

Social and economic marginalisation and sexual and reproductive health and rights of urban poor young women: a qualitative study from Vadodara, Gujarat, India

Renu Khanna,^a Manushi Sheth,^b Parigna Talati,^c Krishna Damor,^d Bhanu Chauhan^e

a Founder, SAHAJ, Vadodara, Gujarat, India

b Coordinator, SAHAJ, Vadodara, Gujarat, India

c Programme Coordinator, SAHAJ, 1 Shree Hari Apartment, Behind Express Hotel, Alkapuri, Vadodara, Gujarat, India.
Correspondence: parigna.sahaj@gmail.com

d District Coordinator, SAHAJ, Vadodara, Gujarat, India

e Health Rights Coordinator, SAHAJ, Vadodara, Gujarat, India

Abstract: *In this paper, we present the results of a qualitative study by a non-profit organisation implementing a community-based urban adolescent development programme. The study highlights the sexual and reproductive health and rights (SRHR) situation of marginalised young women in a developed state of India. Our findings, based on in-depth interviews with young women and frontline health providers, show that structural factors, such as economic and social stratifiers, gender norms and cultural beliefs, result in further marginalisation of young women. In turn, marginalisation adversely affects the realisation of SRHR through discriminatory practices around menstruation and lack of control in matters related to sexuality, contraception, pregnancy and safe abortion. Rights to the highest standards of sexual and reproductive health (SRH) care are compromised. Health system factors like providers' attitudes and knowledge, commodity supplies, and indifference to ensuring delivery of contraceptives and other services often result in unplanned pregnancies and affect the quality of young women's SRH care. Whatever information and support adolescents and young women get is from local community-based organisations. We conclude that structural determinants and violations of fundamental rights to education, equal opportunities and participation constitute a significant barrier to the enjoyment of SRHR by the marginalised young women in the study. Unless these are addressed, government policies and programmes to promote young people's SRHR will not benefit young women from disadvantaged communities. Partnership and complementarity between government programmes, adolescents and health rights civil society organisations are recommended to promote rights-based, equitable adolescent and youth-friendly services to this vulnerable population. DOI: 10.1080/26410397.2022.2059898*

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Introduction: the situation of adolescents' and young women's SRHR in India

About 27% of India's population comprises youth aged 15–29 years, which makes India home to the largest adolescent population (243 million) globally.¹ In the last 20 years, much of the research in India has focused on adolescents' and young people's knowledge and attitudes

related to sexuality and sexual and reproductive health (SRH). Some studies exist on their SRH status and needs, some on sexual behaviour, and others on SRH interventions, including education, information and services.² Evidence points to low awareness of SRH among young people aged 15–24 years, even though a considerable proportion is sexually active.³ The risk of pregnancies, infections of the reproductive tract and sexually

transmitted diseases is aggravated by incorrect information.⁴ Many recent studies highlight that girls are unprepared for menarche, leading to fear and panic when they experience the first menstrual period.⁵

Vulnerabilities arising from multiple factors impact adversely on young women's reproductive and sexual health. A review of research in India on SRH knowledge, attitude, practices and life skills among adolescent girls states that young women below the poverty line and those from Backward Caste communities are not aware of contraceptives and contraceptive practices.⁶ A study from New Delhi on urban disadvantaged adolescents' perceptions of health needs highlighted girls' fear of gender-based violence by boys in the neighbourhood, lack of social networks because of restrictions on mobility, and embarrassment and lack of confidentiality in accessing health services, adversely impacting their sexual and reproductive health and rights (SRHR).⁷ In other contexts, Ninsiima et al. describe interactions between poverty and gender power relations and how they affect the SRHR of adolescent girls in Western Uganda.⁸ George et al. analyse how structural drivers of gender inequality, defined as the "*socioeconomic and political processes that structure hierarchical power relations stratifying societies based on class, occupational status, level of education, gender*", also impact the SRHR of adolescents and young adult women.⁹ All these, and other, authors call upon policymakers to develop policies and programmes that address the determinants of adolescents' and young women's SRHR.

In India, the central and state governments have both responded with programmes and schemes for adolescents' health and nutrition. The Government of India launched an Adolescent Sexual and Reproductive Health Strategy (ARSH)* in 2005,¹⁰ and the Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy (RMNCH + A) in 2013, followed in 2014 by the *Rashtriya Kishore Swasthya Karyakram* (RKSK)[†] ¹¹ which moved beyond adolescent-friendly clinics

to providing community-based services to adolescents aged 10–19 years. The RKSK is designed to be a comprehensive programme that goes beyond the ARSH to include non-communicable diseases, mental health, nutrition, substance abuse, and accidents and injuries. As part of RKSK, peer educators are to be trained, and Adolescent-Friendly Health Clinics are expected to be conducted.

Another major programme is SABLA, the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls,[‡] initiated in 2011.¹² This Government of India programme is intended "to enable adolescent girls' self-development and empowerment and improve their nutrition and health status".¹² The programme is expected to create awareness about health, hygiene, nutrition, adolescent reproductive and sexual health (ARSH) and family and childcare. It also aims to provide a range of home-based, life and vocational skills, and to bring adolescent girls who are out of school into education, either formal or informal.

Against this background, in this paper, we analyse urban poor young women's life events from an SRHR perspective. We seek to answer questions such as: What are the sexual and reproductive rights (SRR) violations experienced by urban poor young women from marginalised communities? How does marginalisation due to social and economic vulnerabilities impact their SRR and access to SRH services? How can programmes address the emerging SRHR needs of these marginalised young women?

