2014

MODULE FOR MASTER TRAINERS

A Module for Survival, Education and Empowerment of the Girl Child

MINISTRY OF WOMEN AND CHILD DEVELOPMENT

GOVERNMENT OF INDIA

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List of Abbreviations

AA	Appropriate Authority
AFHC	Adolescent Friendly Health Clinics
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-Natal Check-up
ANM	Auxiliary Nurse Midwife
APIO	Assistant Public Information Officer
ARSH	Adolescent Reproductive and Sexual Health
ASAT	Anchal se Aangan Tak
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behavioural Change Communication
BCG	Bacillus Calmette-Guerin
BDO	Block Development Officer
BDPO	Block Development and Panchayat Officer
BLMT	Block Level Master Trainers
BMI	Body Mass Index
BPL	Below Poverty Line
BPNI	Breastfeeding Promotion Network of India
CARA	Central Adoption Resource Agency
CBO	Community Based Organization
CDPO	Child Development Project Officer
CES	Coverage Evaluation Survey
CHC	Community Health Centre
CMPO	Child Marriage Prohibition Officer
CNS	Central Nervous System
CPIO	Central Public Information Officer
CSB	Central Supervisory Board
CSR	Child Sex Ratio
CTP	Customs, Traditions and Practices
CWC	Child Welfare Committee
DAVP	Directorate of Advertising and Visual Publicity
DC	District Court
DCPS	District Child Protection Society
DLHS	District Level Household Survey
DLMT	District Level Master Trainers
DLSC	District Legal Services Committee

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DEIC	District Early Intervention Center
DPA	The Dowry Prohibition Act, 1961
DPT	Diphtheria, Pertussis and Tetanus
EAG	Empowered Action Group
ECCE	Early Childhood Care and Education
ECCED	Early Childhood Care Education and Development
ECE	Early Childhood Education
EPI	Expanded Programme of Immunization
FAQ	Frequently Asked Questions
FGD	Focused Group Discussion
FIR	First Information Report
FNB	Food and Nutrition Board
FOP	Friends of Police
FRU	First Referral Unit
GBA	Gender Based Analysis
GBV	Gender Based Violence
GM	Gender Mainstreaming
GOI	Government of India
GSS	Gram Sampark Samoohs
HAMA	Hindu Adoption And Maintenance Act, 1956
HBNC	Home Based New-Born Care
HIV	Human Immunodeficiency Virus
HMA	The Hindu Marriage Act, 1955
ICCW	Indian Council for Child Welfare
ICMR	Indian Council of Medical Research
ICDS	Integrated Child Development Services
ICMA	The Indian Christian Marriage Act, 1872
ICPS	Integrated Child Protection Scheme
ICT	Information, Communication and Technology
IDD	Iodine Deficiency Disorder
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IGMSY	Indira Gandhi Matritva Sahyog Yojana
IMM	Indian Muslim Marriage Act, 1954
IMR	Infant Mortality Rate
INHP	Integrated Nutrition & Health Programme
IPO	Indian Postal Order
IYCF	Infant and Young Child Feeding
IQ	Intelligent Quotient
JJ Act	Juvenile Justice (Care and Protection) Act, 2006
JJB	Juvenile Justice Board
JSSK	Janani Shishu Suraksha Karyakram

JSY	Janani Suraksha Yojana
KSA	Knowledge, Skill and Attitude
KSY	Kishori Shakti Yojana
KGBV	Kasturba Gandhi Balika Vidyalaya
LBW	Low Birth Weight
LPS	Low Performing States
LRP	Local Resource Person
LSA	Legal Services Authorities
MCH	Maternal and Child Health
MCPC	Mother and Child Protection Card
MDG	Millennium Development Goal
MoHFW	Ministry of Health and Family Welfare
MoHRD	Ministry of Human Resource Development
MM	Metropolitan Magistrate
MMR	Maternal Mortality Rate
MO	Medical Officer
MoSJE	Ministry of Social Justice & Empowerment
MTP	Medical Termination of Pregnancy
MUAC	Mid Upper Arm Circumference
MoWCD	Ministry of Women and Child Development
NBCC	New-Born Care Corner
NBSU	New-Born Stabilization Unit
NCD	Non Communicable Disease
NCPCR	National Commission for Protection of Child Rights
NCT	National Capital Territory
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NHM	National Health Mission
NIN	National Institute of Nutrition
NIPCCD	National Institute of Public Cooperation and Child Development
NIPI	National Iron Plus Initiative
NMBS	National Maternity Benefit Scheme
NMR	Neonatal Mortality Rate
NNMB	National Nutrition Monitoring Bureau
NPA	National Plan of Action for Children, 2005
NPC	National Policy of Children, 2013
NPE	National Policy on Education, Amended 1992
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NRP	Nutrition Resource Platform
NSDP	National Skill Development Programme
NSSK	Navjaat Shishu Suraksha Karyakram

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NUHM	National Urban Health Mission
OBC	Other Backward Classes
PCPNDT Act	Pre- Conception and Pre- natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994
PCT	Pre-Conception Techniques
PHC	Primary Health Center
PHED	Public Health Engineering Department
PIO	Public Information Officer
PLA	Participatory Learning and Action
PMDA	Parsi Marriage And Divorce Act, 1936
PNC	Pre-Natal Care
PNDT	Pre-Natal Diagnostic Technique
POCSO	Protection of Children from Sexual Offences Act, 2012
PPI	Pulse Polio Immunization
PPP	Public Private Partnership
PRI	Panchayati Raj Institutions
PSE	Pre-School Education
PTRs	Pupil Teacher Ratio
PWDVA	Protection of Women from Domestic Violence Act, 2005
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
RDA	Recommended Dietary Allowance
REPA	Right to Education Protection Authority
RIP	Routine Immunization Programme
RKSK	Rashtriya Kishore Swasthya Karyakram
RMNCH+A	Reproductive, Maternal, New-Born, Child and Adolescent Health
RTE	Right to Free and Compulsory Education Act, 2009
RTI	Right to Information Act, 2005
SAM	Severe Acute Malnutrition
SBCC	Social and Behaviour Change Communication
SBR	Still Birth Rate
SC	Scheduled Caste
SCPCR	State Commission for Protection of Child Rights
SD	Standard Deviation
SHC	Sub Health Centre
SHG	Self Help Group
SLA	State Legal Aid Board
SLEC	State Level Empowered Committee
SMA	The Special Marriage Act, 1954
SMART	Specific, Measurable, Achievable, Realistic, Time-Based Objectives
SMC	School Management Committee
SNCU	Special New-Born Care Unit

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SRS	Sample Registration System
SSA	Sarva Shiksha Abhiyan
SSLC	Secondary School Leaving Certificate
ST	Scheduled Tribe
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TBA	Trained Birth Attendant
TLAC	Taluka Legal Aid Committees
TLM	Teaching Learning Material
U5MR	Under Five Mortality Rate
UEE	Universalization of Elementary Education
UIP	Universal Immunization Programme
UNCRC	United Nations Convention on the Rights of the Child
UN	United Nations
UTs	Union Territory
UTI	Unit Trust of India
UVAS	Universal Vitamin A Supplementation
VA	Vitamin A
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WASH	Water, Sanitation and Hygiene Education
WDC	Women Development Corporation
WHO	World Health Organisation
WIFAS	Weekly Iron Folic Acid Supplementation

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TRAINING OF MASTER TRAINERS ON BETI BACHAO, BETI PADHAO

Total Duration: 4 Days

PROGRAMME SCHEDULE

DAY 1	
9:00 a.m.-9.30 a.m.	Registration of Participants and Distribution of Kits
9.30 a.m.-10.30 am.	Introductory Session- About the Programme & Ice Breaking Exercise
10.30 a.m.-11:45 a.m.	Status of Girl Child in India
11:45 a.m. – 1:00 p.m.	Gender Mainstreaming – Understanding Gender
1:00 p.m.-2:00 p.m.	**Lunch**
2:00 a.m. – 4:00 p.m.	Constitutional Provisions and Child Rights including Right to Information Act-2005
4:00 p.m.- 5:30 p.m.	Health and Nutrition for Girl Child
DAY 2	
9:00 a.m.-9:30 a.m.	Recap
9:30 a.m.-11: 30 a.m.	Introduction to The Pre-conception and Pre-natal Diagnostic Techniques(Prohibition of Sex Selection) Act (PCPNDT Act), 1994- An Introduction
11:30 a.m.-1:00 p.m.	Acts and Laws Related to Marriage and Adoption- PCMA, 2006
1:00 p.m.-2:00 p.m.	**Lunch**
2:00 p.m.- 3:30 p.m.	Acts and Laws related to Safety and Gender Based Violence- Protection of Women from Domestic Violence Act (PWDVA), 2006; Protection Of Children From Sexual Offences Act (POCSO)-2012
3:30 p.m.- 5:30 p.m.	Right to Education Act, 2009 - Educating the Girl Child including Issues & Challenges

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DAY 3	
9:00 a.m.-9:30 a.m.	Recap
9:30 a.m.-11:00 a.m.	Sarva Shiksha Abhiyan
11:00 a.m.-1:00 p.m.	Schemes and Programmes of MWCD Supporting Girls & Women
1:00 p.m.-2:00 p.m.	**Lunch**
2:00 p.m.- 4:00 p.m.	Schemes and Programmes of MOHFW Supporting Girls & Women
4: 00 p.m. - 5.30 p.m.	Need & Importance of Community Participation and Community Mobilisation - Convergence to Improve CSR
DAY 4	
9:00 a.m.-9:30 a.m.	Recap
9:30 a.m.- 1:00 p.m.	Advocacy for Social and Behaviour Change – Improving CSR & Education of Girl Child - Planning an Advocacy Campaign & Group Presentation - Role of Media
1:00 p.m.-2:00 p.m.	**Lunch**
2:00 p.m.- 3:30 p.m.	Advocacy for Social and Behaviour Change-Contd.
3:30 p.m.- 4:00 p.m.	Evaluation and Feedback
4:00 p.m.- 5:30 p.m.	Concluding Session

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About the Programme – An Introduction

The country has witnessed advancements in various fields and even though the literacy rate amongst women has shown an improvement, century old traditions and customs, biased against a girl child still prevail in large parts of the country. This has casted a shadow on the progress made in the recent years. The major enigma of our society is that the girl child is denied her right to survive. It is matter of great concern that gender biased sex selective elimination still continues in many parts of our country. The problem of declining Child Sex Ratio (CSR) is not an isolated phenomenon since it indicates the low status of women and the girl child. Census 2011, reveals the extensive and significant decline in CSR (0-6 years) recording an all-time low of 918 girls for every 1000 boys.

The Constitution (Article 14), guarantees the right to equality to every citizen of India. It embodies the general principles of equality before law and prohibits unreasonable discrimination between persons within the territory of India. However, gender biased sex selective elimination of girl child is a violation of human rights and of the right to life guaranteed under our Constitution. Therefore, the need to act with urgency and effectiveness on the issues of gender discrimination and empowerment of girl child should take priority. Revision of our policies and programmatic interventions need to be based on our fundamental right of quality. Gender dimensions with special focus on the issue of CSR have to form an integral part of the legislations to bring gender parity, and thereby we may ensure that:

- Every girl child, adolescent girl and young woman should have access to education as it is supremely important for empowering girls;
- Men especially young men and adolescent boys need to be properly oriented through education and counselling so that they respect the status and rights of girl child;
- Immediate interventions to eliminate various forms of gender biased discrimination against girl child, in existence, in areas of cultural and educational sectors;

Gender inequality prevalent in education shows non - availability of separate toilet for girls, inadequate female teachers, distant school, preference of domestic chores over education for

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girls etc., are some of the issues which hinder girls' enrolment, retention and performance in school. Education is the right of every child and it should be made accessible, acceptable and adaptable to the needs of the girl child.

Simultaneously, educating the girl child will have multiple benefits in terms of elimination of child marriage, delay of pregnancy of young girls along with low maternal mortality rate, infant mortality rates, low CSR, economic independence etc. These are the benefits that last many generations. Therefore, education is an important indicator to empower a girl child to live with confidence, dignity and economic independence.

In order to address the issue of declining Child Sex Ratio and promoting girls education in India, the Ministry of Women and Child Development has taken an initiative of "*Beti Bachao Beti Padhao*" to improve Child Sex Ratio, promote the importance of girl child and highlighting the benefit of educating the girl child by formulating various policies, programmes and legislations concerning women and children. Government of India has also announced in the Budget speech, 2014-15 "*Beti Bachao Beti Padhao"* scheme to address the issue of declining CSR and education of girl child through a national level media campaign and multi-sectoral action in selected 100 low CSR districts (List of 100 districts is at ***Annexure-1***). These hundred districts have been chosen covering at least one district in each State/UTs on the basis of three criteria viz;-

i) districts below the national average (87 districts/23 states),
ii) districts above the national average but have shown declining trend (8 districts/23 states),
iii) and districts above the national average but have shown increasing trend (5 districts/5 states).

The initiative *"Beti Bachao, Beti Padhao"* thereafter is being undertaken to:

1. Raise awareness and provide insight into the current situation;
2. Provide strategies and tools for the grass root level functionaries; and
3. Improve the current statistics on the declining CSR.

Ministry of Women and Child Development is designated as the nodal ministry for this initiative. The initiative will also be supported by the Ministry of Health and Family Welfare (MoHFW), Human Resource Development (HRD) and Information & Broadcasting (I & B). The overall objective of BBBP is to improve the declining CSR and promoting education of girl child. The specific objectives of the initiative are:

- Prevent gender biased sex selective elimination;
- Ensure survival and protection of the girl child; and
- Ensure education of the girl child.

There is a need for coordinated and multi-sectoral convergent action including Information Education and Communication (IEC) & Behaviour Change Communication (BCC) Campaigns and community mobilization initiatives to help combat this concern to improve the Child Sex Ratio. Multi-pronged approach to improve CSR should involve youth, adolescents, men, PRIs, community leaders, judiciary and media for achieving behaviour change. Since it is an issue of traditional attitudes and awareness generation, advocacy will continue to be a major plank of the BBBP strategy in addition to stricter implementation of PCPNDT act. It is equally important to generate awareness among general masses about CSR and girl child issues to facilitate building of fair, equitable and safe environment for our women and children.

In order to equip grass root level functionaries to create a mass movement to protect and educate the girl child, it is essential to develop a module for Master Trainer for training the grass root level workers to disseminate information to the community to provide guidance on factors affecting the holistic development of the girl child so as to help empower them.

The task of preparing a module for Master Trainers has been entrusted to NIPCCD, which is an apex body for training of ICDS and ICPS Functionaries.

The objective of the training module is to help the Master Trainers, spread awareness at the grass root level so that the girl children could benefit from information on the health and well-being of girl child.

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The Training Module has been prepared with the objective to:

- Provide guidance and awareness about the various schemes, policies and acts for the education and safety of the girl child;
- Sensitize and train the functionaries as catalysts for social change and to mobilize the community for its engagement for improving the CSR, Sex Ratio at Birth (SRB) and enrolment & retention of girl child in schools;
- To provide information and training for better inter-sectoral and inter-institutional convergence at district/block/grass-root levels; and
- Orient the trainers about planning process of advocacy campaign for social and behaviour change.

Target Audience

The people who will be trained for the BBBP scheme will be National, State and District level officials from the concerned departments, PRIs, elected representatives from the field of education, law, women empowerment, women development etc,. Eventually the grass root level functionaries like AWW/ANM/ASHA along with the community will be the channel for the BBBP Scheme.

Module Structure

The training module is structured around three basic themes which include:

i) Schematic interventions for survival and education of girl child

ii) Polices and legislations related to empowerment of girl child

iii) Advocacy for social and behaviour changes including defined roles of various line ministries

This module will help deliver awareness, direction and focus on girl child which will help improve the CSR and education. Major focus of the training would be to create awareness on importance of girl child by covering topics like situation of the girl child in India, literacy level of the girl child, early marriage, abuse, exploitation, neglect and violence suffered by the girl child and preventing them from social evils like gender biased sex selective elimination, sexual violence, low education rate for girl child, gender discrimination etc., and thereby improving their status in the society.

Training Strategy

As the AWW, ANM, ASHA are the first line of contact for the community and efforts have been taken to define their roles and responsibilities in order to improve CSR and education of the girl child. Thus this training module will help in defining the role of these grass root workers in spreading awareness on improving CSR and education of girl children. This will also provide them with role clarity and help them perform better in their area of work. The training module is designed to encourage holistic development of women and children especially the girl child and thus, help in improving CSR.

The Master Trainers will be entrusted with the responsibility of fulfilling the training needs of the functionaries in the field to spread awareness on the issues focusing improvement in CSR and Education of Girl child. The training will be conducted in a cascade model (three tier training strategy). The States will be encouraged to nominate trainers for the training. The State Level Master Trainers will be selected by the States Government in accordance with the criteria formed by MWCD and NIPCCD. Though every district will be covered in a phased manner under the scheme, however initially, the Master Trainers of selected 100 Districts will be trained. The Master Trainers will be first trained at the NIPCCD Headquarter and Regional Centres in their regional language in a batch comprising 30-35 trainees. The State Level Master Trainers (SLMTs) will in turn impart training to the District Level Master Trainers (DLMTs) who will further train the Block Level Master Trainers (BLMTs). The BLMTs will be responsible to disseminate regular training to the AWWs/ANMs/ASHAs and Supervisors of their respective areas (Figure 1).

The resource faculty of BBBP Scheme will mainly comprise of faculty of NIPCCD Headquarter and Regional Centres and various subject matter experts from the States who have extensively worked in NRHM, SSA and ICDS.

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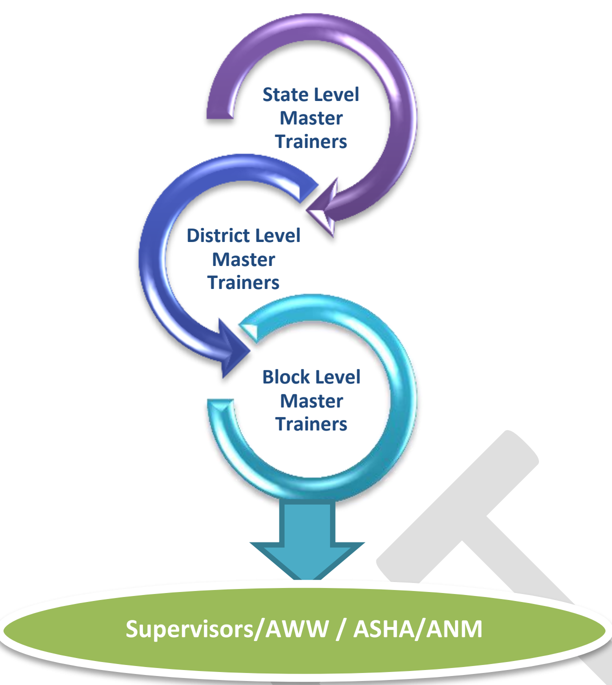

Figure 1: A Three Tier Training Strategy

Methodology

The Training Methodology is participatory in nature and will employ interpersonal communication techniques to help make the training more interactive, practical and more field oriented. The training programme is scheduled for four days which will begin from 9:00 A.M. and will continue till 5.30 P.M., with focused sessions targeting the common problems faced by the Girl Child.

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INSTRUCTIONS FOR TRAINERS

Dear Trainers,

- This training module is developed to facilitate and prepare you for conducting a 4 days training programme for the "*Beti Bachao, Beti Padhao*" Scheme.
- You are expected to go through the entire module and prepare yourself to conduct the training efficiently.
- Each session per day is detailed out. Make sure that you have read the day's sessions before the start of the programme.
- You will also need to plan and manage the time at your disposal so that all sessions are given the required attention and importance.

Prepare

- Make sure that all your participants are aware about the training programme.
- There is proper arrangement of food and water for the participants.
- There is sufficient space for the group activities
- Prepare an entry and an exit level quiz, for the participants to assess the knowledge gain of the participants about the BBBP Scheme.

Instructions

- Concentrate on the essential facts, skills and attitudes. It is neither possible nor desirable to teach everything.
- Base your training on the need of the programme and on the tasks that your trainees are expected to do.
- Make sure that all the training formalities are taken care of.
- The Facilitators Module has been designed to guide the Trainers for an effective session
- Key points to be kept in mind while delivering the lecture are as under:
  - ***Time Management*** **-** A predefined time has been allocated to each session. However, it is to be ensured that the training should be completed within the duration of four days. The Trainer should take care to assign adequate time for the activities listed during the session.
  - ***Guided Objectives*** **-** Each session has a distinct objective, which needs to be reviewed before the beginning of each session. The outlined learning outcomes should be achieved by the end of each session.

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- ***Recapitulate*** **-** At the beginning of each day during the training, a recap of previous day session should be done with the participants. Any gaps can be thus fulfilled after the feedback of the previous day.
- ***Training Approach*** **-** the Trainer should focus on improvising the group activity after doing a need analysis of the group of trainees. Apart from the group activity trainer may address individual issues using various games and activities. The experiences of the trainees can be utilised for the session as well.
- ***Feedback and Evaluation*** **–** At the last day of the training, the Trainer should take effective feedback of the trainees, along with their suggestions so that the training can be evaluated and gaps can be addressed for a successful training programme.

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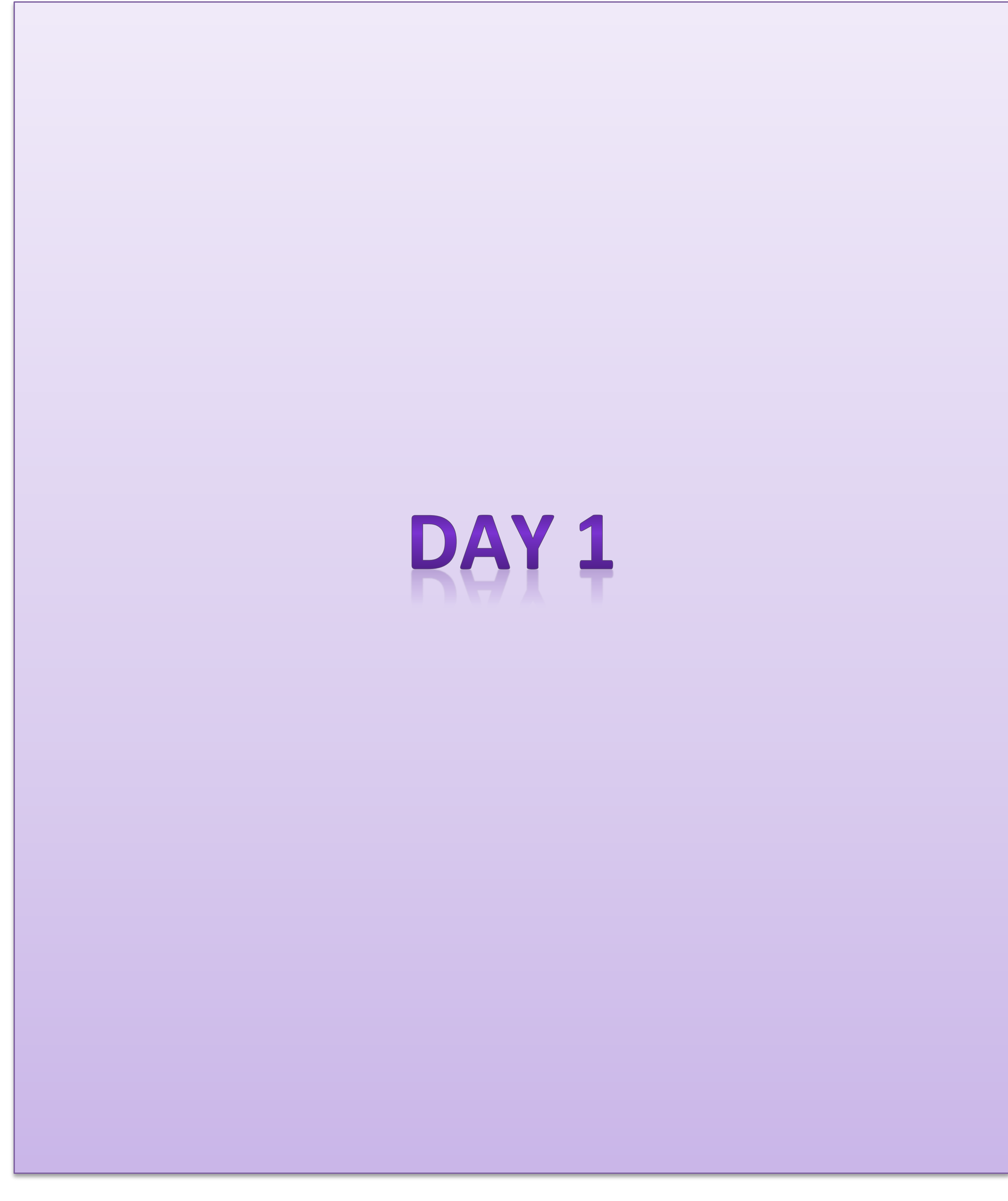
DAY 1

REGISTRATION	REGISTRATION OF PARTICIPANTS AND DISTRIBUTION OF KITS
SESSION 1	**Introductory Session - Welcome and Introduction to Programme**
INTRODUCTORY SESSION	• Welcome the participants • Introductory address by Head of the Institution/Department • Introduction to the Training Programme - Briefing on objectives, programme schedule, working hours, theory sessions, practical • Self-introduction by Trainees • Detailing Training Module
ICE-BREAKING EXERCISE	• Ice-breaking Exercise/Games • Each participant shares his/her experiences of the field
DURATION	1 Hour - Introductory session (30 min), Ice breaking (30 min)
TRAINING METHOD/MATERIAL	Self-information dissemination, flip chart, marker, material for ice breaking exercises
LEARNING OUTCOME	The trainees will be able to understand the objectives of the programme and prepare themselves for the training programme.

Girl Child in India – An Introduction

- Girl child in India is still considered the "Lesser Child" and is deprived of rights and equal opportunities for development.
- Demographic trends indicate gender discrimination and adverse sex ratio.
- Continuing gender inequalities, existing cultural beliefs and practices are seen in almost every aspect of the growing girl child's social and cultural environment.
- Deprived of her childhood, and compelled into early marriage and child bearing, the young girl's prospects of all round development are severely constrained.

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Instructions for Trainers

- Conduct at least two- three activities for ice breaking games for rapport building

Activity –I: My Companion

- Ask each participant to write his/her name on masking tape and stick it on his or her shirt or dress.
- Tell them to stand in a circle, with everyone wearing their name tag.
- Give them two minutes to look around the circle and try to pinpoint a companion whose name starts with the same alphabet.

Activity –II: Name Chain

- Gather the participants in a circle.
- Now, one participant will speak up his/her name. The other participants will speak up their names with the name of previous participant.

Activity –III: What do I feel?

- Ask the participants to sit in a circle; each one of them takes turns acting out certain emotions.
- Others try to guess out what emotion is being acted, the one who guesses right acts out the next emotion.

<table>
<tr><th>SESSION 2</th><th>STATUS OF GIRL CHILD IN INDIA</th></tr>
<tr><td>OBJECTIVE</td><td>To understand the situation of girl child in the country and states, with special focus on neglect and discrimination with reference to health, nutrition and education indicators</td></tr>
<tr><td>CONTENT</td><td>To provide updated information related to the status of girl child in India
Population/Demography
• Child Sex Ratio: An overview
    o Implications and causes
    o Impact of declining sex ratio
• Data for differently abled, vulnerable, marginalised & tribal children
• Health & Nutrition status of girl child
    o IMR and causes of IMR
    o Low birth weight babies
    o MMR and its causes
    o Birth registration
    o Access to health services
    o Immunization status
    o Nutrition - Underweight, stunting and wasted children
    o Micronutrient deficiencies– Status of micronutrient intake among children, Vitamin A, Iron Deficiency Anemia and Iodine Deficiency Disorder
    o Time Trends in nutrient intakes
    o IYCF Practices- Early Initiation, Exclusive Breastfeeding and Complementary Feeding
• Education status of girl child
    o Literacy and dropout rates
• Role of AWW/ASHA/ANM in improving CSR and school enrollment</td></tr>
<tr><td>DURATION</td><td>1 hour 15 minutes</td></tr>
<tr><td>TRAINING METHOD</td><td>Lecture cum discussion, group activity and BBBP videos</td></tr>
<tr><td>LEARNING OUTCOME</td><td>The participants would be able to understand the importance of education, health and nutrition, status of girl child in India and States w.r.t. causes of declining sex ratio and low education. Also the participants will know preventive measures that could help address the problem of declining sex ratio, education and malnutrition.</td></tr>
<tr><td>RESOURCES</td><td>• Power-point presentation highlighting the key contents</td></tr>
</table>

REQUIRED	• Coloured chart papers, pens, paper, scissors, glue, sketch pens
ANNEXURES	• Child Sex Ratio in India – A Map • MCP Card (English/Hindi) • Important Definitions • Immunization Schedule
REFERENCES	• Census 2011 • DLHS 3, NFHS 3, DLHS 4 or the latest statistics

FACILITATORS NOTE

Methodology

The Trainer may refer to the detail contents to make a power point presentation highlighting the key points. You may initiate the discussion showing different videos of BBBP that can be downloaded from you tube *Beti Bachao Beti Padhao* channel. The session should begin with the situation analysis of the status of the girl child in India. The trainers may add the data of their respective states to make it region specific. Engage the trainees to answer questions to assess their knowledge of the situation. A map of India can be shared to show the status of Child Sex Ratio in Indian States (***Annexure- 2***).

Ask

- What do you know about the status of the girl child in India?
- What has been your experience in the state? Participants may share.

The trainer may be able to talk about various issues like gender biased sex selective elimination, child sex ratio, and early marriage etc. Various indicators using latest relevant statistics may be discussed ***(refer to detailed contents)***. This should be followed by discussions on SC/ ST and vulnerable & marginalised children as well highlighting key statistics on survival of girl child.

Activity

- The trainees may be divided into groups. The trainer may provide with the stationary for the activity.
- The groups will make a tree with roots, leaves and fruits and make smiling face of Girl Child. Write the causes of low CSR in the roots and the leaves and fruits will show the measures and outcomes to improve CSR.
- The trainers should display the charts in the room till the end of the training.

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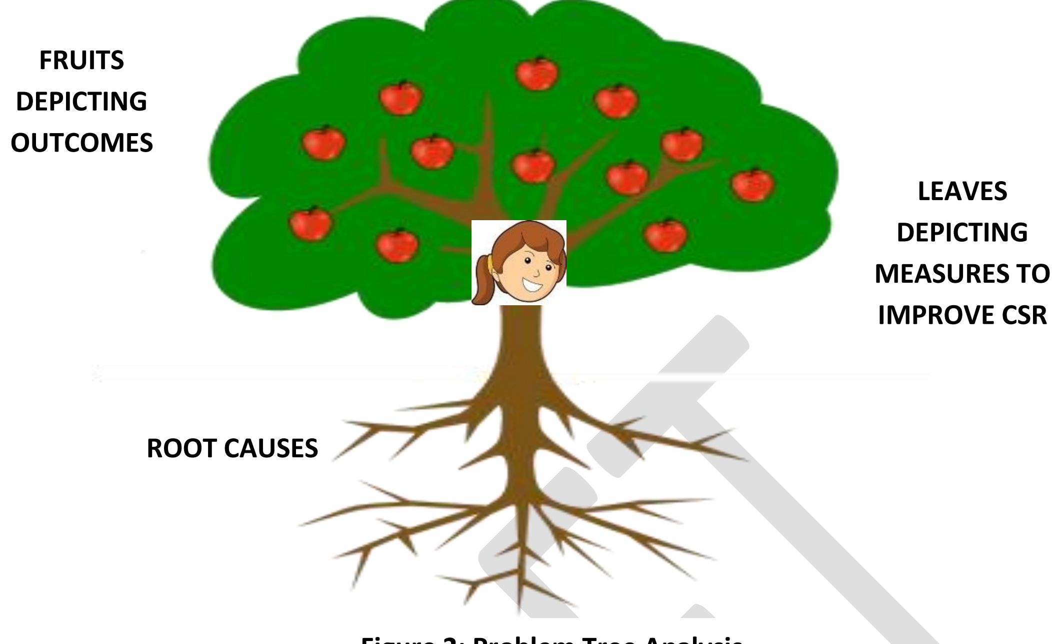

Figure 2: Problem Tree Analysis

Ask

- What may be the causes for the low health indicators?
- What will be the effect on the status of Girl Child?

The answers of the trainees may be discussed during the presentation by the trainer. The trainer may then focus on critical indicators and important definitions related to health (***Annexure-3***) and different dimensions of health on gender basis which affect the children like IMR, U5MR, child mortality, neo-natal mortality, post neonatal mortality, LBW babies, MMR, registration of birth, by explaining the definitions supported by latest statistics ***(refer contents)***.

The trainer may then talk briefly about the status of access to health services and its importance and relevance for the health and survival of the girl child. Hand outs may be provided to the trainees (***Annexure-4***). The focus should then shift to the situation of malnutrition in our country ***(refer contents)***.

Ask

- What is Malnutrition? What are its causes?
- What are the types of Malnutrition?
- Use of New WHO Child Growth Charts and Growth Faltering in detecting under nutrition?

While discussing about the malnutrition, discuss and refer micronutrient deficiencies among children, their intake and nutrient intakes among children. The trainer may then focus on WHO child growth standards for tracing nutritional status of girl child. This should be followed by talking about the Educational Status of Girl Child and the importance of education for them with emphasis on specific causes of low education of girl child. The trainer can explain the use of MCP Card ***(Annexure-5)***.

The role of health workers and ICDS functionaries in preventing under nutrition, improving CSR should be highlighted during the session.

The session should end with a round of questions as feedback.

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CONTENT FOR TRAINERS

Demography

The total number of children in the age group 0-6 years as per the Census, 2011 is 158.8 million, which is about 5 million less than the number recorded in 2001. Out of 158.8 million, the rural child population stands at 117.6 million and urban at 41.2 million in 2011. The decline is recorded in rural areas by 8.9 million however in urban areas an increase of 3.9 million is recorded (Table-1).

Table 1: Child Population in India

S.No.	Age Group	Male	Female	Total
1.	0-6 years	82,952,145	75,837,152	158,789,287
2.	7 years and above	540,772,113	510,632,022	1,051,404,135

Source: Census, 2011

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Child Sex Ratio

Sex composition of the human population is one of the basic demographic characteristics, which is extremely vital for any meaningful demographic analysis. ***Sex ratio*** defined as the number of females per 1000 males in the population, is an important social indicator to measure the extent of prevailing equity between male and female in a society at a given point of time. The ***Child Sex Ratio*** is defined as the number of females in the age group of 0-6 years per thousand males in the same age group. The child sex ratio is primarily influenced by ***sex ratio at birth*** and mortality in the early childhood. The sex ratio at birth refers to the ratio of males to females at the time of birth in a given time period. The major cause of the decrease of the female birth ratio in India is considered to be the cruel treatment meted out to the Girl Child at the time of the birth.

Causes of Uneven Sex Ratio in India

Some of the reasons of the consistently low levels of Child Sex Ratio are:

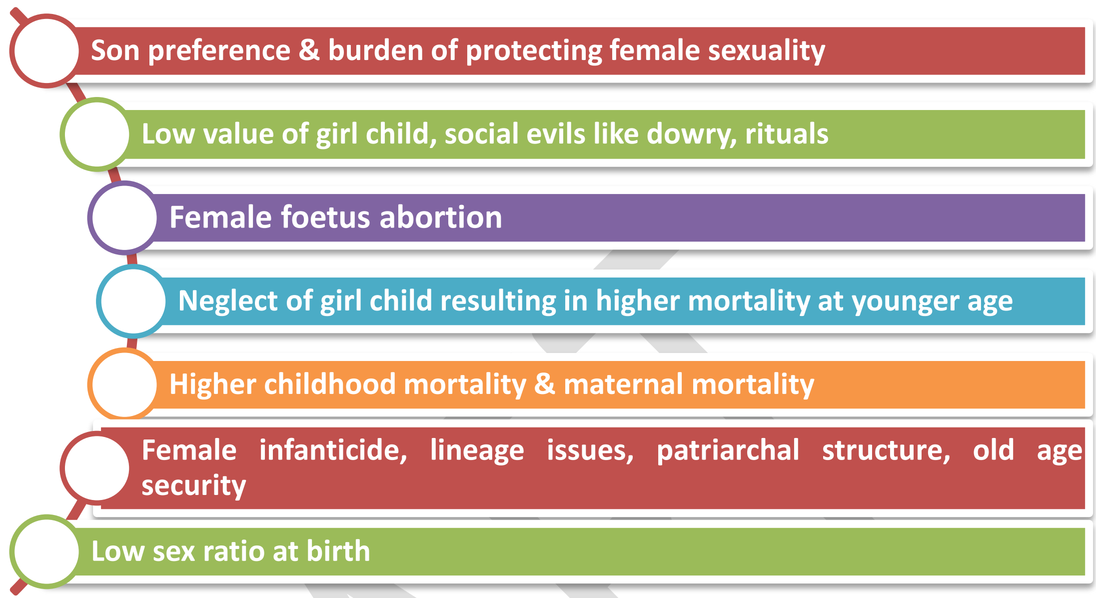

Figure 3: Causes of Uneven Sex Ratio in India

Census 2011, recorded considerable fall in CSR in the age group of 0-6 years and has reached 918, which is 9 points fall from 927 during 2001.

There has been a continuous decline in the Child Sex Ratio since 1961 (Figure 4).

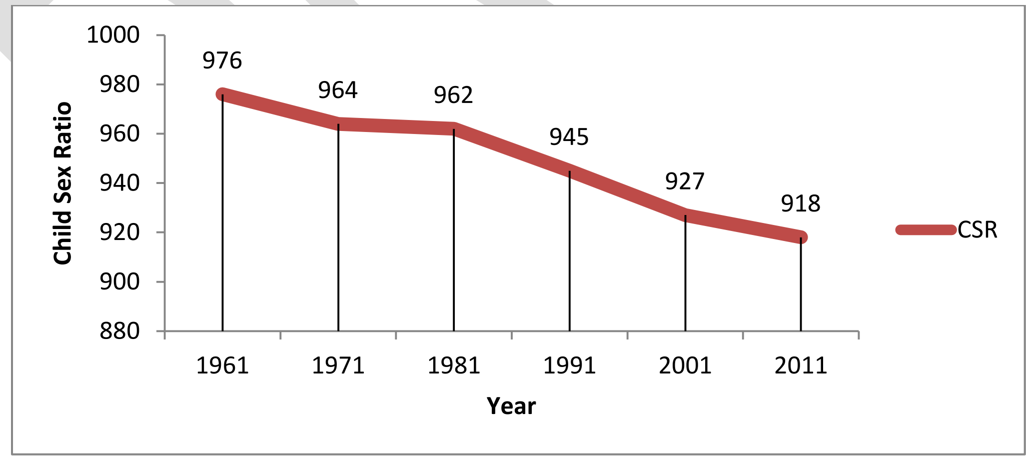

Figure 4: Decline in Child Sex Ratio

Gender Biased Sex Selective Elimination

Gender Biased Sex Selective Elimination, is defined as selective abortion/elimination of the girl child in the womb after the detection of the child's gender through medical means. This is usually done under familial & societal pressure.

