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# Embodied Journeys of Becoming: Urban Poor Adolescents' Lived Experience of Identity, Health, and Space in Surat

*Anuj Ghanekar, Mohit Sood, Khushbu Chauhan, Vikas Desai*

## Abstract

### Introduction

Adolescent identity formation in urban poverty contexts is shaped by simultaneous aspirations and structural constraints. This phenomenological study examines how urban poor adolescents in Surat construct their identity and sense of well-being while navigating constrained circumstances. Rather than viewing identity as individual psychological development, this research centres on lived experience—how adolescents' sense of self emerges through embodied encounters with unsafe spaces, economic precarity, and fragile health connections. The paper illuminates that adolescents actively exercise agency amid constraints, forging relational and spatial practices that create healing and possibility.

### Methodology

Phenomenological inquiry examined the lived experiences of adolescents (n = 90) in Surat's informal settlements through focus group discussions. Data collection examined how adolescents navigate their urban environments, negotiate their identities, and engage with health and well-being. Thematic analysis, grounded in phenomenological philosophy, identified the embodied, spatial, and relational dimensions of lived experience.

### Results

Adolescents experience the city as fragmented and exclusionary, marked by unsafe spaces, economic hardship necessitating early work, and disconnection from health services. These conditions profoundly shape identity and constrain possibilities. Yet adolescents actively create therapeutic micro-spaces through peer networks and relational practices of care and solidarity. Identity emerges as embodied and spatially constituted through daily negotiations with both threats and supports in their urban environments. Adolescents construct themselves as resilient, caring, and hopeful despite marginalisation.

### Conclusion

Adolescent identity in urban poverty is fundamentally embodied, relational, and spatial. Young people demonstrate agency through creative practices of care and meaning-making, revealing that wellbeing emerges through relational support and spatial access rather than institutional interventions alone.

### Implications

This work calls for youth-centred approaches, recognising adolescents as active agents co-creating therapeutic urban spaces. Health and social policy must address structural barriers and centre adolescent voices in designing inclusive, equitable futures.

Keywords- Adolescent, Community Participation, Health Equity, Poverty, Qualitative Research, Urban Health

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## 1. Introduction

Adolescence represents a critical transition phase characterised by profound physical, psychological, and social changes. The World Health Organisation defines this as a transition from childhood to adulthood, a period during which young people navigate identity formation, social relationships, and future aspirations (Singh et al., 2019). Adolescent health is recognised as a key component of India's National Health Mission, given that nearly one-fifth of India's population comprises adolescents aged 10-19 years (Patel et al., 2018). More than 33% of disease burden and almost 60% of adult premature deaths can be linked to behaviours and patterns established during adolescence (Lule et al., 2006), making investment in adolescent health crucial for individual and national well-being.

However, adolescent health experiences are profoundly shaped by structural contexts—particularly urbanisation, economic inequality, and social marginalisation. Rapid urban expansion in India has created stark inequalities, with residents of informal settlements and low-income neighbourhoods facing particular vulnerabilities (Bhan et al., 2014; Agrawal, 2016). Urban poor adolescents navigate complex landscapes where aspirations for health, education, and civic participation coexist with constrained material conditions, unsafe environments, and limited access to services (Kumar & Nagaraj, 2006). The state of urban poverty in India reveals that health inequities are not incidental but structural, reflecting systemic gaps in access and responsiveness (Agrawal, 2016).

While India's Rashtriya Kishor Swasthya Karyakram (RKSK) represents an ambitious policy framework acknowledging the multidimensional nature of adolescent health (Ministry of Health and Family Welfare, 2018), evidence suggests implementation challenges remain significant, including inadequate capacity building and infrastructure gaps (Barua et al., 2024; Jain et al., 2022). More fundamentally, adolescent health in urban poverty contexts has been predominantly examined through institutional or epidemiological lenses—focusing on health outcomes, risk behaviours, and service delivery—rather than centring adolescents' own lived experiences, meaning-making, and agency.

Yet adolescents themselves emphasise dimensions of health engagement that extend beyond institutional frameworks. Research indicates that adolescents prioritise trust, comfort, and relational connection with healthcare providers (Hardin et al., 2021) and that youth-friendly health services require approaches that integrate psychosocial support alongside biomedical care (Tylee et al., 2007; World Health Organisation, 2012). Adolescents' experiences of health are embodied, relational, and embedded in their navigation of urban spaces and social contexts.

