educational programme (Figure 1).

Figure 1. about here

At the first stage, before the training course began, an open-ended questionnaire was administered. At the second stage, after the course was completed, focus groups were organised for post-reflective analysis. This design enabled the analysis of two related qualitative datasets collected for the same educational programme: pre-course written responses and post-course focus group reflections. The datasets were treated as complementary sources rather than as matched individual-level pre-post data.

Participants

The study involved students who voluntarily enrolled in an SRHR training course. Recruitment to the course was based on self-selection, reflecting participants' academic or professional interest in SRHR-related topics. **Students were first enrolled in the SRHR course, after which all course participants were invited to participate in the research component of the project.** Participation **in both stages of data collection** was **entirely** voluntary and independent of course completion. **The pre-course questionnaire and post-course focus groups involved partially overlapping groups of students from the same course cohort. Therefore, the datasets should not be considered matched pre-post data at the individual level.** Participants were informed about objectives and procedures, provided informed consent, and were assured of confidentiality and anonymity in accordance with the principles of ethical research. Fifteen participants completed the questionnaire (13 female and 2 male; 4 psychology students, 4 social work students, 1 sociology student, and 6 medical students). Sixteen students participated in the focus groups: one group of psychology, social work, and sociology students (5 females) and two groups of medical students (6 and 5 participants, respectively; 3 males and 8 females in total). A summary of participant information is provided in Table 1.

Table 1. about here

Data Collection Procedure

The questionnaire and focus group guide were developed specifically for this study by the Ukrainian research team of psychologists and sociologists. Their thematic content was formed by

the aims and learning outcomes of the SRHR course, international guidance on comprehensive sexuality education and rights-based SRHR [13], literature on young people's SRHR knowledge, information and service needs [2, 22], and research concerning the Ukrainian socio-cultural and wartime context [8, 9, 10]. The focus group guide was additionally informed by the professional and higher-education orientation of the broader Swedish–Ukrainian SRHR initiative [5, 17] and by transformative learning theory [20, 21]. The research team reviewed the proposed questions and refined their wording and thematic coverage to ensure relevance to the study aims and the Ukrainian educational and wartime context. **Both instruments included questions that invited participants to reflect on SRHR in relation to adolescents and young people, while also addressing SRHR more broadly.**

Stage 1: Questionnaire. Before the course began, participants completed a questionnaire designed to capture their initial understandings of SRHR and the associated cultural and value-based attitudes. The questionnaire consisted of open-ended questions and was organized into five thematic blocks: (a) interpretation of key concepts ("sexual health," "reproductive health," and "rights in this field"); (b) cultural context, including perceptions of taboo and sensitive topics in Ukrainian society; (c) the impact of war, particularly challenges related to reproductive rights in the wartime context; (d) personal boundaries, referring to topics respondents considered unacceptable for discussion; and (e) information needs of young people in the field of SRHR.

Stage 2: Focus group discussions. The aim of this stage was to explore students' post-course reflections on SRHR, future professional practice, and SRHR-related challenges in wartime Ukraine, **particularly as they relate to adolescents and young people**. The discussions focused not on participants' personal sexual or reproductive experiences, but on their educational experience, professional reflections, and perceptions of SRHR-related issues. The focus groups were moderated using a semi-structured discussion guide covering the following themes: (a) students' reflections on their understandings of SRHR before and after the course; (b) evaluation of the course content, including useful and difficult topics and cultural differences; (c) opportunities and barriers to applying acquired knowledge **when supporting adolescents and young people in professional settings**; and (d) strategic visions for the future development of SRHR **for young people** in Ukraine.

Data Analysis

Framework analysis was employed to process the collected data [23, 24]. This method enables the exploration of how individuals construct and interpret social reality by highlighting certain aspects of a problem while minimising others. Framework analysis views discourses as constitutive of reality rather than merely descriptive of it and focuses on interaction and discursive exchange. All data were collected and analysed in Ukrainian, which was the native language of the participants and the Ukrainian members of the research team. Quotations presented in the manuscript were translated into English during manuscript preparation. The questionnaire responses and focus group transcripts were treated as two related but distinct datasets throughout the analysis.

The analysis process included several sequential stages:
Familiarisation. The authors (L.K., M.K., H.H., I.H.), each from different backgrounds, read the full dataset (questionnaire responses and focus group transcripts) several times to gain an overview and to note initial ideas, including recurring themes and strongly contrasting views.

Coding. Co-authors independently conducted initial open coding of the questionnaire responses and focus group transcripts, labelling relevant segments with descriptive codes. Coding was done manually due to the limited volume of data. The team then compared coded excerpts in consensus meetings, discussed differences in interpretation, and refined code labels and boundaries.

Developing a working analytical framework. An analytical structure was constructed by grouping initial codes into higher-order categories. All transcripts of open-ended questionnaire responses and focus group discussions were systematically reviewed. For each coded sequence, members of the research team discussed why it was interpreted as meaningful, what it revealed about participants' perceptions of SRHR, and how it contributed to addressing the research questions. Following the discussion, the research team reached consensus on a set of codes, each accompanied by a brief definition, which together constituted the initial analytical framework. During this process, it was identified that several codes were conceptually interrelated and could be meaningfully clustered into higher-order categories. For instance, the codes "*cultural and religious attitudes", "socio-economic conditions",* and *"wartime in Ukraine"* all referred to broader background factors shaping participants' understanding of SRHR. These codes were therefore grouped under the overarching category **"**Contextualising SRHR**".** The final analytical framework comprised five categories, each accompanied by a concise explanatory description and illustrative examples of the ideas or phenomena captured within each code. Clear definitions

for individual codes were used to promote consistency of coding across the research team. An example of how individual codes were grouped into a higher-order analytical category is presented in Table 2, using the category "Contextualising SRHR" as an illustration.

