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Vulnerable Youth or Vulnerabilising Contexts? A Critical Review of Youth Sexual and Reproductive Health and Rights (SRHR) Policies in Eastern and Southern Africa

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Abstract

Introduction Policy decisions about young people's sexual and reproductive health and rights (SRHR) have far-reaching implications for their well-being. Few SRHR policies, however, focus specifically on youth. Rather, youth SRHR tends to be subsumed within national policies of Health, Youth, Education and Development Ministries, particularly in the Eastern and Southern Africa (ESA) region, complicating an assessment of the overall state of youth SRHR policies. Given the fact that youth SRHR policies focus on a particular segment of the population—youth, teenagers or adolescents—how policies depict these subjects has implications for how policy objectives, programmes and interventions are conceptualised and the kind of sexual and reproductive health concerns that are prioritised.

Methods Using a subject positioning lens, our critical review of youth SRHR policy in force between 2010 and 2020 spans policy domains to examine depictions of young people across 88 ESA policy documents. Our analysis aimed to identify the qualities and responsibilities associated with different youth subject positions and the broader implications thereof for young people's SRHR.

Results We identify two dominant youth subject positions—risky youth and youth-at-risk—both of which construct risk as inherent to young people, overwhelmingly emphasise negative repercussions of youth sexual practices, foreground individualised interventions and hold young people responsible for preventing negative sexual and reproductive health (SRH) outcomes in the absence of policy objectives that meaningfully address structural constraints on their agency.

Conclusions Considering the dominance of public health research underpinning youth SRHR, our findings contribute a much-needed critical social theory complement that supports holistic, justice-oriented and contextually embedded policy responses to young people's SRHR.

Policy Implications Based on our findings, we provide policy recommendations that support a conceptual shift away from vulnerable youth to vulnerabilising contexts, such that young people's vulnerability to adverse SRH outcomes is situated in the enabling and constraining conditions in which they live their lives.

Keywords Adolescent sexual and reproductive health · Sexual and reproductive justice · Risk discourse · Social inequities · Africa

Introduction

Policy decisions have profound implications for the bodies and lives of young people. These consequences may be intentional or unintentional: even policy frameworks that are meant to advance the sexual and reproductive health and rights (SRHR) of young people may have unanticipated negative repercussions for the very groups they were designed to protect (Pugh, 2019). It is for this reason that policy analysis is helpful in identifying underlying assumptions and implications for young people.

There has been increasing recognition of the importance of the SRHR of young people—defined as those aged 10 to 24—globally and in Eastern and Southern Africa (ESA) (Watson et al., 2021). Research in the region points to persistently high levels of HIV and other sexually transmitted infections (STIs); access barriers to sexual and reproductive health (SRH) information, services and support,

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including a high unmet need for contraception; child, early and forced marriage and pervasive gender-based violence (GBV) including homophobic and transphobic violence (Barral et al., 2022; Freedman et al., 2021; Lawrence et al., 2021). Regional drivers of these challenges include extreme poverty and inequality, overburdened and under-resourced health and education systems and deeply engrained harmful gender and socio-cultural norms (Melesse et al., 2020; Starrs et al., 2018).

The full realisation of young people's SRHR has been identified as a regional priority through several frameworks and agreements, including the Maputo Plan of Action, the Africa Health Strategy, the African Charter on the Rights and Welfare of the Child, the African Youth Charter, the Southern African Development Community (SADC) SRHR Framework and the ESA Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People. These agreements stress providing comprehensive, integrated SRH services and support for young people as a critical objective (Watson et al., 2021). While these agreements are intended to ensure that all young people have full access to SRH services and support, the practice still falls short, leading to a situation where young people across ESA face a high burden of adverse SRH (Melesse et al., 2020).

Despite the far-reaching implications for adolescent and youth SRHR, few such policies focus specifically on young people. Instead, their SRH needs are more commonly addressed in general terms across different policies. This is especially true of ESA where adolescent and youth SRHR issues tend to be driven by international commitments and are subsumed within national policies from Health, Youth, Education and Development Ministries, with only a handful of ESA countries having dedicated, stand-alone youth SRHR policies (Watson et al., 2021).

Given the embeddedness of adolescent and youth SRHR in multiple policy-making spaces, it is difficult to gain an overall perspective of policy responses, and thus ascertain the current status of adolescent and youth SRHR policies in ESA. To date, no reviews have been conducted to assess policy responses to youth SRHR across policy domains in the region. Our policy review, spanning national ministries, can thus provide insight into how youth SRHR issues are being dealt with in the region.

Considering that youth SRHR policies focus on a particular segment of the population—youth, teenagers or adolescents—how policies depict these subjects will have implications for which programmes or interventions are proposed and how they are conceptualised. For this reason, we used a discursive theory lens, with a specific focus on subject positioning, as the analytical framework. Discursive theory examines the constitutive character of language and proceeds from the understanding that language, also that used in policies, is not ideologically neutral, but instead enables and constrains certain understandings of the world, with implications for the kinds of actions available to people (Parker, 2002).