This phenomenological study centres on adolescent voices and lived experiences to understand how urban poor adolescents in Surat construct their identity, exercise agency, and experience wellbeing while navigating fragmented urban landscapes marked by economic hardship, spatial insecurity, and disconnection from health services. By illuminating adolescents' embodied journeys of becoming—their aspirations, their creative practices of care and solidarity, their resilience—this research seeks to reframe adolescent health not as individual risk management but as fundamentally relational, embodied, and embedded in broader questions of urban equity, social inclusion, and therapeutic space creation.

## 2. Literature Review

Adolescent is a key transitional phase of life marked by changes in emotions, identity and social roles (Erikson 1968; Singh et al. 2019). Adolescent health research is often looked through biomedical and psychological frameworks. These studies often focus on risk behaviours, health outcomes, and use of services (Blum et al. 2014; Patton et al. 2016). These studies however don't completely capture the daily lived experiences of adolescents especially in poor urban settings where survival needs, unsafe environments, and weak institutional support shape daily experiences (Ager and O'May 2001; Morrow 2001; Viner et al. 2012).

Phenomenological study design helps us to address this gap by understanding lived experience. Identity is understood through daily interactions between body, relationships and surroundings (van Manen 2016; Merleau-Ponty 1962). Adolescents understand themselves through interacting with neighbourhoods, balancing work and school, caring for family and dealing with public institutions. Understanding adolescence phase in urban poor context is vitally important where early responsibilities, limited choices, uncertain futures reduce the adolescence phase (Morrow 2013).

Increasing urbanization has increased inequality, particularly in low-income and informal settings (Agrawal 2016; Bhan, Jana, and Bhattacharya 2014). The adolescents growing in these areas face challenges like food insecurity, irregular income, starting work early which often comes at the cost of interrupted schooling (Rani et al. 2018). These issues are linked with health issues like anaemia, poor nutrition, substance misuse, violence and stress (Lu, Li, and Patel 2018). These issues are not shaped by individual attributes of adolescents but rather the broader structural conditions shape adolescent's lives (Patton et al. 2016; Viner et al. 2012).

Urban spaces also play a prominent role in adolescents wellbeing. Evidence has shown that public settings in low-income urban areas are often unsafe for adolescent girls who regularly experience harassment and fear of violence (Datta 2016; Phadke, Khan, and Ranade 2011). Due to these reasons, many adolescents may limit their movement and avoid community engagement and participation which also hinders their mental wellbeing and confidence. Yet, the issues of safety and security are rarely addressed in adolescent health programs (Patton et al. 2016; Viner et al. 2012).

Although RKSK program is ambitious in terms of its design, the implementation of RKSK has been uneven across different contextual settings. RKSK relatively comes low on priority list compared to other government agendas like maternal and child health (Barua et al. 2023). RKSK program faces shortage of skilled staff like peer educators, counsellors etc. which compromises the delivery of healthcare services. Frontline health workers receive inadequate capacity building to cater to adolescent health and the training curriculum lacks depth and cohesiveness across different states (Jain et al. 2022). Despite RKSK program stressing on peer educators and community involvement, there is limited involvement of adolescents in formal decision making, policy level feedback loops and monitoring. This dilutes the programs responsiveness to adolescent specific needs (Kansara et al. 2018).

The majority of RKSK services are delivered through schools and Urban Primary Health Centres (UPHCs). However, adolescents may find it difficult to access these settings due to

a mismatch in timing, work, not being enrolled in formal education in schools, and restrictions on movement due to safety concerns. Decision-making on healthcare is often parent-led, and clinic timings are unsuitable for adolescents. Health services are also not responsive to the needs of adolescents. Due to this, low use of services is unintentionally understood as a lack of interest rather than barriers and mistrust (Hardin et al. 2021; Patton et al. 2016; Viner et al. 2012).

Adolescents place more emphasis on trust, comfort level with the provider, rather than the infrastructure of the health facility and the availability of health services (Hardin et al. 2021). These attributes are often given less relevance under RKSK, which is focused on targets, reporting and clinical indicators (Ministry of Health and Family Welfare 2014). Recent studies have argued for more adolescent participation, which sees adolescents as active contributors to their own well-being (Patton et al. 2016; Viner et al. 2012). Our study sets out to understand the lived experiences of urban poor adolescents in Surat. Using a phenomenological approach, it examines how adolescents experience identity, health, and urban space in their daily lives, and how these insights can help improve the implementation of programmes like RKSK.

## 3. Objectives

 To explore urban poor adolescents lived experiences of identity formation, health engagement, and community participation in Surat within constrained urban environments.

 To examine how adolescents exercise agency and construct wellbeing through relational and spatial practices of care and solidarity despite structural constraints.

 To illuminate implications of adolescent lived experiences for youth-centred urban design and health policy.