Table 2 about here

Applying the analytical framework (indexing). Indexing involved the systematic application of the developed codes to the entire dataset, including focus group transcripts and open-ended questionnaire responses. All transcripts were indexed independently by the authors (L.K., M.K., H.H., I.H.) using the final analytical framework.

Charting data into the framework matrix. Charting involved summarising the coded data and organising it into a matrix to allow for a compact representation while preserving the original meaning. Coded data were summarised and charted into matrices in separate tables. Matrices were organised by analytical category and by data source (questionnaires and focus groups). Summaries were kept close to participants' wording and linked to verbatim excerpts to preserve meaning and facilitate transparency.

Interpreting the data. Interpretation involved in-depth analytical reflection on the systematised data, including the identification of patterns, the development of explanatory interpretations and typologies, and the comparison of findings with existing theoretical concepts and empirical literature.

Results

The findings are based on pre-course written responses from 15 students and post-course focus group discussions with 16 students from the same SRHR course cohort. The two voluntary samples partially overlapped and included students from medicine, psychology, sociology, and social work.

The framework analysis identified five interrelated analytical categories through which participants conceptualised and discussed SRHR: contextualising SRHR, institutional responsibility, barriers to SRHR realisation, pathways for action, and understandings of SRHR. These categories were present across both data sources, but were articulated differently. Pre-course written responses primarily captured concise individual accounts of socially available meanings, common assumptions, and perceived knowledge gaps. Post-course focus group discussions provided more elaborated reflections on SRHR, including rights-based language, institutional responsibility, and professional application. Since the two subsamples were only partially overlapping, the analysis does not claim individual-level change. Instead, it examines differences in SRHR framings across the two qualitative phases of the study.

Each quotation is followed by an anonymised identifier indicating the data source and participant number (Q = questionnaire response; FG = focus group participant). To minimise the risk of indirect identification, gender, field of study, and age were removed from quotation labels.

Analytical Category 1: Contextualising SRHR

This category captures how participants located SRHR within broader social, cultural, and wartime conditions in Ukraine. Rather than treating SRHR as only a matter of individual knowledge or personal choice, they connected it with taboo, conservative norms, limited access to reliable information and services, and the ongoing war.

In the pre-course written responses, these factors were mostly described as background conditions influencing young people's access to knowledge, support, and healthcare. Sexuality was presented as a topic that is rarely discussed openly and is often surrounded by shame, moral judgment, and fear of public disapproval: *"People don't talk about them (sex and reproductive health), it is still shameful to bring this into the public because others will bully you. This is a problem, since Ukrainians also do not receive sexual education, while at the same time conservative narratives and the fear of discussing sexual issues are simply passed down from generation to generation"* (Q3).

War appeared as another central contextual frame. In the written responses, it was described as a condition that threatens rights in general and pushes SRHR into the background, including through changes in intimacy and priorities: *"This provokes the situation where, for most people, sex may serve as 'discharge,' a way to release tension, rather than an intimate contact with a person. Rights to sexual and reproductive health are pushed into the background"* (Q3). In the focus groups, the wartime context was discussed more as a practical and professional challenge: participants linked it to disrupted access to services, the need for confidential support, sexual violence, displacement, and the responsibility of institutions and future professionals. One participant summarised this hierarchy of concerns directly: *"The most important thing right now, I believe, is the war"* (FG2-P1).

Overall, participants interpreted SRHR through the lens of broader social and wartime realities. In the pre-course responses, these realities were mainly described as conditions that shape young people's experiences. In the focus groups, participants more often reflected on their implications for professional practice and institutional action.

Analytical Category 2: Institutional responsibility

This category reflects participants' understanding of the role of institutions in supporting SRHR. In the pre-course written responses, institutional responsibility was most often associated with access to healthcare, information, legal protection, confidentiality, and reproductive services. Institutions were primarily viewed as providers of individual services and rights. For example, one participant defined reproductive rights as including *"the right to reproductive health – the right to free examinations, as well as access to treatment and abortions"* (Q3).

In the focus groups, participants discussed institutional responsibility in broader and more interconnected terms. Rather than referring only to individual services, they emphasised the need for coordinated action across healthcare, education, social services, public authorities, and civil society organisations. Participants highlighted the importance of youth-friendly services, professional training, and mechanisms that would ensure access to support in wartime conditions. As one participant noted, there is a need for *"Mobile clinics, hotlines for consultations. Anonymous hotlines for consultations, where there would be specialists able to competently answer questions. Also, access to contraception, access to certain laboratory diagnostics as preventive measures, along with chatbots and support lines"* (FG2-P3).