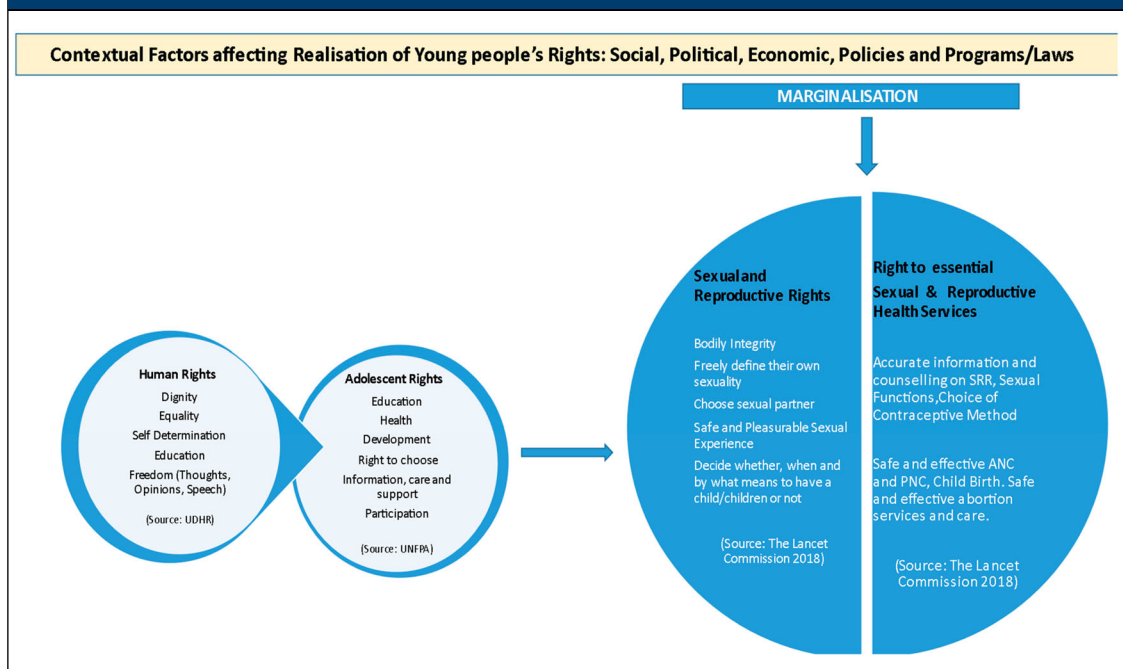
Conceptual framework

We have used an SRHR framework to report on the findings of this study. Our framework proposes that contextual factors – social, political and economic – as well as the policy, programme and legal environment (or "structural drivers of gender inequality", as described by George et al.⁹) determine young women's experience of vulnerabilities and their resultant marginalisation (or otherwise) and that these vulnerabilities and marginalisation influence the realisation of adolescents' and young women's SRHR.¹³ The core SRR of young married women are embedded in broader rights such as the rights to development, education,

*ARSH is a community-level intervention to cater for the needs of adolescent girls from the 10–19-year-old age group in rural areas, launched in 2005.

†RKSK (Adolescent Youth Health Programme) is a more comprehensive programme for all adolescents; being in the pilot phase, has limited outreach.

‡SABLA is a government-initiated scheme primarily for out of school adolescent girls providing their services on nutrition, health and vocations through the ICDS, but confined to the rural and tribal population.

Figure 1. Attempts to capture some key concepts that are central to this study.^{14–16}

information and participation. Fulfilling the broader set of rights prevents young women's marginalisation and creates enabling conditions for young women's SRHR to be realised (Figure 1).

Study setting

SAHAJ, a non-governmental organisation (NGO), carried out the study⁵ in six low-income neighbourhoods (*bastis* or slums) in Vadodara city in the state of Gujarat, India. SAHAJ has been implementing an adolescents' and young people's programme in around 25 low-income neighbourhoods in Vadodara city for over two decades. The interventions – capacity building of peer leaders, organising girls and boys into collectives, imparting knowledge and skills, engaging with parents on adolescents' and young peoples' rights issues – aim to develop leadership among adolescent boys and girls, with a gender and rights perspective. A large part of the programme is built around adolescent SRH, developing appropriate

interventions to address issues articulated by adolescents and young people.^{17–19}

Vadodara is the third-largest city in Gujarat. The urban health network of the Vadodara Municipal Corporation is reasonably good but does not serve many of the SRH needs of women and girls, who mostly rely on the commercial private health sector or the tertiary medical college hospital. Gujarat is recognised as an economically and infrastructurally developed state and is also cited as having one of the better-performing health systems in the country. Despite this, Gujarat does not have very good gender equality and health indicators. Around 22% of women aged 20–24 years are married before the age of 18 years.³ Less than half the urban girls (47.9%) make it to secondary school and complete 10 years of schooling.³ Around 65% of women aged 15–49 years are anaemic,³ and their number has increased in the last five years. Only around 54% of married women use modern methods of contraception. Access to safe abortions and contraceptives remain services with little or no scope for informed choice for the young population.

The RSKS and SABLA are not available in urban Vadodara. Currently, only the *Mamta Taruni*

⁵SAHAJ, a 36-year-old non-governmental organisation (NGO), has been working with different adolescents and youth groups (between ages of 10 and 24) for 20 years. (www.sahaj.org.in)

*Abhiyan*** (Campaign for the Care of Adolescent Girls), limited to girls aged 10–19 years, operates in the city’s low-income neighbourhoods. The Anganwadi worker (AWW)^{††} is supposed to provide SRH information, but only covers the two topics of menstruation and nutrition. Peer educators selected by the AWW have a limited role of mobilising adolescents to use the services, but no role as educators or guides. Each Anganwadi also provides supplementary nutrition to the 20 girls enrolled in the *Abhiyan*. The second cadre of frontline worker is the Accredited Social Health Activists (ASHAs), whose central focus is target-oriented tasks related to married women’s antenatal and postnatal care and contraception. Although the ASHA is expected to stock sanitary pads that girls can buy at subsidised rates, there is often no stock. The role of the third cadre, Auxiliary Nurse Midwives (ANMs), is to conduct educational sessions with adolescent girls on menstrual health problems, nutrition and care of under-five children. These sessions are part of the *Mamta Diwas* (Maternity Day), to be managed within the already tight schedule of antenatal check-ups of pregnant women’s and children’s immunisation.²⁰

Adolescent SRH clinics are conducted at the Urban Primary Health Centre (UPHC) and Ward level Community Health Centre once weekly, with separate days assigned for boys and girls. There is no guarantee of a male doctor in the weekly boys’ clinic. Boys have expressed that they feel shy to approach a lady doctor. The ARSH services are limited to dispensing medicines and dosage-related information. Counselling or other SRH information is rarely available. Adolescents say that they prefer going to private practitioners, most of whom have AYUSH (non-allopathic) degrees.