## 4. Research Methodology

### 4.1 Study setting

This study was done in Surat, a coastal city in the western Indian state of Gujarat. The city is known for its economic growth, urbanisation, high influx of migrants, climate vulnerability, as well as urban reforms and a functional health system in response to the 1994 Plague episode. Known as the fourth fastest growing city in the world, Surat has a Mid-census estimated total population of 6,078,457 (2018). As per the Family Health Survey (2018), the total Adolescent population registered in Surat was 6,46,459 (10.6% of the total). During the study period (March-December 2022), the health department of the urban local body provided primary healthcare services through 41 Urban Primary Health Centres (UPHCs). Surat is facing a challenge of double burden of diseases, a great mix of historical lead rank for communicable diseases like Filariasis, Malaria, HIV, Dengue, H1N1 and recent rise of non-communicable diseases like other Indian cities. The city must be on alert for flood-linked infections, such as plague and Leptospirosis. The COVID-19 pandemic also had its impact recently.

### 4.2 Study design

The studied phenomenon of interest- lived experiences of adolescents- required the "naturalistic" understanding of the issue (in real-life situations) over "controlled" experiments. Therefore, a flexible research design with a qualitative exploratory

approach was considered appropriate. The findings were developed from the data itself rather than from preconceived and structured operational definitions. The iterative process, guided by the inductive approach, facilitated the generation and exploration of new ideas throughout the entire process. The data in this study mainly comprised 8 FGD and informal interactions where the views of 90 adolescents were captured.

### 4.3 Participants Recruitment and Data Collection

Focused data collection was conducted from March 28, 2022, to July 12, 2022. The field investigators were well-trained in qualitative data collection methods and familiar with the local context. The authors of the research team combined public health and social anthropological disciplinary perspectives, which were discussed, debated, and negotiated throughout the fieldwork process. The participants' recruitment support was provided by Community Health Workers (CHWs) of primary health centres, Government School teachers, and Anganwadi (local government playschool) workers; however, the finalisation of recruitment was done by the research team only to avoid the bias that might have been introduced by the workers. Once introduced by health workers/Anganwadi workers/teachers, the research team explained the purpose of the study to participants and inquired about their willingness to participate. Urban adolescents are not a homogeneous group, and they have many sub-groups within them, like out-of-school adolescents, those with special needs, working or married adolescents, those from seasonal migrant families, pregnant girls, those living on the streets, etc. The diversity of participants was ensured as much as possible for the research team during the recruitment process.

The participants' preferred local languages, Hindi and Gujarati, were used during the interactions. On average, the FGDs lasted 30-45 minutes. FGDs were facilitated by a moderator and a note-taker. As is the practice in qualitative studies, the exact sample size was not pre-determined. The data collection was stopped when it was saturated.

### 4.4 Data analysis

All the data and field notes were either audio-recorded or maintained as handwritten notes. Observation notes were recorded in field notebooks and a diary. Anonymity and confidentiality were ensured when storing data in both hard-copy and soft-copy forms. Original data sets, as well as backups, are being preserved for a minimum of 5 years, in accordance with standard guidelines. The qualitative data available in the form of audio recording transcriptions/ field notes were organised for further analysis. Individuals proficient in Hindi, Gujarati, and English were responsible for translating the data. As is typical of qualitative studies, data analysis processes were initiated simultaneously with data collection. Data debriefing sessions were held after every data collection visit to discuss emerging themes. Ideas from the transcripts were also discussed in a team to arrive at a standard set of codes. The transcripts and field notes were manually sorted and coded. The qualitative data were analysed using the "reflexive iteration" method, whereby the data were continuously revisited to identify and refine the emerging themes. Debriefing with mentors and member checking were used for review and feedback. Maintaining the anonymity of insiders has been done appropriately to avoid easy identification.

### 4.5 Ethical Considerations

Ethical clearance was obtained from the local Institutional Review Board to conduct the study. Informed consent was taken from adolescents' guardians during all formal interactions.