Educational institutions were also discussed as key actors in SRHR promotion. Participants emphasised that SRHR should be introduced systematically at different levels of education, from school to professional training. One participant linked school-based SRHR education with the prevention of unwanted pregnancies and diseases: *"If this were really implemented somewhere at the level of secondary school, starting from Year 5* [note: Year 5 corresponds to ages 10–11], *then everything would be fine, there would be fewer unwanted pregnancies and diseases"* (FG3-P1). Another participant stressed the need to *"Integrate issues of sexual and reproductive health into the curricula of medical universities as well. Organise training sessions for medical professionals"* (FG2-P1).

Overall, institutional responsibility was present in both datasets, but it was articulated differently. In the written responses, the focus was primarily on access to individual rights and services. In the focus groups, participants more often described SRHR as requiring coordinated institutional and professional action across multiple sectors.

Analytical category 3: Barriers to SRHR realisation

This category reflects how participants understood the barriers that limit young people's access to sexual and reproductive health and rights. In the pre-course written responses, these barriers

were most often described at the level of knowledge, communication, and personal experience: lack of reliable information, absence of systematic sexuality education, shame, fear of judgment, and difficulty discussing sexuality openly. One participant noted that *"young people often learn about the nuances of sexual life on the internet, and they cannot always see whether that information is true or not"* (Q6). Another emphasised the emotional and social difficulty of speaking about SRHR: *"The topic of reproductive health and abortion often provokes controversy in society, making it hard to discuss openly without fear of judgment"* (Q5).

In the focus groups, barriers were discussed more often as interconnected cultural, legal, institutional, and economic constraints. Participants linked shame and silence not only to individual discomfort, but also to family norms, parental control, lack of confidential services, legal restrictions, and insufficient institutional support. For example, one participant expected resistance from parents if SRHR topics were introduced in schools: *"Many parents will write refusals for their children not to attend* [note: lessons with topics dedicated to SRHR] *because it is 'too early,' 'they are too young,' 'why is it needed,' or 'better to explain it at home'"* (FG1-P1).

Overall, this category shows that barriers to SRHR were present in both datasets, but were articulated with different levels of complexity. In fact, this category shows a gradual increase in the complexity of participants' language when describing SRHR barriers across the two data sources. In the written responses, participants mostly described barriers as a lack of knowledge, taboo, shame, and fear of judgment. In the focus groups, these barriers were more often discussed as part of a wider system of cultural silence, unequal access, legal restrictions, and insufficient support from educational, healthcare, and social institutions.

Analytical Category 4: Pathways for action

The fourth analytical category concerns how participants envisaged addressing issues related to sexual and reproductive health and rights. In written responses to the course, these solutions were most often formulated as a general need for access to information, healthcare services, legal protection and educational work. Such responses were substantively important, but largely remained at the level of broad expectations: young people should know their rights, have access to quality care, receive reliable information and be protected from violations. This is confirmed by brief statements such as: *"Every young Ukrainian needs knowledge about their reproductive and sexual rights and the protection of these rights by the state"* (Q8) or *"Access to accurate information and quality medical services related to sexuality and reproduction"* (Q5). Such responses show that even before the course, participants recognised information provision,

service accessibility and rights protection as key areas of action. However, these areas were largely not detailed as a specific system of responsible actors, mechanisms and practical steps. In this sense, the written responses tended to set out an initial normative framework: "this is how it should be", but not yet a fully developed model of exactly how to achieve this.

In the post-course focus groups, the courses of action were articulated in a much more specific and multi-layered manner. Participants spoke not only of the need to take action in key areas (for example, information) but also of the necessity of combining educational, medical, social, legal, and communication tools. They identified government bodies, the education system, healthcare institutions, social services, civil society organisations, youth councils, the media and young people themselves as potential agents of change. In other words, SRHR began to be described not as an area where a single educational initiative is sufficient, but as a field of shared responsibility among various institutions and professional groups. This was particularly evident in the discussion of the state's role and inter-agency coordination. One participant described the necessary response as *"a very complex legal and bureaucratic structure, which must include elements of the Ministry of Health, the Ministry of Education and Science, and the Ministry of Social Policy"* (FG1-P1). This contrasts with the more general pre-course demand to "protect rights," reflecting an understanding that the realisation of SRHR requires not a single responsible actor but coordinated policies across different sectors.

Another key aspect of the post-course reflections was the idea of early, evidence-based sex education that is appropriate for young people's age. Students emphasised that sex education should not begin only once problems have already arisen. It should gradually introduce topics such as bodily boundaries, consent, reproductive health, safety, the emotional aspects of relationships and human rights. In one comment, this was put as follows: *"It should start with social networks, with ordinary parents, ordinary kindergartens, educators. So that the child understands their boundaries, from the age of 5–6, these can be just some basic things. Later, in secondary school… it is possible to explain how the reproductive system works and already some psychological aspects. So that children receive information not in secret*" (FG2-P2). Here, SRHR is presented as an ongoing educational process, rather than a one-off lecture or crisis information provided after a risky situation.

Another key area is the creation of accessible and confidential services for young people. Participants discussed youth clinics, helplines, chatbots, laboratory diagnostics, and consultations with gynaecologists, psychologists and social workers. Particular emphasis was placed on the

fact that support must not only be formally accessible, but also safe, anonymous, youth-friendly and genuinely usable in situations of war, displacement, financial dependence or fear of disclosure.