Essential health and sexuality education is missing in the school curriculum. Biology chapters in the textbooks (reproductive organs,

menstruation, conception, contraception) contain technical language, inappropriate terms and inadequate explanations. For example, reproductive tract infections and sexually transmitted infections find their place in the chapter on the excretory system (Gujarat State curriculum). Teachers expect the students to read these chapters on their own. Examination questions from these chapters are included as choice questions, giving the message that these topics are not important.

The population in these *bastis* is mainly from socially and economically vulnerable groups – Scheduled Castes, Other Backward Castes, Scheduled Tribes, migrants and working-class people. There is a mixture of Maharashtrian, Gujarati and tribal communities. Many of these settlements are not “recognised” by the city administration, which means that they have no “official” electricity, water or sewage connections. They are prone to floods, densely populated and overcrowded.

Methods

We documented young women’s narratives of their sexual and reproductive lives through in-depth interviews (IDIs), conducted by SAHAJ’s community programme staff who are all postgraduates with at least five years of community mobilising experience and proficient in the local language. Each interview was conducted by a team of two, with one researcher as the interviewer and the other taking notes.

Sample selection and inclusion criteria

Respondents and neighbourhoods were selected purposively to include different geographical locations and socioeconomic groups, including Scheduled Tribes. The inclusion criteria consisted of young women aged between 18 and 26 years, representing both married and unmarried women, and marginalised groups like Scheduled Tribes and Scheduled Castes. Only 14 of the 16 planned IDIs could be carried out with the young women as a “lockdown” was imposed, due to the COVID pandemic. Two IDIs were done with frontline health providers, one an Anganwadi worker in a neighbourhood where SAHAJ works and the other an ASHA^{‡‡} who has been associated with SAHAJ for 15 years as a community health worker.

**This is a community-level intervention to cater to 10–19-year-old adolescent girls in rural areas. It is an add-on to Mamta Divas, providing fixed-day services to pregnant and lactating mothers and under-five children. This Government of Gujarat initiative is an important outreach service for adolescents.

††Anganwadis are government childcare centres for every 1000 population run under the Integrated Child Development Scheme. Anganwadis are staffed by an Anganwadi Worker and an Anganwadi Helper.

‡‡ASHA is an Accredited Social Health Activist - and all-female cadre of community health workers constituted by the Ministry

Study design

In-depth interview guidelines for women and health care providers were developed collectively in a Methodology Workshop.^{§§} The SAHAJ team translated the guidelines into Gujarati and piloted and revised them based on the results of the pilots. Focus group discussion (FGD) guidelines, derived from the study tool, were designed to explore specific gaps in data starting from childhood to the reproductive stages of life that they experienced.

Most interviews were conducted away from respondents' homes in private spaces like SAHAJ's Education Support Centers, homes of the Field Officers, all within the respondents' neighbourhood. Three interviews were conducted in respondents' homes when they were alone. Most of the respondents were interviewed in one sitting and the remainder in two sittings each. The length of the interviews ranged between 45 min and 2 h 53 min. The frontline workers were interviewed in the SAHAJ office (Anganwadi worker) and the ASHA's home. Both interviews were completed in one sitting, and the average length of the interview was around an hour and a half. Interviews were recorded after the respondent gave informed consent, and transcriptions were done by the interviewing team using the BOARD software. Three respondents refused the recording, and field notes were later expanded.

Following a review of the draft findings, follow-up interviews were carried out between December 2020 and January 2021 (one year after the first round of data collection) with four respondents to probe further on gaps in data. In addition, two FGDs were conducted in February 2021 to fill data gaps. Young women of the same area who matched the characteristics of the in-depth interview respondents were invited for the FGDs. Each FGD had eight participants.

of Health and Family Welfare under the National Rural Health Mission in 2006. ASHA is the first port of call for any health-related demands of deprived sections of the population, especially women and children.

^{§§}This study is a part of larger research undertaken by six CommonHealth members on Sexual and Reproductive Health Histories of Marginalized Women of different communities across India. The conceptual framework, methodology and tools were developed collaboratively in a series of Methodology Workshops.

Analysis

The first level of coding consisted of the main life events according to the interview tool (e.g. background, childhood, education, work and employment, puberty, romantic relationships, marriage, first sexual experience, SRH). The second level of coding followed the conceptual framework of the study. Each interviewer team member did the first level of coding on the transcript independently, and then the two reviewed the codes and reached a consensus. Code-wise Excel sheets were developed for the second-level codes. A similar process of independent and collective discussion was done for the second-level coding of each interview. Second-level codes for each interview were entered on the excel sheet and summarised thematically.

From each interview, a life story was created around SRH experiences and events (both positive and negative), enjoyment of sexual rights and reproductive rights. Following the life story, the thematic analysis was compiled according to the conceptual framework. The FGD data were merged with the thematic content and used to triangulate the data emerging from the in-depth interviews. The analysis sought to explore (1) various aspects of SRHR and adolescent rights; (2) enabling factors; and (3) barriers to the realisation of sexual and reproductive health rights.

Ethics review and considerations

The SAHAJ Ethics Committee certified the methodology and the tools in April 2019. All measures were taken to anonymise the respondents and their locations by removing all identifiers. Privacy at the time of the interview was ensured. Follow-up help was arranged through SAHAJ programme staff in case any respondent required it.

Results

Profile of the respondents and their vulnerabilities

Table 1 shows the profile of the 14 respondents, who were all from marginalised social groups, such as the Scheduled Castes and Tribes, but differed in educational attainment, marital status and work experience. Some were migrants. Focus group discussion participants matched this profile.

	ST	SC	Total
Age (in years)			
18–20	3 (21%)	1 (7%)	4 (28%)
21–23	8 (57%)	1 (7%)	9 (65%)
24–26	1 (7%)	0	1 (7%)
Education*			
Class I–V	2 (14%)	0	2 (14%)
Class VI–VII	2 (14%)	0	2 (14%)
Class IX–X	3 (21%)	1 (7%)	4 (28%)
Class XI–XII	4 (28%)	0	4 (28%)
College	1 (7%)	1 (7%)	2 (14%)
Marital status			
Married	7 (50%)	0	7 (50%)
Unmarried	5 (36%)	1 (7%)	6 (43%)
Engaged	0	1 (7%)	1 (7%)
Occupation			
Homemaker	7 (50%)	1 (7%)	8 (58%)
Domestic helper	3 (21%)	0	3 (21%)
Services	2 (14%)	1 (7%)	3 (21%)

Note: *Highest level attained.