## 5. Research Problem

Urban poor adolescents in rapidly urbanizing Indian cities navigate profound contradictions between aspirations for health, education, and civic participation and the structural barriers imposed by economic precarity, spatial insecurity, and institutional marginalization. While adolescent health is recognised as critical to national development, existing research and policy interventions predominantly adopt institutional, epidemiological, or risk-focused frameworks that centre on health outcomes and service delivery gaps rather than adolescents' own lived experiences, meaning-making, and agency. This gap is particularly acute in urban informal settlement contexts where adolescents encounter unsafe public spaces, family financial hardship, early vocational pressures, and fragile connections to formal health services—conditions that profoundly shape identity formation and wellbeing trajectories. Yet, adolescents remain largely absent from research that centres on their voices, embodied experiences, and the relational and spatial practices through which they actively construct their identity and resilience. Understanding how urban poor adolescents experience and navigate their complex urban worlds—how they exercise agency, forge solidarity, and create therapeutic spaces amid constraint—is essential for reimagining health systems, urban design, and social policies that genuinely respond to adolescent needs and recognise young people as active agents in shaping equitable, inclusive futures. This phenomenological study addresses this gap by centring adolescent lived experiences and embodied narratives in Surat, a rapidly urbanising city characterised by significant informal settlements and health inequities.

## 6. Analysis and Interpretation

The urban landscape inhabited by adolescents under study emerged not only as a neutral geography but as a deeply fragmented terrain of constraint, vulnerability, and truncated possibility. Adolescents lived experiences revealed how structural precarity became embedded in their bodies, spatial practices, and temporal horizons.

Adolescents lived worlds were inhabited by multiple, intersecting concerns from poverty and safety to mental health, social media use, and inadequate physical infrastructure. However, to honour the phenomenological depth required to understand how these concerns are actually lived and embodied, this results section foregrounded the two concerns that emerged most insistently across fieldwork discussions: economic hardship and safety. These concerns constituted the material and existential ground upon which other vulnerabilities, including mental health struggles, substance misuse risks, and social disconnection, took root and developed. By examining these foundational constraints in depth, the structural context has been illuminated within which all other adolescent health concerns are situated.

### 6.1 Economic Precarity

Economic hardship pervaded the lived world of the adolescents under study, not as an abstract statistical reality, but as a visceral, daily presence that shaped the texture of

their existence. The burning concern articulated repeatedly during fieldwork revealed poverty not as a background condition but as an active, demanding force that structured temporal rhythms, spatial movement, bodily practices, and imaginings of future possibility.

For many adolescents, work was not a choice but a necessity- an embodied obligation woven into the fabric of family survival. For example, 12-year-old Raghav from Limbayat shared,

"Every day after school, I sit down to fold saree boxes. It's what my family needs me to do. We fold the cardboard, create the boxes, and for every hundred boxes I complete, I get 25 rupees. On my best days, when I'm really focused and fast, I can fold around 1500 boxes and earn between 200 to 250 rupees. That money matters to my family—we need it. However, by the time I finish folding boxes and help my family with their tasks, I'm exhausted. There's barely any energy left for studying or homework. Sometimes my parents bring more boxes home, and the whole family works together to complete them. I notice other kids doing the same—we even compete with each other to see who can fold the most. Everyone's trying to earn as much as possible. I understand what's happening, though. I notice that the older kids, those aged 15 or 16, have mostly stopped attending school. They work full-time now, folding boxes all day. I know that's probably where I'm heading too. It feels like once you start this work, it's hard to get out of it."

FGD 2, Udhna Limbayat Road, Dated 25th June 2022

For several adolescents, work fragmented their temporal experience. School hours, labour hours, household obligations, and the desire for peer socialisation all competed for time and energy.

The COVID-19 pandemic had also crystallised this precarity into an acute crisis. Adolescents' narratives reveal a stark before-and-after temporal marker. Pre-pandemic, economic hardship was chronic but navigable; post-pandemic, vulnerability intensified dramatically. Another most immediate loss was the cessation of mid-day meals in schools—a loss that adolescents experienced not merely as nutritional deprivation but as symbolic abandonment by institutions.

Limited access to essential resources became a chronic condition that shaped embodied experiences and constrained life trajectories. The body became the site where economic precarity is inscribed—in undernourishment, in untreated health concerns, in the fatigue of insufficient rest. The case of Rekha reflected the complexities arising from economic deprivation.

Rekha, a 17-year-old girl from the Sarita Vihar slum, originally hailed from Bhavnagar, Gujarat. Following the death of her father from a chronic illness, Rekha's mother moved the family to Surat, bringing along Rekha, her four sisters, and her brother. To make ends meet, Rekha's mother worked as a street vendor, selling balloons. Rekha had to drop out of school after completing the 6th standard. She shouldered significant responsibilities at home, including household chores and caring for her younger siblings. She also assisted her mother in earning a livelihood. During a conversation, Rekha revealed the daily struggle to provide two meals for the entire family. She

suffered from chronic weakness and frequent dizziness, which recently led to a fall at home. Although she visited a doctor, she was unaware of her haemoglobin levels. Her condition usually worsens during her menstrual periods, and she worries about not being able to help her mother with street vending during those times.

