Policy Brief

Rethinking 'risk' in sexual and reproductive health policy

Implications for marginalised youth

Why, after almost two decades of dedicated attempts to improve Sexual and Reproductive Health in Aotearoa/New Zealand, are we still seeing significant inequities between groups? Why is it that the ones lagging behind—youth, Māori, Pasifika—are the very groups who are prioritised in Aotearoa/New Zealand's Strategy? In this Policy Brief, ***Tracy Morison****,* ***Sarah Herbert****, and* ***Daygan Eagar*** *show that the current 'risk-centred' policy approach cannot fulfil the government's aspirations for reducing youth SRH disparities by reaching those "most in need"*[1]*. They offer an alternative policy approach that draws on a Reproductive Justice framework for addressing the SRH needs of all young people.*

'Sexual and Reproductive Health for all' yet to be realised

It has been almost two decades since the inception of Aotearoa/New Zealand's Sexual and Reproductive Health (SRH) Strategy. The strategy's overarching goals were to "reduc[e] sexually transmitted infections [STIs] (including HIV/AIDS), sexual abuse and unwanted/unintended pregnancies" and to "maximis[e] the health of at-risk groups, such as Youth, Māori, and Pacific peoples".[1] While there have been some overall improvements in SRH since the strategy's introduction, not all groups have benefitted equally. The very groups that were initially singled out in the policy as 'at risk'— Pasifika, Māori, and young people—continue to experience poor SRH relative to the general population.[2] For example, in comparison to their peers, socio-economically deprived, Māori, and Pacific youth[3-5] have comparitively poor access to contraception and are more likely to report having had an STI[6] (figure 2)[i]. Both of these indicators highlight the pervasive and structural challenges confronting Māori and Pacific youth in accessing low or no-cost, culturally appropriate, youth-friendly information and services.[2]

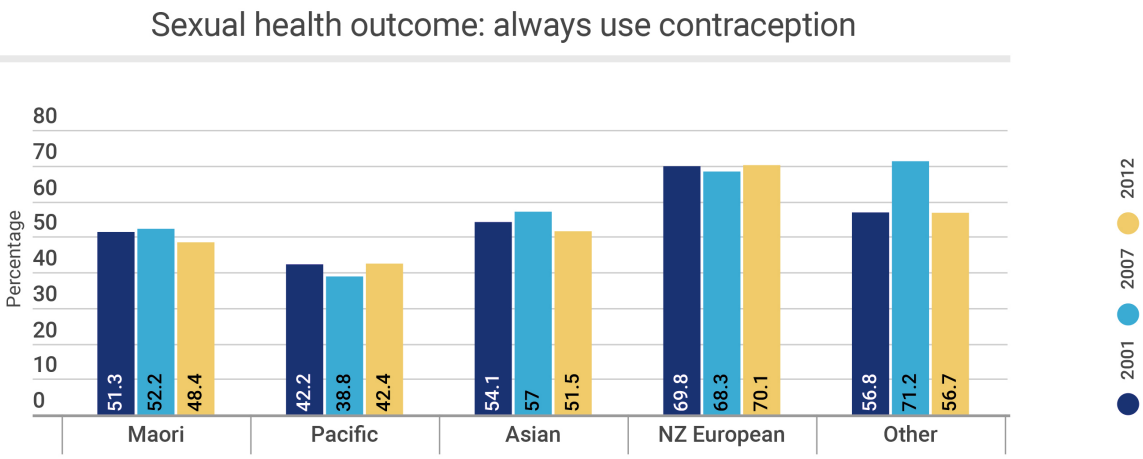

Figure 1: Proportion of sexually active NZ secondary school children participating in survey reporting that they always use contraception (source Clark et al., 2016)