Vulnerabilities

The interviews with the young women described the multiple vulnerabilities that the 14 respondents experienced as they were growing up. Poverty, precarious livelihoods of family members, seasonal wage labour and migrant status played out in different ways in their lives. Two spoke about how they had to live with their grandparents as their parents could not afford to look after them because of financial constraints.

About a third of the respondents had to drop out of school because of financial constraints. Two out of five dropped out in primary school, and the remaining three did not continue their education after secondary school: “... *only my father was earning, so our condition was not good, and then my father also had a fall and fractured his hand. His operations cost a lot, so I left my study*”. (Sita,*** age 24, married, tribal community)

***All names were changed to protect the identity of respondents.

Some respondents said that they had to stop their education because they had to look after their younger siblings: “*I have studied till fifth grade – as I am the eldest sibling and have two younger brothers and one sister, I had to do household chores and look after their food preparation. So I dropped out of school from fifth grade*”. (Parul, age 24, married, tribal community)

Lack of educational opportunities resulted in low exposure and confidence, as in Sheikhha’s first experience of going out of the house on her own: “... *so when I went out for the job for the first time, I was so scared – how am I going to manage in an auto alone ... how am I going to reach there [her workplace]? What type of people will I meet in my job?*” (Sheikha – 24 years, unmarried, tribal community)

Poverty created other emotional issues for these young girls. Sunita, a 19-year-old college student from the tribal community, described how she began distancing herself from her peers because of fear of peer pressure. Her family income is limited, and she had to think twice before spending any money. As a result, she had chosen to keep away from her financially better-off friends who often spent substantial amounts on mutual gifts. She even stopped talking to them or asking them for their notes from the coaching classes that she could not afford.

All these and other vulnerabilities resulted in experiences of marginalisation that impacted the young women’s sexual and reproductive health and rights, as described in subsequent sections.

Young women’s experiences related to SRHR

We focus on the perception of respondents about their rights. While respondents could not articulate their rights or name them, they could undoubtedly identify the violation of their rights. They shared experiences related to their rights as young people – the broader set of rights like the right to information and autonomy, as well as sexual and reproductive rights, including the right to bodily integrity and SRH services.

The right to SRH information

Young women reported a lack of awareness about several SRH issues, including menstruation, contraception, sexual relationships.

Awareness about menstruation

Menarche was the first significant reproductive health milestone in the respondents' lives. Most of the respondents got their first period around 13–14 years. Half of the respondents said that they knew nothing about periods the first time they had them; five had some awareness about menstruation. More than one respondent spoke about how they were scared when they first got their period. Describing her fears, Kajal, a domestic helper, said, *"I did not know. I was afraid. There was no itching or pain at the urinary place, but the bleeding was flowing continuously"*. (Kajal, age 21, married, tribal community)

Although Sheikhha had two elder sisters, she was not aware of menstruation. She only knew that her mother or sisters "behaved strangely" during some days of the month. They would not cook food or do the *puja* (religious ritual). Now she too had to follow the same practices. Another respondent added that no one told her what to use when she got her period: *"I did not get any information from the school regarding menstruation. When I got my first period, my friends told me."* (Sheela, age 24, married, tribal community)

Almost all those who had prior information on menstruation were unmarried. Their source of information was the NGO representatives from SAHAJ. Four respondents said that information given by the NGO helped them when they started menstruating. They were better able to manage their first menstruation because they knew what it was and what to expect. As Sudha explained,

"At the age of 13, I was at home and asleep, and I felt something so went to the bathroom. Alpaben [SAHAJ worker] had oriented us, so I was aware of this. When she conducted the session, I was not able to understand much I was too young. But everything was in my head. I remembered everything – have to use one pad for max three hours, have to take a bath two times, to clean ourselves." (Sudha, age 18, unmarried, tribal community)

Knowledge of contraceptives

A majority of respondents talked about contraceptives. Many married women said that they did not know what to use to prevent an unwanted pregnancy. The unmarried girls who talked about contraceptives were aware that condoms could prevent pregnancy.

Because of lack of awareness, Parul and Urmila, two married respondents, were not using any method of contraception. Sheela also said her pregnancy *"was unplanned as I was not aware of what to use to prevent pregnancy"*.

Thus, despite the Government of India's long-term emphasis on family planning (dating back to 1952), some young women – even in better-off states like Gujarat – still lack essential knowledge about contraceptive options and are forced to continue with unplanned pregnancies.

Other SRHR-related information

Most of the married respondents shared that they did not know about sexual relationships before getting married. They were nervous on the first night of marriage, and they did not talk about it with anyone. Seema, a 22-year-old married woman from the tribal community, who lives in a nuclear family, told us she *"did not even know that we have to sleep in the same room"*.

Four of the six mothers among the respondents mentioned that they did not receive any information about postnatal care after their delivery. Sheela commented that *"No doctor has told me anything about how to take care. As I had a normal delivery, I never visited the doctor because there were no complications."*

In a small sample of 14 young women, we see significant violations of the right to SRHR information, leading to undesirable lifelong consequences for many respondents.

The right to explore sexuality and choose a sexual partner

The findings show that patriarchal social and cultural norms were also profoundly internalised by the young women, with many respondents experiencing social control over their sexuality, in different ways.

Reena described how she was "caught" with her boyfriend, and she was extremely scared when she went home. She also believes that going out with boys is wrong, an example of internalising the prevailing social norms about how "good girls" conduct themselves. When asked about it, she explained:

"I was thinking that my father would not leave me alive (laughing), but he did not hit me much. He just [our emphases] slapped me two or three times and asked me why I was doing this behind

their back? Then they made me understand that whatever I had done was wrong. I also agree with them. Whatever they say is correct.”