- FGD 5, Adajan, Dated 16th May 2022

Economic hardship, thus, was not a background condition but an active force structuring adolescent temporal experience and life trajectories. While adolescents pursued vocational skills with the hope of financial independence, their futures remain fundamentally constrained by family poverty, pandemic disruptions, and the necessity of early work that truncates their education and forecloses alternative possibilities.

### 6.2 High Risk Social Environment

The social environment in which adolescents were studied was saturated with threats. This was not an occasional danger, but a pervasive, normalised insecurity that seeped into the fabric of daily life. The risky social environment was a constant backdrop against which adolescents must navigate their worlds and negotiate their safety.

Substance misuse pervaded the local landscape. Tobacco and cannabis-based products circulate openly; their use is visible and normalised within peer networks and community spaces. Adolescents were not passive observers of this landscape but were embedded within it, exposed to substance use practices, pressured toward participation, and aware that substance involvement carries consequences- legal trouble, health risks, social stigma. For example, consider the case of 16-year-old Amit, as he expressed it in one of the discussions.

Amit dropped out of school after completing 8th standard to help his parents run their food stall. In his free time, Amit often spent time with a group of older boys who regularly gathered at a specific spot in a neighbourhood lane. One day, while Amit was at this spot with the older boys, the police arrived, suspecting the group of possessing marijuana (ganja). Although no drugs were found, the police took all the boys, including Amit, to the local police station (chowki) and detained them for several hours. While the other boys in the group were involved in using marijuana, Amit mentioned that he was innocent and had never smoked or consumed any drugs. This incident served as a wake-up call for Amit, prompting him to refrain from participating in social circles and activities.

- FGD 4, Udhna, Dated 5th June 2022

Violence inhabited this world in multiple forms, each leaving its mark on adolescent consciousness and bodily experience. Verbal harassment, particularly of girls, was pervasive and casual. Vulgar comments, abusive language, and unsolicited attention on streets and during commutes become normalised features of public space. Girls navigated streets braced for assault, anticipating harassment as inevitable rather than exceptional. Beyond visible violence lay the spectre of sexual assault and domestic violence, heard about, feared, and understood as real possibilities that constrained girls' sense of bodily safety and autonomy. The following case of Kinjal, for instance, depicted how the adolescent's concerns were intertwined with broader systemic issues

of work informality, where both parents are working, and how the space-safety dynamics altered her mobility patterns.

Kinjal was a 14-year-old girl living in Rewanagar Vistar, within the RN coverage area. She was studying in the 8th standard at a public school, which she attends in the morning. Both of her parents worked long hours; her father was employed in textile looms, and her mother worked as a housemaid. Kinjal had two younger sisters to look after during the day, as her parents left early in the morning and returned late in the evening. One of Kinjal's regular tasks is visiting a nearby grocery shop, about 5-7 minutes from her home. However, she faced harassment from boys who stood along her route to the shop. They teased her by shouting a distorted version of her name and laughing amongst themselves. Although they had never physically harassed her, this behaviour made Kinjal feel unsafe. Kinjal was reluctant to share this issue with her parents, fearing they might blame her dressing style or accuse her of lingering too long at the shop. To avoid these confrontations, Kinjal preferred to purchase groceries in the morning or evening when her parents were around, ensuring she felt safer.

- FGD 4, Udhna, Dated 5th June 2022

The phenomenological consequence was profound: adolescents, particularly girls, impose self-curfews. They restrict their movement not only through external prohibition but also through an internalised awareness of danger. Coming home before dark becomes a necessity rather than a parental demand. Avoiding certain streets, certain times, and certain spaces becomes tactical knowledge essential to survival. The city, which should be a space of exploration, social connection, and opportunity, became instead a terrain to be managed and feared.

Bullying in schools also reflected and reinforced these broader patterns of social violence. Adolescents describe incidents of peer cruelty, exclusion, and intimidation that create unsafe educational spaces. In the digital realm, cyberbullying extended harassment into spaces that were once private refuges.

Safety concerns thus had become a persistent presence in the landscape of adolescent life, shaping how they navigate space, inhabit their bodies, and envision their futures.

### 6.3 Limited Connect with Public Healthcare Services

The limited connection of adolescents to nearby urban primary health centres (UPHCs) was evident from several findings. In the Indian context, healthcare decisions for adolescents were predominantly made by parents, especially fathers, based on community opinions and traditional practices. Fieldwork indicated that families often preferred private clinics or tertiary public hospitals over UPHCs due to greater trust in these institutions. This created initial barriers for adolescents to engage with UPHC services and adolescent health programs, which are largely implemented there.