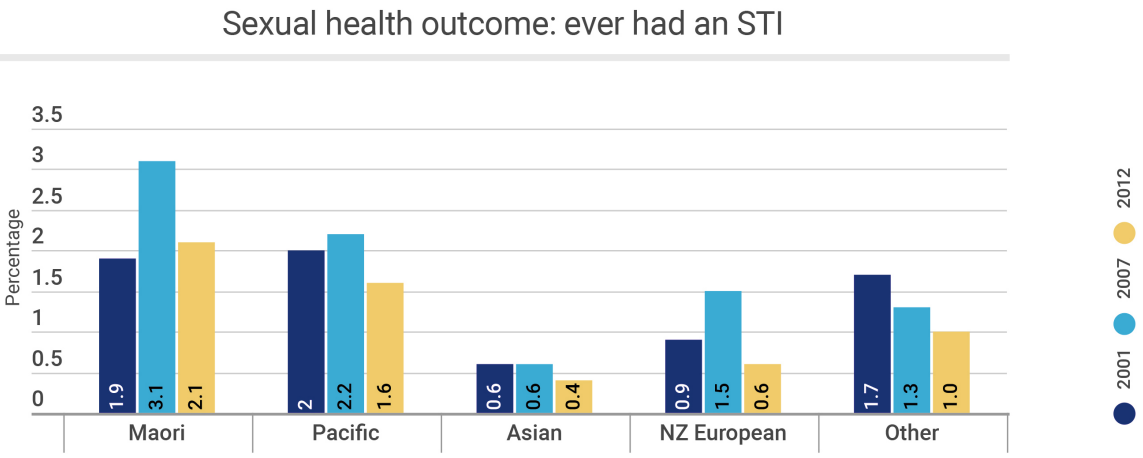

Figure 2: Proportion of secondary school children from nationally representative survey sample reporting that they have ever been diagnosed with an STI by ethnicity (Source: Clark et al., 2016)

A new policy approach is needed if we wish to meet the objective of significantly improving SRH for all who live in Aotearoa/New Zealand. Recent commitments by the government to implement a SRH action plan that improves service access for youth offers a good opportunity to develop a plan that contributes to addressing SRH inequalities.

To do so, the plan needs to move away from the current policy approach that individualises risk and responsibility for SRH.[9] Drawing on a recent analysis of the current youth SRH policy, this Brief highlights the need for policy development, and offers some recommendations toward this.

Policy Analysis

The policy analysis that informs this brief was conducted as part of a larger project exploring the public discussion of youth SRH. The policies selected for analysis were identified using a systematic online search of academic databases and relevant websites (e.g., District Health Boards, Ministry of Health). We identified ten policy documents for analysis published under the current national SRH Strategy from 2001 onward. (See summary in table 1 below.) The earliest policies (5) produced between 2001 and 2003 form part of the Labour-led government reform of SRH policy. These mostly set the tone for those produced afterwards (5), largely at the regional level, which develop from and extensively cite policy statements from the original SRH strategy.

The analysis of Aotearoa/New Zealand SRH policy identified risk as the main explanatory framework used within SRH policy. A focus on risk is common in the social and health policy of many developed countries, particularly in regards to youth.[10] Young people are commonly addressed in SRH policy under the theme of 'at-risk youth'.[11,12] The idea of being 'at-risk' is often used to describe some youth as being at the mercy of 'risk-factors' and to benchmark them accordingto their vulnerability relative to others of the same age. A risk framework also questions young people's ability to successfully transition into the expected adult by themselves.

Ministry of Health	2001	Sexual and reproductive health strategy (Phase 1)	Policy
Ministry of Youth Affairs.	2002	Youth Development Strategy Aotearoa	Policy
Ministry of Health	2002	Youth Health - A guide to action.	Action plan
Ministry of Health	2003	HIV AIDS action plan (Phase two of the SRH strategy)	Action plan
Ministry of Health	2003	Sexual and Reproductive Health, resource book (Phase 2)	Action plan
Tairawhiti District Health	2008	Sexual health over Tairawhiti strategy	
West Coast District Health Board	2009	Youth/Rangatahi Plan	Action plan
YouthLine Auckland Charitable Trust	2011	Youth sexual and reproductive health	Position statement
Taranaki District Health Board	2013	Taranaki Taiohi Health Strategy 2013 - 2016	Action plan

Table 1: Policy documents from 2001

The emphasis on risk in Aotearoa/New Zealand's SRH policy is rooted in positive intentions. Primarily, it intends to make appropriate SRH services available to those who most need them. The concepts of risk and resilience may also avoid holding young people responsible for issues that are beyond their control.[9] Thus, in our analysis we note that the language of blame, moralising, and stigmatising are explicitly avoided in policy. For instance, the Youth Health policy warns against describing young people as 'the problem'.