Another respondent shared that she felt threatened by her mother’s disapproval, so she could never think of having an affair or feeling attraction towards any boy. Meena spoke about how her father controlled her and her siblings as they were growing up:

“When I was young and living with my maternal family in the village, boys and girls generally ran away at an early age. So my father would not allow us to play or even talk with boys. My father would not allow us to go anywhere. Whenever he went to the farm, we had to go with him and come back with him.” (Meena, age 26, married, tribal community)

Four women shared their experiences about relationships and how families reacted when they got to know of any. One of them was beaten by her elder brother, while the other was beaten and forced to quit her job. Kaira said that *“If my family found out that I was in a relationship with someone, they would kill me.”* (Kaira, age 19, engaged to be married, Scheduled Caste)

Girls also spoke about how puberty was a major marker in terms of their restrictions to control their sexuality. Sheikha commented that *“Earlier, we can go anywhere without any hesitation, but after [getting menstruation], half the things get changed”*.

Three young women said that parents would choose the appropriate partner for them and that they accepted not having a say in the matter, like Sheikha, who lives with her single parent and has been working in a nursing home for last six years: *“Whoever [the boy] parents find is the best”*.

The two Scheduled Caste women amongst the respondents were very conscious of caste issues. They nipped their romances in the bud to avoid conflict with their families and in the community. However, two married respondents said that they exercised their choice and their fathers respected their right to choose their husbands. Kajal told us that *“My father asked me whether I like a boy. And I said yes, and then we got married”*.

The right to bodily autonomy

Respondents described how their rights over their bodies were violated in different ways: their

fertility decisions, rights to sexual pleasure, dress codes, shame related to notions of pollution and purity, to mention a few.

Fertility decisions

Gender power relations played a significant role in women’s fertility decisions. The most common reason for choosing contraceptive pills was that the husband did not like to use condoms. Two out of three contraceptive pill users reported lack of support from their husbands. Kajal shared that

“... all this [referring to not getting pregnant] I have to take care of. He does not like the condom, so I take pills from the frontline worker Sarikaben”. Similarly, Seema said that *“My husband does not like a condom. I take pills. Once I forgot to take pills and got pregnant. My child just came because of this reason.”*

Sita had wanted to go for an operation (sterilisation) after her second delivery. Her husband also wanted the same, but her mother and father-in-law said, *“no, – It’s good to have a second son, then the two brothers can handle the work on the farm. ... In [our way of life] farming, one person is not enough ... there is lots of work, so then who will help him?”* Meena shared that she was the one who decided to get her sterilisation operation done: *“The child’s father was saying no, but I will go for the operation”*. In contrast, Sita, who had two children and was pregnant again, said, *“Mother-in-law was saying that it would be good if the second boy comes. I thought that I already have one boy and a girl, I will go for an operation, but my mother-in-law says no”*.

Sexual pleasure

Given all the societal norms that control women’s sexuality, only four of the six married respondents felt somewhat comfortable talking about their sexual relationships. Two of them spoke frankly about non-consensual sexual relationships with their husbands. One respondent’s husband is a driver in a nearby city who comes home once a month and thinks it is his right to have his sexual desires fulfilled on those occasions.

Two married respondents said they could negotiate sexual relations with their husbands and their husbands respected their desire and need for consent before having a physical relationship. Seema explained that

“If I want to do ‘that’ [sexual intercourse], I talk with him, sit near him, hold his hand, and he understands [my signals] and then we do it. When he wants to do, at that time he comes close to me, praises me and helps me, then says, ‘today I want’. If I say, ‘today you will not get’, he agrees.”

Gender norms, bodily autonomy and sexual rights
Rights over one’s own body are inextricably linked with prevalent gender norms governing the exercise of autonomy through prescribed dress codes, restrictions on mobility and discriminatory practices around purity and pollution that inculcate a sense of shame amongst girls because of their “dirty bodies”. Parul described how her life changed completely after she attained puberty because of the restrictions placed upon her.

“... When I was small, used to play, dance – then suddenly it was all stopped... when I got my first period. They [the elders] said, ‘now you have become mature (moti thayee gayee). You will get your menstruation every month, and then you will get married... Childhood had mostly gone at the age of 13... [During my period] I am not allowed to cook, fetch water, go to the kitchen and pray for at least six to seven days. Not to perform puja for six or seven days even after the periods are over. Not to have sexual relations with my husband for seven days. We have to sleep separately.”

Dress codes, as described by some respondents, are a specific way of controlling women’s sexuality. Sheela said she has to wear only saris because her in-laws insist that daughters-in-law wear saris and a *laaj* (veil). When they are not around, she wears a *Salwar Kameez* (a long shirt and a trouser), clothes which are comfortable and practical, but are considered “modern”:
“... When they are around, I have to wear ghunghat (veil), which means a sari. He [husband] asks me to wear Salwar Kameez, but parents in law don’t let me... When they are not here, I wear Salwar Kameez”.

In addition to the violation of sexual and reproductive rights experienced by these young women, the respondents also described how the sexual and reproductive health services failed them.

The right to SRH care

As the earlier sections show, many respondents could not access reproductive health care for

multiple reasons: societal norms, lack of awareness about services available and decision-making power. In this section, we discuss the health systems factors that violated their rights to the highest attainable standards of SRH care. Respondents spoke about accessibility, availability, affordability and quality of health care services.

Contraceptive care

The most common modern method used by married women was contraceptive pills; one had used an injectable, and one had the experience of using an IUD. As mentioned earlier, Urmila and Parul were not using any contraceptive, even though they did not want a pregnancy. Almost all the married respondents stated that their pregnancies were all unplanned.

Sita’s experience points to supply chain issues with contraceptive commodities. She described how the nurse from her area gave her a packet of contraceptive pills but did not tell Sita how to use them and for how long. The supply of the tablets stopped after two months as the nurse did not have enough stock. Sita did not ask for more because she did not have all the information. All of this begs the question of what the health system is doing about its critical role of supporting young women and providing information about contraceptives to those who need them the most.

Meena said that she was using an injectable contraceptive because the doctor advised the couple to use this. She is not aware of any other contraceptives. Her experience belies the Government of India’s “cafeteria approach”, which is supposed to enable couples to make an informed choice about a preferred contraceptive.