Consequences of Gender Biased Sex Selective Elimination:

- Skewed sex ratio
- Female/women trafficking
- Increase in violence against women like rape and assault

Differently Abled, Vulnerable, Marginalised & Tribal Children

- Differently abled cover impairments, activity limitations, and participation restrictions.
- Impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.
- Differently abled is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between a disabled person and society in which he or she lives.

- In India, children with disabilities mainly come under the purview of the Ministry of Social Justice & Empowerment.
- Some of the issues are dealt with by the Health Ministry as well.
- Statistics of disability id shown in Table-2.

Table 2: Disability Statistics

AGE GROUPS	MALE	FEMALE	INDIA
0-4	6.90,315 **(53%)**	6,00,981 **(47%)**	12,91,332
4-9	10,81,598 **(55%)**	8,73,941 **(45%)**	19,55,539
10-19	26,10,174 **(57%)**	20,05,876 **(43%)**	46,16,050

Source: Census, 2011

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The main causes of disability in children are:

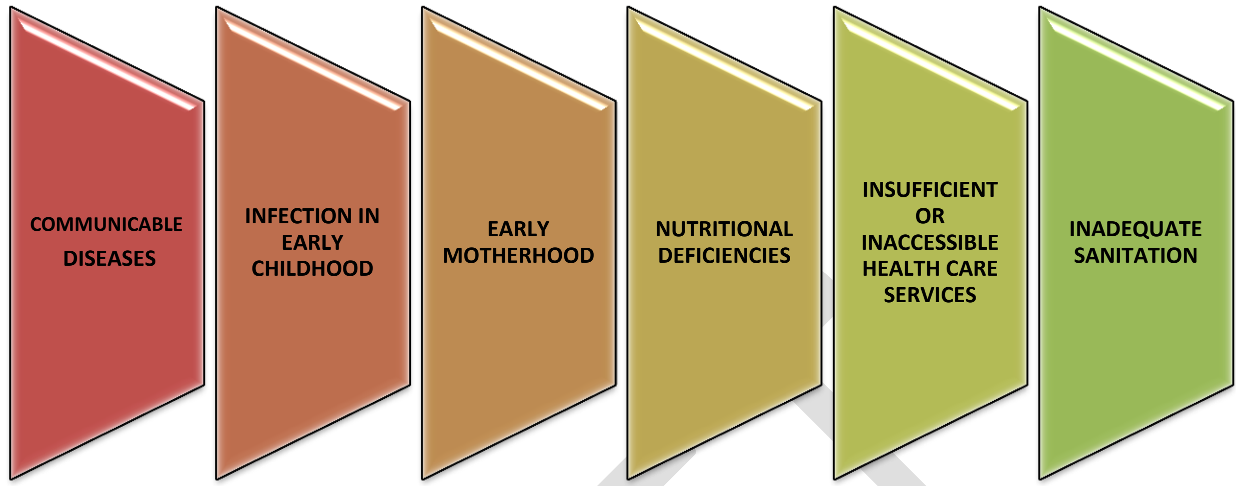

Figure 5: Causes of Disability

- **Vulnerable and marginalised children** include children who are:
  - Street Children, trafficked, child labour, involved in substance abuse, victims of natural calamity, differently abled, HIV/AIDS affected and infected, juvenile in conflict with law
- Children who are trafficked, abused and sexually exploited are at risk for psychological and physical trauma.
- Violence against children which include mutilation of organs, corporal punishment in schools etc., may also lead to disability in children.
- Problems of physically challenged children from poor families are more pathetic.
- Children belonging to **scheduled tribes (STs)** are also victims of discrimination. The population details of STs & SCs are presented in Table-3.
- Children of Dalit and tribal families also are abused at large.
- Literacy among SC/ST population is indicative of the advancement in education.

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Table 3: Population of Scheduled Tribes in India

INDICATORS	MALE	FEMALE	RURAL	URBAN	INDIA
SCHEDULED TRIBES	5,24,09,823	4,71,26,341	9,38,19,162	1,04,61,872	10,42,81,034
SCHEDULED CASTES	103535314	97843058	153850848	47527524	201378372

Source: Census, 2011

Health & Nutrition Status of Girl Child

Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity ***(Source-WHO, 2000).***

- Infant mortality rate (IMR) is the number of deaths of children less than one year of age per 1000 live births.
- The rate for a given region is the number of children dying under one year of age, divided by the number of live births during the year, multiplied by 1,000.

The major causes of IMR include the following:

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Table 4: Health Status of Children in India

S.NO.	MALE	DATA (%)			SOURCE
		Total	**Rural**	**Urban**	
1.	Infant Mortality	42 M: 41 F: 44	46	28	2013, SRS 2012, SRS
2.	U5MR	Total:52 M: 49 F: 56	58	32	2012, SRS
3.	Child Mortality	11	13	7	2012, SRS
4.	Post-neonatal mortality	13	14	12	2012, SRS
5.	Low Birth Weight Babies	22	--	--	NFHS-3
6.	Neo Natal Mortality rate	29	33	16	2012, SRS
7.	Any Anaemia (6-59 months)	69.5 M: 69 F: 69.9	--	--	NFHS-3

Source: MoHFW

Maternal Mortality Rate

- **(MMR)** has declined from 400 maternal deaths per 100,000 live births in 1997-98 to 212 in 2007-09 and finally to 178 in 2010-2012 (SRS, 2013).
- The decline has been most significant Empowered Action Groups (EAG) States & Assam.

Medical Termination of Pregnancy

According to the AHS (2012-2013) second round of updation statistics, one of the indicators used is abortion for assessing the status of MTP. Seven out of every 10 deliveries are `safe' in Madhya Pradesh, Rajasthan, Odisha and Assam, the same in Baseline. The few abortion related statistics are depicted below.

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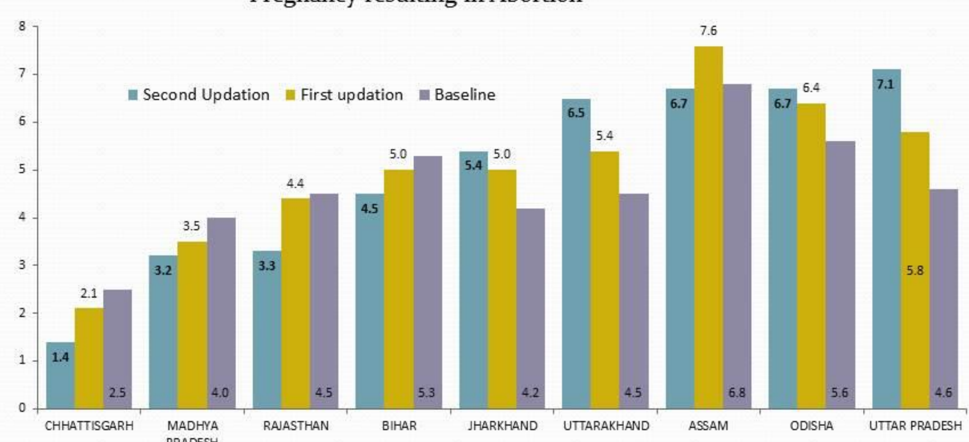
Abortion



✓ Varies from 1.4 % in Chhattisgarh to 7.1 % in Uttar Pradesh, in Baseline , Assam was at the higher end.

✓ Across 284 districts in 9 AHS States, it ranges from 0.3 % in Dantewada(Chhattisgarh) to 16.1 % in Jorhat(Assam).

Source: AHS (2012-2013)

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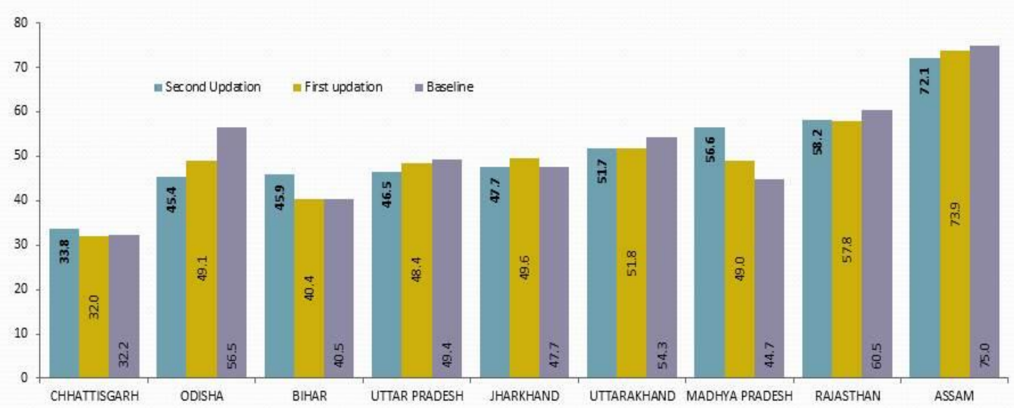
Abortion



✓ Abortion taking place in institution varies from 33.8 % in Chhattisgarh to 72.1 % in Assam.

✓ Across 284 districts in 9 AHS States, it ranges from 11.4 % in Nabarangapur (Odisha) to 92.9 in Jodhpur(Rajasthan).

Source: AHS (2012-2013)

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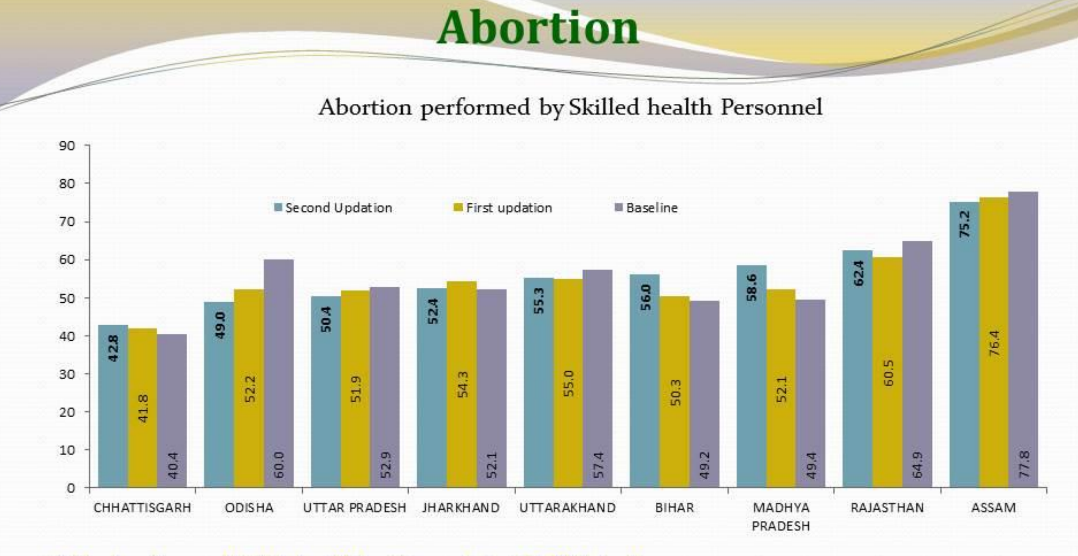

- ✓ Varies from 42.8% in Chhattisgarh to 75.2% in Assam.
- ✓ Across 284 districts in 9 AHS States, it ranges from 11.4 % in Nabarangapur (Odisha) to 100% in Jaisalmer (Rajasthan) – a variability of more thsan 5 times.
- ✓ More than 50% of the abortion is performed by skilled health personnel in all the States except Chhattisgarh and Odisha. Odisha is newly added in the second updation round.

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Source: AHS (2012-2013)

Registration of Births

- In India, the registration of births and deaths is compulsory under the Registration of Births and Deaths (RBD) Act of 1969. Under this act, institutional heads are responsible for registering all births that take place within their institution within 21 days of their occurrence. Heads of households are responsible for registering any births that take place within their homes. After registration, the birth certificate is obtained by applying to the registrar or sub-registrar of the area, either on plain paper or by filling in a form.
- Nationally, 41 percent of children under age five years have had their births registered with the civil authorities. However, only 27 percent of children under age five years have a birth certificate. Girls and boys are equally likely to have their births registered and to have birth certificates (Table 5). It is the children with more educated mothers and fathers and children from the higher wealth quintiles who are more likely to have their births registered and to have birth certificates.

Table 5: Birth Registration of Children Under Age Five

	Registered, has a birth certificate	Registered, does not have a birth certificate	Total Registered
Male	27.1 %	13.9 %	41.0 %
Female	26.7 %	14.6 %	41.3 %

(Source: NFHS-3)

Access to Health Services

1. **Ante-natal check-up (ANC):** Around 55 percent of women received ANC check up from a government health facility as compared to 36 percent from private health facility and around 10 percent from community based services like nongovernment hospital/trust hospital or clinic, own home, parents home, other home and others. The ANC check-up services received from government health facilities are higher than private and community based services.
   The timing of the first visit and number of ANC visits are the important factors for the health of mother and outcome of the pregnancy. 24 percent of women in India had 1-2 ANC visits and around 50 percent of women had three or more visits. A higher proportion of urban women (around 68 percent) had at least three ANC visits, compared to 43 percent among rural women. Seventy-nine percent of women educated for 10 years and above had at least three ANC visits, while it was just 29 percent for non-literate women.
2. **Full ANC:** The DLHS-3 defines full ANC as "at least three visits for ANC check-up, at least one TT injection received and 100 IFA tablets/syrup consumed". The full ANC has increased from DLHS-2 (16.4 percent) to DLHS-3 (18.8 percent).

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3. **IFA Tablet/Syrup**: 16 percent of women who had still/live birth in the three years preceding the survey received no IFA supplements. Only 47 percent of women consumed 100 IFA Tablets. Thus, the coverage of IFA supplement is below average. The utilisation of full ANC across different states is shown in Figure 6.

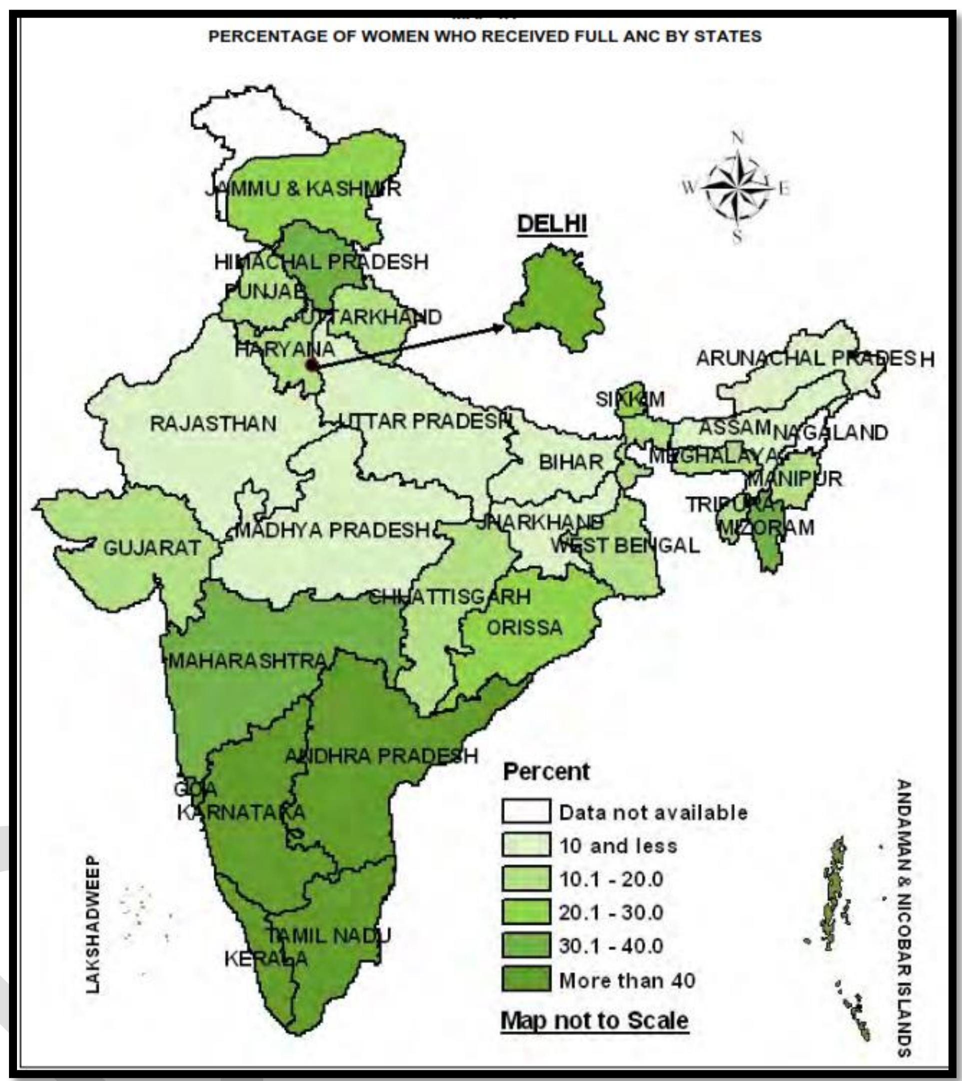

Figure 6: Percentage of Women who Received Full ANC by States

4. **Place of Delivery**: Around 47 percent of the deliveries took place in government health institutions and 52 percent at home. At least 70 percent of the deliveries in urban areas and only 38 percent of deliveries in rural areas took place in the health institutions. Only around 6 percent of home deliveries were assisted by skilled persons.
5. **Immunization:** Universal Immunization Programme is one of the key interventions for protection of children from life threatening conditions, which are preventable. It is one of the largest immunization programmes in the world and a major public health

intervention in the country averting between 2 and 3 million deaths each year. Immunization is the process whereby a child is made immune or resistant to an infectious disease, typically by the administration of a vaccine.

- It is one of the most cost-effective health investments, with proven strategies that make it accessible to even the most hard-to-reach and vulnerable population.
- Despite a long standing national programme for universal immunization in India, poor coverage and multiple inequalities in immunization continue still exist. At the national level, The Universal Immunization Programme (UIP) targets approximately 2.7 crore infants and 3 crores pregnant women. Children are immunized against six vaccine preventable diseases which are Tuberculosis, Polio, Tetanus, Measles, Pertussis and Diphtheria. As per Coverage Evaluation Survey (CES) - 2009, 61 percent children (12-23 months) received full immunization.
- The proportion of children receiving full vaccination was 54 percent as per NFHS-3. The full vaccination includes one dose of BCG, three injections against DPT, three doses of Polio (excluding polio 0) and one vaccine against measles. About 5 percent of the children at the national level had not received single vaccine. The trends in immunization coverage at the national level are not at all encouraging. According to DLHS-1(1998-99), it was 54 percent. It declined to 46 percent in DLHS-2 (2002-04). It has shown some improvement as per DLHS-3 (2007-08) with coverage of 54 percent. 55 percent of boys were fully immunized as against 52 percent of girls. The Table 7 below reveals the vaccination of children by sex of the child.

Table 6: Immunization Status

	BCG	DPT-All 3 doses	Polio- All 3 doses (includes dose 0)	Measles	Full Vaccination	No Vaccination
Male	87.3	64.6	66.7	70.1	54.6	4.5
Female	86.0	62.0	64.4	67.9	52.3	4.7

6. **Source of Immunization**: Nearly 16 percent of the children received vaccination from Sub-Centres, 15 percent from Primary Health Centres and 67 percent from the other government health facilities. The contribution of the private sector in the immunization programme was about 10 percent only.
7. **Vitamin A Supplementation**: At the national level, 57 percent of the children received at least one dosage of vitamin A. However, the proportion who received three to five dosages of vitamin A was only 19 percent. However, no major difference was found about the Vitamin A supplementation among boys (18.4 percent) and girls (18.7 percent).

Morbidity

- It is a diseased state, disability, or poor health in a population.
- Around 9 million children die every year before reaching their fifth birthday.
- Most deaths among under-fives are still attributable to conditions like acute lower respiratory infections, like pneumonia (17 percent), diarrhoea (16 percent), malaria (7 percent), measles (4 percent), HIV/AIDS (2 percent) and other neo-natal conditions mainly pre term births, asphyxia and infections account for 37 percent of all deaths in under-fives as shown in Figure 4 below.
- Poor and delayed care seeking contributes to 70 percent of child deaths

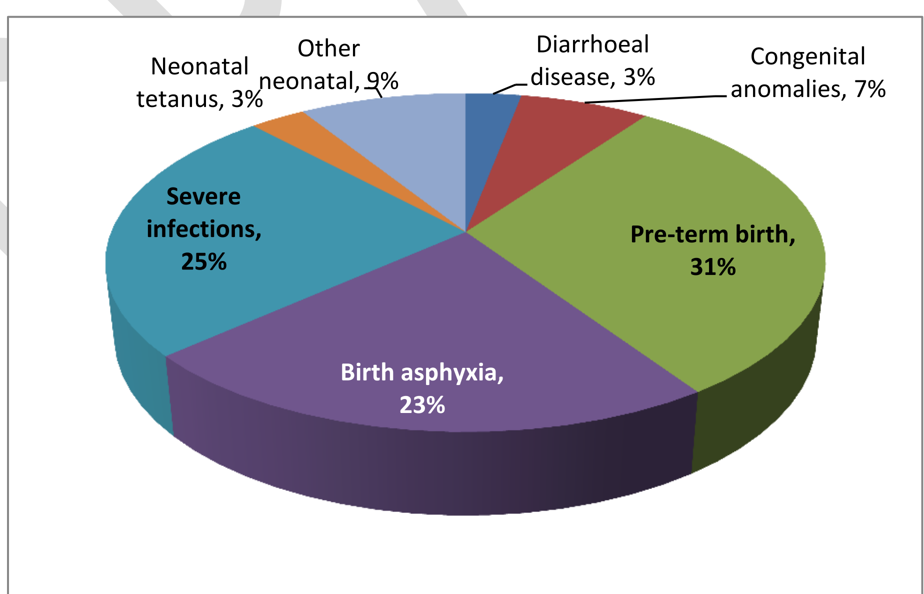

Figure 7: Neonatal Causes of Death (37%)

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Nutrition

- India is undergoing nutrition and socio-economic transition and is facing the dual burden of malnutrition i.e., problem of under-nutrition and micronutrient deficiencies along with emerging problems of overnutrition and obesity within the same population which presents threat to human health and economic progress and development of the Nation as a whole.
- The nutritional status of children is presented in Table-7.
- **Child malnutrition** is the single biggest contributor to under-five mortality due to greater susceptibility to infections and slow recovery from illness.
- Children do not reach their optimum size as adults (and so may have less physical capacity for work), their brains are affected (resulting in lower IQs) and they are at greater risk of infection (which kills many children during their early years).
- Child malnutrition has an impact on education attainment. The degree of cognitive impairments is directly related to the severity of stunting and Iron Deficiency Anaemia.
- Child malnutrition has major implications on economic productivity as well.

Table 7: Nutritional Status

INDICATORS	MALE	FEMALE	INDIA
STUNTING			
(% BELOW -3 SD)	23.9	23.4	23.7
(% BELOW -2 SD)	48.1	48.0	48.0
WASTING			
(% BELOW -3 SD)	6.8	6.1	6.4
(% BELOW -2 SD)	20.5	19.1	19.8
UNDERWEIGHT			
(% BELOW -3 SD)	15.3	16.4	15.8
(% BELOW -2 SD)	41.9	43.1	42.5

Source: DLHS-3

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- **STUNTED:** Stunted growth refers to low height-for-age, when a child is short for his/her age but not necessarily thin. It reflects failure to receive adequate nutrition over a long period of time and is also affected by recurrent and chronic illness.
- **WASTING:** refers to low weight for height. The weight-for-height index measures body mass in relation to body length and describes current nutritional status.
- **UNDER-WEIGHT:** Under-weight refers to low weight-for-age, when a child can be either thin or short for his/her age. This reflects a combination of chronic and acute malnutrition.

The main underlying conditions that determine adequate nutrition are food, health and care along with the degree of an individual's or a household's access to these preconditions affects how well they are nourished which are as under:

- Food Quantity and Quality
- Health and Sanitation Environment
- Social and Care Environment

Nutritional Status of Women & Adolescent Girls

Nutritional status of adolescent girls and women is critical as this affects the reproductive age of the women. Following table highlights some of the major statistics on health and nutrition of adolescent girls and women:

Table 8: Nutritional Status of Children, Women & Adolescents of India

NUTRITIONAL CHALLENGES IN INDIA: SOME FACTS		
CHILDREN	WOMEN	ADOLESCENT GIRLS
• LBW- 22 % • IMR- 42 • 42.5% (0-5 years) underweight • 79% (6-35 months) anaemic • Bitot Spots (preschool children) -0.6%	• Women with BMI below 18.5 (Chronic Energy Deficiency)- 36% • Anaemia (15-49 years) - 56.2% • Overweight- % of ever-married women (15-49 years) – 15% • Under nutrition declines and over nutrition increases with age of women	• 11-18 years Approx. 8.32 Crore - (16.75 % of female population) • BMI below 18.5 - 47 % • Anaemia : 56 % • 58 % women married and 30% gave first birth before age of 18 years • Dropout rate (I-X): 63.5%

Source: DLHS 3, NFHS 3, NNMB

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Micronutrient Intake among Children

Vitamin A: NFHS-3 collected information on the consumption of vitamin A-rich foods. For the youngest child age 6-35 months living with the mother, 47 percent consumed foods rich in vitamin A in the day or night preceding the survey. These foods include meat, organ meat, fish, poultry, eggs, pumpkin, carrots, sweet potatoes that are yellow or orange inside, dark green leafy vegetables, ripe mango, papaya, cantaloupe, and jackfruit. No difference was found in male (46.8 percent) and female (47.3 percent) children in the intake of vitamin A rich food.

Iron: The consumption of iron-rich foods (such as meat, organ meat, fish, poultry, and eggs) is considerably lower than the consumption of foods rich in vitamin A. Overall, only 15 percent of children ate foods rich in iron during the day or night before the survey. Girls and boys are about equally likely to receive these items.

Salt iodization: Iodine is an important micronutrient. A lack of iodine in the diet can lead to Iodine Deficiency Disorders (IDD), which can cause miscarriages, stillbirths, brain disorders, and retarded psychomotor development, speech and hearing impairments, and depleted levels of energy in children. Iodine deficiency is the single most important and preventable cause of mental retardation worldwide. Among the households that had their salt tested, just over half (51 percent) were using salt that was adequately iodized.

(Note: The details about micronutrient deficiencies and information about their related preventive programmes may be referred from Day 1, Session 5-Health & Nutrition of Girl Child)

Time Trends in Nutrient Intakes

1-3 year children: The average intake of protein, energy, calcium and iron decreased over the period. The extent of decrease in the intake of energy was 67Kcal and that of protein was about 2g from 1975-79 to 2011-12. The intake of vitamin A increased from 136µg to 151µg and iron decreased from 10.2mg to 5.8mg during the same period.

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4-6 year children: The average daily intake of energy has declined by about 36Kcal over 4 decades. The intake of micronutrients such as vitamin A and niacin increased from 159µg to

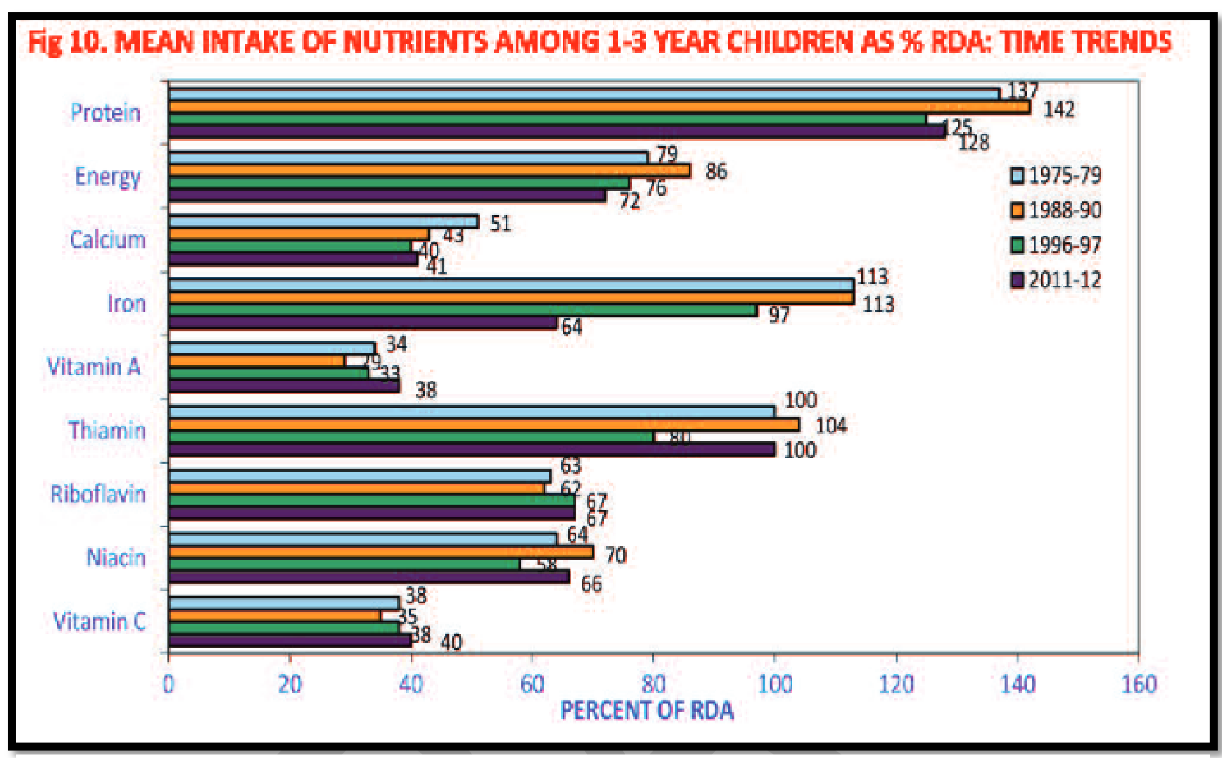

Figure 8: Mean Intake of Nutrients Among 1-3 Year Children as % RDA: TIME TRENDS

177µg and 7mg to 8mg respectively, while the intake of thiamine and riboflavin were comparable.

7-9 year children: The average daily intake of all the nutrients except thiamine, vitamin C and niacin declined from 1996-97 to 2011-12.

10-12 year girls & boys: Among girls, the mean intake of energy (1635Kcal to 1401Kcal), protein (42.6g to 38.6g), calcium (422mg to 293mg), iron (20.3mg to 11.4mg) and vitamin A (241µg to 198µg) declined during the period from 1996-97 to 2011-12, and the intake of rest of the nutrients remained similar. On the other hand, among boys, the average daily intake of all the nutrients decreased except for thiamine, niacin and vitamin C, which either remained same or marginally increased. The extent of decrease with respect to energy was 276Kcal while that of protein was 5.4g during 1996-97 to 2011-12.

13-15 years girls & boys: The intake of all the nutrients declined considerably from 1996-97 to 2011-12. The extent of decline was 294Kcal of energy, 5.6g of protein and 144mg of calcium for girls and 45Kcal of energy, 6.4g of protein, and 121 µg of Vitamin A for boys.

16-17 year girls & boys: The intake of all the nutrients except thiamine and niacin declined considerably from 1996-97 to 2011-12 among both girls and boys. The intake of energy declined by 374Kcal, protein by about 6g iron by 10mg and calcium by 188mg for girls and among boys the energy declined by 530Kcal, protein by about 12g and Vitamin A by 112µg.

Infant and Young Child Feeding

Optimal infant- and young child-feeding (IYCF) practices are crucial for growth, development, health, and ultimately the survival of children. Brief look at the statistics of IYCF are provided for situation analysis.

Table 9: Data on IYCF

INDICATORS	DLHS-3 (2007-08)	NFHS-3 (2005-06)
Children received Colostrum	80.1% (15-49 months)	---
Mothers fed water/pre-lacteals to their infants before 6 months	---	57.2% (pre-lacteals)
Initiation of breastfeeding within one hour of birth	40.5%	24.5%
Initiation of breastfeeding within one day	70.9%	55.3%
Initiation of breastfeeding after 24 hrs of birth	29.1%	---
Initiation of breastfeeding after three days	---	---
Exclusive breastfeeding of children under 6 months	46.4%	28% (4-5 months)
Introduction of complementary feeding upon completion of 6 months, along with continued breastfeeding for 2 yrs	23.9 % in the age group of 6-9 months	53% (6-8 months)

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Educational Status of Girl Child

Education is a critical input in human resource development and is essential for the country's economic growth. A high literacy rate, especially of girls, correlates with improvement in several socio-economic indicators, namely low birth rate, low IMR and increase in life expectancy. Educational status of children is shown in Table-10.

Table 10: Education Status of Children

<table>
<tr><th>Education</th><th>Male</th><th>Female</th><th>Rural</th><th>Urban</th><th>Total</th><th>Source</th></tr>
<tr><td>Literacy</td><td>82.1</td><td>65.5</td><td>--</td><td>--</td><td>70</td><td rowspan="5">Census 2011</td></tr>
<tr><td rowspan="3">Drop-out rate</td><td>I-V</td><td></td><td>28.7</td><td>25.1</td><td>27</td></tr>
<tr><td>I-VII</td><td></td><td>40.3</td><td>41</td><td>40.6</td></tr>
<tr><td>I-X</td><td></td><td>50.4</td><td>47.9</td><td>49.3</td></tr>
<tr><td>Literacy Rate 7+ years</td><td>82.14</td><td>65.46</td><td>--</td><td>--</td><td>74.04</td></tr>
<tr><td>Population below age 15 years</td><td>--</td><td>--</td><td>34.4</td><td>28.8</td><td>32.6</td><td>DLHS-3</td></tr>
</table>

Drop Out: Dropout is a universal phenomenon of education system in India, spread over all levels of education, in all parts of the country and across all the socio-economic groups of population. The dropout rates are much higher for educationally backward states and districts. Girls in India tend to have higher dropout rates than boys. Similarly, children belonging to the socially disadvantaged groups like Scheduled Castes and Scheduled Tribes have the higher dropout rates in comparison to general population.

Reasons for dropping out from schools:

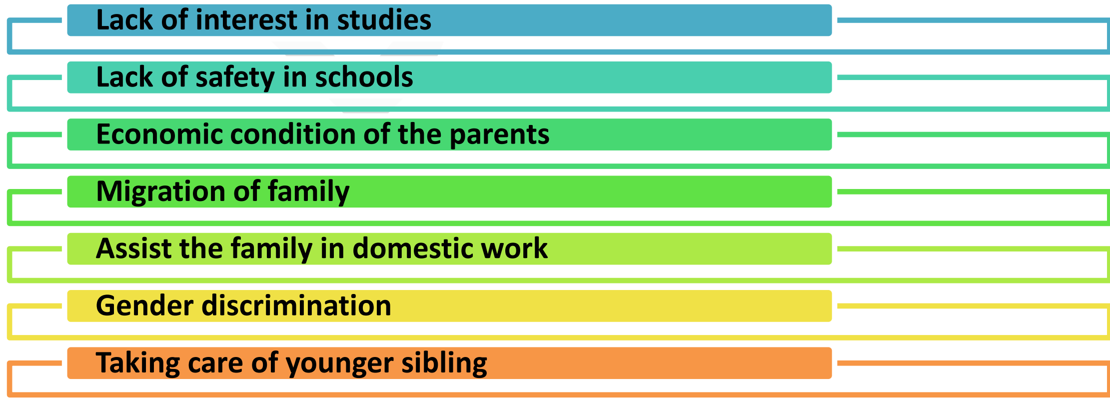

Figure 6: Reasons for Dropping out from School

Government of India has taken ~~few~~ many initiatives to encourage girl's education. One of the initiatives is ***Sarva Shiksha Abhiyan*** **(SSA)**, the National Programme for Universalisation of Elementary Education for children in the age group 6-14 years, was launched by the Government of India in mission mode in partnership with the States and Union Territories (For more details refer ***Day 3 Session 1***). The other initiatives taken up by Ministry of Human Resource Development for the development for school education and literacy are mentioned below:

School Education & Literacy

Elementary Education

- Sarva Shiksha Abhiyan
- Mid-Day Meal
- Strengthening of Teachers Training Institute
- Schemes for Infrastucture Development of Private Aided/Unaided Minority Institutes (IDMI)
- Mahila Samakhya
- Strengthening for providing quality Education in Madrassas (SPQEM)

Secondary Education

- Rashtriya Madhyamik Shiksha Abhiyan (RMSA)
- Inclusive Education for Disable at Secondary Stage (IEDSS)
- Incentives to Girls at Secondary Stage
- National Merit cum Means Scholarship
- Financial Assitance for Appointment of language Teachers
- Adolescene Education Programme
- Girls Hostel
- Model School
- ICT at School
- Vocationalisation of Secondary Education
- Model School Under Public- Private Partnership (PPP) Mode

Adult Education

- Saakshar Bharat
- State Resource Center (SRCs)
- Jan Shikshan Sansthans(JSSs)
- Assistance to Voluntary Agencies

Teacher Education

- Centrally Sponsored Scheme

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Role of AWW/ASHA/ANM

- They must gather information on the status of girl child in their area through family survey or secondary data.
- Based on the data, the workers must educate and make the community aware about the status of girl child, adolescents and women.
- Educate the community about the low CSR, low educational level of girls, health and nutritional status of girl child- its importance and disadvantages there off.
- Identify disabled and marginalised children and facilitate the access to various Government programmes marked for them.
- Discuss with other health functionaries as well about the status of girl child in your community.
- The data thus collected will help you in planning various IEC and advocacy programs for the community.
- Motivate mother for early registration of pregnancy, institutional delivery, birth registration.
- Make sure that the AWCs are equipped with Mother and Child Protection Card and it should be disseminated to all pregnant and lactating mothers.
- AWW may help drop out children to join the education system.