Another motivation for using a risk framework might be to avoid a deficit view of particular groups that has been criticised in policy-making in the past. For instance, the 'Closing the Gaps' policy approach from the late 1990s was condemned for 'using non-Māori as the benchmark' and thus promoting 'a deficit model of Māori development'[13] and 'social apartheid'.[14]

Consequently, SRH policy in Aotearoa/New Zealand deliberately includes a 'strength-based approach to child development'. This approach is outlined in the Ministry of Health's Youth health action plan as "applying a consistent strengths-based approach to young people's health and wellbeing, which addresses both risk and protective factors, as well as developing the range of skills they need".[15]

While the intention of the current approach may be to highlight youth resilience and other positive attributes, as we demonstrate below, this objective may be undercut by the notion of risk.

The limitations of risk thinking

While there may be some benefits to understanding youth SRH in terms of risk, our analysis indicates that the language of risk and vulnerability may not actually address some of the negative outcomes policy-makers seek to avoid. We identified three main problems with using this framework.

1. Risk is understood as an individual attribute with individual solutions –

In current SRH policy, youth are given responsibility for effective self-management (e.g., practising safer sex, delaying sexual debut).[10] Young people who make the poor choices are then potentially held individually accountable. Consequently, they are subject to corrective measures in the form of interventions intended to equip individual young people to manage risk better (see policy example 1). What this emphasis on personal responsibility and choice fails to recognise are the social and systemic factors, such as poverty, gendered based violence, and racism that may limit an individual's choices.

Policy example 1: "Increase individual's understanding and **personal skills** and teach them to value themselves (personal identity and self-worth) by ensuring appropriate health education is provided for everyone, which aims to increase healthy sexual and reproductive health **choices**. The **skills** to practice safe sex and a guide to provide families with **skills** to support and advise their children regarding aspects that may affect their sexual behaviour can pave the way to a sexually healthy younger generation" (Youthline Auckland Charitable Trust, 2011).

2. Risk becomes seen as a condition of particular groups of young people –

While young people, in general, are viewed as at risk due to their developmental stage, specific groups of young people are singled out as needing more attention than others. For example, by ethnicity, disability status, socio-economic deprivation, and migrant status; certain youth are viewed as 'most vulnerable' or 'most at risk'. In Aotearoa/New Zealand SRH policy, this is mainly done along ethnic lines[17] (see policy quote 2). Despite positive intentions of wishing to assist those most in need, risk can inadvertently become associated with group identity rather than the social conditions that may lead to risk.
The focus is on what may be wrong with these particular youth, rather than the wider social dimension. This can lead to targeting particular groups rather than faulty systems or societal factors.

Policy example 2: "Among young New Zealanders, and rangatahi **Māori [Māori youth] particularly**, unplanned pregnancies, abortion and sexually transmitted infections are becoming more common – with potential long-term consequences for their health and their fertility"- Sexual and Reproductive Health Resource book (Ministry of Health, 2003).

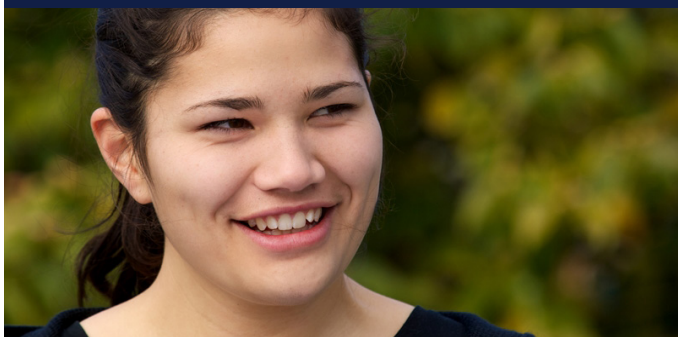

Figure 3: A focus on 'risk' and 'vulnerability' fails to acknowledge the wider systems and societal factors that shape the experience of young people.

3. Value judgements and social stigma become veiled –

Since discussions of youth-at-risk are often regarded simply as the factual description of 'real' dangers, it is believed that this helps to avoid stigmatising young people. However, decisions about who is at risk requires us to single out some dangers or hazards over others. This process is not a neutral one, but based on ideas about the proper development of young people. Risk then becomes about what young people are like rather than their actions within a particular socio-cultural setting and the conditions that may help or hinder them. For example, as policy example 3 shows, the problem is reduced to individual young people's abilities or competences, which then require strengthening. Those who fail to develop 'normally', and who are thus 'at risk', can be potentially held individually responsible for poor SRH outcomes.