Methods

Our critical policy review aimed to identify how policy responses in ESA construct young people and their SRHR needs. Specifically, we were interested in two distinct, yet related, avenues of inquiry:

(i) the subject positions assigned to young people within policy documents
(ii) the implications of these subject positions for young people's SRHR

The review focuses on ESA countries as determined by the United Nations Statistical Division (2021). Countries where policies are only available in French (Burundi, Djibouti and Madagascar) and Portuguese (Mozambique) were excluded due to limited language proficiency in the research team. The remaining 19 countries were included in the review: Botswana, Comoros, Eritrea, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mauritius, Namibia, Rwanda, Seychelles, Somalia, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe.

Given that youth SRHR concerns tend to be addressed in general terms across policies, our search strategy included documents produced by the Ministries of Health, Education, Social Development and Youth of the identified countries. This was done by accessing the websites of the respective ministries, country-specific parliamentary websites, and in cases where this was unsuccessful, contacting representatives of the relevant ministries directly.

The inclusion criteria were as follows:

(a) Period of coverage: Policies in force between 2010 and 2020 (when the search was conducted)
(b) Policy language: English
(c) Policy type: National youth, health, development, education, and HIV/AIDS policies, programmes, strategies and frameworks

Applying these criteria, the search yielded 152 policy documents. In addition to the inclusion criteria described above, the following keywords were applied to ensure relevance to the study focus i.e. young people's SRHR: youth, young people, adolescents, adolescence, sexual and reproductive health (and rights), sexual health, reproductive health, sexual rights, reproductive rights, SRH, SRHR,

sexuality, and reproduction. After screening for relevance against the keywords, 64 policies were excluded due to not referencing both areas of interest: young people *and* SRHR (e.g. we excluded youth policies that did not make mention of SRH or SRHR and health policies that did not mention youth). The final dataset included 88 policies (see the Appendix for the list of policies).

Data Coding and Analysis

As indicated, our analysis was guided by positioning theory. Subject positioning is a discursive process that allows for the production of particular understandings of identities through the deployment of socially and culturally available discourses (Davies & Harré, 1990). By being positioned, subjects (e.g. health service providers and youth) are immediately placed in certain relations with one another, which has implications for what is and is not possible in particular interactive spaces (Davies & Gannon, 2005). The process of interactive positioning (where a subject is discursively positioned by another—in this case, policies) can be understood as a process of continual struggle to set the tone of the 'interaction' and define the parameters of a particular situation. Certain discourses (and, by extension, certain subject positions) enjoy greater ideological power and institutional support (Wooffitt, 2005). An analysis informed by positioning theory helps avoid simplistic analyses that reduce subjects to single, homogenous identity groupings by recognising the intersection of multiple and contingent subjectivities within a variety of contexts (Taylor & Littleton, 2006).

In practical terms, our analysis entailed an iterative process of thematic coding drawing on guidelines by Braun and Clarke (2012). Data coding was conducted by IL, MTC and SM, and analysis was conducted by all authors. Based on an in-depth reading of the data, we generated codes relating to youth SRHR and the depiction (subject positions) of youth in the policies, manually capturing coded excerpts in an Excel sheet. For example, we noted frequent policy references to young people's 'dangerous behaviour' which we selected as a code and applied to the dataset by capturing excerpts that described relevant actions of young people. Discrepancies in coding were addressed through re-examination of the data and discussion between researchers to reach consensus.

We grouped codes into potential themes and sub-themes, creating overarching candidate themes or subject positions. The emerging themes were reviewed for coherence and clarity, resolving inconsistencies by refining themes or collapsing them if necessary e.g. merging 'vulnerable youth' and 'marginalised youth' positions into one theme. After refining the thematic map, we reviewed the validity of the themes in relation to the dataset, ensuring they accurately reflected the data as a whole. The final stage of analysis entailed producing the analytic narrative to identify, explore, and draw out certain arguments in relation to the research questions. We were interested in the qualities and responsibilities associated with different subject positions and the broader implications of positioning for young people's SRHR. This analytical approach acknowledges complexity, allowing for multiple, even contradictory subject positions to be identified across a dataset.

Findings

Two overarching subject positionings emerged in our analysis. In the first—risky youth—the very nature of adolescence is seen as leading to risk. In the second—youth-at-risk—more nuance is introduced with particular groupings of young people being viewed as vulnerable or marginalised. For each of the subject positions described below, we include illustrative policy extracts.

Risky Youth

The first subject position identified in our review is that of risky youth, intertwined with notions of youth sexuality as dangerous. Drawing on a construction of adolescence as a transitional period where young people are considered lacking the ability, knowledge and experience to make responsible choices, youth sexuality is cast as irresponsible and a threat to young people's SRH. In the policy excerpts below, adolescents and young people are described as cognitively underdeveloped, impulsive and irresponsible and, consequently, unable to make sound decisions about their sexuality:

> Adolescents and youth are a complex and heterogeneous population with different characteristics that influence their needs and vulnerabilities […] However, all adolescents share common neurobiological and psychological characteristics including cognitive/brain development lagging behind physiological development, "hot" emotions and challenges in projecting future outcomes and anticipating consequences (Kenya Guidelines for the Provision of Adolescents and Youth Friendly Services, 2016, p. 30).
>
> Unprotected sex during adolescence generally occurs without prior planning or consideration to the consequences (South Africa Adolescent and Youth Health Policy, 2012, p. 14).