The idea of interdisciplinary collaboration was discussed in the focus groups. One participant emphasised: *"In this situation, we cannot separate medical staff from social workers. A social worker is the first person who will meet an adolescent with a problem. Then they will refer them, for example, to me (a doctor), and I can already help or provide support… everyone is responsible for ensuring that a child can find help. We need to be together, to work together"* (FG2-P3). This excerpt is important because it demonstrates the professional logic of post-course reflection: SRHR cannot be the sole responsibility of a doctor, psychologist or social worker alone; it requires coordination, communication between specialists and a shared understanding of responsibility.

Overall, this category shows that, in the pre-course written responses, pathways for action were primarily formulated as general needs: greater access to information, services, legal protection, and support for young people. In the post-course focus groups, these expectations were articulated as a more concrete and multi-level response, including early sexuality education, youth-friendly healthcare and counselling services, intersectoral policies, involvement of civil society organisations, the use of social media, and interdisciplinary collaboration among professionals. In this sense, SRHR was discussed not only as a matter of knowledge or access to services, but also as a field of professional and institutional action.

Analytical category 5: Understanding of SRHR

The fifth analytical category concerns how participants understood the meaning of SRHR itself. This is the central category of the findings, as it most clearly shows the contrast between the pre-course written conceptualisations and the post-course focus group reflections. In the written responses, SRHR was mainly described through a medical and physiological frame. Reproductive health was associated with contraception, pregnancy, family planning, prevention of sexually transmitted infections, absence of disease, and the functioning of the reproductive system. Rights were mentioned, but they were often less clearly articulated than the medical aspects of SRHR. This medicalised frame was clearly expressed by one participant: *"I thought that reproductive health… it is limited only to physical processes, and sexual health – for us it was simply the absence of diseases or infections. And rights in this field seemed to me as something on the level of personal beliefs, and that it was not so important for health, general health"* (FG2-P1). Here, health is understood primarily as the absence of disease, while rights appear as secondary or almost separate from "real" health.

In the post-course focus groups, SRHR was more often articulated through a broader rights-based, psychological, social, and ethical frame. Participants discussed not only physical health, but also autonomy, consent, bodily integrity, confidentiality, non-discrimination, psychological consequences of violence, access to support, and institutional responsibility. One participant summarised this broader focus as the need *"To fight the causes, not the consequences… we must not forget about rights, about the reason why all these problems arise"* (FG1-P3). In this logic, SRHR was no longer reduced to treatment, prevention, or risk management, but was discussed as a field in which deeper causes must be addressed: taboo, lack of education, unequal access, violence, and insufficient institutional support.

An important element of the focus group reflections was a more complex understanding of sexual violence. Participants emphasised that it should not be reduced to a physical act, but also includes psychological pressure, coercion, violation of consent, and imposed contact: *"…the emphasis was correctly placed here on the issue of sexual violence. It is not only a direct, physical act, but the psychological factor is also very important. When one person insists on some kind of contact, and the other person does not agree"* (FG1-P4). This indicates a more sensitive language for discussing SRHR, where boundaries, consent, psychological safety, and ethical responsibility become central.

SRHR was also more often formulated as a universal human right rather than as a topic limited to women, reproduction, or disease prevention. One participant defined it as follows: *"Human rights, they give everyone the opportunity to independently determine their sexual orientation, their choices regarding health and reproductive functions. I also believe that this can include access to proper medical services and resources to support reproductive health at all stages of our lives"* (FG2-P1). The emphasis on "everyone" is important here: SRHR is presented as a right of every person, regardless of gender, identity, sexual orientation, reproductive status, or life stage.

At the same time, the post-course reflections were not simply optimistic. Participants recognised the tension between a rights-based model of SRHR and the Ukrainian social and wartime context. They pointed to social resistance, parental fears, differences between the Ukrainian and Swedish contexts, and the way war pushes SRHR into the background. One participant noted: *"Our society, and especially parents of children, in most cases, are not ready for such kinds of implementation, and our society differs drastically from, let's say, the society of Sweden. Therefore, attempts at such implementation will most likely be perceived very sharply and will*

provoke a corresponding reaction" (FG1-P5). Another participant linked these limitations directly to war: *"But the most important thing now, I believe, is the war. Because many people may think that this is not the right time"* (FG2-P1).

Overall, this category shows the contrast between two ways of articulating SRHR across the two qualitative data sources. In the pre-course written responses, SRHR was mainly framed as a medical and physiological issue related to reproduction, contraception, pregnancy, prevention of infections, and absence of disease. In the post-course focus groups, SRHR was more often discussed as a comprehensive human right involving physical, psychological, social, ethical, and institutional dimensions. This contrast should not be interpreted as a proven individual-level transformation among the same participants. More cautiously, it shows the difference between initial written conceptualisations and post-course group reflections within the same educational cohort.

Table 3 summarises the main patterns identified across the five analytical categories. It compares pre-course written responses and post-course focus group reflections and presents possible interpretative links to transformative learning theory.