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SESSION 3	**GENDER MAINSTREAMING**
OBJECTIVE	• To understand the concept of gender and gender mainstreaming in education

CONTENT	• Understanding gender
	  ○ Gender mainstreaming
	  ○ Gender issues in education
	• Role of AWW/ASHA/ANM

DURATION	1 hour 15 minutes
TRAINING METHOD	Brain storming, lecture cum discussion, case study
LEARNING OUTCOME	The participants would be able to understand the concepts related to gender and gender mainstreaming and also importance of mainstreaming gender in education and strategies thereof.
RESOURCES REQUIRED	• LCD projector • Power-point presentation highlighting the key contents
ANNEXURE	• Sample story – case study (group activity)
REFERENCES	• Success Story (Refer http://ssa.nic.in/page_portletlinks?foldername=success-story) • Communication Guide – A key to building a people's response to gender- based sex selection by UNFPA

FACILITATORS NOTES

Methodology

The session may be initiated by understanding gender and defining gender and differentiating between genders and conducting an analysis of the roles and responsibilities associated with gender relevant to Indian community.

Ask

- What are the common roles and responsibilities that we associate with the male and female gender in our community?
- Do you believe that there should be gender specific roles and responsibilities?

Discuss about gender relations between men and women, sexual division of labour and how needs, interests and priorities differ between genders. Also discuss about gender equality, gender planning, and gender mainstreaming the need to provide equal opportunities and benefits to both the genders and curbing incidences of gender discrimination across the society.

Ask

- The participants to recall any incidences of gender discrimination in their community? (They may share their experiences with other participants regarding gender discrimination).
- What initiatives have they taken to ensure gender equality in their community/ state?

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Group Activity (Role play):

- The trainees may be divided into groups of 3-4
- Each group may create a story, focussing on the social issue of gender discrimination
- The group may then present the story using role play
- The other trainees may provide with solutions to the problems cited in the story

Progress the discussion to the importance of imparting empowerment to both the genders so as to enable them to take control of their lives and be self-reliant. Also discuss about the gender issues in education and focus on the barriers to girls' enrolment, retention and ~~performance~~ school achievement in education.

Ask

- What are the common barriers they have faced with regard to enrolment and retention of girls in schools in their community/ state?
- What initiatives have they taken to combat these barriers?

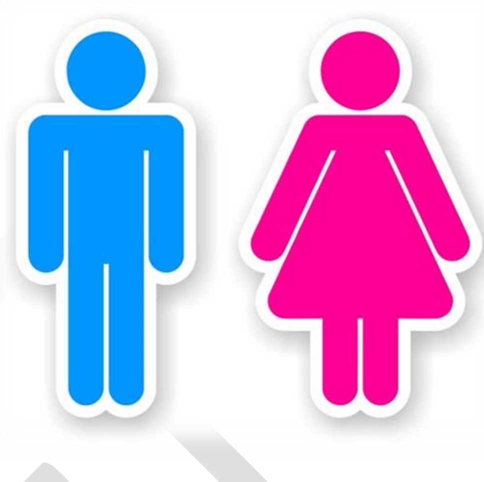
Progress the discussion to the ways and means by which gender mainstreaming can be achieved in the educational sector and how the policies framed at institutional level can be effective in achieving the same effect. Also discuss about prioritising gender equality issues at the primary and secondary level of education and also in non- formal education and training.

The trainer can share the case study presented (***Annexure-6***), and discuss sample questions about the case study with respect to Gender Mainstreaming. The trainer may also refer the framework above to follow the link to share the various success stories of girl's education.

CONTENTS FOR TRAINERS

Understanding Gender

Gender



- Refers to the socially constructed roles and status of women and men, girls and boys. It is a set of ~~culturally specific characteristics~~ specific culture gender bias defining the social behaviour of women and men, boys and girls, and the relationships between them.
- Gender roles, status and relations vary according to place (countries, regions, and villages), groups (class, ethnic, religious, and caste), generations and stages of the lifecycle of individuals.
- Gender is, thus, not about women but about the relationship between women and men.
- Gender identities and associated expectations of roles and responsibilities are therefore changeable between and within cultures.

Sex and gender are terms that are often mixed up and used synonymously due to lack of clarity about the difference between the two. Though the term gender is increasingly heard, many times it is used as a strategically correct term for sex rather than with the understanding of what it indicates. Let us look at the differences between sex and gender and try to understand them.

Sex indicates the physical characteristics of a person. A person is born with a predetermined sex-either male or female. Sex is biologically determined before birth. It is innate. That a person is born male or female is pure chance and is determined at conception itself when the ovum and the sperm unite. It cannot be taught or changed, Biological and physical conditions, chromosomes, external and internal genitalia, hormonal states and secondary sex characteristics lead to determining male or female sex.

Gender is learned through socialization. Gender roles are socially ascribed, taught and maintained. They are perpetuated through tradition and culture. In other words, gender is used to describe the characteristics of women and men which are socially constructed. Social psychological, historical and cultural perceptions of masculine and feminine trains and roles lead to determining male and female gender.

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People are born male and female but learn to become boys and girls. As they grow, sex differences determine how they will behave and what they will be, during the rest of their lives. Boys and girls grow into men and women in a socio cultural context. This learned behaviour and attitude make up gender identity.

Gender refers to the roles and responsibilities of women and men that are socially constructed, learned and perpetuated from generation to generation within a social cultural context. Gender attitude and behaviour are learned and can be changed. Though there are some variations from place to place these gender roles are universally promoted. Gender roles are built on perception of control over resources and the dynamic of power relations.

Gender inequalities arise from the different and unequal roles, and the unequal power relations between men and women in different spheres of life. These inequalities have consequences on their lives, well-being and health. Gender inequalities in most societies lead to women having fewer roles in decision making over their own health, poor access to health services and inadequate capabilities to protect themselves from risks to their health.

Various factors play a role in building up and promoting perceptions of gender-cultural, political, environmental, economic, social and religious. Tradition, custom, law, class, ethics, and individual or institutional bias further strengthen these stereo types. It is this social perception of differences between men and women and the subsequent behaviour that are called gender stereotypes. Both men and women get trapped in this distorted perception created by the dynamic of human relations.

Table 11: Meanings of Terms Related to Gender

ACCESS	Availability of service in the form of infrastructure personnel and material is potential access. This facilitates utilization of service.
EQUITY	Fair treatment in access to resources and services according to ones need. Justice and fairness to both men and women according to their needs rather than biased perception is gender equity.
EMPOWERMENT	The process of generating and building capacities to exercise control over one's life and resources. Women's empowerment refer to the process of enabling women to take a more active role in decision making, planning and monitoring activities for their own welfare and development.
INEQUITY	Unfair inequality. This means that principles of fairness and justice have not been considered while allocating resources.
GENDER	The socially constructed roles and responsibilities assigned to women and men in a given culture or location and the societal structures that support them. Gender is learned and changes over time.

GENDER ANALYSIS	An organized approach for examining factors related to gender in the entire process of program development from conceptualization, need assessment, and design to implementation and evaluation. These factors may include the different activities of men and women, access to and control of resources and benefits, and decision making power.
GENDER BIAS	The tendency to make decision or take action based on prevalent perceptions of gender. This particularly refers to the unfavourable atmosphere to women compared to men.
GENDER DISCRIMINATION	Prejudicial treatment of an individual based on a gender stereotype (Often referred to as sexism or sexual discrimination).
GENDER EQUALITY	A condition in which women and men participate as equals, have equal access to resources, and equal opportunities to exercise control over resources and decisions. The principle of fairness is not necessarily considered.
GENDER ISSUES/CONCERNS	Specific consequences of the inequality of women and men in different spheres which require redressal to bring about gender equity.
GENDER RELATION	Ways in which a culture or society defines rights, responsibilities, and identities of men and women to bring about gender equity.
GENDER SENSITIVE	Being aware of the differences between women's and men's needs, roles, responsibilities, and constraints and taking these into consideration.
SEX	The biological differences between women and men, which are innate, universal, obvious, and generally permanent.
GENDER ROLES	The responsibilities and activities assigned to women and men based on gender perceptions.
GENDER MAINSTREAMING	The process of assessing the implications for men and women of any planned action, including legislations, polices and programme, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experience an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social sphere so that women and men benefit equally, and inequality is not perpetuated.
UTILIZATION	Availing the facilities provided in terms of service providers, materials and infrastructure. It is also called realize access.

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Gender Relations

- Refers to social relations between men and women. Major issues are power and hierarchy. How these relations are formed and supported by family, culture, state and market is an important consideration.
- Gender relations are *not static*; they vary across cultures and time. They are dynamic and *recreate* new ways in which masculinity and femininity are constructed and communicated in a particular context or period.

Sexual/Gender Division of Labour

- Societal pattern where women are allotted one set of gender roles and men another. This division is not based on skill, but on the basis of sex.
- The socially determined ideas and practices which define what roles and activities are deemed appropriate for women and men.
- *"Who does what work?"* is an entry point to understanding gender as a social construct.

Gender Roles and Responsibilities

- Gender roles and responsibilities are extensions of the division of labour, the key issue is the concept of "gender" (the social, not biological concept) and how different roles and responsibilities are assigned to men and women.
- The intersection of these gender roles and responsibilities with a development project's goals and activities is the focal point of a gender analysis.

Gender-Specific Needs, Interests and Priorities

- Refer to the fact that women and men have different roles and responsibilities, they also have different needs in order to fulfil them and they accord differing priorities to their needs.
- Shared and prioritised needs identified by women/men that arise from their common experiences as a gender.

Gender Equality

- Entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices.

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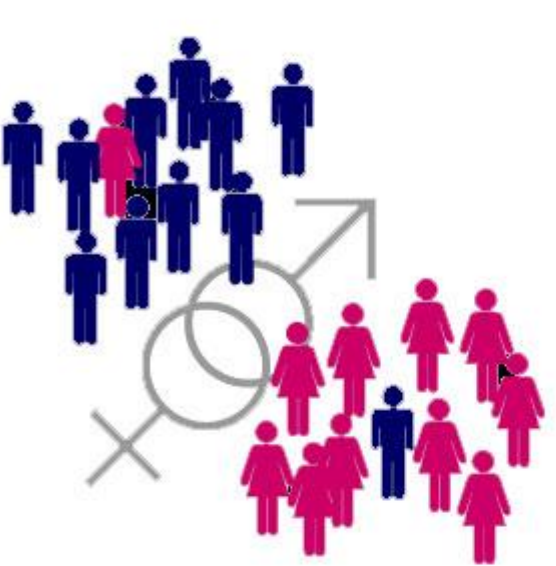
- Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued and favoured equally.
- It does not mean that women and men have to become the same, but that their rights, responsibilities and opportunities will not depend on whether they are born male or female.
- In the Education Sector it is fairness and justice in girls' and boys' access to and benefits from education, and to include important qualitative as well as quantitative dimensions.

Gender Equity

- Gender equity denotes the equivalence in life outcomes for women and men, recognising their different needs and interests, and requiring a redistribution of power and resources.

Gender Analysis

- Is a tool /set of tools to assist in strengthening development planning, implementation, monitoring and evaluation, and to make programmes and projects more efficient and relevant.
- The aim of such analysis is to formulate development interventions that are better targeted to meet both women's and men's needs and constraints.



- It takes into account important social and economic differences between men and women at all stages of the planning and implementation processes and makes it possible to identify potential differential effects before they are put into place.
- Gender based analysis (GBA) challenges decision-makers to question the assumption that policies and programmes affect everyone in the same way.
- It is a basis for gender mainstreaming.

Gender Planning

- The formulation of specific strategies, which aim to provide equal opportunities and benefits for both men and women.

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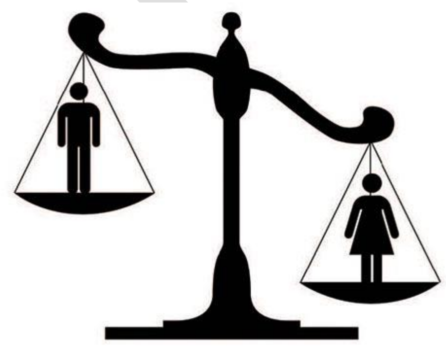
Gender Mainstreaming

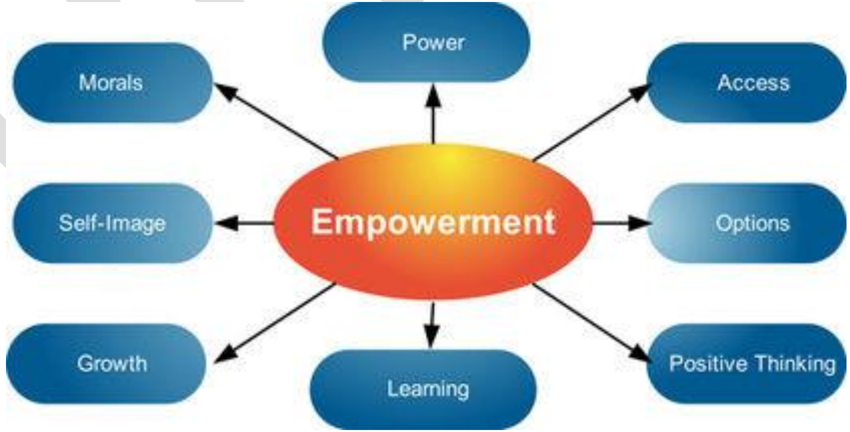
- Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels.
- It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated.
- The ultimate goal is to achieve Gender Equality.
- This approach recognizes the need to take social and economic differences between men and women into account to ensure that proposed policies and programmes have intended and fair results for women and men, boys and girls.

Gender Discrimination



- The systematic, unfavourable treatment of individuals on the basis of their gender, which denies them rights, opportunities or resources
- This involves systematic and structural discrimination against women in the distribution of income, access to resources, and participation in decision making.

Empowerment



- Implies people – both women and men – taking control over their lives by setting their own agendas, gaining skills (or having their own skills and knowledge recognized), increasing their self- confidence, solving problems, and developing self-reliance.
- It is both a process and an outcome.

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- Empowerment implies an expansion in women's ability to make strategic life choices in a context where this ability was previously denied to them.

Major Barriers to Girls' Enrolment, Retention and Performance in Education

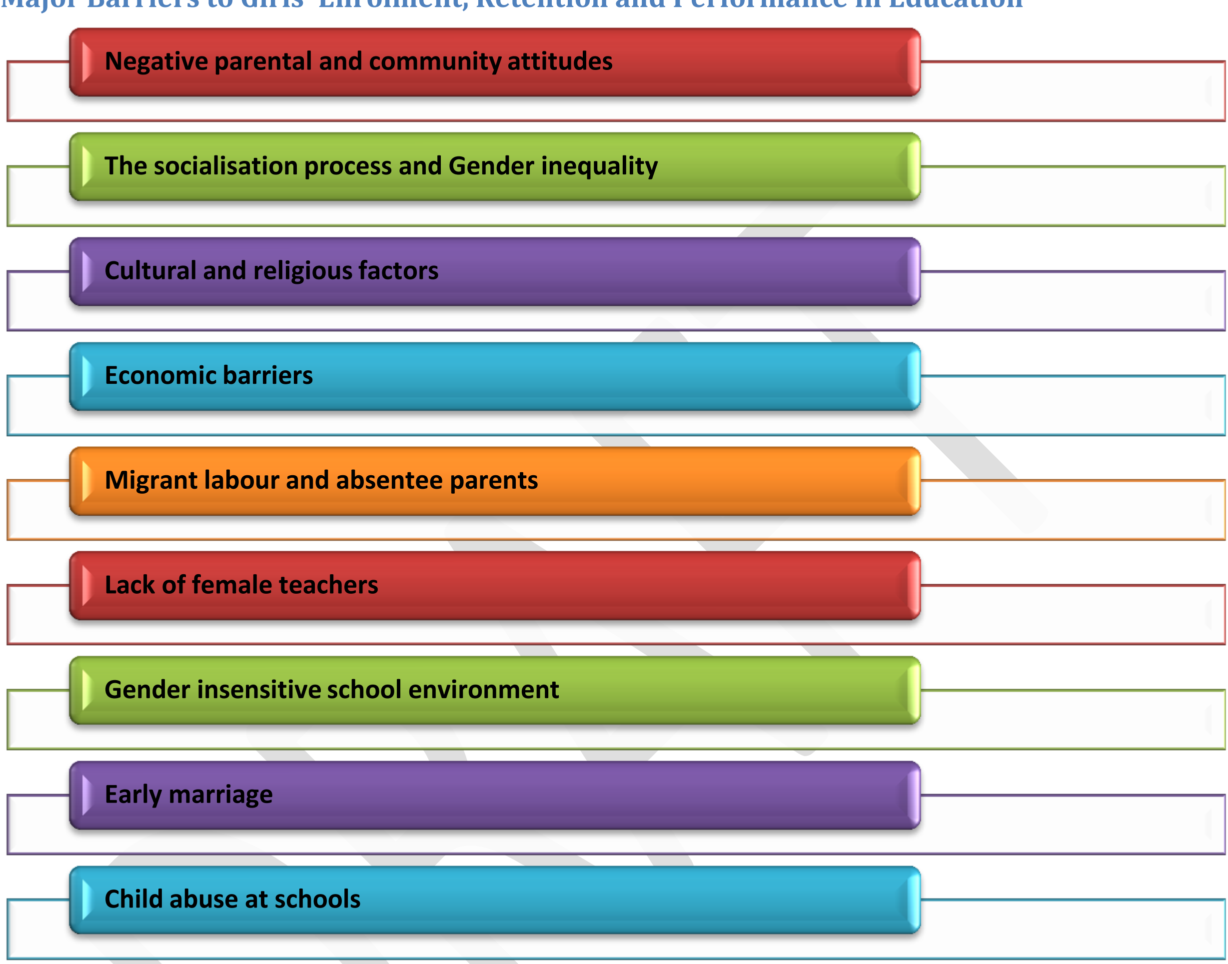


Figure 9: Major Barriers to Girl's Education

Gender Issues in Education

Through the Gendered Looking Glass one needs to understand education to be a right and analyze it through the '4A' framework, which encompasses availability, accessibility, acceptability, and adaptability.

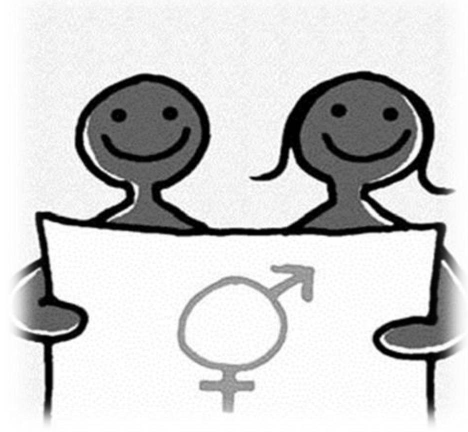
- Is education available to girls and women, throughout the cycle and not simply in terms of primary level enrolments?
- Is education accessible, in terms of the absence of financial, physical, geographical and other barriers?

- Is education acceptable for girls and women as well as boys and men, in terms of its content, form and structure – both what is being taught and learned, and how that teaching and learning happens?
- Is education adaptable in terms of being responsive to girls' and boys' different needs and lives, taking into account phenomena such as girls' and women's labour, early marriage and pregnancy?

Gender Mainstreaming in the Education Sector

Key Element for Gender Mainstreaming is Gender Analysis in the Education Sector

- A thorough gender analysis is a critical starting point for any education sector intervention that aims to be gender sensitive.
- It facilitates the gathering of qualitative and quantitative data to determine the *gender bias* and *discrimination* against the empowerment of women and girls and to the achievement of gender equality in education.
- Both types of data, quantitative sex-disaggregated data and qualitative gender analytical information are necessary to examine the existing gender balance within the context of education.
- The first is roles and responsibilities. What are the productive, reproductive, community level and political roles played by members of each gender? Do these responsibilities differ for men and women?
- Second, it is vital to analyse whether men and women differ in their access and control to assets, resources and opportunities. These may be human, natural, social, p hysical or financial.
- Third, analysts must examine if and how power and decision-making power are divided by gender.
- Finally, it is important to determine whether men and women share the same needs, p riorities and perspectives. These may be based on the situation already at hand or may require addressing areas that may need to be changed in the future.



- Sex disaggregated educational data should include information such as enrolment, retention and completion rates for students in pre-primary, primary, secondary and tertiary schools.
- It is also helpful to collect and analyse data about broader issues that affect educational access and achievement, such as distance between a child's school and home, measures of parental awareness

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about educational opportunities, and adult literacy rates.

- School quality, socio-economic status of families, regional constraints on accessibility to qualified teachers, health barriers and nutrition should all also be considered and measured on school, community, regional and/or national levels.
- Equally important is qualitative data regarding the school and community environment in which a child is being raised. School environments where gender-based violence, discrimination or harassment occurs are not safe for female students, nor conducive to their learning.
- Information about external factors that may affect girl's ability to access education, whether it is physical, psychological or cultural needs to be collected. Data regarding average age when girls begin to marry and have children can provide insights into potential causes for extended absences or dropouts.
- Sexual and reproductive health data, including HIV/AIDS infection rates, information about sexual debut, and maternal health statistics can be useful in determining some of the root causes for gender inequalities, as they are reflective of health-sector factors that affect education.
- Once gender-based discrepancies in access, achievement and acceptance and barriers and constraints in the context of education are identified, these should be addressed by preparing or revising existing policies regarding access, quality and management or developing programmes that transform or improve gender relations and make participation, benefits and effectiveness of school more equal, regardless of gender.

Community Level

- The division of labour productively and reproductively for men and women. This includes the different roles that men and women perform as well as that of girls and boys and how that leads to males and females having different experiences, knowledge, needs, access to and control over resources.
- The resources and assets that are available, and who controls them.
- The levels of participation and control in decision-making of men and women.
- The needs of men and women, and how these needs can be addressed.

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Institutional Level: Policies

- The gender specific policies that exist within an institution, and how these policies have been implemented.

- The level to which gender is integrated in all of the policies.
- The level to which gender issues are exhibited by the attitudes and behaviours of empl oyee, particularly those in influential positions.
- The levels of participation and control in decision-making of men and women.

Institutional Level: Culture

- The extent to which the mission, vision and values incorporate gender equality.
- The attitudes, values and behaviours of the employees within the institution.
- Gender specific employee data – that is the number of men and women at each hierarchical level within the educational institute.
- Salary packages/wages of men versus women.
- The safety and practicality of the environment for women and men.
- Recruitment procedures.
- The existence of policies that advocate for gender equality, such as the Equal Opportu nity Act.

Priority Gender Equality Issues in Basic and Primary Education

- Unequal access and participation rate to school for girls and boys in various social groups;
- Availability of facilities (separate toilet facilities, special financial incentives to ensure; female retention rates, etc.) needed to improve girls' access to schools;
- Dropout rates of girls/boys;
- Inadequate female teachers at the various educational levels to act as role models;
- Poor quality and relevance of teaching/training;
- Limited women involvement in school management;
- Lack of support services such as counselling and health service to address inter-sectoral factor that affect girls participation in education; Inaccessibility of opportunities for training or scholarship for both girls and boys

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Gender Issues in Secondary Education

- Improved awareness of existing education and training opportunities for girls in all available programs;
- Increased availability of secondary education offered in rural communities;
- Improved facilities at secondary education/training institutions (e.g., safe and secure accommodation, study facilities for women where sex segregation is a cultural norm) to allow women to enrol;
- Increased training, recruitment and retention of female teachers at this level.
- The distance of schools and the lack of adequate facilities both have a significant effect on the accessibility of education for girls

Gender Issues in Non-Formal Education and Training

- Restricted free time for girls/women to participate in training;
- Offered at times when girls/women with family responsibilities or jobs are unable to attend;
- Limited girls/women participation in the choice of training programs;
- Courses or training sessions held in locations that are accessible to girls/women as well as men, considering cultural norms and girls/women's mobility? Are childcare services needed to facilitate girls/women's participation;
- Offered stereotype skill training;
- Inadequate mechanisms for poor girls/women, in particular, to receive information about non-formal education/training opportunities;
- High cost of training prevents the participation of girls/women without independent sources of income;
- Lack of arrangements for scholarships, adequate physical facilities, and other special arrangements to ensure female participation;
- Poor understanding by education planners of the contribution of training to improving girls/women's productive capacity and increase of their marketable skills and income-earning potential;
- Lack of consideration of health and population issues or other issues relevant to girls/women in training;

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- Lack of mechanisms in education interventions'' monitoring and evaluation of effects on girls/women' participation and empowerment.

Role of AWW/ASHA/ANM

- AWW should promote Gender Equality in the community.
- She should spread awareness about various government schemes provided to educate the girl child.
- She can hold community sessions and invite families to participate in the counselling sessions so that they can all be aware of the benefits of education of girl child.
- The AWC can be one of the best places where initial education exposure of the girl child can happen and thus it should be an apt Vibrant ECE Centre.
- She should inculcate gender neutral play activities for boys and girls.
- Stories taught at the AWC should be gender neutral.

Role of Community and Other Stakeholders

- PRI should be involved in the enrollment of girl child specifically; they should check the ICDS and mid-day meal quality.
- The functionaries should ensure that the enrollment is done in schools. If the parents do not enroll them the ration card or other facility may be bared.
- SHGs should help and assist in gender sensitization of the community by holding sessions with the male population, to reduce the incidence of gender discrimination.
- Opinion leaders in group for protection and empowerment of the community.

SESSION 4	CONSTITUTIONAL PROVISIONS AND CHILD RIGHTS
OBJECTIVE	~~To discuss the rights of children enshrined under Indian constitution & articulated under UNCRC.~~ To understand constitutional provisions and laws related to survival, development and care of girl child in India.
CONTENT	Discussion on the following : • Constitutional Provisions • Concept of Child Rights – Need based and Rights Based Approach • UN Convention on the Rights of the Child • National Policy for Children, 2013 • The Child Labour (Prohibition & Regulation) Act, 1986 • The Children (Pledging of Labour) Act, 1933 • National Commission for Protection of Child Rights • The Immoral Traffic (Prevention) Act, 1956 • A right to seek information – Right to Information Act, 2005 • Role of AWW/ASHA/ANM
DURATION	2 hours
TRAINING METHOD	Presentation and Discussion
LEARNING OUTCOME	The participants would be able to understand the Constitutional Provisions and Rights of the children for Child Survival, Development, Protection and Participation
RESOURCES REQUIRED	• LCD Projector • Power Point Presentation
ANNEXURES	• Rights of Children – relevant provisions under Indian Constitution and UNCRC • Function and Powers of NCPCR • Quiz on RTI • RTI Application format and Model application format
REFERENCES	• National Policy for Children, 2013 • National Plan of Action for Children,2005 • The Child Labour (Prohibition And Regulation) Act, 1986 • National Commission for Protection of Child Rights • http://ncpcr.gov.in/index1.php?lang=1&level=0&linkid=12&lid=44 • http://rti.gov.in/ • https://rtionline.gov.in/

FACILITATORS NOTES

Methodology

The session may begin with defining the rights of the children and focus on various constitutional provisions for children. It is important for the ground level functionaries to have access to the data of the population including the data of the tribal and/or migrant population in their area as well. This can be done in the form of drafting a questionnaire, which can be used to gather the education related data.

Ask

- What are the basic rights of a child and who all can access them?
- Why everyone be aware of Child Rights?

The trainers should discuss at length the various articles in the Constitution with focused discussion on National Policy for Children. The trainer may refer to the MWCD policy document for further detailed reference. The trainer should highlight aim, principles of the Convention (UNCRC) and the all the rights of children articulated under the Document (UNCRC) for better understanding of the importance of the convention ***(Annexure-7).***

Ask

- Are you aware of the schemes and programmes for children in the country?
- Share experiences of self about any cases of violation of Child Rights?

The trainer may discuss the little relevant legislation concerning children and its repercussions on the child. The trainer may also refer to the link below for more reference.

http://www.prsindia.org/uploads/media/Child%20Labour/Child%20Labour%20%28Prohibition%20and%20Regulation%29%20%28A%29%20Bill,%202012.pdf

The discussion may then move to the role and function of NCPCR ***(Annexure-8).*** The role of SCPCR's can also be highlighted and the information of the same can be sought form the NCPCR website.

The trainer may lead the discussion focussing on the problems faced by the community and its children and also ask the participants questions about the RTI Act and its awareness among them **(*Annexure-9*).**

Ask

- Who all are aware of the RTI Act, 2005?
- Share an experience where you used the RTI Act and did you benefit from it?

The trainer may explain the correct procedure to file an RTI for seeking information highlighting the procedure, fee requirement and personnel responsible along with timelines fixed for the RTI act. The trainers should then be guided towards group activity which will help then write an application for RTI **(*Annexure-10*).**

Activity

- Sample of the RTI Application form will be distributed to the participants.
- 15 minutes will be given to the participants to fill the form and will be collected afterwards.

This activity will help the participants to get a hands on experience on how to apply for RTI, the trainers would further emphasize on the role played by the AWW to help the people of their community to file and RTI.

Finally, the session may conclude by highlighting the role of functionaries.

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CONTENT FOR TRAINERS

Children constitute important assets of any country and their development is important and critical for any nation. Therefore, Government of India has made efforts via policies, programmes and legislations for upliftment of girl child.

Constitutional Provisions

- **Article 14** provides that the State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.
- **Article 15:** Prohibition of Discrimination on grounds of Religion, Race, Caste, Sex or Place of Birth.
- **Article 15(3)** provides that, "Nothing in this article shall prevent the State for making any special provision for women and children."
- **Article 21:** No person shall be deprived of his life or personal liberty except according to procedure established by law (Right to health; Right to clean, safe environment)
- **Article 21A** directs the "State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine."
- **Article 23:** Prohibition of traffic in human beings and beggar and other similar form of forced labour.
- **Article 24** directs that "No child below the age of fourteen years shall be employed to work in any factory or mine or engaged in any other hazardous employment."
- **Article 39(e)** states that "the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength".
- **Article 39 (f)** states that "children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.
- **Article: 45** states that the state shall provide Early Childhood Care and Education to all the children in the age group of 0-6 years.
- **354 A Sexual harassment-** It only protects women. Provisions are: physical contact and advances involving unwelcome and explicit sexual overtures; or a demand or request for sexual favours; or making sexually coloured remarks; or forcibly showing pornography; or any other unwelcome physical, verbal or non-verbal conduct of sexual nature.
- **354 B:** Act with intent to disrobe a woman Imprisonment not less than three years but which may extend to seven years and with fine. Only protects women against

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anyone who "Assaults or uses criminal force to any woman or abets such act with the intention of disrobing or compelling her to be naked."

- **354 C Voyeurism**- Only protects women. By implication, women may prey voyeuristically upon men with impunity. The prohibited action is defines thus: "Watching or capturing a woman in "private act", which includes an act of watching carried out in a place which, in the circumstances, would reasonably be expected to provide privacy, and where the victim's genitals, buttocks or breasts are exposed or covered only in underwear; or the victim is using a lavatory; or the person is doing a sexual act that is not of a kind ordinarily done in public."
- **354 D Stalking**- Only protects women from being stalked by men. By implication, women may stalk men with impunity. The prohibited action is defined thus: "To follow a woman and contact, or attempt to contact such woman to foster personal interaction repeatedly despite a clear indication of disinterest by such woman; or monitor the use by a woman of the internet, email or any other form of electronic communication. There are exceptions to this section which include such act being in course of preventing or detecting a crime authorised by State or in compliance of certain law or was reasonable and justified."

Child Rights

Child rights are specialized human rights that apply to all human beings below the age of 18. A girl child is entitled to the Right to Survival, Development, Protection and Participation.

- **The Right to Survival** includes the right to life, minimum standards of food and clothing, highest attainable standards of health, nutrition and adequate standards of living. It also includes the right to a name, a nationality and the right to live with dignity.
- **The Right to Development** includes the right to education, support for early childhood development and care, social security and the right to leisure, recreation and cultural activities.
- **The Right to Protection** includes freedom from all forms of exploitation, abuse, inhuman or degrading treatment and neglect, including the right to special protection in situations of emergency and armed conflicts.
- **The Right to Participation** includes respect for the views of the child, freedom of expression, access to appropriate information, and freedom of thought, conscience and religion. A child has a right to participate in any decision making that involves him/her directly or indirectly.

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The Right of Survival

Food and nutrition
Clothes
Birth registration
Medical services
Shelter
Caring family

The Right of Participation

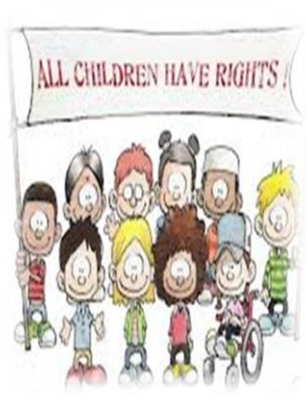
Participate in cultural and religious activities
Express opinions and have a say in matters that affect their lives
Participate in skills development activities

The Right of Development

The Right of Protection

United Nations Convention on the Rights of the Child

- The United Nations Convention on the Rights of the Child (commonly abbreviated as the CRC or UNCRC) is a human rights treaty which sets out the civil, political, economic, social, health and cultural rights of children.
- The Convention defines a child as any human being under the age of eighteen, unless the age of majority is attained earlier under a state's own domestic legislation.
- The UN General Assembly adopted the Convention and opened it for signature on 20 November 1989 and came into force on 2 September 1990, after it was ratified by the required number of nations. Currently, 194 countries are party to it, including every member of the United Nations except Somalia and the United States.



Aim

The aim of the Convention is to set standards for the defence of children against the neglect and abuse they face to varying degrees in all countries every day.

- **Preamble**: Recognizes many of the principles outlines in the Declaration on the Rights of the Child such as family as the best environment for a child to grow, the importance of child protection, best interest of the child, recognizing child participation, etc.

- **Provision**: The right to possess receive or have access to certain things or services (e.g. a name and a nationality, health care, education, rest and play and care for disabled and orphans).
- **Protection**: The right to be shielded from harmful acts and practices (e.g. separation from parents, engagement in warfare, commercial or sexual exploitation and physical and mental abuse).
- **Participation**: The child's right to be heard on decisions affecting his or her life. As abilities progress, the child should have increasing opportunities to take part in the activities of society, as a preparation for adult life (e.g. freedom of speech and opinion, culture, religion and language.

National Policy for Children, 2013

National Policy for Children, 1974 was the first policy document concerning the needs and rights of children. It recognized children to be a supremely important asset to the country. The goal of the policy is to take the next step in ensuring the constitutional provisions for children and the UN Declaration of Rights are implemented.

To affirm the Government's commitment to the rights based approach in addressing the continuing and emerging challenges in the situation of children, the Government of India adopted this resolution in the new National Policy of Children, 2013.

It outlines services the state should provide for the complete development of a child, before and after birth and throughout a child's period of growth for their full physical, mental and social development.

Objectives

- Every child has universal, inalienable and indivisible human rights
- The rights of children are interrelated and interdependent, and each one of them is equally important and fundamental to the well -being and dignity of the child
- Every child has the right to life, survival, development, education, protection and participation
- Right to life, survival and development goes beyond the physical existence of the child and also encompasses the right to identity and nationality
- Mental, emotional, cognitive, social and cultural development of the child is to be addressed in totality
- All children have equal rights and no child shall be discriminated against on grounds of religion, race, caste, sex, place of birth, class, language, and disability, social, economic or any other status
- The best interest of the child is a primary concern in all decisions and actions affecting the child, whether taken by legislative bodies, courts of law, administrative authorities, public, private, social, religious or cultural Institutions
- Family or family environment is most conducive for the all-round development of children and they are not to be separated from their parents, except where such separation is necessary in their best interest
- Every child has the right to a dignified life, free from exploitation safety and security of all children is integral to their well-being and children are to be protected from all forms of harm, abuse, neglect, violence, maltreatment and exploitation in all settings

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including Child Care Institutions (CCI), schools, hospitals, crèches, families and communities

- Children are capable of forming views and must be provided a conducive environment and the opportunity to express their views in any way they are able to communicate, in matters affecting them
- Children's views, especially those of girls, children from disadvantaged groups and marginalised communities, are to be heard in all matters affecting them, in particular judicial and administrative proceedings and interactions, and their views given due consideration in accordance with their age, maturity and evolving capacities.

Key Priorities

Survival, health, nutrition, development, education, protection and participation are the undeniable rights of every child and are the key priorities of this Policy.

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The Child Labour (Prohibition and Regulation) Act, 1986 (Amended in 2012)

- The problem of child labour continues to pose a challenge before the nation.
- Government has been taking various pro-active measures to tackle this problem.
- However, considering the magnitude and extent of the problem and that it is essentially a socio-economic problem inextricably linked to poverty and illiteracy, it requires concerted efforts from all sections of the society to make a dent in the problem.
- National Policy on Child Labour was enacted in 1987.

Provisions under the Act

- No child who is below the age of 14 years can be employed in 15 occupations listed in Schedule A of the Child Labour Prohibition and Regulation Act and in 57 processes listed in Schedule B of the Act.
- That in fact, a child cannot be even employed as a domestic worker or servant. He/She cannot be employed in *Dhabas*, Restaurants, Spas, Resorts, Hotels, Motels, Tea Shops and other recreational centres.
- They cannot be employed in garages, workshop, handloom, powerloom factory, plastic units, fiberglass workshops, mines, *beedi* making, carpet weaving, cement manufacturing, cloth printing, dyeing and weaving, manufacture of matches, explosives and fireworks, mica cutting and splitting, shellac, soap, tanning, wool cleaning, building and construction, state pencils, products from agate, manufacturing process using toxic metals etc., hazardous, printing, cashew and cashew nut, soldering, *aggarbatti* making, automobile repairs, welding, lathe work, brick kilns and roof tiles, cotton, ginning, detergent, fabrication workshops, gem cutting and polishing, handling of chromite, jute textile, lock making, coir making glass, cement pipes, cement products, glass, glassware, dyes and dye stuff, pesticides and insecticides etc.
- No child shall be required or permitted to work in any establishment in excess of such number of hours, and after every three hours, the child has to be given rest for one hour, as may be prescribed for such establishment or class of establishments.
- No child shall be required or permitted to work overtime and inclusive of hours of rest the total working hours of a child should not be more than six hours.
- Every child employed in an establishment shall be allowed in each week, a holiday of one whole day, which day shall be specified by the occupier in a notice permanently exhibited in a conspicuous place in the establishment.