In the first extract, the 'complex and heterogeneous nature' of youth quickly gives way to a deficit subject positioning—i.e. a portrayal of young people as lacking in some way—that, it is implied, applies to all 'adolescents'. Drawing on a scientific discourse ('neurobiological

and psychological' and 'cognitive/brain development') to validate the deficit subject positioning, the policy depicts 'adolescents' as cohering with the stereotypical 'storm and stress' discourse of youth: immature cognitive and planning capacities combined with "'hot' emotions". This deficit subject positioning is neatly tied to poor outcomes in the second extract above, in which lack of planning is seen as leading to unprotected sex. In other words, it is in the very nature of adolescents to engage in risky sexual behaviour (Morison & Herbert, 2019).

In the policies we reviewed, a 'risky youth' subject positioning is predominantly drawn on in relation to two of the leading public health challenges faced by young people in the region i.e. early and unwanted pregnancies and high HIV prevalence. For instance, the Swaziland Health Sector Strategic Plan (2008–2013) notes how the 'adolescent stage' introduces 'new threats to healthy development […] with a risk of contracting HIV/AIDS [and] early pregnancy' (p. 88). Similarly, the Kenya Guidelines for the Provision of Adolescents and Youth Friendly Services (2016) depict early pregnancy as detrimental and even life-threatening for young women and their children:

> [T]eenage pregnancy increases risk of maternal morbidity and mortality, GBV, and has a known negative impact on newborn and child health. SRH interventions should emphasize the importance of delaying first pregnancy until the age of 18, and in case of pregnancy, delaying second pregnancy (p. 35).

Here, the pregnant teenager subject position is homogenised into one representing personal danger (morbidity and mortality) and interpersonal danger (GBV and poor child health). The great variability within the broad category of 'teenager' is glossed over: not only between younger (13 to 14-year-olds) and older (15 to 19-year olds) teenagers but also in relation to a variety of variables, chief of which are socio-economic status and access to resources (Macedo et al., 2020; Wong et al., 2020).

Young people's risky sexuality is constructed not only as a threat to themselves but also as a threat to society. This is hinted at above, where the risk of early sexual activity and pregnancy is linked to the well-being of young mothers' infants. In the policy excerpts below, this expanded threat is stated more directly through describing early sexual debut and pregnancy as potentially posing a risk to national development and economies:

> Early sexual debut coupled with extremely low use of contraceptives is contributing to the high fertility in Malawi and may derail the reality of achieving a demographic dividend (Malawi Youth Friendly Health Services Strategy, 2015–2020, p. 11).
>
> Teenage pregnancies cost the economy an estimated $57 million, placing serious challenges for poverty reduction and development (Malawi Youth Friendly Health Services Strategy, 2015–2020, p. 11).

The emphasis on the potentially devastating impacts of youth sexuality, combined with a construction of young people as unable to make safe and informed decisions, lays the foundation for urgent adult intervention. In the policies under review, such intervention took the form of education and skills-building. For instance, young people, who 'often do not realise they are at risk' (Malawi Youth Friendly Health Services Strategy, 2015–2020, p. 17), are guided to 'reject and resist temptation of engaging in risky sexual relationships and behaviours' (Uganda Sexuality Education Framework, 2018, p. 8) and instead make 'healthy sexual choices' (Ethiopia Adolescent and Youth Reproductive Health Strategy, 2007–2015, p. 39). These healthy choices are intended to result in 'reduce[d] risky sexual behaviours, increase[d] utilization of health services, and improve[d] teen pregnancy rates' (Rwanda Family Planning and Adolescent SRH Strategic Plan, 2018–2024, p. 21). Thus, the assumption underpinning these policy extracts is that once young people are made aware of the SRH risks they face, they will change their behaviour accordingly.

Notably, the cautionary messaging associated with a 'risky youth' subject position is intensely heterogendered, with girls and young women set up as primarily responsible for preventing early sexual activity. For instance, as illustrated below, young people and 'especially girls' are tasked with controlling the timing of the onset of sexual activity and the conditions under which sex takes place:

> Advocacy and IEC/BCC [Information and Education Communication / Behaviour Change Communication] will include educating in and out of school adolescents, youth and *especially girls* on the possibility and advantages of delaying onset of sexual activity and on responsibility to their fertility, the dangers of early sexuality, unsafe sex, STI/HIV/AIDS and unplanned pregnancy and the after effects of abortion should also be highlighted (Mauritius Sexual and Reproductive Health Strategy and Plan of Action, 2009–2015, p. 16–17, emphasis added).

This focus on individual behaviour change implies a universal ability of young people to exercise choice freely, masking the impact of the socio-cultural contexts and power relations within which young people's agency is located. Similarly, the excerpt below foregrounds a lack of contraceptive use among young people as causing the majority of unwanted pregnancies. This is described without engaging broader contextual factors, such as

the large unmet need for contraception in the region and pervasive unequal gender norms, including sexual coercion, in which girls and women's sexual decision-making is embedded (Starrs et al., 2018):

> A recent national study suggests that up to 78 per cent of unwanted pregnancies were attributable to contraceptive non-use, incorrect use, or method failure (Ethiopia Reproductive Health Strategy, 2005–2015, p. 12).