Thus, we see that contraceptive decisions of these young women are governed by lack of knowledge, lack of negotiating power and health systems factors like questionable quality of contraceptive services, including information provision.

Pregnancy and childbirth

Six (of the seven married women) shared their experiences of their combined total of 14 unplanned pregnancies and childbirths. In eight of these pregnancies, the women did not have any antenatal visits despite many of them having high-risk pregnancies. Many of them belonged to the Scheduled Tribe community, which has a high genetic possibility of sickle cell disease.

Others had a bad obstetric history, such as a previous caesarean section, preterm delivery and newborn deaths. None of the 14 pregnancies had any postnatal visits. All the women were anaemic, and two had sickle cell anaemia.

The many shortcomings of maternal health services are reflected in Sheela's experience. As she has sickle cell anaemia, she is a high-risk pregnant woman needing careful monitoring during the antenatal period. Sheela shared that she visited a private hospital for antenatal check-ups, which cost Rs. 500 (US\$ 7) per visit. As she was severely anaemic, she received nine iron sucrose injections during her delivery, which was normal, with no problem or symptoms after delivery and she was discharged from the hospital the following day. The doctor did not give her any information on postnatal care, check-ups, or contraception. Her family had to pay Rs. 35,000 (US\$ 475) for the normal delivery. When her first son was only five months old, she became pregnant again. She was not using any contraceptives although her periods started four months after the delivery.

Sheela's story shows how she, as a high-risk pregnant woman, failed to receive the required quality of care during the antenatal and postnatal period continuum. She was neither given special care as a pregnant woman with sickle cell disease requiring close monitoring of her anaemia, nor provided with contraceptive information and services postpartum to help prevent an immediate pregnancy.

At least three other respondents mentioned the high cost of care. Meena described her experience of caesarean section. In her first pregnancy, the family had to bear expenses of around Rs. 50,000 (US\$ 675), for which they had to sell some of her gold jewellery. In her second pregnancy also, they incurred an expense of Rs. 60,000 (US\$ 810), which her father bore. Despite the *Janani Suraksha Yojana*^{†††} and the *Janani Shishu Suraksha Karyakram*^{†††}, women chose to go to the private sector even though they had to incur high expenditures.

^{†††}Janani Suraksha Yojana is a Government of India conditional cash transfer scheme to promote institutional deliveries.

^{†††}Janani Shishu Suraksha Karyakram, a government programme, is supposed to provide free services for antenatal care, childbirth, postnatal care and infant care to all women in public sector health facilities. If this programme were running well, women would not need to incur any out-of-pocket expenditure on maternal health care.

The young women's choice of the private health sector reflects their lack of confidence in the quality of maternal health care provided through public sector facilities.

The right to the highest standard of maternal health care is thus seen to be compromised for these vulnerable and high-risk women in terms of quality of antenatal and postnatal care and affordability.

Abortion

Abortion was not spoken about much in the 14 interviews. Not surprisingly, none of the unmarried respondents disclosed anything about their own need for abortion, although one of them did speak about having unprotected sex with her boyfriend. The stigma around abortion was reflected in Kaira's interview when she stated, "*We are not allowed to get an abortion in our community*".

An important factor that influences reproductive and sexual health care-seeking is the attitudes and behaviour of service providers. The interview with the Anganwadi Worker revealed an unsympathetic and anti-rights perspective. She described an incident when she told a young married woman, who approached her for information on abortion, that she would tell the girl's in-laws about this. She asserted that girls would "never dare to ask her for pregnancy test kits". She did not appear to understand that, as a service provider, she needs to maintain confidentiality concerning clients.

There appears to be some use of over-the-counter pills for abortion, without any medical consultation. Sheela shared that she got pregnant twice after her first delivery. She became pregnant one year after removing the Copper T because friends and relatives told her that "this was the cause of her weakness". The second pregnancy followed within the next few months. Both times, when Sheela missed her periods, her husband bought her pills for abortion from the medical store, assuming that she was pregnant.

Parul described the pathways to her abortion when she realised that her periods were delayed by 20 days. She went promptly to the Government Hospital (SSG, Vadodara), where she had delivered her babies. The doctor there confirmed her pregnancy and asked her what she wanted to do. She discussed her situation with the SAHAJ community worker immediately on her return home and decided to have an abortion. She went to

the hospital with her husband and terminated the pregnancy and underwent a sterilisation operation on the same day. Parul's story indicates that some familiarity with the health facility and support systems can help access abortion services.

Marginalisation and its impact on SRHR

The stories narrated by the young women show us that their SRHR are inextricably linked with their marginalisation. Based on the stories of two respondents, we trace how multiple vulnerabilities such as intergenerational and historical marginalisation interact with other factors to impact the respondents' SRHR.

Seema's family's acute poverty led to her being sent away to her grandparents' home. She suffered from malnutrition and anaemia from childhood, which affected her general health so much that she had to drop out of school after Class VIII. Early marriage into an equally impoverished family did not improve matters. An unplanned pregnancy, mental stress due to an unpaid loan, hard physical labour and poor nutrition during pregnancy all took their toll and resulted in a neonatal death. Following this, Seema succeeded in convincing her husband to move into a city with better work opportunities for him. Two more unplanned pregnancies followed. However, her parents and husband cared for and supported her. They spent generously to improve her nutritional status, and she gave birth to two children, although with complications in the second delivery. She had three unplanned pregnancies within the subsequent six years, one with an adverse outcome and another with complications.

In contrast, Sheela's story shows how the genetic disadvantage (i.e. sickle cell anaemia) of her tribal identity was offset by a relatively better-off material condition and care by her mother-in-law during two complicated pregnancies. Relatively liberal gender norms in her childhood allowed her to excel in sports and win a sport scholarship, go away to a hostel, and have the freedom to cycle five kilometres to school until Class XII. Nevertheless, gender norms around marriage became an obstacle for her aspirations. Her husband and marital family were not happy that she wanted to study further, as she would surpass her husband's academic achievements, which is unacceptable within a traditional marriage. This became a barrier to her development. On the

other hand, his support enabled the exercise of bodily autonomy through contraceptive use and help to terminate two suspected pregnancies.