For example, in a group of 14 adolescent participants, 9 had never accessed the health centre, 4 became acquainted with it during the COVID-19 vaccination, and only one girl had visited for treatment purposes. In another group of 15 adolescents, only 2 had sought treatment for conditions like fever and tonsillitis, 1 had visited to check their blood group, 1 for COVID-19 vaccination, and the remaining 11 were largely unaware

of the health centre and its services. This highlighted the limited awareness and utilisation of health services among adolescents, who primarily recognised UPHCs for acute care rather than ongoing health programs. The special efforts by centre for its branding and visibility were reported absent.

Regarding access to health centres, adolescents cited timing issues due to school, tuition, or work commitments of their parents, and overcrowding during morning hours. There was a demand to extend the timings, for instance, a 14-year-old boy shared, "The timings of health centres should be extended during evening hours. Also, the morning time should start at 8 am. The ideal time should be from 8:00 a.m. to 6:00 p.m. During morning hours, parents can get a 1-hour window to visit the centre before going to work, and evening hours will be comfortable for children who have morning school."

None of the adolescent patients was aware of any other activity of UPHC in which they could participate. On the contrary, adolescents were vocal about such participatory activities happening in Anganwadi for girls, like Yoga Day celebration, self-defence training or nutritious recipe competitions. This lack of awareness indicated a need to establish the identity of UPHCs beyond clinical services to fulfil the comprehensive agenda of the programs like RKSK. Additionally, none of the adolescents knew about Adolescent Reproductive and Sexual Health (ARSH) clinics and counselling services.

Regular health check-ups under the School Health Program were appreciated, but adolescents demanded more information and individual consultations for themselves. The role of ICDS Anganwadi or NGOs was also found limited in mobilizing adolescents and linking them with UPHCs. Anganwadi services primarily catered to girls, leaving a gap in services for adolescent boys.

To improve the connection with UPHCs, they suggested several measures: Display UPHC advertisements in neighbourhoods to attract more people, Ensure the location is central and easily visible, with bold direction boards, Distribute pamphlets explaining all services in the neighbourhood, Mobilize adolescents through community health workers, Display service banners at all room doors, Promote activities like dance or yoga and notify the community about such programs, Implement traffic regulations and signboards to curb rash driving, making it safer for adolescents to access the centres.

Improving adolescent access and connection to public primary health services should be part of creating an enabling environment for adolescents. Addressing these issues required increasing visibility, enhancing accessibility, and promoting adolescent-focused activities to foster greater engagement with UPHCs.

### 6.4 Adolescent Agency and Willingness to Participate

Despite navigating profoundly constrained circumstances, adolescents demonstrated remarkable agency and active willingness to participate in their communities and in processes affecting their wellbeing. Rather than adopting passive or resigned stances toward their circumstances, young people articulated clear aspirations to contribute meaningfully to community health and social good. Adolescents expressed eagerness to participate in health-related initiatives, educational programs, and community activities when these were designed with genuine attention to their lived realities and concerns. Many described desire to support peers, to share knowledge about health and

wellbeing, and to be recognized as capable contributors rather than merely as recipients of services or interventions. Several adolescents articulated willingness to engage with formal health services and programs if these centered their perspectives, ensured confidentiality and safety, and addressed concerns that mattered to them—economic anxiety, safety threats, mental health struggles, peer relationships—rather than imposing predetermined health agendas. The data revealed that adolescents' apparent "non-participation" or "low engagement" with formal programs reflected not lack of interest or motivation but rather a mismatch between top-down service designs and adolescents' lived experiences, priorities, and need for relational, trustworthy engagement.

A group of adolescents from FGD-7, dated 4th April 2022 from Udhna area narrated,

"Many of us are willing to participate and contribute. Girls & boys in urban poor areas want to learn a new skill. The skills involve speaking English, beauty parlour, basic finance, Computer, Sewing, mehndi, cooking, singing, drawing, growing vegetables, Dancing, TikTok videos and reels making, reading English, and reading Gujarati if it's not the mother tongue. Many of us use smartphones of their parents or nearby youngsters and we like to watch YouTube or applications to learn these skills."

When given genuine opportunities for voice and participation, adolescents demonstrated a sophisticated understanding of their own needs and a commitment to collective wellbeing and community engagement. Their existing experience of participation was also worth consideration. Adolescents, especially girls, showed some level of participation in Anganwadi activities, such as Kishori Shakti Yojana, which includes education on hygiene, menstrual care, and nutrition. Girls expressed their enjoyment of AWC activities, such as cooking competitions, best from waste training, Games, Dish and art object decoration, and festival-related competitions like the Ganesha festival, Navratri, and Diwali. Few girls help in routine Anganwadi activities like calling other girls to join, taking care of younger children during weight measurement etc. Some government schools also had practices of having class monitors who periodically checked whether other children in their class were cutting their nails, washing their hands, and maintaining general hygiene.