In sum, the inherently risky adolescent subject position serves to homogenise a whole swath of the population, downplay the structural constraints and intersectional power relations within which young people (as well as their older counterparts) are located, lay blame for poor SRH outcomes at the door of the young person who is inevitably steeped in 'storm and stress' and locate responsibility for fixing the problem within individual behavioural change (through programmes aimed at increasing youth's knowledge of, and use of, contraception). This positioning creates a conundrum, however. If adolescence is, by definition, a stage of 'storm and stress' and, therefore, inherently risky, the solution—individual behaviour change—is bound to fail. This is where the second positioning—youth-at-risk—comes into play.

Youth-at-Risk

Growing criticism of a narrow public health framing of sexuality and reproduction has, over time, spurred the integration of a human rights framework into efforts to advance SRH, with the 1994 International Conference on Population and Development seen as a turning point in this regard (Pizzarossa, 2018). While public health responses remain essential in improving SRH, there is largely international consensus that embedding these in a human rights framework assists in overcoming some of the limitations inherent in earlier approaches.

In our dataset, this shift from young people as innately risky subjects to a more sympathetic framing of at-risk youth is signalled by the interchangeable use of the terms 'vulnerable' and 'marginalised' to differentiate young people in general from those with 'special needs' (Kenya Guidelines for the Provision of Adolescents and Youth Friendly Services, 2016, p. 19). A risky subject position casts all young people as potentially vulnerable to negative SRH outcomes by virtue of their developmental stage, while a focus on at-risk youth designates *particular groups* of young people as more acutely vulnerable to social exclusion and discrimination, and consequently experiencing a heightened risk to adverse SRH outcomes. This marks marginalised young people as priority groups for policy interventions to 'ensure a health safety net for those that fall outside of the mainstream health sector' (South African Adolescent and Youth Health Policy, 2012, p. 18). Vulnerable youth are described as having distinct needs compared to 'those of the majority [of youth]' (Kenya Guidelines for the Provision of Adolescents and Youth Friendly Services, 2016, p. 19):

> [T]here are certain groups of adolescents and youth that are hard to reach, vulnerable and marginalised and may require special attention or considerations while providing AYFS (Kenya Guidelines for the Provision of Adolescents and Youth Friendly Services, 2016, p. 16).

The policies under review describe this vulnerability in relation to a wide range of youth sub-populations lacking 'adequate care and protection' and at risk of 'being left behind' (Rwanda Family Planning and Adolescent SRH Strategic Plan, 2018–2024, p. 21). For example:

> Marginalised and vulnerable adolescents and youth [include] orphans and street children as well as adolescents and youth with disabilities; adolescents and youth living with HIV and AIDS; adolescents and youth living in informal settlements; adolescents and youth in the labour market; adolescents and youth who are sexually exploited; adolescents and youth living below the poverty line and children affected by disaster, civil unrest or war as well as those living as refugees (Kenya Guidelines for the Provision of Adolescents and Youth Friendly Services, 2016, p. 9).

Other policies in the dataset add young sex workers, young people who inject drugs, incarcerated youth, teenaged parents and immigrant youth to the category 'vulnerable youth'.

Considering the wide array of identities and experiences listed, LGBTIQ+ young people are conspicuous in their absence. Rare exceptions include policies from South Africa, Rwanda and Seychelles—countries that have scrapped colonial-era legalisation criminalising homosexuality. For instance, the Rwanda Adolescent Sexual and Reproductive Health and Rights Policy (2011–2015) lists 'gay, lesbian and transgender' youth as part of 'special groups' the policy aims to target through tailored services (p. 13). The South African Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2014–2019) describes LGBTIQ+ youth as a 'neglected and underserved group' (p. 6). The Seychelles Youth Policy (2013) recognises diversity in sexual orientation when defining youth, stating that the policy includes all young people 'irrespective of their gender, race, colour, religion, political affiliation, sexual orientation, physical or mental ability or any other conditions which could in any way disadvantage them from participating' (p. 6). The general omission of sexual and gender minority youth in policies points to a pitfall of rights-based approaches—not all youth are recognised as rights-bearing. In many of the countries included in the review, same-sex sexualities and

sex work remain criminalised, and access to legal and safe abortion is severely restricted.

Notwithstanding, positioning certain young people as at-risk creates space to acknowledge contextual impacts on youth SRH, thereby extending the focus on risky youth sexualities to consider the 'socio-economic and cultural environment [that] shape adolescent reproductive health' (Ethiopia Adolescent and Youth Reproductive Health Strategy 2007–2015, p. 3). In the policies under review, this contextualisation of youth vulnerability—also described as social determinants of risk—predominantly occurs in relation to poverty, educational attainment, harmful cultural practices, unequal gender norms and GBV. For instance, the Lesotho Education Sector Strategic Plan (2005–2015) notes that girls and young women's school attendance is impacted by their gendered role as caregivers; the Ethiopia Reproductive Health Strategy (2005–2015) states that young women's reproductive health is 'directly affected by the social and institutional context in which they live' (p. 8); and the Swaziland Health Sector Strategic Plan (2008–2013) describes 'gender-based violence [as] rooted in such social pathologies as unequal gender relations and poverty, which are also root causes of most reproductive ill health and HIV/AIDS' (p. 93).