Furthermore, proper development is determined according to dominant cultural values and norms that may not be relevant to all groups.[12] This means that not only is risk, again, located within young people, but certain young people can be seen as the problem themselves.

Policy example 3: "It is important to design policies and programmes that both build young people's capacity to resist risk factors and enhance the protective factors. For example, some young people experience difficulty at some or all stages of their development (and are frequently referred to as 'at risk'). They can have a range of 'youth problems', such as offending behaviour, truancy, unsafe sexual behaviour, self-harm, and drug abuse."- Sexual and Reproductive Health Strategy (Ministry of Health, 2002).

'Youth 'at risk' in this sense is merely a new phrase for the old concept of youth as culturally deficient and even deviant'[18].

Thus, individualised risk-based explanations neglect some of the broader social and structural reasons for why some groups are more vulnerable than others and reinforces the idea that some groups are delinquent.[9]

In so doing, we potentially worsen, rather than reduce, existing health and social inequalities between social groups.[17]
A framework creates the potential for the further stigmatisation and marginalisation of those very groups that SRH policy attempts to help in the first place. In light of these limitations, a revision of the SRH policy framework would be most welcome.

Figure 4: Notions of the delinquent or deviant young person are reinforced by 'risk' thinking. We propose a revision of the SRH policy framework, allowing for a more contextualised and ultimately supportive approach to SRH.

Sexual and reproductive justice: An alternative to risk thinking

Rather than developing youth SRH policy around ideas of individualised risk and responsibility, we suggest using the rights and justice as a framework. Some researchers in Aotearoa/New Zealand have already proposed strengthening a rights-based approach in the existing SRH policy to introduce an equity focus.[5, 19, 20] A rights-based approach is in line with the international human rights instruments that Aotearoa/New Zealand has endorsed.[20] Pairing a rights-based approach with a social justice perspective can help to challenge the individualising tendencies of current policy approaches. A Reproductive Justice perspective can help us achieve this.

A Reproductive Justice perspective promotes a more contextualised view of SRH than the one we see in policy at present. It allows us to locate the SRH gaps in Aotearoa/New Zealand within the social, economic and cultural contexts that shape choices available to youth.[21] Some of the most important contextual factors to include in Aotearoa/New Zealand include (i) unequal social relations (gendered, racialised, class- and location-based); (ii) structural and systemic barriers; and (iii) discriminatory socio-cultural understandings and practices.

> The Reproductive Justice perspective can be used as an approach to understanding SRH and as a "vision" for policymaking and planning both in Aotearoa/New Zealand and beyond.[22]

Figure 5: Adopting a rights and justice framework could challenge the individualising tendencies of 'risk' thinking, where certain groups and individuals are singled out as responsible for poor SRH outcomes.

The practical implications a reproductive justice approach has for the further development of youth SRH strategies would involve developing a policy vision, rationale, and set of goals and objectives that foreground and commit to addressing contextual and structural barriers to SRH, rather than just individual risk factors. This means targeting systems (e.g. education and healthcare) and social factors (e.g. poverty and social marginalisation) rather than individuals or particular groups of individuals for intervention. It also means developing systemic or holistic solutions such as expanded coverage of SRH care; increased investment in comprehensive SRH education; attending to violence and stigma; and removing (social, cultural, and economic) barriers to SRH healthcare for marginalised groups.

As an alternative policy approach, reproductive Justice holds promise for addressing the shortcomings in the current SRH policy framework highlighted in this brief. Moving away from a focus on (certain) individual youth, future policy can instead foreground young people's social realities in order to reduce health inequities and allow Aotearoa/New Zealand to deliver on its promise of good SRH for all youth.