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- Every occupier shall maintain, in respect of children employed or permitted to work in any establishment, a register to be available for inspection and if he fails to do so or maintains fake entries, he would be liable to be punished with fine up to Rs. 10,000 with or without imprisonment up to 1 month.
- The appropriate Government may, by notification in the official Gazette, make rules for the health and safety of the children employed or permitted to work in any establishment or class of establishments.
- Whoever employs a child in the prohibited occupations or processes will be liable to fine ranging from Rs.10,000 to Rs.20,000, with or without imprisonment for 3 months for the first time he commits the offence. If the offence is repeated the employer would be liable to a minimum imprisonment of 6 months which may extend upto two years".
- The certificate of age is to be issued by the medical authority such as a medical board which would be then treated final for the purpose of determining the age under the Act.
- Any person, police officer or inspector may file a complaint of the commission of an offence under this Act in any Court of competent jurisdiction. No Court inferior to that of a Metropolitan Magistrate or a Magistrate of the first class shall try any offence under this Act.

The Children (Pledging of Labour) Act, 1933

- An Act to prohibit the pledging of the labour of children
- It extends to the whole of India
- Under this Act, unless there is anything repugnant in the subject or context,-- "an agreement to pledge the labour of a child" means an agreement, written or oral, express or implied, whereby the parent or guardian of a child, in return for any payment or benefit received or to be received by him, undertakes to cause or allow the services of the child to be utilised in any employment:

- Provided that an agreement made without detriment to a child, and not made in consideration of any benefit other than reasonable wages to be paid for the child's services, and terminable at not more than a week's notice, is not an agreement within the meaning of this definition; "child" means a person who is under the age of fifteen years; and "guardian" includes any person having legal custody of or control over a child.

National Commission for Protection of Child Rights (NCPCR)

- The National Commission for Protection of Child Rights (NCPCR) emphasizes the principle of universality and inviolability of child rights and recognizes the tone of urgency in all the child related policies of the country.
- For the Commission, protection of all children in the 0 to 18 years age group is of equal importance.
- Thus, policies define priority actions for the most vulnerable children.
- This includes focus on regions that are backward or on communities or children under certain circumstances.
- The NCPCR believes that while in addressing only some children, there could be a fallacy of exclusion of many vulnerable children who may not fall under the defined or targeted categories.
- In its translation into practice, the task of reaching out to all children gets compromised and a societal tolerance of violation of child rights continues.
- This would in fact have an impact on the program for the targeted population as well.
- Therefore, it considers that it is only in building a larger atmosphere in favour of protection of children's rights, that children who are targeted become visible and gain confidence to access their entitlements.

In order to attain the Commission's Mandate of ensuring that each and every child gets an access to all entitlements and enjoys all her rights, the Commission's focus is on the following tasks:

- The first is to build public awareness and create a moral force in the country to stand by children and protect their rights. A National conscience has to be generated that captures the imagination of each citizen to take pride in the nation because it takes care of all its children.
- Armed with this kind of a mood the commission's task is to look at the gaps in the policy framework and the legal framework and make recommendations to see that rights- based perspective is adhered to by the Government, while it makes its policies.
- Thirdly, the task of the Commission is to take up specific complaints that come up before it for redressal of grievances and also take up suo moto cases, summon the violators of child rights, get them presented before the Commission and recommend to the Government or the Judiciary, action based on an inquiry.

- Finally, the role of the Commission is in arming itself with the proper research and documentation. The legitimacy and credibility to what the Commission says and does is based on solid research and data. Though everyone in the country knows that the predicament of the majority of children in our country is vulnerable and that children are not treated well, this has to be substantiated by information, it cannot just be an emotional argument.

The above tasks are to be rendered in a manner that the child is regarded as an individual with a character and mind of her own, not be to be patronized in a relationship of benefactor and beneficiary. This is no favour to the child; it is the duty of the State to fulfil its obligations and the duty of society to create the environment where the child is in the centre of all decisions pertaining to the child.

The Immoral Traffic (Prevention) Act, 1956

In India, the legal regime on sex work in India is laid down under the Immoral Traffic (Prevention) Act, 1956 ("ITPA"). ITPA does not proscribe sex work per se but penalises specific activities related to commercial sex. It also provides for rescue & rehabilitation of persons in sex work. The Act is implemented through Police & the Magistracy. Acts punishable under ITPA include:

- Brothel keeping (Section 3)
- Living on earnings of sex work (Section 4)
- Procuring, inducing or detaining for prostitution (Section 5 & 6) Penalties are higher where offences involve children (<16 yrs) & minors (< 18 yrs)
- Prostitution in areas notified by Police & near public places (Section 7)
- Soliciting (Section 8)

All offences are cognizable i.e., Police do not require a warrant to arrest or search.

Rescue & Rehabilitation- Police can remove any person found in premises where sex work is carried out regardless of age & consent. Rehabilitation is synonymous with detention in State run homes for indefinite periods. Viable economic alternatives are either non-existent or unavailable to sex workers on account of stigma.

Right to Information Act, 2005

- The act is designed to empower the citizens of India.
- It was implemented on 12th October, 2005
- It helps to promote transparency and accountability in the working of the Government
- It paves way for a democratic work flow
- The act has created practical regime through which the citizens of the country may have access to information under the control of the public authorities

Short Notes

Public Authority - Any Authority or Body or Institution of self-government established or constituted by or under the Constitution; or by any other law made by the Parliament or a State Legislature; or by notification issued or order made by the Central Government or a State Government. The bodies owned, controlled or substantially financed by the Central / State Government. NGO's substantially financed by the Central / State Government.

Public Information Officer - They are responsible to give information to a person who seeks information under the RTI Act.

Assistant Public Information Officer - These are the officers at sub-divisional level to whom a person can give his RTI application or appeal which they forward to appellate authority. The officer is not responsible to supply the information.

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Right to Information under the Act

~~How to Apply for Seeking Information~~

- A citizen desires to obtain any information under the act should make an application to the Central Public Information Officer (CPIO) of the concerned Public Authority in writing in English or in Hindi or in official language of the area in which the application is made. The information related to CPIO's is posted on the RTI Portal www.rti.gov.in.

- The applicant can send the application by post or through electronic means or can deliver personally in the office of the Public Authority or through a Central Assistant Public Information Officer appointed by the department.
- ~~The application can also be sent through a Central Assistant Public Information Officer appointed by the department of post at sub divisional level or other sub district level.~~

~~Fee for Seeking Information~~

- The applicant, along with the application, should sent a Demand Draft or a Banker's Cheque or an Indian Postal Order of rate of Rs. 10, payable to the accounts officer of the Public Authority as fee prescribed for seeking information.
- ~~The applicant may also be required to pay further fee as prescribed in the rules for getting photocopies etc. of the information required.~~
- If the applicant belongs to Below Poverty Line (BPL) category, he is not required to pay any fee. However, he should submit a proof in support of his claim to belong to the Below Poverty Line.

~~Disposal of the Request~~

- The CPIO is required to provide information to the applicant within 30 days of the receipt of a valid application.
- If the information sought for concerns the life or liberty of a person, the information shall be provided with in **forty-eight (48) hours** of the receipt of the request.
- If an applicant is not supplied information within the prescribed time of 30 days or 48 hours, as the case may be, or is not satisfied with the information furnished to him, he may prefer an appeal to the first appellate authority who is an officer senior in rank to the CPIO. If still not satisfied, he may prefer a second appeal with the Central Information Commission within 90 days from the date on which the decision should have been made by the first appellate authority or was actually received by the appellate.

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Group Activity:

The trainers may ask participants to write a RTI application as per the format discussed below:

The basic requirement needed to write an RTI application consists of:

- Information about Public Information officer, name and address etc.
- Locate central Government PIO's.
- In case you have problems locating your PIO/APIO you can address your RTI application to the PIO C/o Head of Department and send it to the concerned Public Authority with the requisite application fee.

It is always advisable not to address your RTI application to the PIO by his name, just in case if he gets transferred or a new PIO is designated in his place.

ROLE OF AWW/ASHA/ANM

- Educate people about the child rights, legislations and provisions.
- Be alert and use the law to stop child labour and other illegal acts against children.
- Raise awareness and gender sensitivity through public education programmes and local traditional media's.
- Create awareness about the pitfalls of putting children to work.
- Motivate parents to send their children to anganwadi/school.
- Ensure that children are enrolled in anganwadi/ school without difficulty.
- Inform employers about labour legislation banning child labour and the consequences of fluting the law; thus discourage them from employing children and encourage them to employ adults.
- The AWW should gain knowledge about the RTI act so that she can counsel families to request for information for any challenge that they may encounter.
- She should create awareness about the importance of RTI in cases like gathering information for the birth record of the child, any government functioning or any other information pertaining to the welfare of her beneficiaries.
- She can assist the community in writing applications for RTI.
- ~~She can explain to the community and help them decide what information should be attained via RTI.~~
- ~~She must encourage the transparency of the various sectors.~~
- ~~She must discourage the community to misuse the RTI Act.~~
- She must be aware that information regarding functioning of her own AWC also comes in the provision of RTI. Hence all records should be complete at the AWC and all registers should be properly maintained.
- ~~They must be well versed with the procedure to file an RTI.~~

SESSION 5	HEALTH AND NUTRITION FOR GIRL CHILD
OBJECTIVE	To impart knowledge about good nutrition for optimum health and to understand good IYCF practices for child survival
CONTENT	• Defining Optimal Health & Nutrition ○ Need and functions of food ○ Balanced diet ○ Nutritional needs during childhood ○ Micronutrient deficiencies • Importance of correct IYCF practices ○ Breast feeding ○ Complementary feeding ○ Tips for complementary feeding ○ Myths about girl child and mother • Role of AWW/ASHA/ANM
DURATION	1 hour 30 minutes
TRAINING METHOD	Presentation and discussion, demonstration and role play
LEARNING OUTCOME	Participants will be able to understand the functions of food and importance of good nutrition and balnced diet in growth and development of children. It will help in implementation of IYCF practice in India
RESOURCES REQUIRED	• LCD projector • Power-point presentation highlighting the key contents • White board and marker
ANNEXURES	• BPNI update on exclusive breastfeeding • BPNI update on complementary feeding • Case study for role play
REFERENCES	• http://wcd.nic.in/publication/infantandyoungchildfeed.pdf • Dietary Guidelines for Indians developed by National Institute of Nutrition

FACILITATORS NOTES

Methodology

The session can be initiated by conducting a situational analysis of the nutritional status of the children in India with specific focus on the girl child. The trainees must be encouraged to answer the questions about their knowledge of the situation.

Ask

- What is the nutritional status of girls in your community/ state?
- Are there any cases of severe malnourishment among girls in your community/ state?
- What steps must be taken to improve the nutritional status of the girl child?

Progress the discussion towards developing an understanding of optimal health and nutrition. Focus on the concept of balanced diet and give due importance to vital nutrients, their sources and functions in maintaining optimal health.

Ask

- What do you understand by balanced diet?
- Is it necessary to have a good nutritional status for maintaining good health?
- List some foods which are good sources of essential nutrients like carbohydrates, proteins, fats, minerals and vitamins.

The trainers should prepare visual aids to support source and essential nutrients. The session may then highlight the nutritional requirements of children. Explain about optimal infant and young child feeding practices and stress upon their importance in ensuring adequate growth and development in children. Focus on IYCF practices by discussing about the advantages of breastfeeding, timely initiation of complementary foods and the ways and means of making a meal nutritionally rich and adequate for child.

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Ask

- What are the common practices followed in their community/ state with respect to infant and young child feeding?
- Are the babies' breastfed within the first hour of birth in their community? Share experiences.
- In their community at what age is complementary feeding generally started?
- What are some of the common complementary foods given to children in their community/ state?

Trainers may demonstrate the correct positioning of holding the child and the correct feeding method. The trainer should mention about various tips for feeding the child and should stress on the busting of certain myths in the community. Followed by clarification on the role of the functionaries.

Summarize the session by sharing BPNI updates on Exclusive Breastfeeding (***Annexure-11 & 12***) to the trainees and clarifying their doubts.

After the session, the trainer may give some case studies or situations to the group of participants for performing a role play based on the situation (***Annexure)***.

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CONTENT FOR TRAINERS

Optimal Health and Nutrition

What is Health?

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2000).

Health Care Issues

Diarrhoea: Diarrhoea is the passage of 3 or more loose or liquid stools per day, or more frequently than is normal for the individual. It is usually a symptom of gastrointestinal infection, which can be caused by a variety of bacterial, viral and parasitic organisms. Infection is spread through contaminated food or drinking-water, or from person to person as a result of poor hygiene.

Severe diarrhoea leads to fluid loss, and may be life-threatening, particularly in young children and people who are malnourished or have impaired immunity.

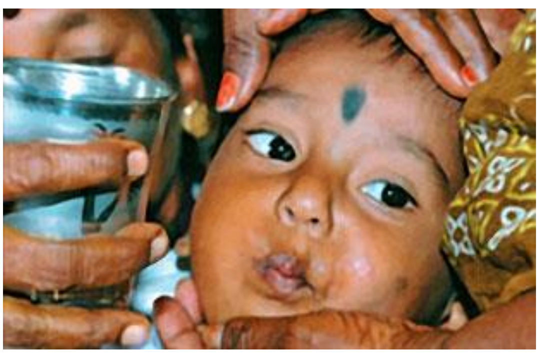
Key facts:

- Diarrhoeal disease is the second leading cause of death in children under five years old. It is both preventable and treatable.
- Each year diarrhoea kills around 760 000 children under five.
- A significant proportion of diarrhoeal disease can be prevented through safe drinking-water and adequate sanitation and hygiene.
- Globally, there are nearly 1.7 billion cases of diarrhoeal disease every year.
- Diarrhoea is a leading cause of malnutrition in children under five years old.

Prevention and treatment

Key measures to prevent diarrhoea include:

- access to safe drinking-water;
- use of improved sanitation;
- hand washing with soap;
- exclusive breastfeeding for the first six months of life;
- good personal and food hygiene;
- health education about how infections spread; and
- rotavirus vaccination.



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Key measures to treat diarrhoea include the following:

- Rehydration: with oral rehydration salts (ORS) solution. ORS is a mixture of clean water, salt and sugar. ORS is absorbed in the small intestine and replaces the water and electrolytes lost in the faeces.
- Zinc supplements: zinc supplements reduce the duration of a diarrhoea episode by 25% and are associated with a 30% reduction in stool volume.
- Nutrient-rich foods: the vicious circle of malnutrition and diarrhoea can be broken by continuing to give nutrient-rich foods – including breast milk – during an episode, and by giving a nutritious diet – including exclusive breastfeeding for the first six months of life – to children when they are well.
- Consulting a health professional, in particular for management of persistent diarrhoea or when there is blood in stool or if there are signs of dehydration.

As per DLHS-3, 78 percent of mothers are aware about diarrhoea management and what to do when a child has diarrhoea. Fifty percent of women are aware about ORS. Only 10 percent of women stated that they continue normal feeding even when a child had diarrhoea. Nearly nine percent reported that they would continue breast feeding and 14 percent were of the opinion that they would give plenty of fluids to the child suffering from diarrhoea.

Acute Respiratory Infection:

Acute Respiratory Infection (ARI) is one of the leading causes of the childhood morbidity and mortality. DLHS-3 revealed that about 57 percent of the women were aware about the danger signs of ARI. The awareness level was higher in urban areas (62 percent) as compared to rural areas (54 percent). Women who were aware of danger signs of ARI were further asked about different symptoms of ARI that they knew. The danger signs as reported by the mothers were difficulty in breathing (61 percent), pain in chest and productive cough

(54 percent), wheezing/whistling (44 percent), rapid breathing (40 percent) and other signs (55 percent). The other signs of ARI includes not able to drink or take a feed, excessive drowsiness and difficulty to keep awake, running nose, etc.

(Note: Other health care issue like Immunization may be referred from Day 1, Session 1 and Hygiene and Sanitation related information may be referred from Day 2, Session 4)

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Optimal Nutrition

Nutrition is the intake of food, considered in relation to the body's dietary needs. Good nutrition means an adequate, well balanced diet combined with regular physical activity. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity.

Why is Food Necessary?

- Life cannot exist without food.
- Proper nutrition and balanced diet is essential for good health.
- It helps in mental and physical growth of all human beings during developmental stages of life, be it the new born child, growing adolescent, pregnant women, or elderly persons.

Table 12: Functions of Food

Functions of Food		
Physiological Functions	**Psychological Functions**	**Social Functions**
• Provides energy • Provides nutrients for growth, tissue building and body repairs • Gives protection from diseases.	• Satisfies emotional need • Gives security	• Brings people together by means of sharing

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Balanced Diet

Figure 10: Food Pyramid

Source: NIN, Dietary Guidelines, 2013

Balanced Diet is one in which all the nutrients are present in the right amount as required by the body. With a balanced diet it is ensured that the body remains in good health and it also helps prevent any nutritional deficiency. The quantities of foods needed to meet the nutrient requirements vary with age, gender, physiological status and physical activity. A balanced diet should provide around 50-60% of total calories from carbohydrates, preferably from complex carbohydrates like whole grains (*bajra, dalia*, wheat etc.), about 10-15% from proteins and 20-30% from visible and invisible fat.

Table 13: Sources and Functions of Essential Nutrients

S. No.	Nutrients	Sources	Functions
1	**Carbohydrates**	Rice, wheat , millets, roots and tubers like potatoes, yam, tapioca, colocasia (arbi), sugar and jaggery, nuts like almond, dry coconut, groundnut, peanut	These are helpful in providing energy to the body
2	**Proteins**	Pulses like bengal gram, black gram, green gram, lentil and red gram roundnuts, nuts & ground nuts, milk & milk products & poultry, fish, meat egg white, Cheese, khoa, skimmed milk powder (cow) and whole milk powder (cow	Proteins are helpful in building and repairing the body tissues, muscles and vital fluids like blood
3	**Fats**	Butter, ghee, vegetable oils and fats, nuts	Fats serve as a concentrated source of energy and provide essential fatty acids
4	**Vitamins and Minerals**	Milk and milk products (curds, butter, ghee) yellow and red fruits, green leafy and yellow vegetables (carrots, pumpkins)	These helps in keeping the body healthy by building up immunity against illnesses
5	**Water**	Safe drinking water, some foods with high water content, including water melon, cucumber etc.	It helps in transportation of vital nutrients in the body and unnecessary waste out of the body to regulate temperature

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Table 14: Importance of Vitamins and Minerals

S. No.	Nutrients	Sources	Functions
1	**Vitamin A**	Dark green leafy vegetables (spinach, mint and radish leaves, drumstick leaves) yellow vegetables and fruits (carrot, pumpkin, mango, papaya) and animal foods like milk, milk products (butter and ghee)	Helps in preventing blindness, good for skin and Provide immunity to the body
2	**Vitamin** B	Legumes and pulses, meat, fish, eggs, milk and milk products, nuts and cereals	Helps to prevent mouth and tongue ulcers. There are a number of vitamins in this group that are essential for normal growth
3	**Vitamin B_6**	Potatoes, nuts, spinach	Promotes white blood cell production
4	**Folate**	Peas, green leafy vegetables, legumes, nuts and live	Increases activity of white blood cells
5	**Vitamin C**	Guava, citrus fruits and vegetables like orange, grapes, green chili and tomato and amla	Enhances immunity, essential for good health and protection against diseases. It is also an anti-oxidant
6	**Vitamin D**	Fish liver oil, cod liver oil, butter and egg	It is essential for the formation of bones

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7	**Vitamin E**	Vegetable oils and grains	It is an anti-oxidant that stimulates immune response to infectious diseases
8	**Calcium**	Vegetables like spinach, mustard greens. **Animal sources Include:** Cheese, milk, yoghurt, curd and butter milk	It is essential for normal development of bone and teeth
9	**Zinc**	Egg, whole grains	Promotes wound healing
10	**Iron**	Green leafy vegetables, like spinach, methi, amaranth etc. watermelon, pumpkin, chick pea, chana, chole, rice flakes, lotus stem, jaggery etc. **Animal source include:** Meat and Meat products	It is needed for oxygen transport and for blood formation
11	**Iodine**	Sea foods like fish, prawns etc. and iodised salt	Promotes mental and physical development. Prevents mental retardation. Needed for the production of thyroid hormone

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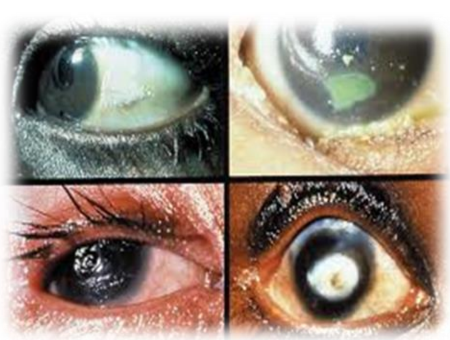
Deficiency of the above vitamins and minerals may lead to the following:

Micronutrient Deficiencies

Micronutrients are essential for good health, and their deficiencies can cause serious health problems. Micronutrients include minerals and vitamins as Vitamin A, Iron, Iodine and Zinc.

Common micronutrient deficiencies which are prevalent in India are:

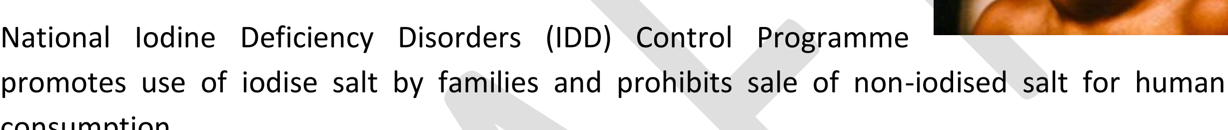
- **Vitamin A Deficiency***:* Vitamin A (VA) is an essential nutrient needed for the normal functioning of the visual system, growth and development, maintenance of epithelial cellular integrity, immune function and reproduction.



National Prophylaxis Programme for Prevention of Blindness due to Vitamin A Deficiency comprises a long term and a short term strategy. While the short term intervention focuses on administration of 9 mega doses of Vitamin A on periodic interval of 6 months. Dietary improvement is the long term ultimate solution to the problem of vitamin A deficiency. It is implemented through the PHC; its sub centres and the Anganwadi.

(Source: vitamin A and IFA supplementation: Ministry of Health and Family Welfare, Government of India. For more details refer: http://motherchildnutrition.org/india/pdf/mcn-vitamin-a-ifa-supplementation.pdf***)***

- **Iodine Deficiency Disorder***:* Iodine is an essential micro nutrient and is a leading cause of preventable mental retardation. Its deficiency can result in poor physical and mental development of children particularly if mother suffers from this condition during pregnancy. It is required at 100-150 micrograms daily for normal human growth and development. Iodine salt can help to prevent iodine deficiency.



National Iodine Deficiency Disorders (IDD) Control Programme promotes use of iodise salt by families and prohibits sale of non-iodised salt for human consumption.

(For more details refer: http://nrhm.gov.in/nrhm-components/national-disease-control-programmes-ndcps/iodine-deficiency-disorders.html)

- **Iron Deficiency Anaemia***:* Iron is necessary for synthesis of haemoglobin. Iron deficiency is thought to be the most common cause of anaemia globally, but other nutritional deficiencies (including folate, vitamin B12 and vitamin A), acute and chronic inflammation, parasitic infections, and inherited or acquired disorders that affect Hb synthesis, red blood cell production or red blood cell survival can all cause anaemia. The effects are most severe in infancy and early childhood.

Data from NNMB, ICMR and DLHS surveys have shown that prevalence of anaemia is very high (ranging between 80->90%) in preschool children, pregnant and lactating women and adolescent girls.

Iron deficiency adversely affects

- The cognitive performance, behaviour and physical growth of infants, preschool and school-age children;
- The immune status and morbidity from infections of all age groups;
- The use of energy sources by muscles and thus the physical capacity and work performance of adolescents and adults of all age groups.
- In pregnancy iron deficiency anaemia can lead to perinatal loss, prematurity and low birth weight (LBW) babies.

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Iron deficiency is a consequence of:

- Decreased iron intake / low dietary intake, poor iron and folic acid intake
- Poor bio-availability of iron (3-4 percent only) in phytate fibre rich diet and also due to high consumption of iron absorption inhibitors like tea, coffee
- Increased iron loss from the body
- Increased iron requirement
- Other micronutrient deficiencies like Vitamin B 12
- Haemoglobinopathy like Sickle cell disease and thalassemia

National Nutritional Anaemia Prophylaxis Programme has been repackaged as National Iron Plus Initiative with IFA supplementation and deworming interventions across life stages. Kindly revise the information as below. For more information you may refer, MoHFW website http://nrhm.gov.in/images/pdf/programmes/child-health/guidelines/Control-of-Iron-Deficiency-Anaemia.pdf

Optimal Infant and Young Child Feeding

Optimal Feeding is defined as exclusive breastfeeding from birth to six month of age and there after continued breastfeeding for two years or beyond with adequate, safe and proper additional foods and liquids after six months of age to meet the nutritional need of a young child.

The optimal IYCF practices include the following:

- Initiation of breastfeeding as early as possible after birth, preferably within one hour.
- Exclusive breastfeeding in the first six months of life i.e., only breastfeeding or breast milk feeding and no other foods or fluids (no water, juices, tea, pre-lacteal feeds), with the exception of drops or syrups consisting of micro nutrition supplements or medicines in compromised/diseased babies.
- Age appropriate and adequate complementary feeding after completion of six months of age while continuing breastfeeding.

(Source: Ministry of Women & Child Development had issued guidelines on Infant & Young Child Feeding -2006)

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Table 15: Nutritional Needs during Childhood

Group	Particulars	Net energy kcal/d	Protein g/d	Fat g/d	Calcium mg/d	Iron mg/dl	Vit. A µg/d		Vitamin C mg/d
							Retinol	*β-Carotene*	
Children	1-3 years	1060	16.7	27	600	09	400	3200	40
	4-6 years	1350	20.1	25	600	13	400	3200	40
	7-9 years	1690	29.5	30	600	16	600	4800	40
Boys	10-12years	2190	39.9	35	800	21	600	4800	40
Girls	10-12years	2010	40.4	35	800	27	600	4800	40

Source: (RDA, 2010)

Advantages of Breastfeeding

- It provides complete nutrition to the infant up to the age of six months almost half of the nutritional requirements between six to twelve months and up to 1/3rd between 12 and 24 months.
- Breast milk is tailor made to suit the requirements of the baby.
- An anti-infective property protects the child against infections like diarrhoea, pneumonia.
- Breast milk is easily digested, hygienic and readily available at any point in time.
- It enhances emotional bond between mother and child and prevents the chances of a child getting diabetes, cardiovascular diseases, obesity etc. in later ages of life stages.
- Breastfeeding enhances brain development and visual development as it contains essential fatty acids. Babies who are breastfed show higher intelligence quotient, language development and mathematical abilities.

Complementary Feeding

After 6 months, breast milk alone cannot suffice the nutritional needs of the child; hence age appropriate adequate complementary food should be provided.

Complementary feeding means giving other foods in addition to breast milk as the breast milk is no longer sufficient to meet the nutritional requirements of an infant.

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Characteristics of Good Complementary Food

- Should be rich in energy and adequate in good quality proteins, vitamins and minerals.
- Should have soft consistency, low dietary fibre which enables a child to swallow properly.
- Should be easy to cook and locally available

Complementary food is good to start only after six months as the babies digestive system is mature enough to digest a range of food products and fills the nutrient gap.

Disadvantages of Starting Complementary Food too Soon

- Adding complementary food too soon replaces the breast milk thereby compromising the child's nutritional need.
- The child becomes more susceptible to illness as less protective factors in breast milk are consumed and the complementary food may not be clean.

Disadvantages of Starting Complementary Food too late

- Introduction of complementary food at a late stage deprives the child of his extra nutrient demand.
- Child's growth and development slows down or stops leading to risk of malnutrition and other nutritional deficiencies.

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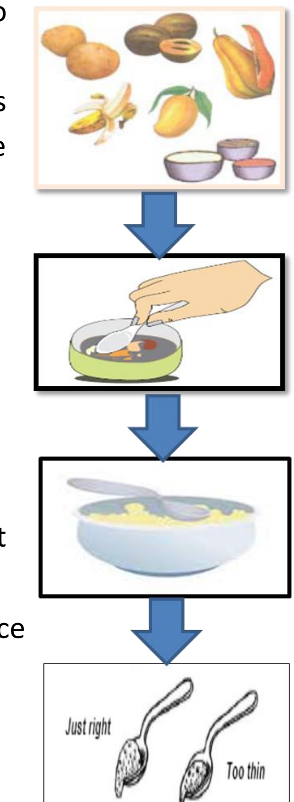
Staple foods are the foods consumed daily in the family. Hence complementary food should include at least one staple food such as cereals like wheat, rice, *ragi* etc., so that the child is introduced to family food.

Since the stomach capacity of the child is not much it is essential that child is given energy and nutrient rich complementary food. This can be done in the following ways:

- Enriching food by adding fats and oils
- Addition of pulses and seasonal vegetables
- Addition of sugar and jaggery
- Addition of locally available millets like *ragi, bajra*
- Adoption of techniques like sprouting and fermentation.



Making Diet Micronutrient Rich

- If family eats non vegetarian food, inclusion of animal food in the diet makes the food iron, protein & vitamins rich.
- If the family is vegetarian inclusion of green leafy vegetables, rice flakes, lotus stem, jaggery etc. could make the meal iron rich.

- Vitamin C rich foods like all citrus fruits – orange, lemon, guava, amla help in iron absorption and hence should be added along with the meal.
- Dark Green Leafy Vegetables, yellow and orange colour fruits, milk fat such as butter, cheese and fortified oils are all rich source of Vitamin A which helps to keep healthy eyes, skin and fight infections.
- There is a need to add in between snacks for children only meals may not suffice the energy and nutrient requirements. Hence good snacks provide both nutrient and energy. These include curds, fruit, potatoes, etc.
- Foods providing empty calories like sweets, candies, etc. should be given in limited quantity.

Table 16: Complementary Feeding Suggestions

Age	Texture	Frequency	Amount at each meal
6 months	Soft and well mashed	2 times per day with frequent breastfeeds	2-3 table spoons
7-8 months	Mashed foods	3 times per day plus frequent breastfeeds	2/3rd of a 250 ml bowl or katori
9-11 months	• Finely chopped finger foods that baby can pick up • Well mashed foods	3 meals plus one snack between and breastfeeds	3/4th of a 250 ml bowl or katori
12-24 months	Family food, finger foods	3 meals plus 2 snacks between meals plus breast feeds	A full 250 ml bowl or katori

When a child starts to eat complementary food he or she needs time to get accustomed to the new taste and texture hence 2-3 small spoonful twice a day should be given to the children.

Eating skills should progress from very soft, mashed foods to foods with some lumps that needs chewing and ultimately to family foods.

Tips for Feeding Children

- Introduce only one new food item at a time.
- Offer small amounts of new food, to increase acceptance.
- Offer new food along with one the child already likes.
- Offer new foods at the beginning of a meal as the child is usually hungry and accepts new food better in comparison to when the stomach is already full.
- First refusal of new foods should not be interpreted as not liking the food.
- Don't provide quick substitutes; this hampers the acceptance.
- Don't bribe or reward with treats or sweets.
- Don't force a child to eat or punish for not eating.
- In order to ensure adequate nutrition to promote optimum growth in children with poor intake:
  - Choose whole milk and dairy products.
  - Add oil/ ghee to food to increase nutrient density.
  - Add nuts and seeds (in forms suitable to the age of the child) to the preparation for increasing calorie content and overall nutrition.

Myths around girl child and pregnant mother

- Pregnant women having low abdomen have a boy, and acne during pregnancy means it's a girl.
- A slow heart rate in the baby ensures that it's a baby boy and a high heart rate means it is a girl.
- Consumption of spicy food leads to abortion.
- Additives present in the food are not good for health.
- Pregnant mother should not eat Papaya and Pineapple during pregnancy.
- Rock salt is better when used in cooking than normal salt.
- Mothers should eat for two.

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ROLE OF AWW/ASHA/ANM

- The AWW along with the ASHA and ANM ensure that children are given supplementary nutrition on time and where ever it is made by the helper it should contain locally available foods especially seasonal vegetables.
- The AWW set up a direct link with families where in they find malnourished children and provide information as well as follow up.
- Help develop a breastfeeding community support group that protects and promotes breast feeding.
- Providing breastfeeding counselling support to new mothers.
- She should have correct and apt nutritional information which pertains to each beneficiary.
- Develop positive role models in the community of mothers who have healthy children and try organizing meeting with other mothers.
- During monthly discussion meeting with mother and caregivers she should discuss nutrition for children, adolescent girls, pregnant and lactating mothers and also help in clearing some of the myths related to food.
- She should keep cooking demonstration sessions for the mothers of the community. Use of local recipes with food that is available in the community is essential as that would help people adopt a diet much more easily.
- She should involve the mothers and encourage the exchange of healthy recipe ideas. Also encourage the idea of kitchen garden especially in the villages so that families have regular supply of seasonal vegetables.
- She should monitor the growth of each child in her community and distribute MCP card to the mothers.
- Make home visits on the birth of child whether it's a girl or a boy.
- Display and sensitise community about the declining CSR and other gender segregated data on various aspects of nutrition and health.
- She should make sure that the mothers do not follow any myths during pregnancy or feeding the child.

DAY 2

SESSION 1	**THE PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES (PROHIBITION OF SEX SELECTION), (PCPNDT ACT, 1994, 2003)- AN INTRODUCTION**
OBJECTIVE	• To help the trainees understand major causes of gender biased sex selective elimination • To discuss various ways and means to prevent Gender Biased Sex Selective Elimination • To apprise trainees about the act, offences and penalties under it
CONTENT	• Sex Selection – Definition ○ Techniques used for sex selection ○ When can you use a prenatal diagnostic technique ○ Main highlights of the PCPNDT Act, 1994 ○ Offences & penalties ○ How to complaint about violation of PCPNDT Act ○ Carry home messages • The Medical Termination of Pregnancy Act, 1971 • Key myths to be addressed by the frontline workers • Role of AWW/ASHA/ANM
DURATION	2 hours
TRAINING METHOD	Power point presentation, group discussion and group activity (role play)
LEARNING OUTCOME	The trainees will be able to learn the importance of PCPNDT Act in order to spread awareness against the social evil like gender biased sex selective elimination
RESOURCES REQUIRED	• LCD projector • Power-point presentation highlighting the key contents • White board and pen
REFERENCES	• http://pndt.gov.in/

FACILITATORS NOTES

Methodology

The session may be initiated by recapitulating /referring to the situational analysis of the child sex ratio in India and the status of the girl child in the Indian community with specific regard to practice of gender biased sex selective elimination and female infanticide ***(refer to contents, Day 1 Session 2).*** The trainees must be encouraged to answer the questions about their knowledge of the situation in order to carry out a need analysis.

Ask

- What are the main reasons for discrimination against the girl child in India?
- Are they aware of any instances of discrimination against the girl child in their community/area?
- Are they aware that it is social cum legal crime to determine the sex of the unborn child?

The session may then progress to discuss the techniques employed for detection of gender of the unborn child. The trainer may deliberate on the criticality, legality and the social impact of detecting the sex of the child prior to its birth. Also, the trainer may discuss about the negative psychological impact on the mother and the community at large.

Ask

- Are they aware of any instances of sex determination in their family, *mohalla* or community/ States?
- What initiatives have they taken to stop or spread awareness about the sex determination of the child?
- Are there any diagnostic centres in their States that are illegally practicing sex determination?

Activity

- Divide the participants into two groups.
- The participants in two groups may be encouraged to do role play for clarity on preventing sex determination and celebrating birth of a girl child (Situations may be given by trainers).

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The session may lead to discussion about legally acceptable circumstances when these prenatal diagnostic techniques can be used in case of any medical emergency so as to avoid instances of abnormalities in the unborn child.

Ask

- If they have experienced any situations wherein such techniques were used/misused for sex determination?
- Do they think it is correct to conduct such tests for ruling out any chances of abnormalities in the unborn child?

The trainers may also discuss the procedure to file a complaint in case of any violation of the PC & PNDT act is observed and deliberate on the penalties served for violating the same.

The trainer may discuss the carry home messages, which can help the trainees be adept with PCPNDT act and are well equipped to deal with prevention of female foeticide in the community.

The trainer may then discuss the Medical Termination of Pregnancy Act and inform the participants about the act thoroughly before moving on to talk about the various myths the front line worker needs to help the community with and the role AWW/ASHA/ANM.