Surfacing the conditions that restrict young people's SRHR is a significant policy expansion with the potential to increase a health equity orientation in public health. However, our dataset indicates that in the absence of further policy objectives to address these contextual drivers of vulnerability, young people are still cast as responsible for overcoming these contextual barriers. As such, a youth-at-risk subject position does not escape the responsibilisation of young people implicit in the risky youth subject position. For example, in the excerpt below, contextual constraints driving negative SRH outcomes are named. However, young people's 'lack of empowerment and decision-making power' and 'lack of confidence to seek out information' are centred as the implied focus of intervention:

> Lack of empowerment and decision-making power over their own sexuality and limited access to information and resources due to culture, coercion, socioeconomic status, etc., often result in [girls'] early sexual debut, having sex against their will, and lack of self-confidence to seek out SRH information and services (Malawi Youth Friendly Health Services Strategy, 2015–2020, p. 14–17).

Similarly, the Kenya Guidelines for the Provision of Adolescents and Youth Friendly Services (2016) describe barriers faced by young people in accessing SRH services as including structural, socio-cultural and individual factors but limits the policy direction it provides to interventions aimed at adolescents' own efforts to overcome these barriers:

> Adolescents and youth-friendly services (AYFS) are meant to help young people overcome barriers to access to quality sexual and reproductive health care services (p. 11).

In this manner, young people are "pre-constituted [as] vulnerable populations, who *then* face issues such as 'structural barriers'" (Katz et al., 2020, p. 605, emphasis in original). The following excerpt provides a striking example of how context (in this instance, legislation) is named as creating vulnerability, yet the policy response is to 'build capabilities' of young girls experiencing educational exclusion:

> [P]regnant adolescent girls have increasingly become more vulnerable and increasingly marginalised as a result of the government's current position which does not allow girls who get pregnant in secondary schools to continue with their formal education. This leaves them with limited options, hence making them even more vulnerable. Future programmes targeted at this group should identify specific ways of building capabilities among such girls by offering them alternative learning and economic empowerment opportunities that enable them to continue learning and also empower them economically as most of them lack financial means to support their families and also to access healthcare (Tanzania Adolescent Health and Development Strategy, 2018–2022, p. 51).

Finally, a policy focus on marginalised youth as distinct from other young people "set[s] up a false distinction between a supposed problematic minority versus a 'normal' majority" (Riele, 2006, p. 129). Risk is inadvertently construed as intrinsic to specific groups—seen as an inherent characteristic associated with particular experiences or identities. This depiction overlooks the contexts that drive disparate SRH outcomes for some young people, such as heteronormative health systems, social and economic exclusion, homophobic and transphobic violence and criminalisation of same-sex sexualities and sex work. Further to this, marginalised young people are considered to belong to discrete groups without acknowledging the manner in which young people's identities and experiences intersect, such that a person might belong to multiple marginalised groups.

Discussion

Analysing the status of youth SRHR policy is complicated because this group's concerns are often subsumed within a range of national policies, with a minority of countries

globally and in ESA having dedicated stand-alone adolescent and youth SRHR policies. Our review is the first to our knowledge that spans national ministries to identify how young people's SRHR are constructed across policy domains. We analysed 88 policies from 19 ESA countries, using a positioning framework for analysis. Our findings contribute to a growing body of scholarship that examines the underlying assumptions of youth policies and the implications of these for young people's SRHR (Freedman et al., 2021; Kangaude & Skelton, 2018; Macleod, 2011, 2017; Morison & Herbert, 2019).

Our analysis identified two ways in which young people are positioned in ESA policies. First, we outlined a 'risky youth' subject position that constructs young people as vulnerable to adverse SRH outcomes by virtue of their developmental stage and emphasises the negative consequences of youth sexual activity. Second, we described a 'youth-at-risk' subject position that constructs young people's vulnerability to adverse SRH outcomes as rooted in their membership to a particular marginalised group.

Both subject positions aid in constructing young people's SRH as a legitimate concern. Indeed, considering the detrimental impact of SRH challenges faced by young people, describing this life stage as a 'crisis period' associated with risk and danger has some merit and may even assist in generating political commitment, invoking policy imperatives, and increasing resource allocation for young people's SRH (Katz et al., 2020). However, an emphasis on the negative repercussions of sex—a 'danger, damage and disease' narrative—inadvertently stigmatises youth sexualities such that young people seeking services are often met with healthcare provider discrimination, thereby limiting their ability to act on cautionary messaging (Macleod, 2009). This creates a double bind for young people, 'as they are tasked with the responsibility of ensuring healthy outcomes for their SRH but do not have access to the support and services required to do so' (Essop et al., 2018, p. S39). Healthcare provider bias is particularly pronounced for young people who do not conform to heterogendered norms about 'decent', 'healthy' or 'appropriate' youth sexuality, such as very young, unmarried or queer youth sexualities (Freedman et al., 2021; Tolla et al., 2018). Significantly, the findings show that cautionary messaging is directed at girls and young women, with policy documents largely silent on the SRHR of boys and young men, also in relation to their SRH needs.