Seema's and Sheela's narratives reveal how their rural and tribal status, poverty and social-cultural gender norms played out and resulted in their marginalisation. Sheela's story also indicates that certain material conditions – a better standard of living, education, care and support – could enable her to realise some of her SRHR.

These two stories typify how structural factors like economic status, working conditions and livelihoods, and social and cultural norms led to varying levels of marginalisation in the 14 young women's lives. The respondents experienced marginalisation in terms of gender discrimination, inability to exercise autonomy, low education, poor nutrition and health status, inadequate care and support, among others. There were, however, some positive dimensions in the respondents' stories, as described below.

Contextual factors as enablers

There were contextual factors that contributed to the realisation of young women's rights. The contextual factors lie in various domains (social, political, policies/programmes/laws) and at various levels (individual, family, community and macro systems).

At an individual level, an enabler that emerges from our interviews is the personal agency exercised by some respondents. Usha spoke about how she continued her education despite opposition from her natal family; Sonal, once exposed to the discussions and analysis facilitated by SAHAJ, decided that menstruation rituals are restrictive and that she would not follow them. Meena and Sita decided to undergo sterilisation operations despite opposition from the family. What enables women to exercise personal agency remains an area for further research.

Within families, we saw examples of progressive fathers and supportive husbands who did not stand in the way of some individual respondents' desires and initiatives. Parul was accompanied by her husband when she decided to terminate her pregnancy and Kajal's father did not stand in her way when she exercised her right to choose her life partner.

There are several examples of support at the community level – friends and peer groups and experienced community facilitators like the SAHAJ field workers. The research team members

also observed that the neighbourhoods where SAHAJ has had more extended engagement appear to have a more liberal atmosphere in relation to gender norms than those where engagement is more recent. Attitudes towards gender-based discrimination and gender norms seem to be changing gradually in areas where SAHAJ has had sustained involvement.

The larger policy and programme environment has also created some enabling factors. Adolescent health issues like menstrual hygiene and nutrition have gained currency and been made part of the job descriptions of frontline workers like the ASHA and the Anganwadi Worker. At the local community level, support by frontline workers for adolescents' and young people's SRH issues is mandated in various government programmes.

Discussion

In this paper, we set out to explore the sexual and reproductive rights (SRR) violations experienced by urban poor young women from marginalised communities. We also wanted to unpack how marginalisation due to social and economic vulnerabilities impacted their access to SRH services.

Our findings show that historic marginalisation – due to structural factors like social and economic stratification, low education, limited livelihoods and decent work opportunities – and social and cultural norms leading to gender inequality impact young women's sexual and reproductive rights and access to SRH care. Many of the SRR (as defined by the Guttacher-Lancet Commission) of the young women respondents in our study were violated.¹⁶ Many respondents did not have the right to bodily integrity and personal autonomy, or the right to choose their sexual partners and have safe and pleasurable sexual experiences. Their rights to decide when and whom to marry, and to decide when and how many children they wanted, were violated. They did not have access to the information, resources and support necessary to achieve all the above. Their rights to quality SRH services consistent with public health and human rights standards were also compromised because of the substandard quality of contraceptive services, antenatal and postnatal care, and unaffordable maternity care. It needs to be

highlighted that this is the situation in a relatively cosmopolitan city of an economically developed state with sound economic and health system governance indicators.

The SRR of the young women are also violated as a consequence of cultural beliefs and practices around the female body, which stigmatise processes like menstruation and lead to gender norms and unequal gender power relations that restrict women's control over their bodies and reproductive decision making.

A significant finding of our study was the failure of the health and education systems to provide SRH information to adolescents and young girls, thereby breaking a critical International Conference on Population and Development (ICPD) Programme of Action affirmation of the right to reproductive and sexual health information.

Young women's right to SRH information is seriously compromised because sexuality is a taboo subject. Parida et al. mention that social and cultural norms prohibit discussions on sexuality.⁶ Parents disapprove of their children being given information related to sexuality. The conservative political regime has created further barriers by banning sexuality education in schools in several states of India.²¹ Teachers are very uncomfortable talking about SRH issues and are not trained to talk about them. Respondents who reported that they received some information said it was from NGO outreach staff. Other studies in India, including among urban poor girls, corroborate young women's need for SRH information and highlight the need for comprehensive sexuality education (CSE). The many challenges to CSE will have to be overcome if young women's right to SRH information is to be upheld.

Provider attitudes are another major factor impacting access to the highest standards of SRH services, as we saw from the interview with the Anganwadi Worker when she implied that unmarried girls are not supposed to need contraceptives. Gendered notions of women as "reproducers" are also evident; the Anganwadi Worker's reported response to a woman in her field area seems to reflect the belief that women have to fulfil their roles as mothers. The family is seen as being entitled to decide whether a woman has a choice in relation to getting pregnant or continuing a pregnancy. Similar gendered notions are reflected in adolescent girls' nutritional programmes that

address the girls as “future mothers” rather than as individuals in their own right.

The longstanding and increasing politicisation of certain core SRHR issues connected with sexuality (for example, abortion), also creates a backlash for young women. “Honour killings” and lynchings of couples who marry across castes or religions are on the rise.²²

Although adolescent development and SRHR have gained global recognition since the ICPD, and there are national programmes catering for them, adolescents and young people are not adequately reached by those programmes.²³ In India, policies such as the ARSH Strategy, for adolescents’ and young people’s health and empowerment, have resulted in programmes like the RSKS and SABLA with some rights elements in their designs. These programmes and schemes provide some space that can be leveraged through social accountability efforts by young people and civil society organisations; young people’s participation can increase the visibility of contextual barriers and suggest workable solutions.

The limitations of this study are that we were not able to get sufficient health provider perspectives, as originally planned, because of the COVID-19 pandemic restrictions. A follow-up study on provider perspectives will be done as soon as some normalcy is restored. A strength of the study is that it was carried out by researchers who are from, and have a long engagement in, these communities and who have been able to incorporate the findings into improving the programme design.

Conclusion and the way forward

This study in an urban area of an economically developed state shows that social and economic factors exacerbate the vulnerabilities of young women, leading to their marginalisation, which creates barriers to the realisation of their SRHR. Based on our analysis, we suggest the following.