Table 3 about here

Discussion

This study explored how SRHR was conceptualised in pre-course written responses and articulated in post-course focus group reflections among students from the same international training course (Table 3). Across both datasets, participants considered SRHR in relation to the Ukrainian socio-cultural and wartime context, institutional responsibility, barriers to the realisation of rights, and possible pathways for action. The main difference concerned the level and scope of elaboration: the pre-course responses generally presented concise accounts centred on knowledge, access to services, and rights protection, whereas the focus group discussions more often connected these issues with structural conditions, professional roles, and coordinated educational, healthcare, and intersectoral responses.

Transformative learning as an interpretative framework

The differences identified across the two qualitative datasets can be interpreted cautiously through the lens of Mezirow's theory of transformative learning [20, 21]. The training course incorporated international comparisons and the analysis of "contrasting" perspectives, which

may have created conditions for critical reflection on habitual assumptions shaped within a conservative socio-cultural environment. In Mezirow's terms, a disorienting dilemma arises when established frames of reference fail to account for new experiences. In this study, the comparison between Ukrainian and Swedish approaches to SRHR, alongside the wartime context, may be understood as a prompt for reconsidering taken-for-granted assumptions about sexuality, rights, consent, and professional responsibility.

The contrast between the two datasets is most visible in the way SRHR was articulated as health and rights. The pre-course written responses mainly reflected biomedical and informational understandings of SRHR, whereas the post-course focus group discussions more often included rights-based, ethical, psychological, and institutional dimensions. This contrast may be understood as an encounter with alternative frames of reference and a possible reconsideration of earlier meaning perspectives. However, given the exploratory design and partially overlapping samples, this should be read as an interpretative account of broader SRHR meanings articulated in post-course reflections, rather than as evidence that the same participants underwent an individual-level transformative process.

Thus, transformative learning theory is used here as an interpretative lens rather than as evidence of a confirmed learning outcome. It helps explain why the post-course reflections included broader SRHR framings related to rights, professional responsibility, and institutional action, while staying within the limits of the exploratory qualitative design.

Contextualising SRHR

The findings of this study are consistent with previous research showing that SRHR in Ukraine is shaped by the combined effects of socio-cultural taboo, limited sexuality education, unequal access to services, and wartime disruption [7, 12]. **The references made by participants to shame, silence, conservative attitudes, and fear of social judgment reflect the historical and cultural background described in earlier Ukrainian research** [8, 9]**.** In the present study, these factors were not only mentioned as background conditions, but also appeared as important interpretative frames through which students made sense of SRHR-related needs and barriers. **In the pre-course responses, socio-cultural and wartime conditions were mainly described as circumstances affecting young people's access to information, support, and healthcare. In the focus groups, participants more often considered what these conditions meant for professional practice, institutional responsibility, and service provision.**

Students' reflections on war-related challenges, including disrupted access to services, increased vulnerability to sexual violence, displacement, and the need for confidential support, are consistent with previous evidence on the effects of war on women's and perinatal health, sexual well-being, and the spread of sexually transmitted infections [10–12, 25]. The contribution of the present study lies in showing how future professionals conceptualised this context in relation to rights, access to care, and professional responsibility.

From the perspective of transformative learning theory [20, 21]**, these more professionally and institutionally oriented reflections may be understood as a more critical consideration of assumptions about SRHR that are often taken for granted in the Ukrainian socio-cultural context.**

Institutional responsibility and barriers to SRHR realisation

In the pre-course responses, institutions were mainly described as providers of healthcare, information, confidentiality, and legal protection. In the focus groups, participants spoke more often about shared responsibility across healthcare, education, social services, public authorities, and civil society organisations. This broader framing is consistent with previous research showing that young people's SRHR needs cannot be addressed through medical services alone - they also require access to reliable information, confidential and youth-friendly care, supportive educational environments, and coordination between different sectors [2, 25].

The barriers identified in the study are also consistent with previous research. Limited access to reliable information, the absence of systematic sexuality education, shame, fear of judgment, and reliance on informal sources are widely recognised obstacles to young people's SRHR [2, 6, 25]. **At the same time, the focus group discussions went beyond individual difficulties and more often connected these barriers with family norms, parental resistance, legal restrictions, economic inequalities, and limited institutional support. In terms of transformative learning theory** [20, 21]**, this broader framing may reflect a reconsideration of where responsibility for SRHR lies. Rather than focusing only on young people's knowledge or individual behaviour, the post-course discussions more often addressed the role of professionals, institutions, and social structures in either reinforcing or reducing vulnerability.**

Pathways for action

Differences between the two datasets were also evident in participants' proposed responses to SRHR-related problems. Pre-course responses mainly referred to broad needs such as access to information and healthcare, whereas focus group participants described more concrete, multi-level educational, medical, social, legal, and communication-based measures.

Their proposals—early comprehensive sexuality education, youth-friendly services, and stronger state-level coordination—are consistent with UNESCO guidance [13]. The emphasis on gradual, age-appropriate education reflects the view that sexuality education should address not only biological information and risk prevention, but also relationships, boundaries, consent, safety, gender, and rights [13]. This is supported by evidence that programmes addressing gender and power relations achieve stronger outcomes than those focused mainly on biological knowledge or individual risk behaviour [27].

Participants' references to mobile clinics, helplines, counselling, digital resources, and referral pathways also align with WHO standards for adolescent-friendly services, which emphasise accessibility, confidentiality, acceptability, equity, and responsiveness to young people's needs [28].