## 7. Conclusion

This phenomenological analysis reveals that adolescent identity formation, health, and well-being in contexts of urban poverty are fundamentally embodied, relational, and spatial phenomena rather than individual or purely psychological processes. Urban poor adolescents in Surat navigate fragmented urban landscapes marked by economic precarity, spatial insecurity, and institutional marginalisation, yet they demonstrate remarkable agency and creativity in forging practices of care, building solidarity networks, and constructing meaning and resilience. The study illuminates that adolescents are not passive victims of constraint but active agents engaged in processes of becoming—actively shaping their identities, relationships, and contributions to their communities. Their lived experiences reveal that wellbeing cannot be understood as an individual health outcome managed through technical interventions but must be conceptualized as emerging through relational practices, embodied safety, spatial access, and recognition of adolescent voice and agency. The findings demonstrate that therapeutic spaces—spaces where genuine healing and

wellbeing can flourish—emerge not primarily through institutional health programs alone but through youth-centred design, relational trust-building, and creation of physically and socially safe environments where adolescents are recognised as active agents and co-creators of their futures.

This work aligns with the Sustainable Development Goals, particularly SDG 3 (Good Health and Wellbeing), SDG 10 (Reduced Inequalities), and SDG 11 (Sustainable Cities and Communities), by demonstrating that achieving health equity and inclusive urban development requires centring adolescent voices and recognising young people as vital stakeholders and agents of sustainable, equitable futures. By prioritising adolescent lived experiences and agency in health and social policy, we move toward more just, responsive, and transformative approaches to building inclusive communities where all young people can thrive.

## 8. Recommendations

 Youth-Cantered Policy and Program Design: Reimagine adolescent health and social policies to centre adolescent voices, lived experiences, and priorities in policy formulation, program design, and monitoring. Establish mechanisms for meaningful adolescent participation in decision-making processes affecting their health and communities, moving beyond tokenistic consultation to genuine co-creation and leadership.

 Address Structural Barriers: Develop integrated approaches addressing the structural conditions constraining adolescent wellbeing—economic precarity, urban insecurity, and spatial marginalisation. This includes poverty alleviation programs, the creation of safe public spaces, violence prevention initiatives, and equitable access to education and livelihood opportunities that expand adolescents' possibilities beyond early work and survival.

 Relational and Embodied Health Approaches: Reorient health systems toward relational, holistic, and embodied approaches to adolescent health that prioritise trust-building, confidentiality, psychosocial support, and attention to adolescents lived concerns alongside biomedical care. Invest in training healthcare providers in adolescent-responsive, culturally sensitive, and trauma-informed practices.

 Create and Protect Therapeutic Spaces: Recognise and support the therapeutic micro-spaces adolescents create through peer networks and informal gathering places. Design public spaces that are physically safe, socially welcoming, and controlled by young people themselves—spaces where adolescents can build solidarity, exercise voice, and construct wellbeing collectively.

 Interdisciplinary Collaboration: Foster collaboration among urban planners, health professionals, social workers, educators, community leaders, and adolescents themselves to reimagine inclusive, equitable, and truly therapeutic urban environments. Recognise that adolescent health and wellbeing are inseparable from questions of urban design, social inclusion, economic justice, and institutional responsiveness.

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**References**

Ager, Alan, and Frances O'May. 2001. "Issues in the Definition and Implementation of 'Best Practice' for Psychosocial Interventions in Complex Emergencies." Social Science & Medicine 52(5):673–686.

Agrawal, S. 2016. "Urban Poverty and Inequality in India: Trends, Patterns and Policy Implications." Indian Journal of Human Development 10(1):1–20. doi: 10.1177/0973703015626673.

Barua, Alka, Venkatraman Chandra-Mouli, Rajesh Mehta, and Swati Shinde. 2023. "Lessons Learned from Conceptualising and Operationalising the National Adolescent Health Programme or Rashtriya Kishor Swasthya Karyakram's Learning Districts Initiative in Six Districts of India." Reproductive Health 20(Supplement 1):1–12.

Bhan, Gautam, A. Jana, and S. Bhattacharya. 2014. "Informal Settlements in Indian Cities: Vulnerabilities and Urban Governance Challenges." Environment and Urbanization 26(1):67–81. doi: 10.1177/0956247813516408.