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CONTENT FOR TRAINERS

Sex Selection

- Any action that is taken in order to select the gender of the child by the use of any artificial method at the time of conception or thereafter is sex selection.
- Main causes identified for Gender Biased Sex Selection are social, political and economic:
    - **Social causes are:** Preference for sons and aversion for daughters, inheritance and carrying forward the family lineage/name, customs and rights, status and honour, devaluation of woman and girls and violation of their rights, dowry, lack of agency, choice, safety, security and sexuality for women and girls.
    - **Political Causes:** Indian population policy prompts parents to have smaller families, ineffective implementation of laws like PCPNDT, lack of political will, lack of coordination between central and state governments.
    - **Government Causes:** Child rearing costs, assets v/s liabilities, costs related to marriage, lack of financial independence for women, devaluation of women's work, the market and the proliferation of technologies.
- The various ways or means used for gender selection may include the following mentioned below:

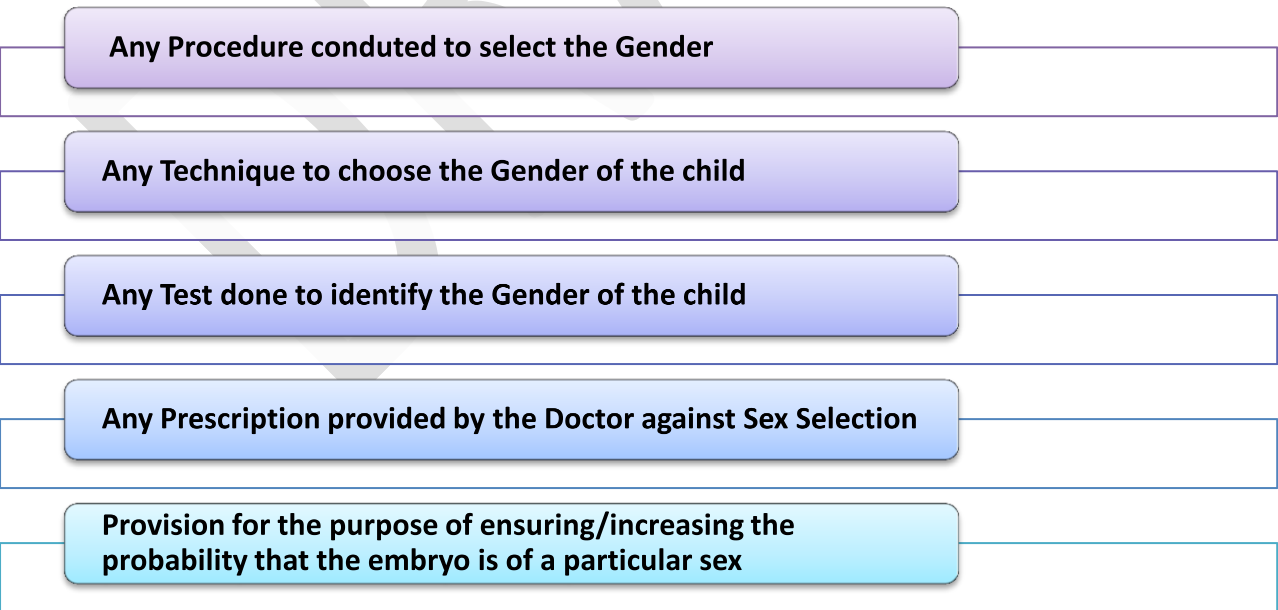

Figure 11: Ways or Means for Gender Selection

Techniques Used For Sex Selection

Pre-Conception Techniques

- All such techniques that may be employed prior to the conception of child, or which may cause and ensure that a woman conceives and gives birth to a child of a particular gender. It includes all prenatal diagnostic procedures and tests.

Pre-Natal Diagnostic Techniques (PNDT)

- Any such technique that may be used with the intention or/and for the purpose of detecting the sex of the unborn child, in order to eliminate the unborn child of a particular sex.

When to Use a Pre-Natal Diagnostic Technique

- Pre-natal diagnostic techniques can be used only for the purpose of detection in case of any of the following abnormalities:
  - I. Abnormalities in the chromosome of the unborn child that may cause birth defects.
  - II. Genetic diseases that may be life threatening or non-fatal
  - III. Diseases leading to malformation of incurable blood diseases
  - IV. Abnormalities likely to occur at birth leading to physical and/or mental disabilities
  - V. Any other abnormalities/or disease as may be specified by the Central Supervisory Board and not for detection of sex of the unborn child

The use of both, pre-conception techniques and pre-natal, diagnostic techniques is an offence punishable under the PC & PNDT ACT

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The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (PC & PNDT) Act) (As Amended in 2003)

- The law prohibits sex selection, both before and after conception.
- It regulates various pre-natal diagnostic techniques, so as to prevent their misuse for sex-determination and also to prevent Gender Biased Sex Selective Elimination
- Under the PC & PNDT Act, prenatal diagnostic tests include:
  - I. Ultrasonography
  - II. Foetoscopy

III. Taking/removing samples of amniotic fluid (fluid from the sac in the womb which contains the unborn child), chronic villi, tissue or blood
IV. Taking/removing blood or tissue from the pregnant woman for genetic testing.

- The pre-diagnostic techniques regulated under the PC & PNDT Act include the techniques used for the purposes of detecting:
  I. Chromosomal abnormalities
  II. Genetic metabolic diseases
  III. Haemoglobinopathies
  IV. Sex-linked genetic diseases
  V. Blood-related disorders
  VI. Any other disorders specified by the Central Supervisory Board
- A prenatal diagnostic technique can be used only when a person qualified under the Act is convinced of any serious anomalies in the foetus and records it in writing. Also, at least one of the following conditions should be fulfilled in each case:-
  I. Pregnant woman being above thirty five years.
  II. The pregnant woman has suffered two or more spontaneous abortions/or foetus loss.
  III. Pregnant woman had been exposed to/had teratogenic agents such as drugs, radiation, infection or chemicals
  IV. If the pregnant woman has a family history of mental retardation or physical deformities such as spasticity or any other genetic disease
  V. Any other condition as specified by the Central Supervisory Board
- A Genetic clinic is a clinic/hospital/nursing home/institute/any other place, where pre-natal diagnostic procedures are conducted.

- A mobile vehicle with machines to conduct prenatal diagnostic tests is also treated under this law as a genetic clinic.
- A Genetic Counselling Centre is any institute/hospital nursing home/ any other place where Genetic counselling is imparted to potential parents.

Offences and Penalties

I. **Prohibition of Advertisement relating to PCPNDT:** An advertisement published stating that they provide services of any kind for sex selection. Any person/ organisation associated with the advertisement related to sex determination is liable to punishment for a term which may extend up to 3 years and

a fine up to Rs.10,000/- .

II. **Offences and Penalties**: Any medical personnel who performs gender selection or offers his services in any medical clinic which offers these services shall be punishable with a term which may extend to three years with a fine of 10,000/- .

III. **Presumption in the case of PCPNDT:** If a pregnant woman is compelled to undergo sex determination by her husband or a relative to undergo detection, they shall be liable for abetment of the offense and shall be punished for a term that can be extended upto three years and a fine which may extend to 10,000/-.

IV. **Offenses by Companies:** If any company is found guilty of PCPNDT, every person in charge, at the time of the offence shall be punished.

How to Complain about Violation of PC & PNDT Act?

- Any violation of PC & PNDT act shall be:
    - Registered by Police immediately upon gaining knowledge/ information from any source and should be investigated
    - It is an offence for which bail shall not be granted
    - Registered by way of FIR and shall not be disposed of by the court on payment of compensation and shall be prosecuted and decided
- Trail of a case/complaint of violation of PC & PNDT Act shall be tried by the court only when a written complaint is filed before it by
    - The Appropriate Authority concerned or
    - The person or social organization who had given notice to the Appropriate Authority, 15 days or more, ahead of filing the complaint in the court and had declared his/its intention of doing so.
- Any complaint for violation of PC & PNDT Act shall be filed only in the court of Metropolitan Magistrate/First Class Judicial Magistrate

- In case the complaint for violation of PC & PNDT act has been made by any person or a social organization, the court may order provision to the complainant, the records are available with the Appropriate Authority.
- A complainant can approach the designated Appropriate Authority (AA) of the State of District or Sub-district.
- The Appropriate Authority at the State Level is a high ranking Health Department official above the rank of Joint Director of Health and Family Welfare.
- There are officials at local level, as well as, in the

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rural and urban areas that may be approached – the civil surgeon or the chief medical officer at the district level; the chief health officer or a ward superintendent.

- A written complaint has to be made to the Appropriate Authority (AA), which has to have an acknowledge receipt.
- If the AA takes no action within 15 days, the complainant can go to Court with the acknowledgment receipt. Alternatively, the complainant can also approach a social organization like a NGO working on women's rights issues in the local area or state. (For details, log on to: http://pndt.gov.in)

Carry Home Messages

- The clinics and doctors should counsel the parents against sex determination.
- Thorough reporting of the places and doctors involved in sex determination should be done.
- The parents should be informed of the repercussions of sex selection. Any amendments in the act should be mentioned to the parents.
- Positive role models should be focused in the community. Records of child birth in the community should be kept and maintained.
- Registration of all genetic counselling centres/clinics/laboratories/scanners is a must. A certificate of registration should be displayed at the clinic.
- Registration of all people, & equipment associated with ultrasound techniques and/or MTP under PC&PNDT Act should be done.
- ~~Employment of qualified and certified staff at medical facilities should be done, who abide by provisions of PC&PNDT Act~~
- Display of a board outside any clinic conducting pre-natal diagnostics, indicating that the practice of sex selective abortion is a penal offence and is not practised at the clinic.
- A copy of the PC&PNDT Act should be available at all medical facilities
- ~~Records should be kept and maintained~~
- ~~Any amendment in the law should be informed to the patients~~
- A monthly report should be shared with the Appropriate Authority by the 5th of every month.

The Medical Termination of Pregnancy Act, 1971

Abortion is legal in India under certain terms and conditions as laid down under the MTP Act. The Act provides for the termination of certain pregnancies by registered Medical Practitioners and for matters connected therewith or incidental thereto within 12 weeks of the pregnancy under the following conditions:

- If continuing the pregnancy would involve a risk to the life of the pregnant woman or would be of grave injury to her physical or mental health.

- If there is a substantial risk that the child-to-be-born would suffer from seriously handicapping physical or mental abnormalities.
- Pregnancy as a result of rape can be justifiably terminated.
- Failure of family planning methods could also be a ground to terminate pregnancy.

Beyond 12 weeks, abortion can be done only on the written advice of at least two registered medical practitioners. Also, this can be done only up to the end of the 10th week.

India is indeed one of the few countries to have legalised induced abortions under the Medical Termination of Pregnancy Act, 1971.abortion is legal in instances where pregnancy carries the risk to the foetus or to the mother, in case of pregnancy due to contraceptive failure or otherwise.

However, the fact is that the abortion services are being provided on demand by an increased number of registered and unregistered service providers. It is estimated that nearly six million abortions are performed every year outside the ambit of the act.

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KEY MYTHS TO BE ADDRESSED BY THE FRONTLINE WORKERS

- Women are Women's Worst Enemy's
- Abortion and sex selection is the same thing
- Sons carry on the family name, they are old age support and they are needed for the salvation of the soul.
- Why invest in girls' education, as she anyways goes to another family?/If girls are educated too much, they will run away."
- As the safety and security of girls is a big concern, it is best not to have them than take care of them for their entire lives."

ROLE OF AWW/ASHA/ANM

- The health workers should spread awareness in the community regarding the evils of discrimination against the Girl Child.
- They should make sure that the mothers of the community understand the law provided for the same and should empower them to stand up for the right of their Girl Child.
- They can organize village drives and mobilise the community to help the mothers avoid Gender Biased Sex Selective Elimination.
- Anganwadi workers should be able to approach the Legal Services Authorities locally to seek Legal assistance in pursuing the cases.

SESSION 2	ACTS AND LAWS RELATED TO MARRIAGE AND ADOPTION
OBJECTIVE	To discuss the key features of various acts & laws related to marriage and adoption in India

CONTENT	• Prohibition of Child Marriage Act, 2006
	• Acts related to Marriage
	  ○ Hindu Marriage Act, 1955
	  ○ The Special Marriage Act, 1954
	  ○ The Indian Christian Marriage Act, 1872
	  ○ Parsi Marriage and Divorce Act,1936
	  ○ Indian Muslim Marriage Act, 1954
	  ○ The Dowry Prohibition Act, 1961
	• Hindu Adoptions and Maintenance Act (1956)
	• Role of AWW/ASHA/ANM

DURATION	1 hour 30 minutes
TRAINING METHOD	Group discussion, role play (sample story)
LEARNING OUTCOME	The trainees will learn about the key features of various acts related to marriage and institutions that can support community in the process adoption
RESOURCES REQUIRED	• LCD projector • Power point presentation highlighting key components • Materials for group activity
ANNEXURES	• Sample story (Group Activity) • Slogans on dowry/ child marriage • FAQs on child marriage
REFERENCES	• http://wcd.nic.in/dowryprohibitionact.htm • http://wcd.nic.in/cma2006.pdf

FACILITATORS NOTES

Methodology

The trainer may initiate the session by introducing marriage as an important social institution in the society, its importance for healthy and mental well-being of the individual and community.

Ask

- Have you ever come across any incident of child marriage or dowry in your community? If yes, what action was taken?
- Are you aware of the legal age of marriage?
- Why is dowry still prevalent in the society? And how can we contribute to curb this practice?

The trainer should write the views of the trainees on white board and discuss in detail during the presentation. The discussion may proceed to the Prohibition of Child Marriage Act, 2006, and the various steps in preventing child marriage. The session should progress to discussing the Hindu Marriage Act, 1955 with the participants and its salient features. Also, the trainer may provide information on various other marriage related acts such as The Prohibition of Child Marriage Act, 2006; The Special Marriage Act, 1954; Parsi Marriage and Divorce Act, 1936; The Indian Muslim Marriage Act, 1954; Dowry Prohibition Act, 1961 and The Hindu Adoptions and Maintenance Act.

Group Activity

(Role play) (*Refer Annexure-14 for Sample Study*):

- The trainees should be divided into groups of 2-3
- Each group can create a story based focussing on evils of dowry
- The group then should present the story using role play
- The other trainees should provide with solutions to the problems cited in the story

Group work: trainees may be asked to write slogans on "child marriage" ***(Refer Annexure-15 for sample of slogans)***

The trainees will be explained about the Hindu Adoption and Maintenance Act, emphasizing on its salient features, methods of adoption, legal implications, and maintenance throughout the life span. The trainers may refer to ***Day 3, Session 2*** for details on Central Adoption Resource Authority.

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The trainer can conclude the session by discussing the role of the AWW/ASHA/ANM and asking few questions about the Acts discussed (***Annexure-16***).

CONTENTS FOR TRAINERS

Acts and Laws Related to Marriage ~~and Adoption~~

The Prohibition of Child Marriage Act, 2006

- It considers girls below 18 years and boys below 21 years as children.
- It defines Child Marriage as the one where one of the parties contracting marriage is a minor.
- A Child Marriage may be dissolved at the instance of the party who was a minor at the time of entering into marriage.
- A petition/application for dissolving the child marriage may be filed at any time, but before the minor completes two years of having attained majority.
- A child born out of child marriage would remain legitimate, even when the marriage has been dissolved.
- Any adult male contracting Child Marriage may be punished through a fine up to Rs. One lakh and rigorous imprisonment up to 2 years.
- A child marriage shall be null and void (not a marriage in the eyes; of the law) if:

  - Minor taken/enticed out of the custody of the lawful guardian/parent.
  - Minor is compelled or deceptively induced to go from any place.
  - Minor is sold for purpose of marriage.
  - Minor is trafficked or used for immoral purposes after being married.

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- Judicial orders for relief under the Prohibition of Child Marriage Act, 2006:
  - Decree of nullity (dissolution) of child marriage.
  - Return of money, valuables, ornaments and gifts received by both parties on occasion of marriage or an equivalent amount of money.
  - Payment of maintenance to minor married female and a child born out of child marriage according to need, status and source of income.
  - Order of residence.
  - Custody of the child born from child marriage, in terms of welfare of the child.
- Orders passed by the court may be modified at any point of time, as required.
- Any person or organization in charge of the minor, who promotes and permits performance of Child Marriage or whose negligence leads to performance of child marriage (it includes attending and participating in such a marriage) is liable to penalty up to Rs. 1 lakh and rigorous imprisonment up to 2 years. The responsibility of proving his/her innocence would lie on the person so accused.
- An order of restraint may be issued by a Judicial Magistrate, who on receipt of a complaint from any source, including the Child Marriage Prohibition Officer (CMPO), appointed by the Government or Non-Governmental Organisation (NGO) or any other person is satisfied that Child Marriage is about to be performed.
- A Judicial Magistrate may himself take notice of Child Marriage on the basis of any reliable report or information and pass necessary orders.
- On special occasions like *"Akshaya Teej"* the District Magistrate shall be deemed to be the Child Marriage Prohibition Officer (CMPO) with all powers, as conferred on the Child Marriage Prohibition Officer (CMPO), and may stop or prevent Child Marriage by the virtue of additional powers and use of force.
- Who-so-ever disobeys knowingly, a judicial restraint order regarding performance/ conduct of Child Marriage, is liable to be penalized by way of penalty up to Rs. 1 lakh and rigorous imprisonment up to 2 years.
- Any child marriage performed in violation of a judicial restraint order shall be deemed to have never taken place.

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- The following may be requested by the State Government to assist the Child Marriage Prohibition Officer (CMPO):

    - An officer of the Gram Panchayat or Municipality or Public Sector Undertaking.
    - Respectable member of the locality with a record of social service.
    - Representative of a Non-Governmental Organisation (NGO).

Duties of the Child Marriage Prohibition Officer (CMPO)

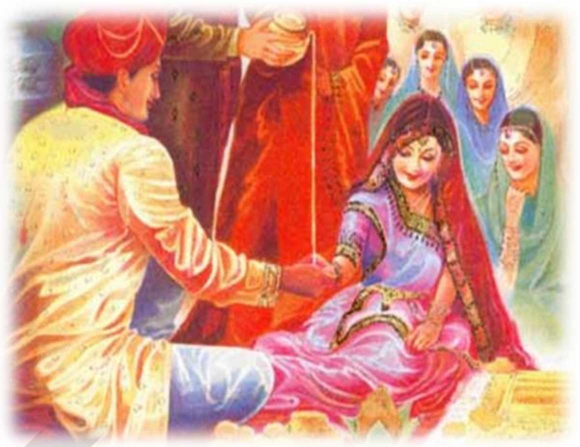
- Taking steps to prevent Child Marriage.
- Collecting evidence for effective prosecution of people violating the law for prohibition of Child Marriage.
- Advising individuals and residents of the locality against indulging in promoting/helping/aiding/allowing performance of Child Marriage.
- Create awareness and sensitisation about the evil consequences of child marriage and discussing related issues.
- Furnish relevant information and statistics to the Government.
- Discharge any, such functions or duties assigned.
- Power and authority to move the court, if required.

- Child Marriage Prohibition Officer (CMPO) is a public servant and no action shall be taken against her/him for acts done in good faith.

The Prohibition of Child Marriage Act, 2006 considers the following also to be responsible and may punish them in cases of performance of child marriage:

- Pundit/ Maulvi who performed the marriage ceremony and
- Tent house owner/Cooks/ Caterers/ Decorators

The Hindu Marriage Act, 1955



- Marriage is considered to be a sacred institution in India.
- Hindu marriages are mainly governed by 'The Hindu Marriage Act,' that came into existence on May 18, 1955. For other religions, the constitution contains different kinds of Marriage Acts.

Some of the salient features of the Hindu Marriage Act are given below.

- The Hindu Marriage Act is enforceable throughout the country except in the State of Jammu and Kashmir.
- It is compulsory to register every Hindu marriage even if it is solemnized through proper rituals.
- A Hindu marriage may be solemnized in accordance with the customary rites and ceremonies of either party thereto. Where such rites and ceremonies include the *saptapadi* (that is, the taking of seven steps by the bridegroom and the bride jointly before the sacred fire), the marriage becomes complete and binding when the seventh step is taken. Therefore, mere exchange of garlands or putting *Sindur* on the forehead would not constitute a valid marriage unless these are the only requirements as per the customs followed by the community of the boy or the girl.
- The act lays down the domain within which an association can be formed. Marriage between people destined to have platonic relationship like mother and son, father and daughter, brother and sister is unacceptable.
- The provisions of the Act are applicable to anyone who is Hindu by birth or a convert. It is also applicable to Buddhists, Jains, and Sikhs as well as to people who are not governed by any other law. A marriage may be solemnized between any two Hindus, if the following conditions are fulfilled :
    - neither party has a spouse living at the time of the marriage
    - neither party at the time of the marriage -
        - is incapable of giving a valid consent to it in consequence of unsoundness of mind; or
        - though capable of giving a valid consent, has been suffering from mental disorder of such a kind or to such an extent as to be unfit for marriage and the procreation of children; or
        - has been subject to recurrent attacks of insanity or epilepsy;
    - the bridegroom has completed the age of twenty-one years and the bride the age of eighteen years at the time of the marriage;

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- the parties are not within the degrees of prohibited relationship unless the custom or usage governing each of them permits of a marriage between the two;
- the parties are not *sapindas* of each other, unless the custom or usage governing each of them permits of a marriage between the two.

- The provision prohibits bigamy or polygamy. It is treated as an offence and is punishable under the Indian Penal code. Therefore, at the time of marriage, none of the partners should already have a spouse staying with them. In case of a second marriage, the concerned partner has to first seek a divorce from the spouse and then re-marry.

- The legalities of divorce are also governed by the law. Divorce can be sought by husband or wife on certain grounds, including: continuous period of desertion for two or more years, conversion to a religion other than Hindu, mental abnormality, venereal disease, and leprosy. A wife can also present a petition for the dissolution of marriage on the ground if the husband marries again after the commencement of his first marriage or if the husband has been guilty of rape, sodomy, or bestiality. Newly married couples cannot file a petition for divorce within one year of marriage.

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The Special Marriage Act, 1954

- The act is to provide a special form of marriage in certain cases, for the registration of such and certain other marriages and for divorce.
- It extends to the whole of India except the State of Jammu and Kashmir, and applies also to citizens of India domiciled in the territories to which the Act extends who are in the State of Jammu and Kashmir.
- It came into force on i.e.1st January, 1955 as the Central Government, by notification in the Official Gazette, appoint.

Some of the salient features of the Special Marriage Act are given below:

- Neither of the two has a spouse living, at the time of the marriage.
- Neither of the two is incapable of giving a valid consent to the marriage due to unsoundness of mind.
- Neither of the party has been suffering from mental ailments to such an extent, that they are unfit for marriage and the procreation of children.
- Neither party has been subjected to recurrent attacks of epilepsy or insanity.
- At the time of marriage, the groom should be of twenty-one years of age and the bride should be of eighteen years of age.
- Both the parties are not within the degrees of prohibited relationship; provided where a custom governing at least one of the parties permits of a marriage between them, such marriage may be solemnized, notwithstanding that they are within the degrees of prohibited relationship.
- If the marriage is solemnized in the State of Jammu and Kashmir, both parties should be the citizens of India, domiciled in the territories to which this Act extends.
- When a marriage is intended to be performed in accordance with the Act, the parties of the marriage shall give notice in writing, in the Form specified in the Second Schedule to the Marriage Officer of the district, where the marriage is going to be solemnized.
- The marriage shall be solemnized after the expiration of thirty days of the notice period that has been published under sub-section of the Act.
- At least one of the parties going to perform the marriage should have resided for a period of not less than thirty days, immediately preceding the date on which the notice for marriage is issued to the registrar.
- **Marriage Notice Book and Publication**: Marriage Officer will make an entry in the Marriage Notice Book on receiving the marriage application. The Marriage Notice Book can be inspected by anyone during office hours.
    - The Marriage Officer will also put up a copy of the marriage application in the marriage office. If the permanent residence of the couple is in another district,

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then the Marriage Officer will provide a copy to that district's Marriage Officer to put up in his/her office.

- The marriage officer is bound to display the notice of the intended marriage, by affixing a copy at some conspicuous place in his office.
- If the marriage officer refuses to solemnize the intended marriage, then within a period of thirty days of the intended marriage, either party can prefer an appeal to the District Court, within the local limits of whose jurisdiction the marriage officer has his office.
- The decision of the District Court, regarding the solemnization of the intended marriage, shall be final.
- **Objection to Marriage**: In the 30 day notice period anyone can raise an objection based on the rules in section 4 of this act. Objections will be noted in the Marriage Notice Book.
- The Marriage Officer has to investigate the objection within 30 days of receiving it. The Marriage Officer will have the same powers as those vested in an Indian Civil Court. If the Marriage Officer upholds the objection, then the groom and the bride can appeal to the District Court.
- **Declaration before the Marriage**: The marriage can be solemnized either at the Marriage Officer's office or at a place of the couple's choosing. Before the marriage, the couple, three witnesses and the Marriage Officer need to sign a declaration form.
- **Solemnization of the Marriage**: Marriage may be solemnized in any form which the couple chooses. The groom and the bride must in the presence of the three witnesses and the Marriage Officer say to each other "I (name) take thee (name of spouse), to be my lawful wife/husband".
- **Marriage Certificate**: The Marriage Officer will issue a marriage certificate.
- After this, Registration of marriage also needs to be done.

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The Indian Christian Marriage Act, 1872

- An Act to consolidate and amend the law relating to the solemnization of the marriages of Christians in India.

- It extends to the whole of India except the territories which, immediately before the 1st November, 1956, were comprised in the States of Travancore-Cochin, Manipur and Jammu and Kashmir.
- The expression "Christians" means persons professing the Christian religion and the expression "Indian Christians" includes the Christian descendants of natives of India converted to Christianity, as well as such converts.

Some salient features of the act are as follows:

- Any person professing the Christian religion although he has not been baptized is a Christian for the purposes of the Act.
- Every marriage between persons, one or both of whom is or are a Christian or Christians, shall be solemnized in accordance with the provisions of the next following section; and any such marriage solemnized otherwise than in accordance with such provisions shall be void.
  Marriages may be solemnized in India by any person who has received episcopal ordination, provided that the marriage is solemnized according to the rules, rites, ceremonies and customs of the Church of which he is a Minister.
- The State Government, so far as regards territories under its administration, may, by notification in the Official Gazette, grant licenses to Ministers of Religion to solemnize marriages within such territories and may, by a like notification, revoke such licenses.
- The State Government may appoint one or more Christians, either by name or as holding any office for the time being, to be the Marriage Registrar for any district subject to its administration.
- Every marriage under this Act shall be solemnized between the hours of six in the morning and seven in the evening.
- If the persons intending marriage desire it to be solemnized in a particular church and if the Minister of Religion to whom such notice has been delivered be entitled to officiate therein, he shall cause the notice to be affixed in some conspicuous part of such church.
- The certificate to be issued by the Minister shall be in the prescribed format of the act.
- Whenever a marriage is not solemnized within two months after the date of the certificate issued by such Minister as aforesaid, such certificate and all proceedings (if

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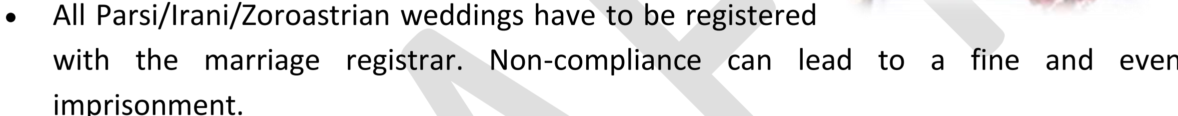
any) thereon shall be void and no person shall proceed to solemnize the said marriage until new notice has been given and a certificate thereof issued in manner aforesaid.

Parsi Marriage and Divorce Act, 1936

This is the act that governs marriage and divorce among members of the Parsi and Irani community in India. It is applicable throughout India, except in Jammu & Kashmir.

Some salient features of the act are as follows:

- Parsi wedding has to be solemnized as per the "Ashirvad" tradition in the presence of a Parsi priest or Parsi Dastur or Mobed. Two witnesses should be present at the time of the marriage.
- The Parsi Priest/ Dastur/Mobed who conducts the wedding should issue a wedding certificate signed by the priest, the couple and two witnesses.
- All Parsi/Irani/Zoroastrian weddings have to be registered with the marriage registrar. Non-compliance can lead to a fine and even imprisonment.



- Only Parsi men over the age of 21 and Parsi women over the age of 18 can marry.
- Marriage is not allowed between blood relatives. The act lists 33 relatives that neither a Parsi man nor woman can marry.
- Bigamy and Polygamy are not allowed.
- The act also states dos and don'ts for the Parsi Priest/ Dastur/Mobed, couple and witnesses.
- The act also covers divorce between Parsi couples.

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The Indian Muslim Marriage Act

The Muslim Marriage Act is based on the Muslim marriage law. As per this act, marriage or "*Nikah*" between an Indian Muslim groom and bride is a civil contract that both the groom and the bride agree to.

Some key features of the Indian Muslim Marriage Act are listed below:

- The act applies only to Indian Muslim men and Indian Muslim women.
- A Muslim marriage is a civil contract in which there is a proposal ("*Ijab*"), usually by the bride and an acceptance ("*Qubul*"), usually by the groom.

- A Kazi (or Qazi) is not necessary for the marriage to take place. The proposal ("*Ijab*") and acceptance ("*Qubul*") in the presence of two adults qualifies as a legal wedding under the act.
- Muslim marriage between certain set of people is not allowed. These include blood relatives, relations by marriage, with two sisters, with a foster mother, if the man already has four wives, if the man and women were previously married and have divorced, but the woman has not remarried, etc.
- Indian Muslim men can have up to four wives, provided he treats all of them equally.

Dowry Prohibition Act, 1961 (Amendment Act, 1986)

Dowry Prohibition Act 1961 prohibits the giving or taking of dowry.

• `Dowry' means any property or valuable security given or agreed to be given either directly or indirectly by any party or parents of either side at the time of marriage, or before or after the marriage ceremony.

• Presents which are given at the time of marriage to the bride or the groom without any demand having being made on this behalf, are not included in the term dowry, provided that such presents are entered in list maintained in accordance with rules made under this Act.

• Penalty for giving or taking dowry is imprisonment for a term not less than 5 years and with fine which shall not be less than Rs. 15000/- or the amount of the value of such dowry, whichever is more.

• Penalty for demanding any dowry directly or indirectly, from the parents or other relatives or guardian of a bride or bridegroom as the case may be, any dowry, is imprisonment for a term of not less than six months and may extend to two years and with fine which may extend to ten thousand rupees.

• Penalty for advertising, printing or publishing such advertisements offering any share in his property or money as consideration for the marriage of his son or daughter or any other relative is imprisonment for a term not less than six months, but which may extend to five years, or with fine which may extend to fifteen thousand rupees.

• Where any dowry is received by any person other than the woman in connection with whose marriage it is given, that person shall transfer it to the woman –

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(a) If the dowry was received before marriage, within three months after the date of marriage; or

(b) If the dowry was received at the time of or after the marriage within three months after the date of its receipt; or

(c) If any person fails to transfer any property as required by sub-section (1) within the time limit specified therefore or as required by sub-section (3), he shall be punishable with imprisonment for a term which shall not be less than six months, but which may extend two years or with fine which shall not be less than five thousand rupees, but which may extend to ten thousand rupees or with both.

Dowry Death- According to section 304B, IPC a dowry death is the death of the woman because of burns, injuries or by any other unnatural reason within seven years of her marriage. Before the death she should have been treated with cruelty in connection with dowry by her husband and his relatives.

The provisions of Sections 113 A and 113 B of the Indian Evidence Act, 1872 regarding the presumption as to abetment of suicide by a married woman or dowry death, puts the burden on the husband and in-laws to prove that the death was not attributes to their acts.

The provisions for dowry death are very strict under the Law. If circumstances of cruelty are proved, the husband and his relatives shall be punished with seven years of imprisonment and sometimes even with life imprisonment.

- According to Section 498 A, if a woman is subjected to cruelty by her husband or husband's relatives for dowry, then they shall be punished with imprisonment which may extend to three years and shall also be liable to fine.

Role Play Activity (*Refer Annexure-14*)

Instructions for Trainers

- **The trainees should be divided into groups**
- **Each group can create a story based on any girl child social evil mentioned in the content or trainers may give different situations to trainer**
- **The group then should present the story in front of the class**
- **The other trainees should provide with solutions**

The Hindu Adoptions and Maintenance Act

- The **Hindu Adoptions and Maintenance Act** was enacted in India in 1956 as part of the Hindu Code Bill.
- This Act applies to Hindus and all those considered under the umbrella term of Hindus. Persons who are Muslims, Christians, Parsis or Jews are excluded from this definition.
- The Adoptions and Maintenance Act (1956) dealt specifically with the legal process of adopting children by a Hindu adult, as well as the legal obligations of a Hindu to provide "maintenance" to various family members including, but not limited to, their wife or wives, parents, and in-laws.
- The Act does not also apply to adoptions that took place prior to the date of enactment. However, it does apply to any marriage that has taken place before or after the Act had come into force.
- Moreover, if the wife is not a Hindu then the husband is not bound to provide maintenance for her under this Act under modern Hindu Law.

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Who Can Adopt?

- Under this Act only Hindus and all those considered under the umbrella term of Hindus may adopt subject to fulfilment of following criteria:
    - The adopter has the legal right to (under this Act that would mean they are a Hindu).
    - They have to have the capacity to be able to provide for the adopted child.
    - The child must be capable of being adopted.
    - Compliance with all other specifications (as outlined below) must be met to make the adoption valid. A Hindu male or female could adopt and if they have a living spouse they have to take the consent of their spouse, except when the spouse is of un-sound mind or has renounced the world or has ceased to be a Hindu. Men who are unmarried can adopt as long as they are not a minor.

Who Can Be Adopted?

- The adopted child can be either male or female.
- The adopted child must fall under the Hindu category. The adoptee also needs to be

unmarried and the law permits the adoption of a child who has not completed the age of 15 years, i.e., the child should be below 15 years.

- An adoption can only occur if there is no child of the same sex of the adopted child still residing in the home.
- In particular, if a son was to be adopted then the adoptive father or mother must not have a legitimate or adopted son still live in the house.
- If the adoption is by a male/female and the person to be adopted is a female/male, the adoptive father/mother is at least twenty-one years older than the person to be adopted.
- The law recognizes equal rights of a father or a mother to give their son/daughter in adoption, but with the consent of the living spouse.
- There can be no payment or reward for giving/taking a child in adoption. Given the fact that people are tempted to pay money to take children from poor parents.

Legal Implications for an Adopted Child

- From the date of the adoption, the child is under the legal guardianship of the new adopted parent(s) and thus should enjoy all the benefits from those family ties.
- This also means that this child, therefore, is cut off from all legal benefits (property, inheritance, etc.) from the family who had given him or her up for adoption **"except that which was vested in such person before he/she was given in adoption".**

Adoption under JJ Act, 2000 (Amendment Act, 2006)

- "Adoption" means the process through which the adopted child is permanently separated from his biological parents and becomes the legitimate child of his adoptive parents with all rights, privileges and responsibilities that are attached to the relationship.
- **Section 40:** The rehabilitation and social reintegration of a child shall begin during the stay of the child in a children's home or special home and the rehabilitation and social reintegration of children shall be carried out alternatively by :
  - Adoption
  - Foster care
  - Sponsorship
  - Sending the child to an after care organization
- **Model Rule 33 (1) and (2):**
  - The primary aim of adoption is to provide a child who can't be cared for by his biological parents with a permanent substitute family.
  - For all matters relating to adoption, the guidelines issued by CARA and notified by the Central Government under sub-section (3) of section 41 of the Act, shall apply.

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- **Section 41 of the Act:**
  - The primary responsibility for providing care and protection to children shall be that of his family.
  - Adoption shall be resorted to for the rehabilitation of the children who are orphaned, abandoned or surrendered through such mechanism as may be prescribed.
  - In keeping with the provisions of various guidelines for adoption issued from time to time, by the State Government, or Central Adoption Resource Agency (Authority) and notified by the Central Government, children may be given in adoption by a court after satisfying itself regarding the investigation having carried out, as are required for giving such children in adoption.
  - The State Govt. shall recognize one or more of its institutions or voluntary organizations in each district as specialized adoption agencies in such manner as may be prescribed for the placement of orphaned, abandoned or surrendered children for adoption in accordance with the guidelines notified under sub-section(3).
  - No child shall be offered for adoption:
    - Until two members of the Committee declare the child legally free for placement in the case of abandoned children.
    - Till the two months period for consideration by the parent is over in the case of surrendered children and
    - Without his consent in the case of a child who can understand and express his consent.
  - The court may allow a child to be given in adoption:
    - To a person irrespective of marital status or
    - To parents to adopt a child of the same sex irrespective of the number of living biological sons or daughters or
    - To childless couples

Maintenance of a Wife

- A Hindu wife, whether married before or after the commencement of this Act, shall be entitled to be maintained by her husband during her lifetime.
- The only way the wife can null her maintenance is if she renounces being a Hindu and converts to a different religion, or if she commits adultery.
- The wife is allowed to live separately from her husband and still be provided for by him.
- A Hindu wife shall be entitled to be maintained after the death of her husband, by her father-in-law provided and to the extent that she is unable to maintain herself out of her own earnings or other property or, where she has no property of her own, or is unable to obtain maintenance from the estate of her husband or her parents or from her children, if any, or their estate.

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Maintenance of a Child or of Aged Parent(s)

- Under this Act, a child is guaranteed maintenance from his or her parents until the child ceases to be a minor.
- This is in effect for both legitimate and illegitimate children who are claimed by the parent or parents.
- Parents or infirmed daughters, on the other hand, must be maintained so long as they are unable to maintain for themselves.

Amount of Maintenance Provided

- The amount of maintenance awarded, if any, is dependent on the discretion of the court.
- Particular factors included in the decision process include the position or status of the parties, the number of persons entitled to maintenance, the reasonable wants of the claimants, if the claimant is living separately and if the claimant is justified in doing so, and the value of the claimant's estate and income.
- If any debts are owed by the deceased, then those are to be paid before the amount of maintenance is awarded or even considered.

ROLE OF AWW/ASHA/ANM

- The AWW must ensure that there are no cases of Child Marriage/Dowry deaths happen in her community.
- If she finds out that there is such an instance happening, she should make the family understand the consequences of the act.
- If the families do not understand then she should report the matter to the legal authorities.
- The AWW should also spread awareness about evils of Child Marriage and Dowry
- She should help empower the women of the community to fight for her rights.
- The AWW should be able to report the matter to the Legal Services Authorities and take their assistance appropriate to the case.

SESSION 3	ACTS AND LAWS RELATED TO SAFETY AND PREVENTION OF GENDER BASED VIOLENCE
OBJECTIVE	To apprise trainees about the provisions of Protection of Women from Domestic Violence Act, 2005 and Protection of Children from Sexual Offences – Act and Rules

CONTENT	• Protection of Women from Domestic Violence Act, 2005
	  ○ ~~Defining the problem of Domestic Violence, nature of Domestic Violence~~
	  ○ ~~Key features of the Domestic Violence Act~~
	  ○ ~~Who can make use of the law?~~
	  ○ ~~Measures for prevention of Gender Based Violence Community involvement~~
	  ○ Domestic violence- an overview
	  ○ PWDVA Act- main highlights
	    ○ Who benefits from PWDVA?
	    ○ Legal aid to vistims of domestic violence
	    ○ Relief
	  ○ Role of NGOs and SHGs in protecting domestic violence
	• Protection of Children from Sexual Offences – Act and Rules (2012)
	• Role of AWW/ASHA/ANM

DURATION	1 hour 30 minutes
TRAINING METHOD	Group discussion, role play
LEARNING OUTCOME	The participants would gain knowledge about various provisions related to Gender based violence and protection of children from sexual offences act and also understand their role in prevention of gender based violence and sexual offences against children.
RESOURCES REQUIRED	• LCD projector • Power-point presentation highlighting the key contents • White board and marker
ANNEXURES	• List of acts and laws related to children • List of acts and laws related to women

REFERENCES	• http://wcd.nic.in/wdvact.pdf • http://wcd.nic.in/childact/childprotection31072012.pdf

FACILITATORS NOTES

Methodology

The session may be initiated by recapitulating the situation of the girl child related to domestic violence (***Day 1 Session 2***) and conducting a brainstorming session, wherein the following concerns may be addressed.