Further, both youth subject positions essentialise risk as intrinsic to young people. The 'risky youth' subject position constructs young people as inherently reckless and inept sexual decision-makers requiring adult guidance and education to act in their own and others' best interests. Similarly, a subject position of 'youth-at-risk' regards vulnerability as 'partially or fundamentally an internal condition, one produced by group membership rather than external conditions' (Katz et al., 2020, p. 609). As such, both subject positions identified in our findings essentialise risk and vulnerability as inherent to young people and omit policy objectives that address structural drivers of risk. Locating risk as fundamental to young people undermines the potential for transformative policy since it implies that 'even if policies and processes change, group vulnerability will remain' (Katz et al., 2020, p. 601). Moreover, identifying specific groups of young people as requiring targeted or special programming, based on their marginalisation in health systems, leaves harmful norms in mainstream services unexamined.

Vulnerabilising Contexts

Laws and policies hold significant influence in creating and sustaining particular versions of 'healthy' adolescent sexualities, with direct consequences for young people's SRHR. The saturation of SRHR policies with risk-focused depictions of youth sexuality has been described as harming young people's access to much-needed SRH information, services and support; contributing to age-related SRH stigma, mistreatment and shame; and restricting the extent to which policy resources are directed to structural drivers of risk (Barral et al., 2022; Hall et al., 2018; Kangaude et al., 2020; Morison & Herbert, 2019; Nyblade et al., 2017, 2022).

We argue for a policy shift away from vulnerable youth, to vulnerabilising *contexts*. This involves situating vulnerability and agency within the settings in which young people live their lives, rather than as fixed qualities inscribed on particular bodies (Ham & Gerard, 2014). Integrating a justice perspective in SRH policy can assist with formulating policy responses that meaningfully address contextual factors that create vulnerability and risk. To this end, sexual and reproductive justice emerged as a guiding concept from black feminists' critiques of the limitations of rights-based approaches to SRH, in particular, the notion that all people have equal access to taking up the rights afforded to them (Roberts, 2015; Ross & Solinger, 2017). This frame does not dismiss the significant gains in young people's SRH attributable to public health and rights-based policy responses. Instead, it strengthens existing responses by providing analytical tools that can assist in developing contextually relevant approaches to young people's SRHR that take structural barriers to claiming rights into account. As such, it emphasises both the establishment of sexual and reproductive rights *and* the creation of enabling conditions to realise these rights. A justice frame resists the tendency for public health and human rights interventions to adopt an 'instrumentalist goal of solving social problems through individual behaviour change' (Macleod, 2017, p. 9). Rather, it sheds light on how the ability of any person to determine their

reproductive destiny is linked directly to the conditions in their community and these conditions are not only a matter of individual choice and access (Ross, 2017).

While policy objectives are generally silent on strategies to address contextual drivers of vulnerability and risk, there are some exceptions. For instance, the Malawi Youth Friendly Health Services Strategy (2015–2020) states that '[s]ocial, cultural, and economic factors strongly influence young people's ability to access SRH/HIV information and services. Communities have been commonly cited by the youth as one of the barriers to accessing YFHS' (p. 31). What remains absent in policies is what evidence-based interventions to address contextual limitations on young people's SRHR would look like.

Finally, a strength of a sexual and reproductive justice framework is the ability to create room for intersectional concerns (Ross & Solinger, 2017). An intersectional lens sheds light on the manner in which 'individual and group inequities are shaped by interactions between multiple sites and levels of power: institutions such as families, governments, laws, and policies; structures of discrimination such as sexism, ableism, and racism; and broader processes of globalisation and neoliberalism' (Kapilashrami & Hankivsky, 2018, p. 2589). This analytical lens yields greater precision in understanding the range of contextual factors that underpin youth SRHR, thereby guiding more effective policy and programme development.

Implications

Based on our findings, we offer the following policy development recommendations that support holistic, equity-oriented and contextually embedded responses to young people's SRHR, drawing on tenets of sexual and reproductive justice.