Blum, Robert W., Nan Marie Astone, Michele R. Decker, and Venkatraman Chandra Mouli. 2014. "A Conceptual Framework for Early Adolescence: A Platform for Research." 26(3):321–31. doi: 10.1515/ijamh-2013-0327.

Datta, Ayona. 2016. "Safe Cities for Girls? Investigating Gendered Urban Safety in Delhi, India." Urban Geography 37(8):1162–1179. doi: 10.1080/02723638.2015.1105220.

Erikson, Erik H. 1968. Identity: Youth and Crisis. W. W. Norton & Company.

Hardin, Heather K., Anna E. Bender, Carla P. Hermann, and Barbara J. Speck. 2021. "An Integrative Review of Adolescent Trust in the Healthcare Provider Relationship." Journal of Advanced Nursing 77(4):1645–1655. doi: 10.1111/jan.14674.

Jain, Neha, Deepika Bahl, Rajesh Mehta, Shalini Bassi, Kiran Sharma, and Monika Arora. 2022. "Progress and Challenges in Implementing Adolescent and School Health Programmes in India: A Rapid Review." 1–8. doi: 10.1136/bmjopen-2020-047435.

Kansara, Khushi, Deepak Saxena, Tapasvi Puwar, Sandul Yasobant, Poonam Trivedi, Shital Savaliya, and Manish Fancy. 2018. "Convergence and Outreach for Successful Implementation of Rashtriya Kishor Swasthya Karyakram." 18–22. doi: 10.4103/ijcm.IJCM.

Lu, Chunling, Zhihui Li, and Vikram Patel. 2018. "Global Child and Adolescent Mental Health: The Orphan of Development Assistance for Health." 1–12.

van Manen, Max. 2016. Researching Lived Experience: Human Science for an Action Sensitive Pedagogy. 2nd ed. London, ON: Routledge.

Merleau-Ponty, Maurice. 1962. Phenomenology of Perception. Routledge & Kegan Paul.

Ministry of Health and Family Welfare, Government of India. 2014. Rashtriya Kishor Swasthya Karyakram (RKSK): Operational Framework. New Delhi.

Morrow, Veronica. 2001. "Using Qualitative Methods to Elicit Young People's Perspectives on Their Environments: Some Ideas for Community Health Initiatives." Health Education Research 16(3):255–268. doi: 10.1093/her/16.3.255.

Morrow, Veronica. 2013. "Troubling Transitions? Young People's Experiences of Growing up in Poverty in Rural Andhra Pradesh, India." Journal of Youth Studies 16(1):86–100. doi: 10.1080/13676261.2012.704986.

Patton, George C., Susan M. Sawyer, John S. Santelli, David A. Ross, Rima Afifi, Nicholas B. Allen, Monika Arora, Peter S. Azzopardi, Wendy Baldwin, Chris P. Bonell, Ritsuko Kakuma, Ellen Kennedy, James Mahon, Terry McGovern, Ali H. Mokdad, Vikram Patel, Suzanne Petroni, Nicola J. Reavley, Kemi Taiwo, Jane Waldfogel, Duleeka Wickremarathne, Carmen Barroso, Zulfiqar A. Bhutta, Adesegun O. Fatusi, Anita Mattoo, Julia Diers, Jian Fang, James B. Ferguson, Fred M. Ssewamala, and Russell M. Viner. 2016. "Our Future: A Lancet Commission on Adolescent Health and Wellbeing." The Lancet 387(10036):2423–2478. doi: 10.1016/S0140-6736(16)00579-1.

Phadke, Shilpa, Sameera Khan, and Sangeeta Ranade. 2011. "Why Loiter? Women and Risk on Mumbai Streets." Indian Journal of Gender Studies 18(3):381–404. doi: 10.1177/097152151101800303.

Rani, D., J. K. Singh, D. Acharya, R. Paudel, K. Lee, and S. P. Singh. 2018. "Household Food Insecurity and Mental Health among Teenage Girls Living in Urban Slums in Varanasi, India." International Journal of Environmental Research and Public Health 15(8):1585. doi: 10.3390/ijerph15081585.

Singh, Susheela, Akinrinola Bankole, Vanessa Woog, and Jacqueline E. Darroch. 2019. Adolescent Health and Well-Being: A Key to a Sustainable Future. Guttmacher Institute.

Viner, Russell M., Emily M. Ozer, Simon Denny, Michael Marmot, Michael Resnick, Adesegun Fatusi, and Candace Currie. 2012. "Adolescence and the Social Determinants of Health." The Lancet 379(9826):1641–1652. doi: 10.1016/S0140-6736(12)60149-4.