Ask

- Do you have any knowledge of domestic violence in your family/Community?
- How prevalent is domestic violence in your community?
- What are the reasons for domestic violence?
- Which acts/ actions can be considered as domestic violence against women?

The trainees must be encouraged to discuss and brain storm with each other on the above issues.

The discussion may progress to explanation about the various forms of domestic violence and later to explaining the PWDVA, 2005 that entitles women in marriage, live-in relationship, widows and children to protect against any form and kind of Domestic Violence.

Ask

- Are they aware that the victims of domestic violence can approach the law and seek legal aid?
- Are they aware of any NGO or SHG that is working on reducing domestic violence in their community/ state?
- What initiatives have they taken to stop or spread awareness about curbing domestic violence in their community/ state?

Trainers may arrange for a role play on domestic violence. The situation may be given by the trainers.

By making a note of the answers provided by the trainees, the trainer may also discuss about how Domestic Violence can be tackled and what are the legal aids and relief that the victims can avail under the law. The role of various NGO's and Self-Help Groups working towards curbing crimes against women and in reducing domestic violence may also be highlighted.

The next part of the session should focus on the safety of children against sexual abuse in India.

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Discuss the following issues:

- Are they aware that children too, can fall victims to sexual abuse?
- Are they aware of any instance of child abuse in their community/state?
- Are they aware of any NGO or SHG that is working for victims of child abuse in their community/ state?
- What initiatives have they taken to stop or spread awareness about curbing child abuse in their community/ state?

Trainers must explain the Protection of Children from Sexual Offences Act and Rules (POCSO), 2012 and the offences and penalties conferred under it. The procedure of reporting such instances and the role of special courts in delivering speedy justice to victims must be discussed. Trainer may also refer the list of acts and laws related to children and women (***Annexure-17 & 18***).

The session may be concluded by summarising the contents.

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CONTENT FOR TRAINERS

Protection of Women from Domestic Violence Act, 2005

Domestic Violence refers to any act, omission or conduct which can cause harm or injury or has the potential of harming or injuring the health, safety or well-being of woman or any child in a domestic relationship (arising out of living together with or without marriage).

An Act of Domestic Violence Includes:

- PHYSICAL ABUSE/THREAT OF PHYSICAL ABUSE
- SEXUAL ABUSE OR A THREAT OF SEXUAL ABUSE
- VERBAL, EMOTIONAL AND/OR MENTAL ABUSE
- ECONOMIC ABUSE

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Indicators of Domestic Violence Include:

Physical Behaviour: Slapping, Punching, Pulling hair, Shoving

Forced or covert acts or behaviour: Unwanted fondling or intercourse, Sexual jokes, Insults

Threats: Threat to hit, harm, use any weapon

Psychological Abuse: Demeaning enough to destroy the self-confidence of woman, attempt to control or limit another person's behaviour, repeated insults or questioning the woman

Stalking/shadowing/keeping a track: Following or stalking a person, appearing at a persons' house or workplace, making repeated phone calls or leaving written, text or voice messages

Cyberstalking: Harassing constantly through threatening/vulgar/coercive messages that disturb the victim mentally, repeated online abuse or sending e-mails that cause substantial emotional distress

What is Sexual Violence?

- Forced sexual intercourse
- Forced to watch pornography or other obscene material
- Forcing a woman (without her consent/against her wishes) to entertain others sexually
- Any other act of sexual nature, sexual abuse, humiliating, degrading or otherwise violating victim's dignity

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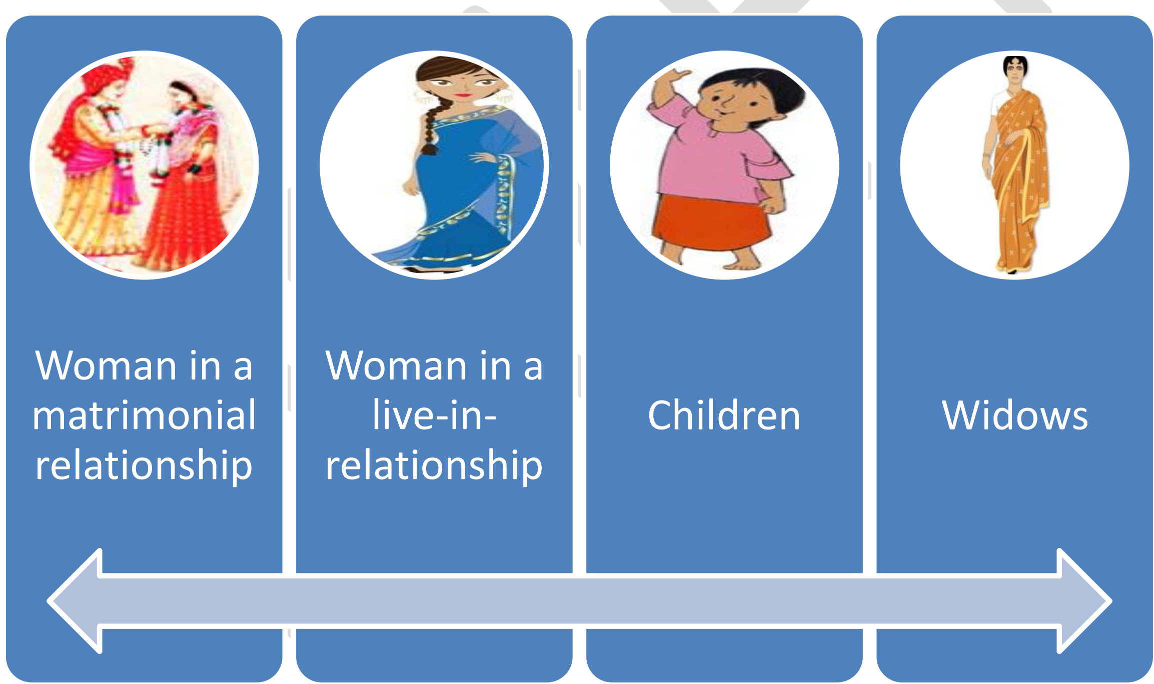
Table 17: Different Types of Abuse

WHAT IS VERBAL AND EMOTIONAL ABUSE?	WHAT IS ECONOMIC VIOLENCE OR ABUSE?
Accusation/adversely commenting on character or conduct, of the victim to cause hurt	Not providing money for maintenance for woman and children
Insulting for not bringing dowry, etc.	Not providing food, clothes, medicine, etc. for woman and children
Insulting a woman for not having a male child	Forcing woman out of the home you live in
Insulting a woman for not having a child	Preventing from accessing or using any part of the house
Demanding, humiliating or undermining	
Ridiculing	Preventing or obstructing from carrying continuing employment
Name calling	Not allowing to take up an employment
Forcing the victim not to attend school, college or any other educational institution	Non-payment of rent in case of a rented accommodation
Preventing a woman from going out of the house	Not allowing to use clothes or articles of general household
Preventing from meeting any particular person	Selling or pawning or disposing of Stridhan or other valuables without informing and without your consent
Forcing to get married against will of the woman	Forcibly taking away salary, income or wages, etc.
Preventing from marrying a person of one's choice	Disposing of one's Stridhan
Forcing to marry a person against his/her wishes	Non Payment of other bills such as electricity, etc.
Any other verbal or emotional abuse	Any other form of economic violence

Protection of Women from Domestic Violence Act, 2005 (PWDVA, 2005)

- The law is enacted for more effective protection of rights of women who are victims of domestic violence within the family and suffering from related issues.
- The law confers same rights to women in a 'live in' relationship in case of domestic violence and abuse, as to legally wedded women.
- This law is in addition to and not a substitute of existing laws under the civil and criminal streams that address matrimonial and maintenance related issues.
- The advantage of this law is that an immediate relief is available to women in a domestic relationship as compared to the other existing laws. An application under this law has to be disposed of by the magistrate with 60 days from the date of notice.
- The relief under this law is designed keeping in view, the status of litigation and relief already granted under any other law.
- Provisions of this law enable a victim of domestic violence to seek shelter in a Short-Stay Home, get immediate medical attention and similar support services on being turned out of the household.

Who Benefits From PWDVA



Legal Aid to Victims of Domestic Violence

- State is duty-bound to provide legal aid to poor, indigent, women and children who do not have sufficient means for legal action for relief under PWDVA, 2005.
- Both women and children can avail legal aid by presenting a complaint to Magistrate and

obtaining relief under PWDVA, 2005 in case of Domestic Violence.

- Poor and/or unemployed women with inadequate means and their children can get free advice and legal services of a lawyer.
- Seeking legal aid is the right of the victim of domestic violence. Legal aid is not a charity.
- If the victim of domestic violence approaches the Magistrate directly for seeking relief under PWDVA 2005, it is the duty of the Magistrate to inform the victim that she may seek legal aid if she does not have the requisite means and support to initiate various or any legal action under PWDVA 2005, and other provisions of law.
- State Legal Aid Boards, District Legal Services Committee and Taluka Legal Aid Committees have been set up throughout the country to provide free Legal Aid.
- The Supreme Court of India has its own Legal Services Committee and regulations governing it, to represent aid and advice needy women and children in any such appeal related to Domestic Violence that may be heard by the Supreme Court of India.
- The Protection Officer, the Service Providers, local NGOs with support of local lawyers may spread legal awareness about laws affecting women and children and their rights within and outside the family.
- Legal literacy is an integral part of legal aid. Making legal aid free for victims.
- Imposing criminal charges in cases where serious injuries have occurred.

Relief

Protection of women victim and her children from dangers and /or insecurities arising out of Domestic Violence through orders passed by Magistrate that result in:

- Restraint against domestic violence at home
- Enjoying peace and comforts of home
- Getting back stridhan, jewellery, etc.
- Medical aid, counseling and legal aid
- Restraint against contact or communication by person committing domestic violence
- Compensation for physical & mental injury or any other monetary loss
- Right to legal action under various laws direct complaint to court
- Maintenance for woman & children
- Compensation for loss
- Compensation for destruction/damage/removal of property from control & possession of a woman
- Free copies of all records created under the act as a consequence of domestic violence

Domestic Violence can be tackled by:

- Opening special cells for women having medical assistance to conduct prompt physical examination and treatment in life-threatening conditions

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- Posting of female police officers in women's cells or hospitals, who will deal with investigation of domestic violence.
- Training staff for emergency services to deal with the medico legal problems
- Counselling to reduce emotional trauma
- Providing assistance in lodging FIR at police station
- The police department should press criminal charges in cases where serious injuries have occurred.
- Legal advice should be made free for victims
- Conducting review meetings at repeat intervals

Role of NGOs and SHGs in Preventing Domestic Violence

Role of NGO'S in Reducing Domestic Violence

- Role of NGO should be preventive, supportive and rehabilitative
- Provide a voice to the victims of Domestic Violence through various means
- Providing counselling to the victims of Domestic Violence
- Act as a pressure group for galvanising the Government and State agencies into action to protect and rehabilitate the victims of Domestic Violence.
- Sensitise judiciary and the executive to respond appropriately to the challenge posed by Domestic Violence.
- Arrange or provide legal aid to victims of Domestic Violence.

Self Help Groups (SHGs) to Curb Crimes against Women

- SHGs may act as sensitized groups on the need to stop crimes against women.
- SHGs as Friends of Police (FOP) as in Thiruvallur, Perambalur and Thiruvarur in Tamil Nadu to curb crime against women.
- SHGs to oppose/stop attack in villages which are known to aggravate domestic violence.
- SHGs to handle cases of dowry, cruelty against women, wife battering and other forms of abuse towards women – as a Social Pressure Group.

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The Protection of Children from Sexual Offences Act, 2012

- Under this law, '**child**' means any person below the age of 18 years.
- It extends to the whole of India, except in the State of Jammu and Kashmir.
- The Protection of Children from Sexual Offences Act (POSCO) protects children from Sexual Harassment, sexual assault and pornography and also provides for establishment of special courts for trial of such offences.
- It also defines sexual harassment and assault in various degrees and forms and enlists the punishments and penalties accordingly.

Reporting Sexual Offences

- If a sexual offence has occurred or might occur against a child, any person (including the child) can report this to the Special Juvenile Police Unit or the local police.
- The information must be recorded in a book by the police unit and the complaint investigated.
- If the child requires treatment or special care and protection, the Special Juvenile Police Unit or the local police must take the child to the hospital or shelter home within 24 hours of the report.
- A person, who fails to report an offence or refuses to record the information, is punishable with up to 6 months of imprisonment and a fine or both.

- If a penetrative sexual assault, aggressive penetrative sexual assault or aggressive sexual assault is evident the court will presume that the accused is guilty. The accused will have to prove innocence.
- The person committing the crime shall be punished with imprisonment of either description for a term which shall not be less than seven years but which may extend to imprisonment for life, and shall also be liable to fine.
- Reporting the identity of the child or making comments in media that invades child's privacy are offences and the person responsible can be punished with imprisonment up to one year.

Trial of Cases

- For speedy justice and to avoid re-victimization of the child, cases are to be tried in special courts with special public prosecutors.

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- The trial must be held in camera and without revealing the identity of the child.
- Such cases must be disposed within one year from the date of offence reported.
- Apart from punishment of the perpetrator the Special Court can give directions for payment of compensation to the child.

ROLE OF AWW/ASHA/ANM

- Establish rapport with all the members of the community so that they can share their experiences with the AWW freely.
- She should be neutral in her behaviour with the community.
- Anganwadi worker should meet other health care providers at regular intervals to review domestic violence case, if any.
- She can make home visits to survivors' homes to check their general wellbeing.
- Make the issue (domestic violence) visible by spreading awareness about the law using Ahimsa Messenger Scheme for girls under the SABLA in the community.
- The AWW should talk to the children coming at the AWC to make sure that no abuse is happening with them.
- She should be aware and conscious and if any bruise marks are seen on children, she should talk to the family and counsel the mother.
- She should develop ties and linkages with the Para Legal Volunteers, District Legal Services Authorities and the Taluka Legal Services Committees to strengthen her interventions at the grassroots.

SESSION 4	EDUCATING THE GIRL CHILD – RTE, 2009
OBJECTIVE	• To understand the importance of educating the girl child. • To help create an enabling environment for girl child education • To familiarise the trainees about the features of RTE, 2009

CONTENT	• Importance of education of girl child
	• Right to Compulsory & Free Education - 2009
	  o Main features of Right to Education Act, 2009
	  o Role envisaged for the community and parents to ensure implementation of RTE
	  o RTE and Promotion of Child-Friendly Schools
	  o Mechanism for prevention of violation of RTE ACT
	• Provisions for higher education of girl child
	• Hygiene and sanitation – Child friendly toilets
	• How do we make an enabling safe environment for the girl child friendly schools
	• Role of AWW/ASHA/ANM
	• Role of Teachers

DURATION	2 hours
TRAINING METHOD	Lecture cum discussion, group activity
LEARNING OUTCOME	• The trainees will be able to understand the need for educating the girl child. • They will be able to learn ways and means to create a secure environment for girls in schools. • The trainees will gain an insight of the key features of the RTE act and understand their role and responsibilities in order to ensure its implementation.
RESOURCES REQUIRED	• LCD projector • Power-point presentation highlighting the key contents • White board and pen • Film on WASH (Amma ji videos)
ANNEXURES	• Case study • Questionnaire on hygiene, sanitation and WASH
REFERENCES	• http://mhrd.gov.in/rte • Right of Children to Free and Compulsory Education (RTE) Act, 2009 • UNICEF WASH Strategies • Nirmal Bharat Abhiyan-Videos of Vidya Balan

FACILITATORS NOTES

Methodology

The session may begin by engaging the trainees in conducting a situational analysis on the literacy status of the girl child in India.

Activity

- The trainees should be divided into groups (State/district Wise), and should discuss the situation of education of girl child in their States/districts and make presentation giving reasons for dropouts of any.

The trainees must be encouraged to provide answers to the questions given below in groups. The groups may be divided state/district wise.

- How many girls in their states/districts are enrolled in schools?
- What is the dropout rate in schools in their states/districts?
- How many girls complete elementary schooling?
- How many girls complete their secondary schooling?
- What are the reasons for dropouts?

After a quick presentation is made by the trainees, the discussion may proceed to the multi-faceted importance of educating girls and its contribution to the development of our society and nation as a whole. The trainer may then discuss about the RTE Act, 2009 and its importance in enhancing the literacy status of the nation.

- Are they aware of free education for all children till 14 years of age?
- How effectively is the act exercised in their states/districts?
- How can they as community mobilizers contribute to ensuring RTE?

Ask

The session may then progress to the ways and means of ensuring safe drinking water, hygiene and sanitation in the schools, community and its importance for ensuring healthy development of the children especially the girl child.

The trainer may discuss a case study wherein a woman walks out of her marital home over lack of toilet facility (copy of case study is provided in ***Annexure-19***). After this, provide questionnaire to the trainees to do a survey of their community ***(Annexure-20)*** regarding

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various parameters such as source of drinking water, toilet facility, disposal of infant's faeces, washing hands etc.

Ask

- Are you aware of the importance of maintaining hygiene and sanitation in the community?
- What measures are being undertaken in the areas for ensuring environmental hygiene and sanitation?
- What are the common practices in the community with regard to purification and storage of potable water?
- What are the common healthy habits that are imparted to children in your community?

The last part of the session should focus on the importance of initiating WASH in schools and on importance of having child friendly toilets in school with separate toilets for the girl child. The trainees must be actively engaged in the discussion for suggestion on Child Friendly Toilets. Trainees may be asked to share their experiences of providing safe environment to girl child.

Ask

The trainers may show the video on "WASH", "Amma ji", and "Nirmal Bharat Abhiyan –Vidya Balan" whichever is available and end the session by discussing the contents.

- Are you aware of WASH (Water, Sanitation & Hygiene)?
- If WASH has been initiated in schools in their states/districts?
- Do schools in their states/districts have child friendly toilets with separate toilets for the girl students?

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CONTENT FOR TRAINERS

Importance of Education of Girl Child

- A girl's education helps improve the future of her family, her community and the Nation.
- Educating the girl child ensures that they are empowered and can play active roles in social and economic development.
- Encouraging female education increases the confidence level of the girl child, which in-turn increases her standard of living and that of her children.
- Education enables the girl child to realize her full potential, to think, question and judge independently. It helps her to be a wise decision-maker, develop civic sense and to be a good citizen.
- If all girl children have access to education, productivity gains would boost economic growth of the nation.
- Education helps girls and women to know their rights and to gain confidence.
- Girls who have been educated are likely to marry late, have smaller and healthier families.
- Educated women can recognize the importance of health care and know how to seek it for themselves and their children.
- Education opens doors to various opportunities for the girl child.

Education is both a process and an outcome. Investing in education, especially for girls, alleviates extreme poverty through securing substantial benefits for health and productivity, as well as democratic participation and women's empowerment. It is one of the critical areas of empowerment for girls that ensures:

- Promotion of self-recognition, a positive self-image and self-actualisation.
- Stimulation of critical thinking.
- Deep understanding of the gendered structures of power, including gender.
- Access to resources, specially to an expanding framework of information and knowledge
- Development of the ability to analyse the options available, and to facilitate the possibility of making informed choices.
- An environment for girls to challenge gendered structures of power and take control of their lives.

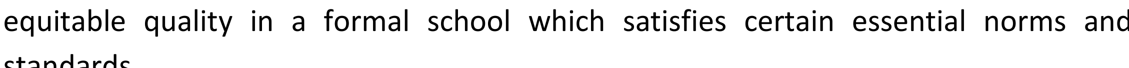
- Setting their own agendas, gaining skills (or having their own skills and knowledge recognized), solving problems, and developing self-reliance.
- National harmony and behaviour change

Girl Child Education for Nation's Welfare

- *Reduces inequality and brings Gender Equality*
- *Increases productivity and earnings*
- *Improves health and nutrition*
- *Reduces women's fertility rates*
- *Lowers infant and child mortality rates*
- *Lowers maternal mortality rates*
- *Protects against HIV/AIDS infection*

Right of Children to Free and Compulsory Education Act, 2009

- The Constitution of India provides free and compulsory education of all children in the age group of six to fourteen years as a Fundamental Right in such a manner as the State may, by law, determine.
- The Right of Children to Free and Compulsory Education (RTE) Act, 2009 which came into force on 1 April 2010 represents the consequential legislation envisaged under Article 21-A.
- It means that every child has a right to full time elementary education of satisfactory and equitable quality in a formal school which satisfies certain essential norms and standards.



The RTE Act provides for the

(i) Right of children to free and compulsory education till completion of elementary education in a neighbourhood school.

(ii) It clarifies that 'compulsory education' means obligation of the appropriate government to provide free elementary education and ensure compulsory admission, attendance and completion of elementary education to every child in the six to fourteen age group. 'Free' means that no child shall be liable to pay any kind of fee or charges or expenses which may prevent him or her from pursuing and completing elementary education.

(iii) It makes provisions for a non-admitted child to be admitted to an age appropriate class.

(iv) It specifies the duties and responsibilities of appropriate Governments, local authority and parents in providing free and compulsory education, and sharing of financial and other responsibilities between the Central and State Governments.

(v) It lays down the norms and standards relating inter alia to Pupil Teacher Ratios (PTRs), buildings and infrastructure, school-working days, teacher-working hours.

(vi) It provides for rational deployment of teachers by ensuring that the specified pupil teacher ratio is maintained for each school, rather than just as an average for the State or District or Block, thus ensuring that there is no urban-rural imbalance in teacher postings. It also provides for prohibition of deployment of teachers for non-educational work, other than decennial census, elections to local authority, state legislatures and parliament, and disaster relief.

(vii) It provides for appointment of appropriately trained teachers, i.e. teachers with the requisite entry and academic qualifications.

(viii) It provides for development of curriculum in consonance with the values enshrined in the Constitution, and which would ensure the all-round development of the child, building on the child's knowledge, potentiality and talent and making the child free of fear, trauma and anxiety through a system of child friendly and child centred learning.

(ix) It prohibits (a) physical punishment and mental harassment; (b) screening procedures for admission of children; (c) capitation fee; (d) private tuition by teachers and (e) running of schools without recognition.

Role Envisaged For the Community and Parents to Ensure RTE

- The landmark passing of the Right of Children to Free and Compulsory Education (RTE) Act 2009 marks a historic moment for the children of India.
- For the first time in India's history, children are guaranteed their right to quality elementary education by the state with the help of families and communities.

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- Schools shall constitute School Management Committees (SMCs) comprising local authority officials, parents, guardians and teachers.
- The SMCs shall form School Development Plans and monitor the utilization of government grants and the school environment.
- RTE also mandates the inclusion of 50 per cent women and parents of children from disadvantaged groups in SMCs.
- Such community participation will be crucial to ensuring a child friendly *"whole school"* environment through separate toilet facilities for girls and boys and adequate attention to health, water, sanitation and hygiene issues.

RTE and Promotion of Child-Friendly Schools

- All schools must comply with infrastructure and norms for teachers for an effective learning environment.
- Teachers are required to attend school regularly and punctually, complete curriculum instruction, assess learning abilities and hold regular parent-teacher meetings.
- Two trained teachers will be provided for every sixty students at the primary level.
- The number of teachers shall be based on the number of students rather than by grade.
- The state shall ensure adequate support to teachers leading to improved learning outcomes of children.
- The state will provide the policy framework and create an enabling environment to ensure RTE becomes a reality for every child.
- The community and civil society will have an important role to play in collaboration with the SMCs to ensure school quality with equity.

Mechanism for Prevention of Violation of RTE Act

- The National Commission for Protection of Child Rights (NCPCR) has been mandated to monitor the implementation of this historic right and shall review the safeguards provided under this act, investigate complaints and have the power of a civil court in trying cases.
- States should constitute a State Commission for the Protection of Child Rights (SCPCR) or the Right to Education Protection Authority (REPA).

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- Any person wishing to file a grievance must submit a written complaint to the local authority. Appeals will be decided by the SCPCR/REPA.
- Prosecution offences require the sanction of an officer authorised by the appropriate government.

Provision of Higher Education of Girl Child

The Ministry of Human Resource Development has various provisions for the higher education of the girl child in order to incentivize higher education, scholarship to girls, skill building etc. so as to empower them for a better future. The following table highlights the provisions for the same.

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Table 18: State & Centre Schemes for Higher Education of Girl Child

SL. NO.	SCHEMES	BENEFICIARIES	PROVISIONS
1	Incentives to girls for secondary education	• Girl child in the age group of 14-18 • SC/ST girls who pass class VIII	• A sum of Rs. 3, 000 is deposited in the name of girls as fixed deposit.
2	Scheme for construction and running of Girls' Hostel for students of secondary and higher secondary schools	• Girls in the age group 14-18 studying in classes IX to XII and belonging to SC, ST, OBC , Minority communities and BPL families	• Construction of one hostel with the capacity of 100 girls in each of the 3500 educational backward blocks.
3	Kasturba Gandhi Balika Vidyalaya (KGBVs)	• Adolescent girls who are unable to go to regular schools • Younger girls of migratory populations	• Setting up residential upper primary schools for girls schools in the block.
4	Scheme of Vocationalisation of Secondary Education at +2 level	• Students from class IX onwards	• Diversification of educational opportunities to enhance Individual employability. • Reduce the mismatch between demand and supply of skilled manpower. • Provides an alternative for those pursuing higher education.
5	Lal Bahadur scholarship to meritorious students (Delhi scheme)	• Students of economically weaker sections of society.	• Recognition and financial help to the meritorious students of economically weaker sections of society.
6	Welfare of Educationally Backward Minorities A. Scholarship to Educationally Backward Minorities (Delhi scheme)	• Students of backward minorities (Muslims and Neo- Buddhists only)	• To promote education among educationally backward minorities.
7	Stipend to Girl Students (Delhi scheme)	• Girl students belonging to rural areas of Govt. of NCT of Delhi	• Promoting education among girl students and retain them till their education is completed.

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8	Incentives for education of single girl child	• Any girl who is the only girl child of her parents	• A scholarship of Rs. 2000 per month to pursue Post-Graduation in any recognized institution of higher learning in the country.

Hygiene and Sanitation for Children Especially Girl Child

Tips for Environmental & Household Sanitation

- Home and surroundings should be kept clean. The use of smokeless chulhas may be encouraged.
- Garbage should be collected in a closed container and buried every day or given to thrash collector.
- Wastewater should be drained away to soakage pits in the absence of drains.
- Cattle should be kept away from the place where people live.
- The single most important action to prevent spread of germs is to dispose of all faeces - both human and animal safely.
- Construction and use of sanitary latrines should be encouraged. It should be constructed away from source of water.
- Human faeces need to be put in a toilet or a latrine, which needs to be kept clean.
- If it is not possible to use sanitary latrines, people should defecate far from houses, drinking water and place where children play. The faeces should be buried immediately or covered with mud if defecated in open areas.

- It is important to wash hands with soap and water after defecation to help protect against illnesses. Soap and water should be placed conveniently near the latrine or toilet.
- It is also important to wash hands after handling animals or raw food.

WASH in Schools

- Poor sanitation, water scarcity, inferior water quality and inappropriate hygiene behaviour are disastrous for young children and are a major cause of mortality for children under five.

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- Providing schools with safe drinking water, improved sanitation facilities and hygiene education encourages the development of healthy behaviours for life.
- This strategic approach is known as ***Water, Sanitation and Hygiene Education (WASH) in Schools***.
- WASH in schools not only promotes hygiene and increases access to quality education but also supports national and local interventions to establish equitable, sustainable access to safe water and basic sanitation services in schools.
- WASH in schools aims to improve the health and learning performance of school-aged children – and, by extension, that of their families – by reducing the incidence of water and sanitation-related diseases.
- Every child friendly school requires appropriate WASH initiatives that keep the school environment clean and free of smells and inhibit the transmission of harmful bacteria, viruses and parasites.

WASH in Schools Intervention Should Include

- Sustainable, safe water supply points, hand-washing stands and sanitation facilities;
- Fully integrated life skills education, focusing on key hygiene behaviours for schoolchildren and using participatory teaching techniques;
- Outreach to families and the wider community.

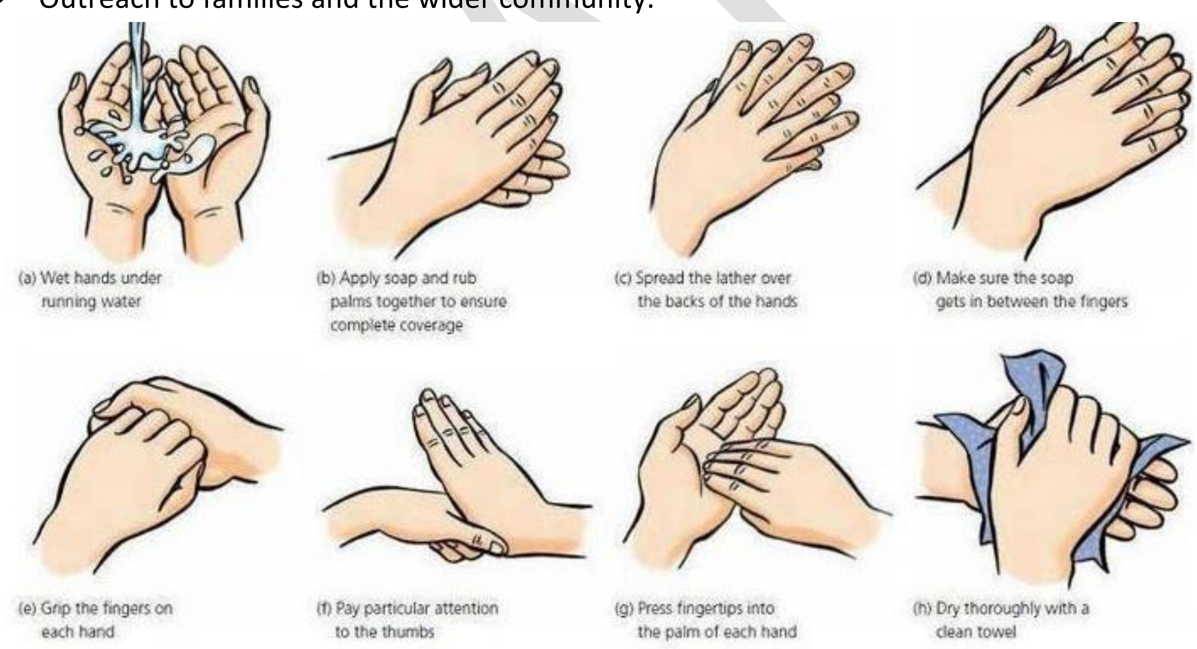

Figure 12: Process of Hand washing

An efficiently and effectively implemented WASH Strategy in Schools wills lead to students who:

- are healthier;
- perform better in school;

- positively influence hygiene practices in their homes, among family members and in the wider community;
- learn to observe, communicate, cooperate, listen and carry out decisions about hygienic conditions and practices for themselves, their friends and younger siblings whose hygiene they may care for (skills they may apply in other aspects of life);
- change their current hygiene behaviour and continue better hygiene practices in the future;
- learn about menstrual hygiene and physical and emotional changes during puberty (learning to avoid menstrual odour, discomfort and urinary or vaginal infections will encourage girls to come to school during menstruation);
- practice gender-neutral division of hygiene-related tasks such as cleaning toilets, fetching and boiling water and taking care of the sick.

Child Friendly Toilets

Toilets in Schools and Anganwadi's are necessary for the healthy growth of the children but there are issues, for instance, of privacy, safety, dignity, cost, child friendly designs, etc., which need to be addressed and solved before providing sanitation facilities in schools.

Where Should the Toilet Site be Located?

Location of the site of toilet is very important for its effective and proper use. The following issues must be considered while choosing a location for hygienic sanitation facilities:

Safety

- Children must feel 'safe' when going to visit the facilities without having fears and risks for harassment and attacks by animals (such as snakes) or people.
- Access routes must be open and clear, without long grass and bushes.
- The facilities must also be at hearing distance and/or have visual contact with the school to get assistance, if needed.

Supervision

- Somebody has to be responsible for overseeing proper use of the facilities (including after school hours and during holidays).

Privacy

- Facilities must offer privacy when entering and using the sanitation services especially for the girls.

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Environmental Degradation

- Hygiene and sanitation facilities are often brought together with other 'unwanted' activities, such as waste collection which causes nuisance, such as bad smell, flies and other pests. This will demotivate people to use the facilities.

Risk of Groundwater Contamination

- Facilities have to be located at a safe distance especially from water sources to avoid the groundwater contamination.

Accessibility

- It must be possible to reach facilities at all times and in all weather conditions especially heavy rains.

Separate Toilets for Girl Child

- It is reported that education for girls can be supported and fostered by something as basic as a girls-only toilet arguing that the lack of access to separate and decent toilets at school is impeding girls' access to their education.
- Hygiene and sanitation facilities should be very gender specific as girls have specific physical and sometimes cultural needs than men and boys, hence, demanding different solutions.
- It is therefore, very important to select appropriate and child friendly design especially for girls both at school and anganwadi center.
- Special facilities for menstrual hygiene must be provided for girls in toilet complex in schools.

> ***'Girl-Friendly Toilets'*** – a concept growing in popularity as a mass movement – It should not only be separate from boys, but provide water, soap, supplies for menstrual management, and privacy from other girls as well as boys.

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Child Friendly Especially Girl Child and Physically Challenged Friendly Design Option be Selected

- Access to toilet must be open and clear without any hindrance
- If the toilet for boys and girls are in one complex, they should have separate entrances preferably on opposite sides to avoid inconvenience and ensure privacy.
- There should be hooks for hanging *duppattas* for girls.
- Factors like lighting, ventilation, provision of doors with system of latching, etc. also need to be taken into account.
- The superstructure should be such that students feel safe and comfortable using toilets.
- Hand washing space should be located at the most convenient place.
- Availability of water and other cleaning material such as brush, phenyl, mug, must be secured.
- Toilet designs should also cater to the needs of physically challenged children with simple adaptations such as :
    - Low level of hand rail and wash basins in toilet.
    - Ramps, in case the toilet is at higher level or raised stool in case of Indian.
    - Steps should be avoided as far as possible.
    - A pipe to be attached to the tap for self-cleanings (as the child will be holding the bar/ hand -rail for balance).

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ROLE OF AWW/ASHA/ANM

- The AWC is the first contact point for the community; therefore the AWW should have sufficient and correct knowledge to provide to the community.
- She should be well versed with all the laws and acts so that she will be able to spread awareness in the community.
- The health workers should emphasis on the issue of child sex ratio
- She should be able to make the community a child and girl friendly place for the Girl Child.
- She should teach children the correct way to wash hands.

ROLE OF TEACHERS

- Teachers should encourage children especially Girl Child for education.
- Teachers should provide interactive and Child Friendly environment to the Children.
- She should make sure that there are Child Friendly Toilets available within the school premises.
- Teachers should not discriminate and should uphold the rights of the child.

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DAY 3

SESSION 1	SARVA SHIKSHA ABHIYAN (SSA)- AN INITIATIVE TO PROMOTE THE EDUCATION OF CHILDREN
OBJECTIVE	To discuss in detail the initiative of MoHRD for educating the girl child under SSA

CONTENT	• What is SSA?
	  ○ Provisions under SSA
	  ○ Broad strategies under SSA
	  ○ Norms for intervention under SSA
	  ○ Schemes under SSA
	  ○ Convergence with ICDS
	  ○ Provisions for higher education of girls
	• Role of AWW/ASHA/ANM
	• Role of Teachers

DURATION	1 hour 30 minutes
TRAINING METHOD	Lecture, group activity
LEARNING OUTCOME	• The trainees will gain thorough knowledge about the SSA scheme and its provisions. • The trainees will be able to spread awareness in the community regarding the importance of education of girls.
RESOURCES REQUIRED	• LCD projector • Power point presentation
ANNEXURES	• Child Assessment Card-English • Child Assessment Card-Hindi
REFERENCES	• www.ssa.nic.in • http://wcd.nic.in/schemes/ECCE/ecce_01102013_eng.pdf

FACILITATORS NOTES

Methodology

The trainer may start the session by highlighting the importance of education for all children and various benefits of education.

Ask

- Are you aware of the SSA?
- What are the provisions under SSA which benefit children?

After discussion with the trainees, the trainer may extensively explain the provisions and norms under the SSA scheme and how children can be benefitted from it. The trainer may lay emphasis on the various strategies under the SSA. The session may progress to discussion on other initiatives like Kasturba Gandhi Balika Vidyalaya (KGBV) schemes under the SSA.

Ask

- What are the various education related initiatives started by State Governments?
- Are the trainees aware of the initiatives started by their States?
- Share experiences with the group.

The trainer may quote examples of various education related State initiatives that are being run to strengthen the education of children. The session should then focus on convergence with ICDS and how it can help in strengthening the ECCE aspect of ICDS. The trainer may refer to annexed "Child Assessment Cards' (***Annexure-21 & 22***) that can be shared with the participants.

The next step would be to highlight the ECCE policy. Finally summarise how the AWW can contribute in encouraging education in the community and also elaborate on the role of teachers in the SSA.

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CONTENT FOR TRAINERS

Sarva Shiksha Abhiyan

- Education of girls has been a high priority with the Government of India.
- The National commitment to provide free and compulsory education to all children in the age group of 6-14 years is now a Fundamental Right of every child in India after passing of the Constitution 86th Amendment in 2002.
- Sarva Shiksha Abhiyan (SSA) is Government of India's flagship programme for achievement of Universalization of Elementary Education (UEE) through a time bound integrated approach in partnership with the States.
- SSA is an effort to recognise the need for improving the performance of school system and to provide community owned quality elementary education in the mission mode.
- Under SSA, reaching out to the girl child is central to the efforts to universalize elementary education. Sarva Shiksha Abhiyan, or 'Education for All' programme recognizes that ensuring girl's education requires changes not only in the education system but also in societal norms and attitudes.
- A two-pronged gender strategy has therefore been adopted, to make the education system responsive to the needs of the girls through targeted interventions which serve as a pull factor to enhance access and retention of girls in schools and on the other hand, to generate a community demand for girls' education through training and mobilisation.