Policies for adolescent and youth development need to have a multi-sectoral vision and action plan for addressing marginalisation. While health and education sectors have important roles to play for improved adolescents’ and young people’s SRHR, multi-sectoral interventions such as poverty alleviation and livelihoods programmes are required to address the contextual factors that result in the marginalisation of young women.

The first step is to enable transformation of unequal gender norms within all institutions – family, education, health – to promote young women’s empowerment. Sexual and reproductive health programmes and schemes then need to be tailored to address the specific challenges and barriers faced by young people from marginalised populations.

Service delivery through the adolescents’ and young people’s SRH programmes should be non-judgemental and rights-based. For example, girls should not be viewed merely as “future mothers”.

The RSKS should be made available all over the country, with sufficient investments. Systematic monitoring of implementation, including by young people, should be ensured to make the programme more responsive.

Other health programmes, like the Maternal and Child Health and Family Planning programme, should recognise the specific needs of young married couples and address them. For example, there should be special programmes to cater to the contraceptive information and service needs of young couples. These issues should be addressed urgently through public campaigns, as well as through well-supervised service delivery programmes.

The analysis shows that an enabling factor for the realisation of young women’s SRHR and increased gender equality is the support of their partners. Gender-transformative interventions with boys and young men, with inputs and sensitisation on masculinities, would be an important area of intervention. One implication of this is the need for male health workers to work on the men and boys’ component of the RMNCH + A strategy.

Service providers across sectors need to be trained on the meaning of adolescent-friendly and non-judgemental adolescents’ and young people’s SRH services, including on how to transact a curriculum on comprehensive sexuality education.

The findings show that young women value the support provided by SAHAJ field staff. The health system could leverage such support by collaborating with NGOs working with adolescents and young people with a gender and rights perspective, as well as with feminist groups, who have a relationship of trust with young people, to reach this vulnerable population with information and services. These organisations and groups could usefully be included in the technical experts’

pool to support training, monitoring and evaluation for the rights-based implementation of all adolescents' and young people's programmes.

Disclosure statement

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Résumé

Dans cet article, nous présentons les résultats d'une étude qualitative menée par une organisation à but non lucratif qui applique un programme communautaire de développement des adolescents en zone urbaine. L'étude met en lumière la situation de la santé et des droits sexuels et reproductifs des jeunes femmes marginalisées dans un État indien développé. Nos résultats, fondés sur des entretiens approfondis avec des jeunes femmes et des prestataires de santé de première ligne, montrent que des phénomènes structurels, comme des facteurs sociaux et économiques de stratification, des normes de genre et des croyances culturelles, contribuent à marginaliser encore plus profondément les jeunes femmes. À son tour, la marginalisation influe négativement sur la réalisation des droits sexuels et reproductifs par des pratiques discriminatoires autour des menstruations et du manque de contrôle dans les questions relatives à la sexualité, la contraception, la grossesse et l'avortement sûr. Le droit aux normes les plus élevées de soins de santé sexuelle et reproductive (SSR) est aussi compromis. L'étude montre que des caractéristiques du système de santé comme les attitudes et les connaissances des prestataires, l'approvisionnement en fournitures de base et l'indifférence face à la prestation de services de contraception et autres aboutissent souvent à des grossesses non désirées et sapent la qualité des soins de SSR reçus par les jeunes femmes. Les informations et le soutien qu'obtiennent les adolescentes et les jeunes femmes proviennent d'organisations communautaires locales. Nous en concluons que les déterminants structurels et les violations des droits fondamentaux à l'éducation, à l'égalité des chances et à la participation constituent un obstacle de taille à la jouissance de la santé et de droits sexuels et reproductifs de la part des jeunes femmes marginalisées de l'étude. Sans mesures correctives, les politiques et programmes gouvernementaux destinés à promouvoir la santé et les droits sexuels et reproductifs des jeunes ne bénéficieront pas aux femmes issues de communautés défavorisées. Les partenariats et la complémentarité entre les programmes gouvernementaux et les organisations de la société civile actives en matière de droits à la santé et d'adolescents sont recommandés pour promouvoir des services équitables et fondés sur les droits, adaptés aux adolescents et aux jeunes de cette population vulnérable.

Resumen

En este artículo presentamos los resultados de un estudio cualitativo realizado por una organización sin fines de lucro que ejecutó un programa comunitario urbano sobre el desarrollo de adolescentes. El estudio destaca la situación de salud y derechos sexuales y reproductivos (SDSR) de mujeres jóvenes marginadas en un estado desarrollado de India. Nuestros hallazgos, basados en entrevistas a profundidad con mujeres jóvenes y prestadores de servicios de salud de primera línea, muestran que los factores estructurales, tales como estratificadores económicos y sociales, normas de género y creencias culturales, causan la continua marginación de las jóvenes. A su vez, la marginación afecta adversamente la realización de los derechos sexuales y reproductivos por medio de prácticas discriminatorias en torno a la menstruación y la falta de control en asuntos relacionados con la sexualidad, anticoncepción, embarazo y aborto seguro. Además, se compromete el derecho al más alto nivel de servicios de salud sexual y reproductiva (SSR). El estudio muestra que factores del sistema de salud tales como actitudes y conocimientos de los prestadores de servicios, insumos y la indiferencia con relación a garantizar la prestación de servicios de anticoncepción y otros servicios, a menudo contribuyen a embarazos no planificados y afectan la calidad de los servicios de SSR de las jóvenes. La información y el apoyo que reciben las adolescentes y jóvenes proviene de organizaciones comunitarias locales. Concluimos que los determinantes estructurales y las violaciones de los derechos fundamentales a la educación, igualdad de oportunidades y participación constituyen una barrera significativa al goce de SDSR por las jóvenes marginadas que participaron en el estudio. A menos que estos factores se aborden, las políticas y los programas gubernamentales para promover SDSR de jóvenes no beneficiarán a las jóvenes en comunidades desatendidas. Se recomienda establecer alianzas y complementariedad entre los programas gubernamentales, adolescentes y organizaciones de la sociedad civil defensoras del derecho a la salud, con el fin de promover servicios equitativos, basados en los derechos y amigables a adolescentes y jóvenes, para atender a esta población vulnerable.