1. *Include clear policy objectives to address contextual drivers, including harmful state systems and structures that impact young people's SRHR.* Bay-Cheng (2010) notes that a 'preoccupation with the dangers related to sex deflects attention away from the systems of injustice that put women at risk' (p. 99). In addition to the immediate need for comprehensive SRHR information, services and support, policies should target contextual factors fuelling adverse SRH outcomes, including longer-term investment in 'the systems (e.g. education and healthcare) and social factors (e.g. poverty and social marginalisation)' (Morison et al., 2018, p. 6). Context-responsive policy avoids inadvertently holding young people responsible for meeting their SRH needs in unsupportive environments. Such policy development can benefit from integrating critical social science approaches alongside implementation research for evidence-based programming.
2. *Adopt an intersectional framework in policy making.* Our findings indicate that ESA policies largely acknowledge diversity among young people. This awareness can be expanded to reflect how young people's identities and experiences do not exist in silos, such that individuals inhabit multiple identities that intersect to compound vulnerability (Crenshaw, 1991). These intersecting identities have implications for young people's 'access to resources, socio-material conditions, and power relations within and among groups' (Morison & Mavuso, 2022, p. 4). Policy can play an essential role in institutionalising the practice of disaggregating and analysing data—attending to age, class, sexual orientation, gender identity, disability, and migrant/refugee status, among other identities and experiences—in meaningful and non-stigmatising ways.
3. *Acknowledge both adverse SRH outcomes and positive, healthy aspects of sexuality.* An over-emphasis on the risks and negative consequences of sex reduces young people's sexuality to a problem perspective, contributing to stigma and discrimination when young people attempt to access SRH services and support. Moreover, 'when sexuality is not only isolated from regular life but also depicted solely as a site of vulnerability and submission, girls and women are deprived exposure to alternative models and scripts, thus leaving them few opportunities to imagine themselves as anything but victims' (Bay-Cheng, 2010, p. 100). Policies can integrate positive aspects of sexuality alongside risk management, recognising adolescent sexuality as developmentally normative (Macleod, 2017). Central to achieving this is actively involving young people in research and policy-making.
4. *Recognise the evolving capacity of young people as sexual agents.* The child rights principle of 'evolving capacities' is a useful reframing of youth sexual agency in policies aimed at supporting young people's SRHR (Kangaude et al., 2020; Savage-Oyekunle & Nienaber, 2015). Our findings show that existing SRHR policies largely deny the agency and capabilities of young people to successfully navigate their sexuality and their social environments. In contrast, the notion of evolving capacities—present in international law as well as the African Charter on the Rights and Welfare of the Child (ACRWC)—considers young people as having 'an evolving capacity for autonomy, for responsibility, and for forming views to which adults must have due regard' (Kanguade et al., 2020, p. 699). Recognising young people's evolving capacities opens up possibilities for policies to respect

young people's agency and the necessity for creating the conditions in which they can safely exercise their choices (e.g. having confidential and comprehensive access to SRH information and services).

5. *Enhance legal protection of the rights of all young people.* Finally, the findings indicate that while rights-based approaches have been vital in advancing the SRH of young people, not all young people are recognised as rights-bearing citizens and included in policy protections. In the policies under review, this was particularly relevant to LGBTIQ+ youth, young people who sell sex and young people needing legal access to safe abortion. Repealing colonial-era 'sodomy' laws, decriminalising sex work and ensuring unrestricted legal access to safe abortion allow for policy development that supports the SRHR of *all* young people.

Limitations

Our review has some limitations, notably excluding policy documents unavailable in English. Future studies can build on the current review to contrast and compare SRHR policy development in ESA Francophone and Lusophone countries excluded from this review. An analysis of family planning policies in one of the excluded countries, Burundi, provides interesting parallels to our findings, highlighting the dominance of an instrumentalist, individualising approach to girls' and women's fertility management at the expense of engaging systemic and structural injustices (Schwarz et al., 2022). Our review did not include a comparative analysis of national policies and instead focused on trends spanning the dataset. Considering the highly contextual nature of constraints on young people's SRHR in the region, policy reviews that examine commonalities and differences within and across countries will provide valuable comparative insights.

Conclusion

Our critical policy review demonstrates the importance of taking seriously how policy responses can mark certain young people as risky, dangerous, vulnerable or marginalised, with implications for their agency in exercising their SRHR. Our findings provide guidance for policy development that embraces a holistic formulation of SRH issues that addresses young people's embodied needs as these exist in local contexts to facilitate the full realisation of their SRHR. Policies serve as starting points and reflect state commitments, for which they should be held accountable. Once context-responsive, holistic SRHR policies are in place, these must be adequately resourced and implemented by states. Investigating this may be the next frontier in this research agenda.

Appendix

Appendix. List of Policies Included in Analysis

Country	Policy	Ministry/policy domain
Botswana	Botswana Revised National Youth Policy (2010)	Youth
	Botswana National Health Policy (2011)	Health
	Botswana National Youth Action Plan (2010–2016)	Youth
	Botswana Integrated Health Service Plan (2010–2020)	Health
	Botswana Policy Guidelines and Service Standards: National SRH Programme (2015)	Health
	Botswana SRHR and HIV and AIDS Linkages Integration Strategy and Implementation Plan (2013)	Health
	Botswana Adolescent Sexual and Reproductive Health Implementation Strategy (2012–2016)	Health
Comoros	Comoros National Health Development Plan (2010–2014)	Health
	Comoros Adolescent and Youth Health Strategy (2018)	Health
Eritrea	Eritrea National Health Policy (2010)	Health
	Swaziland National Health Sector Strategic Plan (2008–2013)	Health
Eswatini	Swaziland Second National Health Sector Strategic Plan (2014–2018)	Health
Ethiopia	Ethiopia Education Sector Development (2010/2011–2014/2015)	Education
	Ethiopia Education Sector Development Program III (2005/2006–2010/2011)	Education
	Ethiopia National Girls' Education Strategy (2010)	Education
	Ethiopia National School Health & Nutrition Strategy (2012)	Education
	Ethiopia National Reproductive Health Strategy (2005–2015)	Health
	Ethiopia National Reproductive Health Strategy (2016–2020)	Health
	Ethiopia National Adolescent and Youth Health Strategy (2016–2020)	Health
	Ethiopia National Adolescent and Youth Reproductive Health Strategy (2007–2015)	Health
Kenya	Kenya Adolescent Reproductive Health and Development Policy Plan of Action (2005–2015)	Health