Their emphasis on interministerial cooperation and multidisciplinary teams suggests that they understood SRHR as a systemic field requiring coordinated action across healthcare, education, psychology, and social services. This is particularly relevant for higher education, where SRHR content remains insufficiently represented in some professional programmes [4, 5]. Integrating SRHR into university curricula may therefore support not only specialist knowledge, but also ethical responsibility, confidentiality, referral skills, and interdisciplinary cooperation.

From the perspective of transformative learning theory [20, 21], the more specific and action-oriented focus group reflections may indicate a closer connection between understanding a problem and considering possible professional responses.

Understanding of SRHR

The clearest contrast between the two datasets concerned the understanding of SRHR itself. Pre-course written responses were mainly framed in biomedical and informational terms, with attention to reproduction, contraception, pregnancy, prevention of sexually

transmitted infections, and access to medical care. This is consistent with previous studies showing that students' and professionals' understandings of SRHR may remain focused on biomedical knowledge, while rights, relationships, consent, psychological well-being, and social context receive less attention [4, 5, 6]**.**

In the post-course focus groups, SRHR was more often discussed as a broader human right involving physical, psychological, social, ethical, and institutional dimensions. **Participants referred to autonomy, bodily integrity, consent, confidentiality, non-discrimination, sexual diversity, psychological consequences of violence, and access to support.** These elements correspond with international rights-based approaches that define SRHR as extending beyond the absence of illness to include physical, emotional, mental, and social well-being, autonomy, and the ability to exercise sexual and reproductive rights [1, 13, 29].

The discussion of sexual violence was especially important in this regard: participants did not limit it to direct physical acts, but also referred to coercion and psychological pressure. This understanding is consistent with contemporary rights-based approaches and with current attention to conflict-related sexual violence and survivor-centred support in Ukraine [7, 14, 25]**.**

SRHR was also more often discussed as relevant to people across genders, identities, sexual orientations, reproductive statuses, and stages of life. **This broader framing is important because political and ideological debates may narrow SRHR by excluding sexuality, gender, diversity, and rights from public health agendas** [1, 26]**.**

From the perspective of transformative learning theory, the contrast between predominantly medicalised pre-course accounts and broader rights-based post-course articulations may be interpreted as an encounter with alternative frames of reference [20, 21]**. The comparison of Swedish and Ukrainian approaches, together with reflection on wartime conditions, may have encouraged participants to reconsider familiar assumptions about sexuality, rights, consent, professional responsibility, and institutional roles.**

Strengths and Limitations

A strength of this study lies in its exploration of SRHR conceptualisations and reflections within a real international educational programme implemented during wartime. Although the two-stage design does not allow conclusions about individual-level change, the use of two related

qualitative datasets enabled examination of pre-course written conceptualisations and post-course focus group reflections in relation to each other within the same educational cohort. Another strength was the interdisciplinary composition of the participant group, which included students of medicine, psychology, sociology, and social work, thereby reflecting the multi-professional nature of SRHR-related practice. The use of framework analysis provided a structured, transparent approach to working across the two datasets and to identifying shared analytical categories [23, 24]. Finally, transformative learning theory offered a useful interpretive lens for discussing how broader SRHR framings were articulated in post-course reflections [20, 21], while keeping interpretations within the limits of the exploratory qualitative design.

The study has certain limitations. A self-selection bias may exist, as students who voluntarily enrolled in the SRHR course likely had a pre-existing interest in the topic, which may have influenced their openness to reflective engagement with SRHR issues. Participation was voluntary, and the sample size reflected the number of students who agreed to take part. In qualitative research, sample adequacy depends not only on the number of participants but also on the study aim, sample specificity, theoretical grounding, data quality, and analytical strategy [30]. Although small, the sample was closely aligned with the study aim, included participants from four professional fields, and provided two related qualitative datasets. However, formal saturation or information power was not established; therefore, the findings should be considered exploratory.

A further limitation is that the pre-course questionnaire and post-course focus groups involved partially overlapping voluntary samples rather than the same matched participants. Consequently, the findings should not be interpreted as evidence of individual-level change attributable to the educational programme. Instead, they should be understood as exploratory insights into how SRHR was conceptualised and discussed in two related datasets collected in connection with the same course.

The small size of the participant groups (n = 15 and n = 16) and the specific educational and wartime context limit the transferability of the findings beyond the study setting. Providing sufficient contextual and methodological detail allows readers to assess the relevance of the findings to other settings [31]. Accordingly, we have described the course context, participant characteristics, data collection procedures, and analytical process in detail.

The discrepancy between the total number of course participants (n = 40) and those who participated in the research stages (n = 15 and n = 16) may be explained by the voluntary nature

of research participation, which was independent of course completion, and by the wartime context. Frequent power cuts, interruptions due to air raids, and high levels of psychological stress may have reduced students' capacity to participate in additional, non-compulsory activities. In addition, gender imbalance meant that the male perspective was underrepresented, although within the sample of professions, this largely reflects the actual distribution.