References

1. Ministry of Health. Sexual and Reproductive Health Strategy Phase One. Wellington, New Zealand; 2001. http://www.moh.govt.nz.
2. Green A, Tipene J, Davis K. Mana Tangata Whenua: National Guidelines for Sexual and Reproductive Health Promotion with Māori. Hamilton, New Zealand; 2016. http://tewhariki.org.nz.
3. Clark TC, Lucassen MFG, Fleming T, et al. Changes in the sexual health behaviours of New Zealand secondary school students, 2001-2012: Findings from a national survey series. Aust N Z J Public Health. 2016;40(4):329-336. doi:10.1111/1753-6405.12543.
4. Clark TC, Crengle S, Sheridan J, Rowe D, Robinson E. Factors associated with consistent contraception and condom use among Māori secondary school students in New Zealand. J Paediatr Child Health. 2014;50(4):258-265. doi:10.1111/jpc.12450.
5. Redstone N, Conn C. Sexual Health and "Asian" and "Pacific" Young People from Auckland Diasporas. Auckland, New Zealand; 2011.
6. Social Policy and Evaluation Research Unit. Teen Births : Current Trends in New Zealand. Wellington, New Zealand; 2015. www.superu.govt.nz.
7. Crengle S, Clark TC, Robinson E, et al. The Health and Wellbeing of Māori New Zealand Secondary School Students in 2012 Youth2000 Survey Series. Auckland, New Zealand; 2013. www.youthresearch.auckland.ac.nz.
8. New Zealand Labour Party. Youth Policy Manifesto. 2017. https://d3n8a8pro7vhmx.cloudfront.net/nzlabour/pages/8578/attachments/original/1505285218/Youth_Policy.pdf?1505285218.
9. Terry G, Braun V, Farvid P. Structural impediments to sexual health in New Zealand: Key informant perspectives. Sex Res Soc Policy. 2012;9:317-326. doi:10.1007/s13178-012-0089-y.
10. te Riele K. Conundrums for youth policy and practice. In: te Riele K, Gorur R, eds. Interrogating Conceptions of "Vulnera ble Youth" in Theory, Policy and Practice. Volume 2. Rotterdam, Boston, Taipei: Sense Publishers; 2015:17-32.
11. Monterro K, Kelly P. Young People and the Aesthetics of Health Promotion : Beyond Reason, Rationality and Risk. London and New York: Routledge; 2016.
12. Brown S, Shoveller J, Chabot C, LaMontagne AD. Risk, resistance and the neoliberal agenda: young people, health and well-being in the UK, Canada and Australia. Heal Risk Soc. 2013;15(4):333-346. doi:10.1080/13698575.2013.796346.
13. Durie M. Nga Kahui Pou: Launching Māori Futures. Auckland, New Zealand: Huia Publishers; 2003.
14. New Zealand First. Better economics but socially "racial apartheid." Scoop Independent News. http://www.scoop.co.nz/stories/PA0006/S00307.htm. Published 2000.
15. Ministry of Health. Youth Health: A Guide to Action. Wellington; 2002. www.moh.govt.govt.nz.
16. Kelly P. Growing up as risky business? Risks, surveillance and the institutionalized mistrust of youth. J Youth Stud. 2003;6(2):165-180. doi:10.1080/1367626032000110291.
17. Ware F, Breheny M, Forster M. The politics of government "support" in Aotearoa/New Zealand: Reinforcing and reproducing the poor citizenship of young Māori parents. Crit Soc Policy. 2016:1-21. doi:10.1177/0261018316672111.
18. te Riele K. Youth "at risk": Further marginalizing the marginalized? J Educ Policy. 2006;21(2):129-145. doi:10.1080/02680930500499968.
19. Green A. A discursive analysis of Maori in sexual and reproductive health policy. (Masters of Maori and Pacific Develop ment at the University of Waikato , Hamilton, New Zealand). 2011.
20. Signal L, Ratima M. Critical reflections and future challenges. In: Signal L, Ratima M, eds. Promoting Health in Aotearoa. Otago, New Zealand: University of Otago Press; 2015:285-296.
21. Macleod C. "Adolescent" sexual and reproductive health: Controversies, rights And justice. In: Cherry AL, Baltag L, Dillon ME, eds. An International Handbook on Adolescent Health and Development: The Public Health Response. New York: Springer; 2017:169-181.
22. Luna Z, Luker K. Reproductive justice. Annu Rev Law Soc Sci. 2013;9(1):327-352. doi:10.1146/annurev-lawsocs ci-102612-134037.

i Note: These figures only include live births and do not include other outcomes of pregnancy such as termination or still birth. Consequently, teenage pregnancy rates on the whole are likely to be significantly higher than represented here. The data also do not differentiate between planned or unplanned and unwanted or wanted pregnancies.

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MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

SCHOOL OF PSYCHOLOGY
TE KURA HINENGARO TANGATA