- Main highlights of SSA scheme are as under:
  - SSA is a programme with a clear time frame for universalisation of elementary education
  - A response to the demand for quality basic education all over the country
  - An opportunity for promoting social justice through basic education

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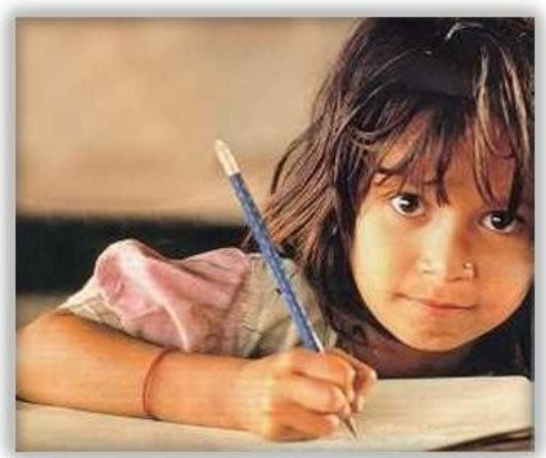
- An effort to effectively involve the Panchayati Raj Institutions, the School Management Committees, the Village and Slum Level Associations, the Tribal Autonomous Councils in the management of elementary schools
- An expression of political will for universal elementary education at the highest level
- A partnership between the Central, State and the local government
- An opportunity for States to develop their own vision of elementary education

Provisions under SSA

- The programme seeks to open new schools in those habitations which do not have schooling facilities and strengthen existing school infrastructure through provision of additional class rooms, toilets, drinking water, maintenance grant and school improvement grants.



- Existing schools with inadequate teacher strength are provided with additional teachers, while the capacity of existing teachers is being strengthened by extensive training, grants for developing teaching-learning materials and strengthening of the academic support structure at a cluster, block and district level.
- SSA seeks to provide quality elementary education including life skills.
- SSA has a special focus on girl's education and children with special needs.
- SSA also seeks to provide computer education to bridge the digital divide.

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Broad Strategies Central to SSA

Institutional Reforms	Sustainable Financing	Community Ownership	Institutional Capacity Building	Improving Maninstream Educational Administration
Communiity Based Monitoring with Full Transparency	Habitation as a Unit of Planning	Accountability to Community	Priority to Education of Girls	Focus on Special Groups
Pre project Phase	Thrust on Quality	Role of Teachers	District Elementary Education Plans	

Norms for Interventions under SSA

The targeted provision for girls under Sarva Shiksha Abhiyan includes:

- Free textbooks to all girls upto class VIII
- Separate toilets for girls
- Back to school camps for out-of-school girls
- Bridge courses for older girls
- Recruitment of 50% women teachers
- Early childhood care and Education centers in/near schools/convergence with ICDS programme etc.
- Teachers' sensitization programmes to promote equitable learning opportunities
- Gender-sensitive teaching and learning materials including textbooks
- Intensive community mobilization efforts
- 'Innovation fund' per district for need based interventions for ensuring girls' attendance and retention.
- Maintenance and repair of school buildings

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Kasturba Gandhi Balika Vidyalaya (KGBV)

- Kasturba Gandhi Balika Vidyalaya (KGBV) is a scheme launched in July 2004, for setting up residential schools at upper primary level for girls belonging predominantly to the SC, ST, OBC and minority communities.
- The scheme is being implemented in educationally backward blocks of the country where the female rural literacy is below the national average and gender gap in literacy is above the national average.
- The scheme provides for a minimum reservation of 75% of the seats for girls belonging to SC, ST, OBC or Minority communities and priority for the remaining 25%, is accorded to girls from families Below Poverty Line (BPL) in 27 States/UTs.
- The Kasturba Gandhi Balika Vidyalaya scheme is merged with Sarva Shiksha Abhiyan in the XIth Plan with effect from 1st April, 2007.

State Initiatives for Promoting Girls Education

- ***Uttar Pradesh:***

  1) Meena Manch - Forum for adolescent girls to discuss their own issues and motivate girls to attend school.

  2) Intensive campaign for community mobilisation in selected villages; 21 days training of instructors; use of TLM; residential arrangement for girls and instructors; arrangements for sports, cultural programmes and life skills.
- ***Haryana:*** *Bicycles are given to girls on joining class VI in a Govt. school located outside the village to prevent dropout at the end of class V and help girls to complete 8 years of schooling.*
- ***Uttaranchal:*** *Provisioning ECE in a convergent mode with ICDS; SSA supporting with additional TLM; capacity building; honorarium; constructing rooms in primary schools for running ECE centres; relocation of ICDS centres in/near primary schools; synchronized timings of ECE and primary school*
- ***Orissa –*** *Kalasi Dhara (carrying earthen vessel) - An initiative to mobilise the community and Mother Teacher Associations to monitor the attendance of teachers and children, cleanliness of the school compound and regularity of classes being held at school. The designated mothers are also required to bring to school those children found to be absent by motivating their parents etc.*
- ***Bihar:*** *Summer Camps for Remedial Teaching, provided to girls.*

Convergence with ICDS

- ❖ Early Childhood Care and Education (ECCE) is a critical and essential input in freeing girls from sibling care responsibilities, leading to their regular attendance in school and in providing school readiness skills to pre-school children.
- ❖ The SSA works in a convergent mode with the Integrated Child Development Services (ICDS) programme to promote pre-school education by providing for training of AWWs and primary school teachers for a convergent understanding of pre-school and ECCE.

Early Childhood Care and Education (ECCE)

- The National Policy on Education (NPE), 1986 (Modified in 1992) has given great deal of importance to Early Childhood Care and Education (ECCE).
- It has also taken into account the holistic nature of ECCE and has pointed out the need for early care and stimulation of children belonging to the vulnerable sector.

- The importance of community involvement has also been highlighted and emphasis has been given to establishing linkages between ICDS and other ECCE Programmes.
- The SSA realises the importance of pre-school learning and Early Childhood Care and its role in improving participation of children in schools.
- Recognizing the continuum of learning and development, SSA developed an integrated approach to meet the educational needs of the pre-school children.
    - Strengthening pre-school component in ICDS by need based training of AWW, provision of additional person and learning materials.
    - Setting up Balwadis for importance of Early Childhood Development
    - Building advocacy for importance of Early Childhood Development
    - Organizing training programmes for community leaders
    - Providing for intensive planning for ECCE
    - Development of materials
    - Promoting convergence between the school system and the ECCE arrangement

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National Early Childhood Care and Education Policy

National Early child hood Care and Education Policy (NECCEP) has been adopted by Government of India in 2013 with the vision to achieve holistic development and active learning capacity of all children below six years of age by promoting free, universal, inclusive, equitable, joyful and contexualized opportunities for laying foundation and attaining full potential. The policy envisages to improve pathways for a successful and smooth transition from care and education provided at home to Centre based ECCE and thereafter to school-age provision by facilitating an enabling environment through appropriate systems, processes and provisions across the country.

The key areas of the policy are to achieve access with equity and inclusion , improving quality (in terms of minimum specifications, quality standards, regulation, curriculum, play and learning material , programme assessment and child assessment) , strengthening capacity, monitoring and supervision, advocacy and awareness generation , convergence and coordination amongst policies and programmes , institutional and implementation arrangements (National and State ECCD councils) , increased investments etc.

The policy envisages certain non-negotiable standards for promoting quality ECCE. These are ECCE programme for 3-4 hours duration, one classroom measuring at least 35 square meters for a group of 30 children and availability of adequate (at least 30 square meter) space for a group of 30 children, adequate trained staff, age and developmentally appropriate child centric curriculum transacted in the mother tongue/local vernacular, adequate developmentally appropriate toys and learning materials, a safe building, adequate and safe drinking water, adequate and separate child friendly toilets, separate cooking space, immediate health services in terms of first aid/medical kit and adult child ratio of 1:20 for 3-6 years old children and 1:10 for under 3s. A regulatory framework in phased manner moving progressively from registration to accreditation and ultimately to regulation would be established.

The National Early Childhood Care and Education Curriculum Framework lays emphasis to have gender sensitive curriculum so as to ensure that gender stereotypes are broken. The curriculum framework envisages that;

- Caregivers should not perpetuate gender stereotypes. Instead, they should be encouraged to have equal and appropriate expectations of boys and girls and promote equal opportunities for them. They can provide opportunity to explore the children's thinking about gender and help children expand their understanding of gender.
- ECCE teachers /Caregivers have had gender training and know how to routinely do gender analysis. This equips them to see gender bias in the community and to actively keep it out of the classroom. Girls and boys receive equal attention and

respect. It is ensured that during the day the tone of voice and comments given, wait time provided for answering questions, feedback provided, opportunity in classroom tasks are same for both boys and girls. As a result, they learn to value themselves and others equally. Equal treatment sends messages that each child is worthy and valued regardless of her /his sex or other differences.

- Facilitate as much active learning as possible through play and other activities which are free of gender bias. Stories, songs, activities and facilitation aids should depict girls and boys in the same roles and men and women in all professions. Both women and men should appear as leaders, heroes and problem solvers etc.
- Girls do some things that boys don't do and some things more or less than the boys. So boys and girls have different ideas, experiences and behaviours. However, preschoolers enjoy imitating adults and role plays are good ways for them to show the different things they do and know. Girls like to pretend to be boys or fathers and boys like to role play female roles. While enacting they understand the other sex and teachers/caregivers can explore what feelings girls and boys have, build the comfort of both sexes in discussing their feelings too. As the educator treats each child well, it may be easier to get children to listen to each other, to share and to play respectfully.
- There are few male ECCE teachers and Caregivers. Encourage male ECCE teachers so that learners will benefit from male role models.
- The families and local community is encouraged to participate and support the programme. Parents need to be sensitized and educated so that they can support these practices at home. It is important here to help them understand and stop discrimination against boys or girls.

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ROLE OF AWW/ASHA/ANM

- Health Workers should create awareness about education of the Girl Child
- AWW should ensure that the AWC is a vibrant ECE centre for children
- She should enlighten the parents and community about age and developmentally appropriate early child care and education practices.
- Inform parents about the progress of their child on growth, development and learning milestones.
- AWW should celebrate the fixed monthly ECCE day (Refer to MWCD Guidelines)
- She should survey her community and find out the status of girl child education in the community.
- She should motivate the families to send their daughters for primary education.

ROLE OF TEACHERS

- A teacher must ensure that all children especially girl child are protected from all forms of exploitation, abuse, inhuman or degrading treatment and neglect.
- Learnt to recognise and identify abuse, neglect, learning disorders and others not so visible disabilities.
- Create a relationship where children can express their views, concerns, anguish, fear etc. Try to engage with children in informal discussions.
- Make children feel it is worthwhile attending the school and classes.
- Be a good listener. Share and discuss various issues and problems which children are facing either in school or at home.
- Focus on classroom process and organise exposure visits for effective development of the child.
- Say NO to discrimination. Take active steps to reach out to children from minority and other discriminated groups.
- Organise meetings with parents and discuss important issues like ill-effects of low CSR and importance of educating the girl child etc.
- Follow-up on girls who drop out or attend irregularly to ensure it does not continue.

<table>
<tr><th>SESSION 2</th><th>SCHEMES/ PROGRAMMES OF MINISTRY OF WOMEN AND CHILD DEVELOPMENT (MWCD) SUPPORTING GIRL CHILD AND WOMEN</th></tr>
<tr><td>OBJECTIVE</td><td>• To provide information on various schemes being implemented by Ministry of Women and Child Development for the benefit of girl child</td></tr>
<tr><td>CONTENT</td><td>• An overview of the following schemes implemented by MWCD- Target group / Beneficiaries; Provisions in the Schemes/ Services offered ; and Ways and means to increase access to the services:
State Initiatives for Girl Child
○ New Girl Child Scheme – Ladli
○ Kanya Jagriti Jyoti Scheme
○ Balri Rakshak Yojana/Janani Suraksha Yojana
○ Devi Rupak Scheme
○ Mukhyamantri Kanya Suraksha Yojana
○ Nandadevi Kanya Scheme
○ Ladli Laxmi Yojana
○ Sivagami Ammaiyar Memorial Girl Child Protection Scheme
○ Bhagyalakshmi Scheme
○ Mahamaya Gareeb Balika Ashirwad Yojana
○ Delhi Ladli Scheme
○ Beti Hai Anmol Scheme
○ Indira Gandhi Balika Suraksha Yojana
Other Initiatives
○ Central Adoption Resource Authority (CARA)
• Role of AWW/ASHA/ANM</td></tr>
<tr><td>DURATION</td><td>2 hours</td></tr>
<tr><td>TRAINING METHOD</td><td>Lecture cum discussion, brain storming session, programme specific video films (if available), group activity</td></tr>
<tr><td>LEARNING OUTCOME</td><td>The trainees would have an overview of the various schemes implemented for development of children and women under MWCD and State. They would be able to learn ways and means to increase access to services rendered under various schemes.</td></tr>
<tr><td>INSTRUCTIONS FOR TRAINERS</td><td>• Trainers to provide small write up of the programmes/schemes being discussed in the session.
• Trainers may arrange for films from State/ Regional Sources.</td></tr>
</table>

RESOURCES REQUIRED	• LCD projector • Power point presentation highlighting the key components • Chart papers and markers
ANNEXURES	• Schemes and initiatives for girl child and women • NRP brochure
REFERENCES	1. The trainers may also refer to MWCD Schemes booklet 2. The trainers may refer to Ahimsa Messenger booklet-1 (schemes booklet) 3. The following websites can be visited by the trainees for further information • http://wcd.nic.in/ • http://ncpcr.gov.in/ • http://cara.nic.in/ • http://rmk.nic.in/ • http://ncw.nic.in/ • http://www.poshan.nic.in/jspui/index.html

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FACILITATORS NOTES

Methodology

The session may begin with the importance of girl child. The focus should then switch to the initiatives taken by MWCD for welfare of children especially for girl child's survival and development. An overview of the various schemes/ programmes of Ministry of Women and Child Development, for supporting girl child and women will be given to the trainees **(*Annexure-23*)** for their reference.

Ask

- Are they aware of the role played by MWCD for supporting survival and development of girls and women?
- How are the AWC services being availed by the people?
- What are the various schemes for women and children?
- What state specific programmes/schemes are being implemented in their area?

The session may progress to discuss in details the various states initiatives for the girl child like Ladli, Beti Hai Anmol, Bhagyalakshmi Scheme etc.

Activity

- Divide the trainees in groups
- Give 15 minutes to the trainees to share their personal experiences in implementing the programme/scheme.
- Ask a group leader to come and write the problems faced in implementation of programmes/scheme.
- The trainer should then discuss the solution as a group.

Share information on the Nutrition Resource Platform (NRP), a web portal dedicated to maternal and child nutrition and care as this would help the community with easy access to all nutrition information related to children and women **(*Annexure-24*).**

The session may be concluded by discussing the roles of AWW/ASHA/ANM.

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CONTENTS FOR TRAINERS

State Initiatives for Girl Child

1) New Girl Child Scheme “LADLI”

Ladli Scheme was launched by Haryana State Government on 20th August 2005. It is being implemented through the Women and Child Development Department.

Objective

The aim is to raise the status of the girl child in the family and in the society. To change the mind-set of people and the society. To provide the girl child with right to birth and the right to survive.

Eligibility Criteria

The following are the criteria for selection of beneficiaries under the scheme:-

- All parents of girl children who are residents of Haryana, or Haryana domiciles, entitled for financial assistance, provided, there is at least one alive real sister of the second girl child of the family.
- At least one of the parents along with the girl children should be residing in Haryana.
- The birth of both the girl children should be registered.
- The parents should ensure proper immunization of the girl children and immunization record (as per age of the girl child) may be produced at the time of receiving each payment.
- Both sisters should be enrolled in school/ Anganwadi centers as per their age
- If the parents of the second girl child (born on or after 20th Aug, 2005) are receiving benefit under any other scheme like Balika Samridhi Yojana etc. they would still be entitled to benefit from this scheme.

Financial Benefits

- Under the Scheme the government will provide all parents the benefit/ financial assistance of Rs.5000/- per year upto 5 years whose second girl child is born on or after 20th August, 2005 irrespective of their caste, creed, religion, income or number of sons.
- Under the scheme Rs. 5000/- per family per year will be given to the parents on the birth of

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their 2nd daughter born on or after 20th Aug 2005 for 5 years.

- The money is to be invested in Kisan Vikas Patras in the name of 2nd girl child through mother. In case, mother is not alive then the money would be deposited in the name of 2nd girl and the father. If both the parents are not alive then this money will be deposited in the name of 2nd girl child and guardian.
- In case of twin daughters, the incentive will start with immediate effect.
- The first installment would be released within one month of the birth of 2nd girl child. Successive installments would be released on the birthdays of the 2nd daughter every year.
- In case of death of either of the girl the incentive shall be stopped with immediate effect. However the same will be restored from the date it was discontinued on birth of another girl child.
- The accumulated amount will be released after second girl child attains the age of 18 years.

2) Kanya Jagriti Jyoti Scheme

Kanya Jagriti Jyoti Scheme was launched in the year 1996-97 by Government of Punjab. It is implemented by the State Department of Social Security.

Eligibility Criteria

- Scheme is admissible to girl children born in BPL
- Parents should have adopted two child norm.

Benefits under the Scheme

- Rs. 5000/- is deposited at the time of birth of girl child with LIC
- Beneficiaries in the age group of 6-12 years and 12-18 years, are paid annual scholarship of Rs. 1200/- and 2400/-, respectively.
- Lump sum amount at the age of 18 or on 21 years as decided by the family.

3) Balri Rakshak Yojana/ Janani Suraksha Yojana

This is a state government funded scheme launched in 2005 by the Health and Family Welfare Department. The scheme was formulated against the backdrop of the worsening sex ratio in Punjab. It also has a strong component to motivate the couples to adopt the terminal method of sterilization in order to stabilize the growth rate of the population

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Objectives

The objectives of the scheme are to:

- promote the cause of girl child for correcting the skewed sex ratio;
- stabilize the population by motivating couples to adopt a terminal method of family planning;
- Reduce Infant Mortality Rate (IMR) by affecting a decline in the number of higher birth order.

Eligibility Criteria

- Eligible couple will have to open a joint account in the Post office and intimate the same to the civil surgeon.
- Couples within the child-bearing age group, upto 45 year for husband and 40 years for wife are covered under the scheme.
- The benefit will be available to the child/ children of those couples who have adopted terminal method and the age of the youngest child is less than 5 years.
- The birth of the child must have been registered with the appropriate birth registration authority within the stipulated period.
- The eligibility of the couple to receive monthly payment of incentive shall commence from the date of adoption of the terminal method of family planning.

Financial Benefits

- An incentive of Rs. 500 per month would be given to the female child provided the parents adopt terminal method of sterilization after the birth of the only girl.
- Similarly, an incentive of Rs. 700 per month will be available for two girls, provided the family adopts the terminal method of family planning after the birth of the second girl child.
- In case the couple is blessed with twin girls during the first delivery, a monthly incentive of Rs. 700 (350 for each) will be paid.
- The incentive will be available to the beneficiary till the age of 18, unless she becomes an income tax assesse.

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4) Devi Rupak Scheme

In order to stabilize the population in the State of Haryana and to check the declining trend in the sex ratio, apart from already existing spacing and permanent methods **"DEVI RUPAK"** or the Ch. Devi Lal Rashtriye Uttan Aivam Parivar Kalyan Yojana scheme was introduced on 25 September, 2002 in Haryana with the aim to sensitize the community towards the need of adopting one child norm and spacing of children.

Objective

It is a scheme to provide monthly incentive to eligible couples in order to stabilise the population of the State and to check the declining trend of CSR, adopting of one child norm and spacing of child birth.

Eligibility Criteria

- None of the partners constituting the couple should be an income tax payer.
- To be eligible under the scheme a couple would have to get themselves registered with the local Gram Panchayat/Municipal Committee within whose jurisdiction the couple ordinarily arises.
- Couples within age group of 45 years for male and 40 years for female irrespective of date of marriage.
- Benefit will be available after terminal method is adopted before the youngest child attains the age of 5 years.
- In case neither of the partners adopts a terminal method of family planning after the birth of the first girl child, then in order to be eligible for this scheme he/she will adopt a terminal method of family planning before the youngest girl child attains the age of 5 years.

Financial Benefits

Monthly incentives at the rates under the scheme (Table 17) up to 20 years from the date of adoption of terminal method of family planning by either of the partner of a couple are as follows:

Table 19: The Amount of Monthly Incentive

S.NO	STATE OF ADOPTION	INCENTIVE AMOUNT PER MONTH
1	At the birth girl child	Rs. 500
2	At the birth of first boy child	Rs.200
3	At the birth of second girl child (provided that the first child is a girl child)	Rs.200

5) Mukhyamantri Kanya Suraksha Yojna

Mukhyamantri Kanya Suraksha Yojana was initiated in July 2008 by the Social Welfare Department, the Women Development Corporation (WDC) and the UTI asset management company. It is operational in all 38 districts of Bihar and ensures the rightful place of pride in the society for a girl child, her safety and security. It also hopes to improve the sex ratio and encourage the registration of births.

Objectives

The main objectives of the Scheme are to:

- Benefit the girl child born in BPL families
- Improve education of girl child

Eligibility Criteria

- The Scheme is meant only for the families below poverty line.
- The benefit of the Scheme is available at the first two girl children, born on or after 22.11.2007 in the family.

Financial Benefits

- The State Government would invest Rs. 2,000/- for the first two girls in a family living under the Below Poverty Level (BPL) and born on or after November 22, 2007.
- The amount of Rs.2000/- will be invested by Women Development Corporation, Patna, Bihar on behalf Government of Bihar in UTI-Children's Career Balanced Plan-Growth Option.
- On completion of 18 years, the amount equal to the maturity value will be paid to the girl child (Rs. 18000/-).
- This money could be utilised for pursuing higher education or to start a small business if the girls wished to do so.
- In case of death of the girl child during the intervening period the amount will be paid back to WCD, Patna, Bihar.

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6) Nanda Devi Kanya Scheme

Uttarakhand Government is implementing the Nandadevi Kanya Scheme, aimed at ending the gender inequality and female foeticide.

Objective

The scheme has been launched to discourage child marriage, Gender Biased Sex Selective Elimination and to provide financial security to the girl child.

Eligibility Criteria

As per the scheme a girl child born after 1st January, 2009 in BPL families will be eligible.

Financial Benefits

- Under the scheme, newborn girl child from 'Below Poverty Line' families are given a fixed deposit cheque of Rs 5,000/-
- The benefit is payable to the maximum of two girl child's of the family.

7) Ladli Laxmi Yojana

The Ladli Laxmi Yojana Scheme was launched in Madhya Pradesh in the year 2006.

Objective

The objective of the scheme is to lay a firm foundation of a girl's future through improvement in their educational and economic status and bring about a positive change in social attitude towards birth of a girl.

Eligibility Criteria

- Extended to parents, who had adopted family planning after two live children.
- Registered at the anganwadi centre
- Non income tax payers

Financial Benefits

- At the time of registration of the girl child, the Government purchases a Rs. 6,000/- National Savings Certificate in the name of the child after her birth till the amount reaches 30,000.
- At the time of girl's admission in the sixth standard, Rs. 2,000/- and on admission in ninth standard Rs. 4,000/ - is paid to the girl child.
- When she gets admitted in the eleventh standard, she receives Rs.7,500/-.
- During her higher secondary education, she receives Rs. 200/- every month.
- On completion of 21 years, the girl receives the amount, which is Rs. 1,00,000/-.

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8) Sivagami Ammaiyar Memorial Girl Child Protection Scheme

The scheme has been launched by Government of Tamil Nadu and is implemented by Social Welfare & Nutritious Meal Programme Department in two types.

Objective

The main objective of the scheme is to provide financial assistance to the girl child belonging to poor families.

Eligibility Criteria

- Family income should be below Rs. 50,000/- per annum
- Either of the parents should have undergone sterilization within 35 years of age.
- Family should have only one/two female children and no male child. In future no male child should be adopted.

Financial Benefits

- ***Under Scheme-I –*** Fixed Deposit Receipt of Rs. 22,200/- in the name of girl child, in case of the family which has only one child.
- **Under Scheme-II –**Fixed Deposit Receipt for Rs. 15,200/- for each girl child where the family has two girl children.
- An amount of Rs. 150/- as monthly incentive shall be given to the girl child on completion of 5 years from the date of deposit and up to 20th year of deposit for her educational purpose.

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9) Bhagyalakshmi Scheme

In 2006-07, the Bhagyalakshmi Scheme was launched by the Government of Karnataka for the BPL families having upto 3 children.

Objectives

The main objective of the scheme is to promote the birth of girl child in economically weaker families.

Eligibility Criteria

- Scheme is restricted to two girl children.
- Benefit will be available if the father or mother of the beneficiary girl has undergone terminal family planning

methods so that the total number of children of the BPL family does not exceed three in the said family.

- The beneficiary must have completed 8th standard and not married before the age of 18 otherwise the maturity will be forfeited.
- If the beneficiary dies within 18 years, the amount will be forfeited.

Financial Benefits

- When the girl child is enrolled after due verification by the department, each girl child could be given an amount of Rs. 10,000/- deposited in her name in FD.
- The amount deposited in the financial institution will be maximised and paid along with interest to the beneficiary on her attainment of 18 years.
- Certain interim payments such as annual scholarships and insurance benefits will be made to the beneficiary on continued fulfilment of the eligibility criteria.

Class	Amount of Annual Scholarship
I - III	Rs. 300/- per annum for each class
IV	Rs. 500/-
V	Rs. 600/-
VI-VII	Rs. 700/-
VIII	Rs. 800/-
IX-X	Rs. 1000/-

10) Mahamaya Gareeb Balika Ashirwad Yojana

The State Government of Uttar Pradesh initiated the "Mahamaya Gareeb Balika Ashirwad Yojana" on 15 January, 2009 with the overall objective of improving the status of the girl child in the society.

Objectives

The main objectives of the scheme are to:

- check the falling sex ratio in the State;
- bring about a positive change in the attitude of people towards the birth of a girl child;
- make girls self-reliant and to enable them to live with dignity; and
- Supporting marriage of girls only on reaching adulthood.

Eligibility Criteria

- Girls born on or after 15 January, 2009 to parents who are native of Uttar Pradesh and belong to 'Below Poverty Line' (BPL) families.
- First girl child born in a BPL family will be a beneficiary.
- The second girl born in a BPL family, where even the first born child is also a girl, will also be a beneficiary.

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- In the event of birth of more than one girls during the first or second pregnancy of a woman belonging to BPL family, all such girl children shall be beneficiaries under the scheme.
- If a BPL family adopts a girl child and fulfils the other prescribed eligibility criteria, such a girl child shall be considered first daughter in the BPL family and shall be eligible for benefits under the scheme.
- The birth of the beneficiary girl child should have been registered in the Births & Deaths Register.

Financial Benefits

- The birth of the girl child has to be registered under the Scheme within one year of her birth.
- A lump-sum amount shall be fixed in a fixed deposit account in the name of the girl child for a period of 18 years.
- On maturity, the fixed deposit amount shall be Rs. One lakh, that shall be payable only to the beneficiary girl child if she is unmarried till the age of 18 years.

11) Delhi Ladli Scheme

Government of NCT of Delhi launched a scheme for protection of the girl child called the **Delhi Ladli Scheme**. This scheme is enforced in Delhi w.e.f. 01.01.2008.

Objective

The scheme aims at enhancing the social status of girl child in the society as well in the family, ensuring proper education to make the girls self-reliant, ensuring her economic security and protecting them from discrimination and deprivation.

Eligibility Criteria

- The applicant must be a bonafide resident of the National Capital Territory of Delhi for at least three years preceding the date of birth.
- The annual income of the parents of the girl child should not exceed Rs. 1,00,000/-
- The girl child must have been born in Delhi as shown by the birth certificate issued by Registrar (Births & Deaths).

Financial Benefits

- Financial Assistance under this scheme is restricted up to two girl children only in a family.

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- This scheme envisages periodic payments by the Govt. in name of the girl child, which would be kept as fixed deposit in her name and redeemed along with accrued interest when the child reaches 18 years of age and has passed the Xth class as a regular student.
- Payment for the child will be deposited in the following manner:-
    - Payment of Rs. 11,000/- if the girl child is born in a Hospital/ Nursing Home/institutions in the NCT of Delhi.
    - Payment of Rs. 10,000/- if the girl child is born outside the above mentioned Hospitals/ Nursing Homes/institutions.
    - Payment of Rs. 5000/- on admission of the child in Class I.
    - Payment of Rs. 5000/- on admission of the child in Class VI.
    - Payment of Rs. 5000/- on admission of the child in Class IX.
    - Payment of Rs. 5000/- on the child's passing the Class X.
    - Payment of Rs. 5000/- on admission of the child in Class XII.

- The amount disbursed to them at the end of lock-in-period will vary depending on the stage at which each girl child enters the scheme and registers under it.
- Financial arrangements for implementation of this scheme have been made with the SBI Life Insurance Company Ltd. and with the State Bank of India providing the front and services for accounting purposes.

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12) Beti Hai Anmol Scheme

'Beti Hai Anmol' scheme was initiated by the Department of Social Justice and Empowerment, Government of Himachal Pradesh.

Objective

The scheme aims at changing the negative attitude of society towards girl child, check child marriage and make girls self-dependant.

Eligibility Criteria

- All girls born belonging to the BPL families upto two girl children.

Financial Benefits

- After the birth, the department deposits Rs. 10,000/- per girl child in the post office/ bank account.

- These girls get scholarships ranging from Rs. 300 to Rs. 1200 from 1st to 12th class for their books and dresses.

13) Indira Gandhi Balika Suraksha Yojana

This scheme was introduced in 2007 by the Department of Health and Family Welfare, Government of Himachal Pradesh, with the following objective.

Objective

The objective of the scheme is to improve the deteriorating sex ratio, to encourage the small family norm and to promote gender equality.

Eligibility Criteria

The beneficiaries of the scheme are couples who adopt a permanent method of family planning after having one girl child or two girl children. There should not be any male child.

Financial Benefits

The Government will deposit Rs. 25,000 for one girl child in an interest bearing account that will be given to the girl at the age of maturity (18 years) and Rs. 20,000 will be deposited for those having two girls.

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Other Initiatives

Central Adoption Resource Authority (CARA)

- Central Adoption Resource Authority (CARA) is an autonomous body of the Ministry of Women & Child Development, Government of India.
  - It functions as nodal body for adoption of Indian children and is mandated to monitor and regulate in-country and inter-country adoptions.
  - CARA is designated as the Central Authority to deal with inter-country adoption in accordance with the provisions of the Hague Convention on Inter-country Adoption, 1993.
- CARA primarily deals with adoption of orphan, abandoned and surrendered children through its associated/recognised adoption agencies.

Vision

- To find loving and caring homes for all orphans, abandoned and surrendered children through family-based non- institutional services.

Objectives

- Function as a nodal body on non-institutional child care services in the country.
- Act as a Central Authority as envisaged under the Hague Convention on Inter-country Adoption.
- Facilitate and promote adoption of orphan, abandoned and surrendered children.
- Streamline adoption procedures and delivery systems.

Achievements of CARA

CARINGS (Child Adoption Resource Information & Guidance System)

- CARINGS is CARA's response for a transparent and friendly adoption process.
- It offers a more child-centric approach and is an online platform which helps in building bridges and creating a link through a robust web-based management system.
- It facilitates expeditious and smooth adoption, ensures transparency in the adoption process, increases accountability of implementing agencies, creates a network of stakeholders towards synergy and helps in maintaining a National database.

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- Central System of receiving inter-country adoptions dossiers has been operational since January 2012.
- Special needs module has been launched since June 2012.

CARA has taken up the following initiatives for expeditious adoptions:

Provisional registration for domestic adoption → **Inter-state adoption** → **Linkage of Recognised Indian Placement Agencies (RIPAs) with Specialised Adoption** → **Specialised Adoption Agencies (SAA) for rehabilitation of special needs children.**

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Guidelines Governing Adoption of Children 2011

- CARA guidelines have been revised from time to time.
- The last guidelines have become functional since June 2011. The guidelines are further under revision and the website is being updated regularly. Visit CARA website regularly.
- These guidelines contain roles and functions of various authorities and recognised agencies and step by step procedure of in-country and inter-country adoption for orphan, abandoned and surrendered children.

ROLE OF AWW/ASHA/ANM

- The health workers should be aware with all the schemes launched by other Ministries so that she can make the community well aware of the benefits of the schemes and help in convergence.
- She should survey the community to make sure that all the beneficiaries in the community are availing the services of the AWC.
- She should make sure that the children, pregnant and lactating women in the community are taken good care of.
- She should disseminate knowledge which will benefit the beneficiaries.
- She should share good and best practices within the community for the development of the girl child.
- AWW should be well aware about the cash benefits which the beneficiaries are eligible for during IGMSY/JSY.
- The AWW should make sure that she refers all special cases to ANM.
- The AWW should work together with ASHA for better implementation of schemes.

SESSION 3	SCHEMES/ PROGRAMMES BY MINISTRY OF HEALTH AND FAMILY WELFARE (MoHFW) SUPPORTING THE GIRL CHILD AND WOMEN
OBJECTIVE	To make the trainees aware about the various schemes of Ministry of Health and Family Welfare, implemented for welfare of the girl child and women
CONTENT	• Overview of the following schemes/programmes of MoHFW including target group/beneficiaries, provisions in the schemes/services offered - National Health Mission-An Overview ○ *Maternal Health* ✓ Janani Shishu Suraksha Karyakaram (JSSK) ✓ Janani Suraksha Yojana (JSY) ○ *New-Born and Child Health* ✓ Facility Based New-Born and Child Care ✓ Home Based New-Born Care (HBNC) ✓ Navjaat Shishu Suraksha Karyakram (NSSK) ✓ Routine Immunization Programme ✓ Rashtriya Bal Swasthya Karyakram (RBSK) ✓ Enhancing Optimal Infant and Young Child Feeding Practices (IYCF) through Health Systems ✓ National Iron Plus Initiative (for control of Iron Deficiency Anaemia across life stages) IFA and Deworming ✓ Nutrition Rehabilitation Centres (NRC) for treatment of Severely Acute Malnourished children ✓ Vitamin A Supplementation Programme ○ *Adolescent Health* ✓ Adolescent Reproductive & Sexual Health Programme (ARSH) ✓ Scheme for Promotion of Menstrual Hygiene ✓ Weekly Iron Folic Acid Supplementation (WIFS) ✓ Rashtriya Kishore Swasthya Karyakram (RKSK) ✓ National Iron Plus Initiative (NIPI) • Role of AWW/ASHA/ANM
DURATION	2 hours

TRAINING METHOD	Lecture cum discussion, group activity
LEARNING OUTCOME	• The trainees will gain insight into the provisions and services of various schemes by MOHFW thereby improving access to services. • They will be able to motivate community to avail the services for their benefit.
RESOURCES REQUIRED	• LCD projector • Power point presentation highlighting key components
ANNEXURES	• Leaflet on safe practices during menstruation (Hindi)
REFERENCES	• http://www.mohfw.nic.in/ • http://nrhm.gov.in/ • http://www.nihfw.org/ • http://mohfw.nic.in/showfile.php?lid=421

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FACILITATORS NOTES

Methodology

The session may begin with the introduction of Ministry of Health and Family Welfare and the contents that will be covered during the session.

Ask

- What is the role of MoHFW in improving the health status of children and women?
- Are you aware of the schemes or programmes running in your State?
- Approximately how many people or families in your community are being benefitted from the programmes and schemes?

The session may then progress to providing an overview about the NRHM scheme. The session should focus on the schemes related to maternal health like JSSK and JSY, discussing the objectives, entitlements, and provisions for financial assistance to the beneficiaries and their convergence with MWCD schemes.

A brain storming session with the trainees may include highlights of the programmes for adolescent girls, the trainer may conduct an activity on problems of adolescent girls and efforts made by GOI to curb the practice.

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Activity

Ask the participants to assemble into groups and discuss the following questions:

- Why are adolescents a special group?
- What are the problems faced by adolescents? And how can these problems be solved?
- What are the health risk factors for the adolescent girls?
- Are you aware of the programmes/ schemes designed for adolescents?
- How have you spread awareness about IFA Supplementation in your community?

The trainer may discuss about new-born and child health schemes and target the components, services of schemes like Facility Based New-born Child Care, Home Based Neonatal Care (HCNC), Navjaat Shishu Suraksha Karyakram (NSSK), Routine Immunization Programme (RIP), and Rashtriya Bal Swasthaya Karyakaram (RBSK).

The trainer may discuss the points at large with the trainees and highlights the objectives, services provided, importance, benefits that can be availed from the various schemes like ARSH, Menstrual Hygiene Scheme (refer ***Annexure-25*** for good practices during

menstruation), Weekly Iron Folic Acid Supplementation (WIFS), Rashtriya Kishore Swasthaya Karyakram (RKSK), Iron plus initiative for the children, adolescent girls and women. The trainer should discuss the various norms and recommendations for supplementation as per the MoHFW.

The session may conclude with discussion the role of the health workers and fulfilling any gaps in the training.

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CONTENTS FOR TRAINERS

National Health Mission

National Health Mission (NHM) encompasses two Sub-Missions, National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). It is both flexible, dynamic and is intended to guide States towards ensuring the achievement of universal access to health care through strengthening of health systems, institutions and capabilities.

NHM provides emphasis on strategies for improving maternal and child health through a continuum of care and the life cycle approach. The inextricable linkages between adolescent health, family planning, maternal health and child survival have been recognized. The strategy is to increase knowledge and access to reproductive health services and information for adolescents and to address nutritional anaemia.

NHM includes all schemes and programmes that are constituted under RCH-II. All these aspects are embodied in the 'Strategic Approach to Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCH+A) in India'. The main strategies for RMNCH+A include services for mothers, new-borns, children, adolescents and women and men in the reproductive age group.

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Reproductive Health

- Focus on spacing methods, particularly PPIUCD at high case load facilities
- Focus on interval IUCD at all facilities including subcentres on fixed days
- Home delivery of Contraceptives (HDC) and Ensuring Spacing at Birth (ESB) through ASHAs
- Ensuring access to Pregnancy Testing Kits (PTK-"Nischay Kits") and strengthening comprehensive abortion care services.
- Maintaining quality sterilization services.