Conclusions and Practical Recommendations

This study **suggests** that educational programmes grounded in transformative learning theory may provide a meaningful context for broader reflection among future professionals in SRHR. They **may not only provide knowledge but also create opportunities for students to consider professional responsibility, interdisciplinary cooperation, and possible systemic responses**. The findings emphasise that SRHR cannot be regarded as a secondary issue, particularly during wartime; rather, it constitutes **an important component** of public health, human rights, and **professional training in crisis contexts**. At the higher education level, the findings support the further integration of evidence-based SRHR courses into the curricula of medicine, psychology, social work, sociology, and education, promoting interdisciplinary learning and peer-to-peer knowledge exchange. At the **policy and service** level, the development of **coordinated SRHR responses may help to** unite the efforts of the ministries of health, education, and social policy, ensure alignment of school-based sex education with UNESCO standards, and **strengthen access to youth-friendly services, including confidential counselling and support** within the system of state-guaranteed medical services.

Future research should include large-scale quantitative studies to assess the prevalence of the perceptions and attitudes toward SRHR identified within this qualitative framework, enabling statistical examination across different **student and professional training groups**. Such studies would allow for the identification of key socio-cultural barriers, stigmas, and knowledge gaps that require targeted educational interventions, including the further implementation of comprehensive sexuality education in line with UNESCO standards. A complementary research direction involves longitudinal studies examining how the rights-based SRHR perceptions identified among students are translated into professional practices after graduation. This includes developing ethical sensitivity, professional agency, and readiness for advocacy within institutional and intersectoral contexts. Particular attention should be given to evolving perceptions of institutional responsibility, service accessibility, and the role of multidisciplinary cooperation in SRHR provision.

CRediT authorship contribution statement

Maryna Klimanska: Conceptualisation, Resources, Investigation, Data curation, Formal analysis, Writing - original draft, Writing - review & editing. Catrin Borneskog: Methodology, Writing - original draft, Writing - review & editing. Inna Haletska: Investigation, Formal analysis, Writing - original draft, Writing - review & editing. Liliia Klos: Writing - original draft, Writing - review & editing. Halyna Herasym: Investigation, Formal analysis, Writing - original draft, Writing - review & editing. Kerstin Erlandsson: Funding acquisition, Project administration, Writing - review & editing, Supervision. Iryna Mogilevkina: Investigation, Writing - original draft, Writing - review & editing. Valeriia Marichereda: Writing - review & editing. Viktoriia Borshch: Writing - review & editing. Kateryna Nitochko: Investigation, Data curation, Writing - review & editing. Larysa Klymanska: Conceptualisation, Resources, Methodology, Data curation, Formal analysis, Supervision, Validation, Writing - original draft, Writing - review & editing.

Ethical approval

Ethical approval was not required. The study involved voluntary participation of university students in an educational setting, with informed consent obtained and no collection of sensitive or health-related personal data.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have influenced the work reported in this paper.

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Figure 1. Research design and stages of data collection