Country	Policy	Ministry/policy domain
	Kenya Policy Framework for Education and Training (2012)	Education
	Kenya National Education Sector Plan (2013–2018)	Education
	Kenya Education Sector Policy on Peace Education (2014)	Education
	Kenya National Adolescent Sexual and Reproductive Health Policy (2015)	Health
	Kenya Health Policy (2012–2030)	Health
	Kenya National School Health Strategy (2011–2015)	Education
	Kenya National Adolescent SRH Policy Implementation Framework (2017–2021)	Health
	Kenya National Guidelines for the Provision of Adolescent and Youth Friendly Services in Kenya (2016)	Health
Lesotho	Lesotho National Health Policy (2011)	Health
	Lesotho Health Sector Strategic Plan (2012/13–2016/17)	Health
	Lesotho Education Sector Strategic Plan (2005–2015)	Education
	Lesotho Education Sector Plan (2016–2026)	Education
	Lesotho Health Strategy for Adolescents and Young People (2015–2020)	Health
Malawi	Malawi National Youth Policy (2013)	Youth
	Malawi Education Sector Implementation Plan (2009–2013)	Education
	Malawi National Education Sector Plan (2008–2017)	Education
	Malawi National Youth Friendly Health Services Strategy (2015–2020)	Health
	Malawi Health Sector Strategic Plan (2011–2016)	Health
	Malawi National Plan of Action for Scaling up SRH and HIV Prevention Initiatives for Young People (2008–2012)	Health
	Malawi National Youth Friendly Health Services Strategy (2015–2020)	Health
Mauritius	Mauritius Education and Human Resources Strategy Plan (2008–2020)	Education
	Mauritius National Youth Policy (2010)	Youth
	Mauritius Sexual Reproductive Health Strategy Plan (2009–2015)	Health
	Mauritius Health Sector Strategic Plan (2020–2024)	Health
Namibia	Namibia National Health Policy Framework (2010–2020)	Health
	Namibia Education and Training Sector Improvement Programme (2006–2011)	Education
	Namibia Strategic Plan of the Ministry of Education (2012–2017)	Education
	Namibia Ministry of Health and Social Services Five-Year Strategic Plan (2009–2013)	Health & Social Services
	Namibia Youth Policy (2020–2030)	Youth
Rwanda	Rwanda Adolescent Sexual Reproductive Health and Rights Policy (2011–2015)	Health
	Rwanda National Family Planning and Adolescent Sexual and Reproductive Health Strategic Plan (2018–2024)	Health
	Rwanda National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Policy (2017–2030)	Health
Seychelles	Seychelles Education for all National Action Plan (2001–2015)	Education
	Seychelles National Youth Policy (2013)	Youth
	Seychelles National Youth Policy (2018–2023)	Youth
Somalia	Somalia National Youth Policy of The Federal Government of Somalia (2017)	Youth
South Africa	South Africa National Youth Policy (2015–2020)	Youth
	South Africa Adolescent and Youth Health Policy (2012)	Health
	South Africa Strategic Health Plan (2010–2013)	Health
	South Africa National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2014–2019)	Health
	South Africa Integrated School Health Policy (2012)	Education
	South Africa School Health Policy and Implementation Guidelines (2011)	Education
	South Africa Adolescents and Youth Health Policy (2016–2020)	Health
South Sudan	South Sudan National Health Strategic Plan (2016–2020)	Health
	South Sudan Family Planning Policy (2013)	Health

Country	Policy	Ministry/policy domain
	South Sudan Adolescence Sexual and Reproductive Health Strategic Plan (2018)	Health
	South Sudan Youth Development Policy (2019)	Youth
	South Sudan Reproductive Health Strategic Plan (2013–2016)	Health
	South Sudan National Reproductive Health Strategy (2018–2022)	Health
Tanzania	Tanzania Education Sector Development Programme (2008–2017)	Education
	Tanzania Health Sector Strategic Plan III (2009–2015)	Health
	Tanzania Proposed Secondary Education Development Program II (2010–2014)	Education
	Tanzania National Adolescent Health and Development Strategy (2018–2022)	Health
Uganda	Uganda National Strategy for Girls' Education in Uganda (2015–2019)	Education
	Uganda Education Sector Strategic Plan (2004–2015)	Education
	Uganda Revised Education Sector Strategic Plan (2007–2015)	Education
	Uganda Adolescent Health Policy Guidelines and Service Standards (2012)	Health
	Uganda National Sexuality Education Framework (2018)	Health
Zambia	Zambia National Health Policy (2011)	Health
	Zambia National Health Strategic Plan (2011–2015)	Health
	Zambia National Youth Policy (2015)	Youth
	Zambia National Health Strategic Plan (2017–2021)	Health
	Zambia National Adolescent and Youth Health Strategy (2016–2020)	Health
Zimbabwe	Zimbabwe National Health Strategy (2009–2013)	Health
	Zimbabwe National Youth Policy (2013)	Youth
	Zimbabwe National Adolescent Sexual and Reproductive Health Strategy (2010–2015)	Health
	Zimbabwe National Adolescent Sexual and Reproductive Health Strategy (2016–2020)	Health

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