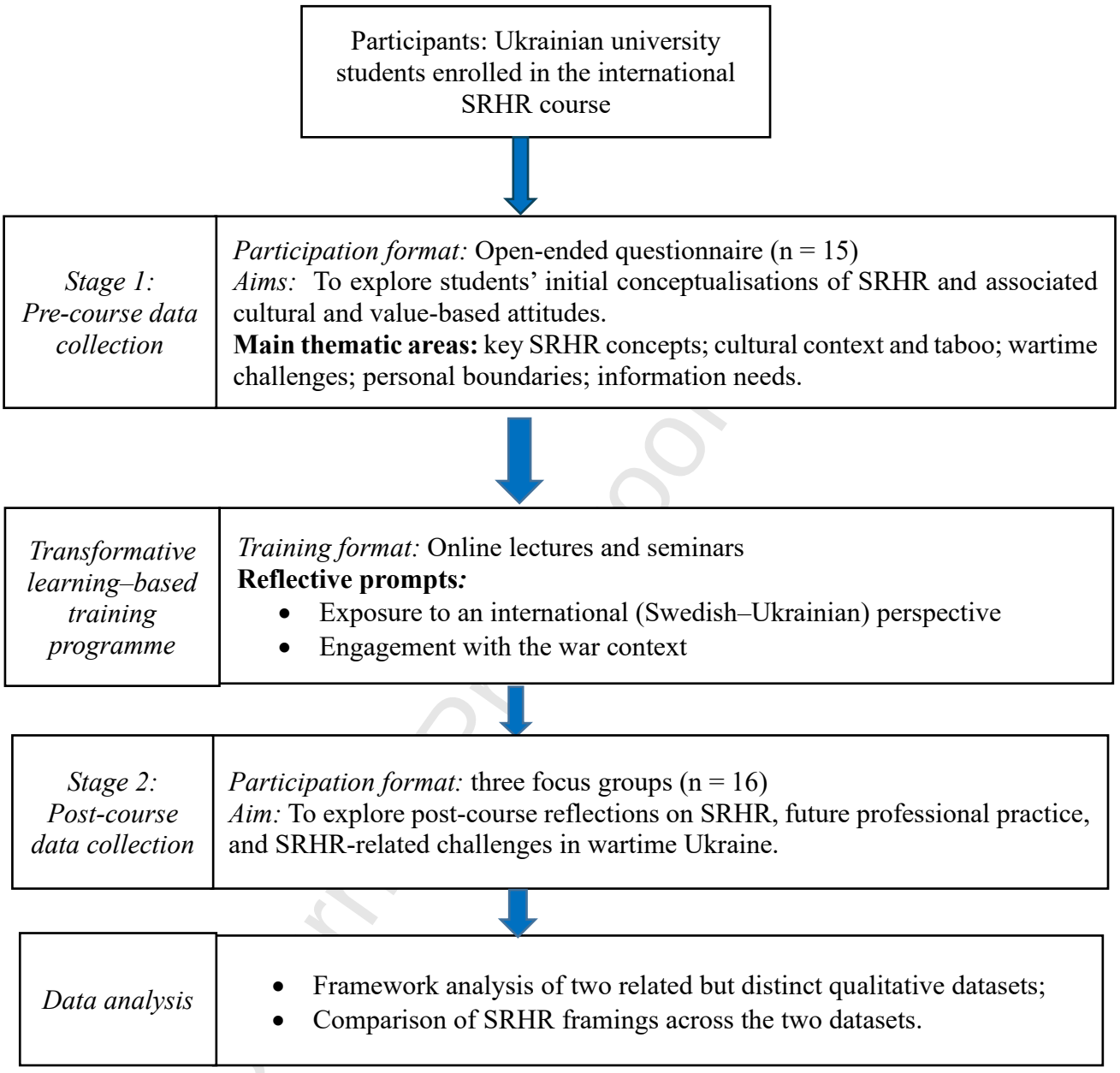

Table 1. Characteristics of study participants

Characteristic	Stage of data collection	
	Pre-course questionnaire (n = 15)	Post-course focus groups (n = 16)
Participation format	Individual open-ended questionnaire	Three focus groups
Field of study	Psychology (4) Social work (4) Sociology (1) Medicine (6)	Psychology (2) Social work (1) Sociology (1) Medicine (11)
Gender	13 female, 2 male	13 female, 3 male
Age, years (M ± SD; range)	20.07 ± 2.19 (18–26)	20.94 ± 1.65 (19–24)

Table 2. Example of category formation from individual codes for Analytical Category 1: *Contextualising SRHR*

Code	Description	*Illustrative quotation*
Cultural and religious attitudes	Attitudes toward sexuality shaped by traditional Ukrainian culture and Christian morality	*"Ukrainian society has historically been quite conservative in matters of sexuality and reproduction. This has led to the stigmatisation of certain topics such as sexual health, family planning, and abortion"* (Q1)
Socio-economic conditions	The set of living conditions and social circumstances that influence levels of awareness, access to services, and willingness to exercise SRHR.	*"In Ukraine, there are problems with access to quality medical services, particularly in rural areas, which affects reproductive health"* (Q4)
Wartime in Ukraine	An extreme social context that alters young people's living conditions, access to services, and priority structures.	*"Due to the background wartime pressure, financial difficulties, and blurred future, one can observe how people fall back to the level of meeting basic needs, that is, more about survival than reproduction"* (Q3)

Table 3. Comparison of SRHR framings in pre-course written responses and post-course focus group reflections

Pre-course written responses	*Post-course focus group reflections*	*Possible interpretative link to transformative learning theory*
Analytical category 1: Contextualising SRHR		
SRHR was framed through socially shared understandings related to taboo, conservative norms, limited sexuality education, unequal access to healthcare, and wartime disruption.	The same contextual issues were more often discussed as challenges requiring institutional, educational, and professional responses.	Critical reflection on contextual assumptions shaping understandings of SRHR
Analytical category 2: Institutional responsibility		
Institutions were primarily understood as providers of healthcare services, information, legal protection, and confidentiality.	Institutions were discussed as interconnected systems involving healthcare, education, social policy, youth services, and civil society organisations.	Reframing responsibility from access to individual services toward broader institutional and professional obligations.
Analytical category 3: Barriers to SRHR realisation		
Barriers were mainly described as a lack of information, absence of sexuality education, shame, fear of judgment, and dependence on adults.	Barriers were more often conceptualised as interconnected cultural, legal, economic, and institutional constraints.	Critical examination of structural assumptions underlying barriers to SRHR.
Analytical category 4: Pathways for action		
Proposed responses focused on increasing knowledge, improving access to services, and strengthening legal protection.	Proposed responses included coordinated educational, healthcare, social, legal, and policy interventions involving multiple stakeholders.	Increased consideration of professional roles and possible courses of action.

Analytical category 5: Understanding SRHR		
SRHR was predominantly framed as a medical and physical issue related to reproduction, contraception, prevention of infections, and absence of disease.	SRHR was articulated as a broader human right encompassing physical, psychological, social, ethical, and institutional dimensions.	Encounter with alternative frames of reference and broader meanings of SRHR.

Note. The table summarises differences in SRHR framings across two related qualitative datasets collected within the same educational programme. Because the pre-course and post-course samples were only partially overlapping, the findings should not be interpreted as evidence of individual-level change, but rather as a comparison of pre-course written conceptualisations and post-course focus group reflections.

Highlights

- Ukrainian students initially conceptualised SRHR mainly in biomedical and informational terms.
- Post-course focus group reflections articulated broader rights-based, ethical, social, and professional dimensions of SRHR.
- The international SRHR course provided a context for reflection on SRHR in wartime Ukraine.
- Participants discussed SRHR in relation to institutional responsibility, structural barriers, and youth-friendly services.
- Integrating SRHR into higher education may support professional reflection and multidisciplinary training.