Maternal Health

- Use MCTS to ensure early registration of pregnancy and full ANC
- Detect high risk pregnancies and line list including severely anemic mothers and ensure appropriate management.
- Equip Delivery points with highly trained HR and ensure equitable access to EmOC services through FRUs; Add MCH wings as per need
- Review maternal, infant and child deaths for corrective actions
- Identify villages with low institutional delivery & distribute Misoprostol to select women during pregnancy; incentivize ANMs for domiciliary deliveries

Newborn Health

- Early initiation and exclusive breastfeeding
- Home based newborn care through ASHA
- Essential Newborn Care and resuscitation services at all delivery points
- Special Newborn Care Units with highly trained human resource and other infra structure
- Community level use of Gentamycin by ANM

Child Health

- Complementary feeding, IFA supplementation and focus on nutrition
- Diarrhoea management at community level using ORS and Zinc
- Management of pneumonia
- Full immunization coverage
- Rashtriya Bal Swasthya Karyakram (RBSK): screening of children for 4Ds' (birth defects, development delays, deficiencies and disease) and its management

Adolescent Health

- Address teenage pregnancy and increase contraceptive prevalence in adolescents
- Introduce Community based services through peer educators
- Strengthen ARSH clinics
- Roll out National Iron Plus Initiative including weekly IFA supplementation
- Promote Menstrual Hygiene

Figure 13: RMNCHA + Interventions

Maternal Health Schemes

Janani Shishu Suraksha Karyakaram (JSSK)

In view of the struggles faced by the pregnant women and parents of sick new- born children, along-with high expenses incurred by them on delivery and treatment of sick- new-born, Government of India (MoHFW) has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The key features of the scheme are:

- All pregnant women delivering in public health institutions have access to absolutely free and no expense delivery including Caesarean section in Government health institutions in both rural & urban areas.
- The initiative stipulates free drugs, diagnostics, blood and diet (free diet up to 3 days during normal delivery and up to 7 days for C-section), besides free transport from home to institution, between facilities in case of a referral and drop back home.
- Similar entitlements have been put in place for all sick new-borns accessing public health institutions for treatment till 30 days after birth. This has now been expanded to cover sick infants.
- All the States and UTs have initiated implementation of the scheme.

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Table 20: Entitlements under JSSK

FREE ENTITLEMENTS FOR PREGNANT WOMEN	FREE ENTITLEMENTS FOR SICK NEW-BORNS TILL 30 DAYS AFTER BIRTH
✓ Free delivery	✓ Free treatment
✓ Free C-Section	✓ Free drugs and consumables
✓ Free drugs and consumables	✓ Free diagnostics
✓ Free diagnostics	✓ Free provision of blood
✓ Free diet during stay in the health institutions	✓ Exemption from user charges
✓ Free provision of blood	✓ Free transport from home to health institutions
✓ Exemption from user charges	✓ Free transport between facilities in case of referral
✓ Free transport from home to health institutions	✓ Free drop Back from Institutions to home
✓ Free transport between facilities in case of referral	
✓ Free drop back from Institutions to home after 48hrs stay	

Janani Suraksha Yojana (JSY)

- JSY was launched in April 2005 by modifying the National Maternity Benefit Scheme (NMBS).
- Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the NRHM. It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women.
- The scheme is under implementation in all States and Union Territories (UTs), with a special focus on Low Performing States (LPS) like Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu and Kashmir.
- JSY is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care.
- ASHA, AWW and TBAs are engaged in providing the services associated with the Yojana.

Table 21: Eligibility for Cash Assistance

Eligibility	
Low Performing States (LPS)	Available to all women regardless of age and number of children for delivery in government/private accredited health facilities
High Performing States (HPS)	Available only to BPL/SC/ST women regardless of age and number of children for delivery in government/private accredited health facilities
Home Delivery	Available only to BPL women who prefer to deliver at home regardless of age and number of children

Table 22: Financial Assistance for Institutional Delivery

Scale						
Category	**Rural area**			**Urban area**		
	Mother package (Rs.)	ASHA package (Rs.)	Total (Rs.)	Mother package (Rs.)	ASHA package (Rs.)	Total (Rs.)
LPS	1400	600	2000	1000	400	1400
HPS	700	600	1300	600	400	1000
Financial Assistance for Home Delivery						
LPS	**500**	**NIL**	**500**	**500**	**NIL**	**500**
HPS	**500**	**NIL**	**500**	**500**	**NIL**	**500**

(Source: Order No. Z.14018/1/2012-JSY dated 13th May, 2013)

Disbursement of Cash Assistance
For pregnant women going to a public health institution for delivery, entire cash entitlement should be disbursed to her in one go, at the health institution. Considering that some women would access accrediting private institution for antenatal care, they would require some financial support to get at least 3 ANCs including the TT injections. In such cases, at least three-fourth (3/4) of the cash assistance under JSY should be paid to the beneficiary in one go, importantly, at the time of delivery.

New-Born & Child Health Interventions

Facility Based New-born and Child Care

To address the issues of higher neonatal and early neonatal mortality, facility based new-born care services at health facilities have been emphasized. It includes following:

Special New-born Care Units (SNCU)

- States have been asked to set up at least one SNCU in each district. SNCU is 12-20 bedded unit and requires 4 trained doctors and 10-12 nurses for round the clock services.

New-born Stabilization units (NBSUs)

- NBSUs are established at community health centres /FRUs. These are 4 bedded units with trained doctors and nurses for stabilization of sick new-borns.

New-Born Care Corners (NBCCs)

- These are 1 bedded facility attached to the labour room and Operation Theatre (OT) for provision of essential new-born care. NBCC at each facility where deliveries are taking place should be established.

Home Based New-Born Care (HBNC)

- Launched in 2011 by MoHFW, GOI to provide framework and guidance to enable a coherent home based new-born care strategy and act a reference tool for the states to plan necessary interventions.
- Scheme has been launched to incentivize ASHA for providing Home Based New-born Care. ASHA will make visits to all new-borns according to specified schedule up to 42

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days of life. The proposed incentive is Rs. 50 per home visit of around one hour duration, amounting to a total of Rs. 250 for five visits. This would be paid at one time after 45 days of delivery, subject to the following :

- recording of weight of the new-born in MCP card
- ensuring BCG , 1st dose of OPV and DPT vaccination
- both the mother and the new-born are safe till 42 days of the delivery, and
- registration of birth has been done

Navjat Shishu Suraksha Karyakram (NSSK)

- NSSK is a programme aimed to train health personnel in basic new-born care and resuscitation, has been launched to address care at birth issues i.e. prevention of hypothermia, prevention of infection, early initiation of breast feeding and basic new-born resuscitation.
- The objective of this new initiative is to have a trained health personal in basic new-born care and resuscitation at every delivery point.
- The training is for 2 days and is expected to reduce neonatal mortality significantly in the country.

Routine Immunization Programme

- Immunization Programme is one of the key interventions for protection of children from life threatening conditions, which are preventable.
- Immunization Programme in India was introduced in 1978 as Expanded Programme of Immunization (EPI).
- The programme gained momentum in 1985 and was expanded as Universal Immunization Programme (UIP) to be implemented in phased manner to cover all districts in the country by 1989-90.
- Under the Universal Immunization Programme, Government of India is providing vaccination to prevent seven vaccine preventable diseases i.e., Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B.
- In addition, Japanese Encephalitis (JE vaccine) vaccine was introduced in 112 endemic districts in campaign mode in phased manner from 2006-10 and has now been incorporated under the Routine Immunization Programme.

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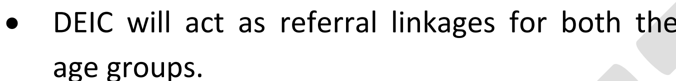
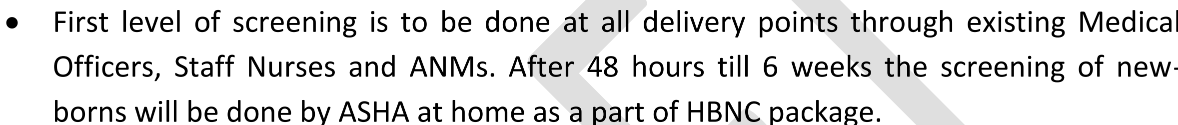
Rashtriya Bal Swasthya Karyakram (RBSK)

- Rashtriya Bal Swasthya Karyakram (RBSK) is an initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. defects at birth, deficiencies, diseases, development delays including disability.
- 0-6 year's age group will be specifically managed at District Early Intervention Center (DEIC) level while for 6-18 years age group, management of conditions will be done through existing public health facilities.
- DEIC will act as referral linkages for both the age groups.



- First level of screening is to be done at all delivery points through existing Medical Officers, Staff Nurses and ANMs. After 48 hours till 6 weeks the screening of new-borns will be done by ASHA at home as a part of HBNC package.



- Outreach screening will be done by dedicated mobile block level teams for 6 weeks to 6 years at AWCs and 6-18 years children at school.
- Once the child is screened and referred from any of these points of identification, it would be ensured that the necessary treatment/intervention is delivered at zero cost to the family.

Promotion of Infant & Young Child Feeding (IYCF) Practices by Health Department

- The key reasons for malnutrition setting in early in life is the faulty and sub-optimal infant and young child feeding practices, which is further compounded by factors such as repeated episodes of childhood illnesses and low birth weight.
- Looking at the national scenario of child malnutrition, it is apparent that early preventive action is crucial for accelerating reductions in infant and young child under-nutrition and related mortality, on a large scale.
- Large scale scientific evidence recommends specifically the promotion of infant and young child feeding practices as a major intervention that impacts morbidity and child mortality and promotes optimum growth & development.
- Now there has been evidence on importance of nutrition and IYCF in eminent scientific publications such as Lancet which says that 13% of under-five mortality can be prevented by exclusive breastfeeding and around 6 % can be prevented through adequate complementary feeding.
- Optimum growth in the first 1000 days of life is also essential for prevention of overweight.
- Adding to the role which traditionally belongs to ICDS, Health Department has taken proactive intervention and launched IYCF promotion guidelines through Health

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Department where there is a provision of RMNCHA counsellor at all high case load facilities of counselling and support to mothers including breastfeeding and feeding during infancy and proactive efforts on breastfeeding and correct infant feeding through ASHA at village level under Home Based New-born Care programmes and growth monitoring and counselling during routine immunization sessions and also utilising any contact of child with health services for counselling on IYCF practices.

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National Iron Plus Initiative for Control of Iron Deficiency Anaemia across Life Stages (IFA And Deworming)

National Iron plus Initiative has been launched to undertake supervised administration of IFA syrup in under five children. This initiative has brought together existing programmes (IFA supplementation for: pregnant and lactating women and; children in the age group of 6–60 months) and introduce new age groups.

- The National Iron+ Initiative also defines a minimums service of packages for treatment and management of anaemia across levels of care.
- It is an attempt to look at Iron Deficiency Anaemia comprehensively across all life stages including adolescents and women in reproductive age group who are not pregnant or lactating.
- Under National Iron+ Initiative, age groups given in Table -21 are covered for lifelong supplementation of Iron from the age of 6 month onwards.
- In young children, iron deficiency is due to increased iron requirement during periods of rapid growth.
- In addition, infant and toddler diets are often poor in bio-available iron, particularly post weaning.
- Children who suffer from anaemia have delayed psychomotor development and impaired performance; in addition they have 5–10 point deficits in intelligence quotient.
- Iron deficiency can cause significant central nervous system (CNS) damage even in the absence of anaemia. There seems to be a vulnerable period for these damages particularly between 9 and 18 months of age.
- Under National Iron+ Initiative, the following age groups are covered for lifelong supplementation of Iron from the age of 6 month onwards:
    - Bi-weekly 20 mg elemental iron and 100 microgram (mcg) folic acid per ml of liquid formulation and age appropriate de-worming for preschool children of 6-59 months.
    - Weekly supplementation of 45 mg elemental iron and 400 mcg folic acid per child per day for children from 1st to 5th grade in Govt. & Govt. Aided schools, and at AWC for out of school children (6 to 10 years).
    - Weekly dose of 100 mg elemental iron and 500 mcg folic acid with biannual de-worming in adolescents (10–19 years) under WIFS

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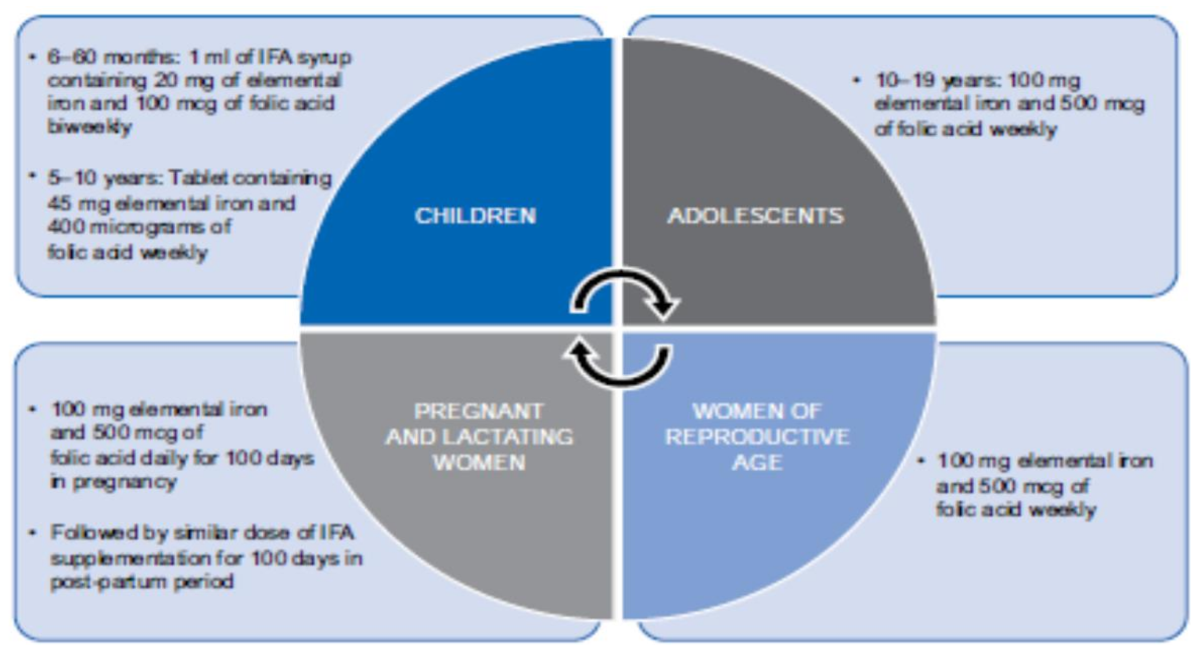

Supplementation for Children 6–60 Months as Per GOI Guidelines

- One ml of IFA syrup containing 20 mg of elemental iron and 100 mcg of folic acid biweekly for 100 doses in a year. Iron folic acid supplements be supplied in bottles of 100 ml each and composition, preparation dose and duration of IFA supplementation will remain same as the existing guidelines.
- The bottle comes with an auto-dispenser so that only 1 ml of syrup will be dispensed at a time.
- Albendazole tablets will be provided to children for biannual de-worming, with dose half tablet between 1-2 years age and full tablet from the age of 2 years onwards.
- For implementation among all children aged 6 to 60 months it is proposed that IFA supplement will be administered under the direct supervision of ANM/ASHA on fixed days on a biweekly basis.
- The micro plan for reaching out to these children can be worked out at village level. It is recommended that a particular child should receive the supplement on the fixed day (Monday and Thursday), though it can vary for the groups of children depending on the home visits schedule prepared at block/district level. The nutritional status of children should be assessed by MUAC (Mid Upper Arm Circumference less than 11.5 cm) to ensure that IFA syrup is not given to children with Severe Acute Malnutrition (SAM).
- ANM/ASHA would give IFA syrup bottles to mothers for safe storage and to lessen the logistic hurdle of carrying bottles around, but the IFA syrup will be administered under her direct supervision only.
- During the visits, the ANM/ASHA will also advise/inform the caregiver about the following issues:

- Time of administration – half an hour after food if the child has been breastfed (in LBW infants)/fed semisolid/solid food
- Benefits of regular intake of IFA syrup in physical and cognitive development of the child e.g. improvement in well-being, attentiveness in studies and intelligence etc.
- Minor side effects associated with IFA administration such as black discolouration of stools.
- Preservation of IFA bottle – in a cool and dark place, away from reach of children, keeping the lid of the bottle tightly closed each time after administration, etc.
- IFA supplementation should be recorded in the Mother and Child Protection (MCP) Card.

Table 23: Supplementation Recommendation

Age Group	Intervention/Dose	Regime	Service Delivery
6-60 months	1 ml of IFA syrup containing 20 mg of elemental iron and 100 mcg of folic acid	Biweekly throughout the period 6–60 months of age and de-worming for children 12 months and above	Inclusion in MCP card Through ASHA/ ANM
5–10 years	Tablets of 45 mg elemental iron and 400 mcg of folic acid	Weekly throughout the period 5–10 years of age and biannual de-worming	In school through teachers and for out-of school children through AWC
10–19 years	100 mg elemental iron and 500 mcg of folic acid	Weekly throughout the period 10–19 years of age and biannual de-worming	In school through Teachers and for those out-of-school through AWC
Pregnant and lactating women	100 mg elemental iron and 500 mcg of folic acid	1 tablet daily for 100 days, starting after the first trimester, at 14–16 weeks of gestation. To be repeated for 100 days post-partum	ANC/ ANM /ASHA Inclusion in MCP Card

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Women in reproductive age (WRA) group	100 mg elemental iron and 500 mcg of folic acid	Weekly throughout the reproductive period	Through FHW during house visit for contraceptive distribution

Nutritional Rehabilitation Centres (NRCs)

- Under National Rural Health Mission which is now termed as National Health Mission, Nutrition Rehabilitation Centers (NRCs) have been set up at health facilities in many districts. Currently 875 such centres are functional in 23 States

- Since 2005, Nutritional Rehabilitation Centres are being set up in Health facilities across various States under NRHM for treatment and rehabilitation of sick Severe Acute Malnourished (SAM) children. It is estimated that India has around 8 million SAM children, among them 10% are sick cases requiring facility based treatment.
- Children with Severe Acute Malnutrition (SAM) have nine times higher risk of dying than well-nourished children.

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Objectives of NRCs:

- To provide clinical management and reduce mortality among children with severe acute malnutrition, particularly among those with medical complications.
- To promote physical and psycho-social growth of children with severe acute malnutrition (SAM).
- To build the capacity of mothers and other care givers in appropriate feeding and caring practices for infants and young children
- To identify the social factors that contributed to the child slipping into severe acute malnutrition

Services at NRCs:

- 24 hour care and monitoring of the child.
- Treatment of medical complications.
- Therapeutic feeding.

- Providing sensory stimulation and emotional care.
- Social assessment of the family to identify and address contributing factors.
- Counseling on appropriate feeding, care and hygiene.
- Demonstration and practice- by -doing on the preparation of energy dense child foods using locally available, culturally acceptable and affordable food items.
- Follow up of children discharged from the facility.
- Children are admitted as per the defined admission criteria and provided with medical and nutritional therapeutic care. Once discharged from the NRC, the child continues to be in the Nutrition Rehabilitation program till she/he attains the defined discharge criteria from the program.
- In addition to curative care, special focus is given on timely, adequate and appropriate feeding for children; and on improving the skills of mothers and caregivers on complete age appropriate caring and feeding practices. In addition, efforts are made to build the capacity of mothers/caregivers through counselling and support to identify the nutrition and health problems in their child.

Vitamin A Supplementation Programme

- In 1970, the National Prophylaxis against nutritional blindness was initiated as a centrally sponsored scheme. Under this scheme, all children between ages of one and three years were to be administered 2,00,000 IU of vitamin A orally once in six month. In 2005, an expert group chaired by Indian Council of Medical Research, endorsed 9 months to 3 years as the target age group for universal vitamin A supplementation (UVAS).
- In 2006 the age group was broadened to include children between 6 months and 5 years after reconsidering recommendations of the WHO, UNICEF and Ministry of Women and Child Development.
- To prevent deficiencies of Vitamin A in children in the age of 6month to 5 years, Vitamin A solution is supplied up to sub-centre level.
- The ANM is responsible for administering the doses of Vitamin A to children of age 6 month to 59 month. 1st dose (1 lakh International Units of Vitamin A) is being given to the child at the time of immunization at 9 months of age, and thereafter, the child has to be administered dose of Vitamin A (2 lakh International Units of Vitamin A) at 6 monthly interval, so that a child receives 9 doses of Vitamin A till the age of 59 months.

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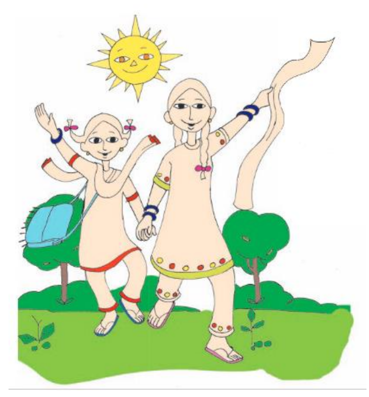
Schemes for Adolescent Girls

Adolescent Reproductive & Sexual Health (ARSH)



- The National Adolescent Reproductive and Sexual Health strategy provides a framework for a range of sexual and reproductive health services to be provided to the adolescents.
- The strategy incorporates a core package of services including preventive, promotive, curative and counselling services. Effective implementation of policies and programmes has progressed from the past few years and has led to strengthening of Adolescent Friendly Clinics and subsequently the outreach programmes.

Preventive Services	Promotive Services	Curative Services	Referral Services	Outreach Services
•Services for Tetanus Immunization •Services for Prophylaxis against Nutritional Anaemia •Nutrition Counselling •Services for early and safe termination of pregnancy and management of post abortion complications	•Focused care during the ante-natal period •Counselling and provision for emergency contraceptive pills •Counselling and provision of reversible contraceptives •Information/advice on SRH issues	•Treatment for common RTIs/STIs •Treatment and counselling for menstrual disorders •Treatment and counselling for sexual concerns •Management of sexual abuse among girld	•Voluntary Counselling and Testing centre •Prevention of Parent to Child Transmission	•Periodic health check-ups and community camps •Periodic health education activities •Co-curricular activities

Figure 14: Services covered under ARSH

- The package of services is to be made available for all adolescents, married and unmarried girls and boys.
- The ARSH services can be delivered in health centres, in the community, through outreach services or at school.
- Actions are to be taken to ensure that adolescents are well informed about the availability of health services. Communication activities are to be carried out at the level of village outreach, AWC, and/or youth group. Such group communications are to be carried out once a month by ANM, ASHA, AWW, Youth Coordinator and/or link worker.

Communication activities are to cover topics related to:

- BCC on delaying marriage and first pregnancy, importance of spacing, fertility awareness, menstrual hygiene, care during pregnancy
- Risk reduction counselling on RTIs/STIs and HIV/AIDS prevention
- Nutrition education on balanced diet, sign and symptoms of common nutritional deficiencies like anaemia
- Immunization and importance of TT
- Prevention and management of unwanted pregnancy
- Gender relations and role of men
- Adverse sex ratio and related legislations on sexual abuse and violence

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Scheme for the Promotion of Menstrual Hygiene

- The scheme aims at ensuring that adolescent girls (10-19 years in rural areas) in the target group have adequate knowledge and information about menstrual hygiene and the use of sanitary napkins, that high quality, safe products are made available to them, and that environmentally safe disposal mechanisms are readily accessible.

- The pilot is being implemented in 152 districts across 20 States in the country.
- Procurement of sanitary napkins, whether through central supply by the Government of India, or through SHGs, has to be done at a fixed price of Rs. 7.50/- per pack of six sanitary napkins.
- The sanitary napkin packs (containing 6 pieces each) is branded as ‘Freedays’. These napkins are being sold to adolescents girls at the rate of Rs. 6 per pack of six napkins by ASHAs. The ASHA gets an incentive amount of Re. 1 per pack, besides getting a free pack of sanitary napkins per month and the balance Rs. 5 is to be deposited in the State/district treasury. Supply of sanitary napkins in 107 districts initially is being done in a Central supply mode, wherein sanitary napkins are being supplied by the Government of India. The supply of sanitary napkins in the remaining 45 districts is to be done through Self Help Groups (SHG), wherein SHGs are to manufacture the sanitary napkins that are to be sold to adolescent girls.

Table 24: Operationalization of the Programme at the District & Sub-District Level

Step 1:	Sanitary napkins are supplied to the block warehouse. Storage will need to be organised by states at the block level. Such storage needs to be clean, dry, rodent-free and secure.
Step 2:	The ANM will collect the sanitary napkins from the block during her monthly meeting visit and transport it to the Sub-Centre. Even when packaged for delivery at the level of the PHC, the commodity is lightweight but bulky, needing adequate space which is free of moisture and pests/rodents. It will be stored at the Sub-Centre or at a place rented for this particular purpose, if the space in the Sub-Centre is insufficient. Such storage will need to be organised by States.
Step 3:	The ANM will provide the ASHA with a one-time imprest fund of Rs. 300 (or more if decided by the State Steering Committee) which she will take from the untied funds pool of the Sub-Centre.
Step 4:	The ASHA will use the imprest funds to purchase sanitary napkins from the ANM. ASHA will also get a pack of sanitary napkins free every month for her own use to be able to become an effective change agent
Step 5:	The ASHA will sell sanitary napkins to the adolescent girls at a price decided by the Government.
Step 6:	In case ASHA is selling the sanitary napkin packs, she will retain an incentive for every pack sold, the incentive amount being decided by the State Steering Committee.
Step 7:	The ASHA will retain the amount recovered from the sale to replenish the imprest amount which the ASHA will use for subsequent purchase.
Step 8:	The ANM will deposit the funds obtained from the sale of napkins to the ASHA in the united funds of the Sub-Centre.
Step 9:	These funds will be used for meeting the costs of transportation from Block to Sub-Centre and then to the village and rental to store the sanitary napkins at the Sub-Centre level if required.
Step 10:	The balance fund, if any after, meeting the above costs will be returned to the District Health Society through the block. The District Health Society should use these funds for programmes for adolescents.

Weekly Iron Folic Acid Supplementation (WIFS) Programme

- The main objective of WIFS programme is to reduce the prevalence and severity of nutritional anaemia in adolescent population (10-19 years).
- It is implemented to the following two target groups in both rural and urban areas:
    a. Adolescent girls and boys enrolled in government/government aided/municipal schools from 6th -12th classes.
    b. Adolescent girls who are not in school.

3. The WIFS programme covers married, pregnant and lactating adolescent girls.
4. Under this programme, IFA supplements are to be distributed free of cost on a weekly basis to the target groups. In addition to IFA supplements, Albendazole tablets for de-worming are to be administered twice a year to the same target groups.
    a. Administration of Weekly Iron and Folic Acid Supplementation (WIFS). Each IFA tablet containing 100 mg elemental iron and 500 µg folic acid for 52 weeks in a year

b. Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.
c. Biannual de-worming (Albendazole 400mg), six months apart, for control of worm infestation.
d. Information and counseling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

5. The WIFS strategy involves a "fixed day'' approach for WIFS distribution and to ensure high compliance supervised consumption of the IFA tablets.
6. In ICDS, Out-of-school adolescent girls in the age group of 10-19 years (married and unmarried) will be provided IFA and Albendazole tablets free of cost under the SABLA through the AWC.
7. In non SABLA districts, the programme will be implemented through the ICDS mechanism.
8. Annual supplies of IFA and deworming tablets received should be stored in a clean, dry and dust free area away from the direct sunlight.
9. AWW, ICDS helper and ASHA will also be supplied IFA tablets for weekly consumption these frontline workers will be encouraged to consume the supplement in the presence of the girls.

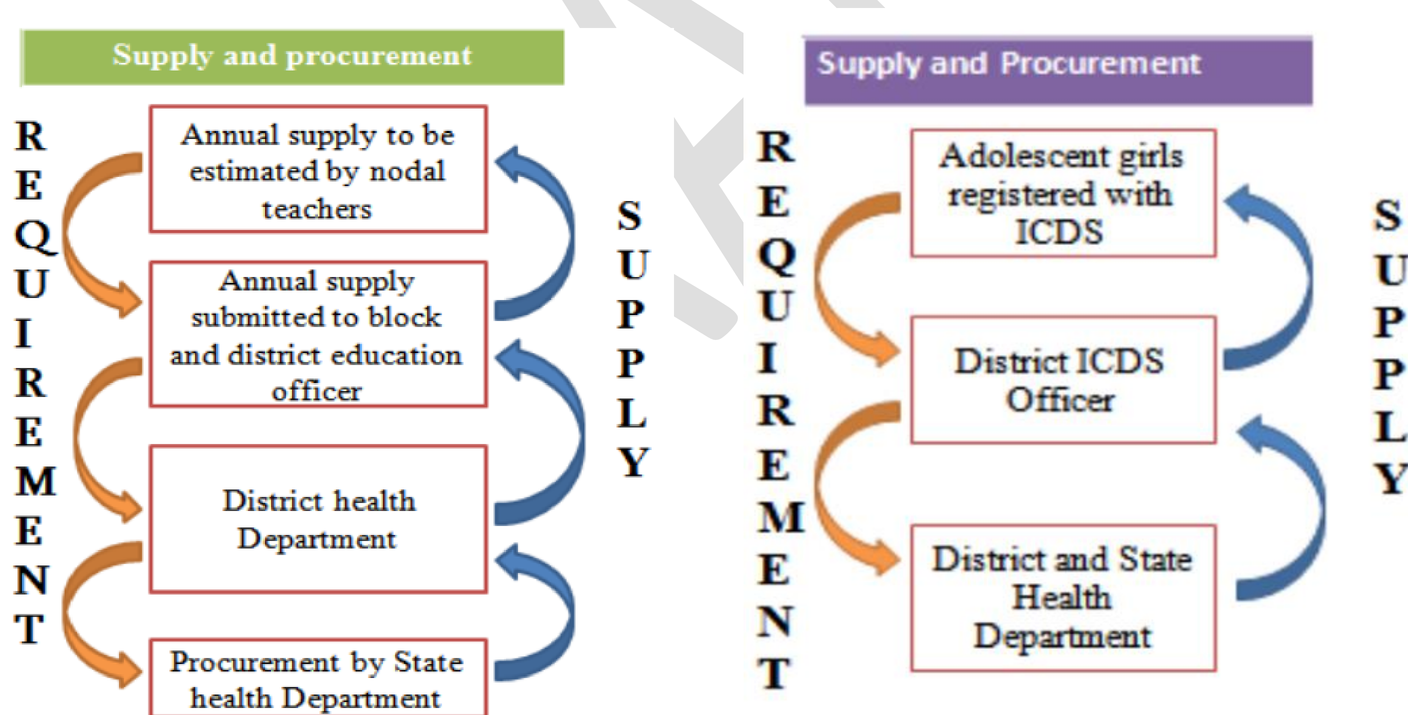

Figure 15: Supply & Procurement at School & ICDS Level

Rashtriya Kishor Swasthya Karyakram (RKSK)

The programme envisages strengthening of the health system for effective communication, capacity building and monitoring and evaluation. Further, RKSK underscores the need for several constituencies to converge effectively and harness their collective strength to respond to adolescent health and development needs. The strategy seeks to achieve the following objectives:

- Improve nutrition by
  - reducing the prevalence of malnutrition and iron deficiency anaemia
- Enable sexual and reproductive health-
  - Improve knowledge, attitudes and behaviour, in relation to SRH
  - Reduce teenage pregnancies
  - Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents
- Enhance mental health
  - Address mental health concerns of adolescents
- Prevent injuries and violence
  - Promote favourable attitudes for preventing injuries and violence (including Gender Based Violence (GBV)) among adolescents
- Prevent substance abuse
  - Increase adolescents' awareness of the adverse effects and consequences of substance misuse
- Address conditions for Non-communicable Diseases (NCDs)
  - Promote behaviour change in adolescents to prevent NCDs, such as , hypertension, stroke, cardio-vascular diseases, diabetes and cancer

- The strategy focuses on age groups 10-14 years and 15-19 years with universal coverage, i.e. males and females; urban and rural; in school and out of school; married and unmarried; and vulnerable and under-served.
- Strategies for achieving the objectives of the adolescent health program are:
  - Celebration of *Adolescent Health Day* in every village once every quarter on a convenient day (preferably on a Sunday) following the VHND, in Sabla districts, this day should coincide with the existing Kishori Diwas.
  - Adolescent Friendly Health Clinics (AFHCs) - to provide a combination of commodities like WIFS, Sanitary napkins, contraceptives, medicines etc., IEC &

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IPC along with curative services like treatment of severe malnutrition, treatment of common RTI/STI problems, treatment of menstrual disorders etc.

- Adolescent Helpline – to seek health related information as well as grievance redressal cell for public at large and service providers.
- Convergence within Health Department/ with other Departments & Programmes.
- Capacity Building, communication and strengthening role of parents are other strategies

Mother and Child Tracking System

It has been decided to have a name-based tracking system (being put in place by Government of India, MoHFW) whereby pregnant women and children can be tracked for their ANCs and immunisation along with a feedback system for the ANM, ASHA etc., to ensure that all pregnant women receive their Ante-Natal Care Check-ups (ANCs) and post-natal care (PNCs); and further children receive their full immunisation.

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ROLE OF AWW/ASHA/ANM

- Create awareness and educate the target groups about the various schemes, programmes and facilitate its access.
- Ensure convergence and participate in the various programmes and schemes of MoHFW with MWCD.
- Encourage people, especially, adolescent girls and parents to participate in the programmes and act as peer educator.
- Ensure the provision of MCP Card with all the eligible mothers.
- To guide ASHA engaged in the delivery of health care services
- To assist in implementation of SABLA, Kishori Shakti Yojana (KSY), and VHND and motivate and educate the adolescent girls and their parents and community in general by organizing social awareness programmes/ campaigns etc.
- Ensure the participation of Medical Officers, ASHA and ANM in Immunization programmes, VHND and other related programmes.
- There should be Joint Meetings with the MO and the CDPO.
- AWW can function as depot holder for RCH Kit/contraceptives and disposable delivery kits. However, actual distribution of delivery kits or administration of drugs, other than OTC (Over the Counter) drugs would actually be carried out by the ANM or ASHA as decided by the Ministry of Health & Family Welfare.
- Identify the disability among children during her home visits and refer the case immediately to the nearest PHC or District Disability Rehabilitation Centre.
- Support in organizing Pulse Polio Immunization (PPI) drives and assist ANM in the administration of IFA and deworming.
- Inform or refer in case of emergency cases like diahorrea, cholera etc. and health centre.

<table>
<tr><th>SESSION 4</th><th>NEED AND IMPORTANCE OF COMMUNITY PARTICIPATION & COMMUNITY MOBILIZATION</th></tr>
<tr><td>OBJECTIVE</td><td>To guide the trainees understand the role of the community in implementing a programme and techniques to elicit community participation/mobilization
To define roles and responsibilities of various sectors in order to create a safe environment and converge with other field functionaries
Help improve Child Sex Ratio</td></tr>
<tr><td>CONTENT</td><td>Define the process of community participation & community mobilization
Methods and techniques of knowing the community-their customs, traditions and practices etc.
Role of community in improving Child Sex Ratio
Strengthening community participation using PLA techniques
Roles and responsibilities of line Ministries
Role of PRI's in improving CSR
Role of Gram Sabha in improving CSR
Role of Mahila Sabha in improving CSR
Role of Child Friendly Anganwadi Centres
Role of Schools
Role of AWW/ASHA/ANM</td></tr>
<tr><td>DURATION</td><td>1 hour 30 minutes</td></tr>
<tr><td>TRAINING METHOD</td><td>Power point presentation, lecture, demonstration (PLA techniques) and focused group discussions</td></tr>
<tr><td>LEARNING OUTCOME</td><td>The trainees will be able to mobilise the community and elicit their participation.
Trainees will be able to take corrective measures to promote value of girl child and improve Child Sex Ratio (CSR) in their communities
The trainees will be well versed with the roles of various ministries in improving CSR and help in effective convergence</td></tr>
<tr><td>RESOURCES REQUIRED</td><td>LCD projector
Power point presentation highlighting key components</td></tr>
<tr><td>ANNEXURES</td><td>Community Mobilisation
Tips for effective PLA exercises</td></tr>
</table>

FACILITATORS NOTES

Methodology

The trainer may begin the session by a brain storming exercise to help establish rapport with the trainees. This will also help trainees assess the problem in their community.

Ask

- What is Community?
- What do you understand by community participation and mobilisation?
- Why Community Participation is essential? Cite examples of community participation in their area?

The trainer may then discuss the importance of community participation concentrating on community, importance of community mobilization, community organization etc. and highlight the role of community in the implementation of any programme. The trainer may refer the hand out for better understanding of the concept of Community mobilization (***Annexure-26***).

- What are the common issues that are faced by the girl child in your community?
- What initiatives have been taken to address the same?

Ask

Trainer may explain using responses provided by the trainees, how community participation can help in improving the status of the girl child. Trainer may plan exercises to explain PLA techniques used for community participation. The trainer can provide hand out on tips for effective PLA techniques to the trainees **(*Annexure-27*).** The trainer should then focus on how the grass root level workers can mobilize the community to participate in government programmes.

Ask

- How can the community improve status of girl child?

In session, the trainer may then discuss the need for creating a safe and enabling environment for the girl child and the need for having girl child friendly schools. The trainer can then focus on various strategies needed to achieve the same.

Ask

- How can various forums e.g. ECCE day, VHND day etc. be utilised in the community to improve the CSR and education of the girl child?

The discussion should then proceed to highlighting the various roles and responsibilities of various line ministries in order to ensure holistic development of the girl child. The trainer may discuss in depth about the role of PRI's, Gram Sabha, *Mahila Sabha* etc., in their responsibility to promote the girl child. This will help establish a clear direction for the trainees in order to help converge to eliminate various evils against girl child.

The trainer may end the session by highlighting the key points to be taken up by the AWW/ASHA and ANM along with summarising the chapter and fulfilling any gaps.

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CONTENT FOR TRAINERS

Community Participation

The success of any community based programme depends on active community participation. It is voluntary and democratic involvement of elders, local and religious leaders, institutions and organizations. It includes community action and decision making in planning, implementation and monitoring of the programme which leads to self-reliance, ownership and sustainability of the programme.

Community refers to a village or a group of villages with families inhabiting them, who are dependent on one another in their day to day transactions for mutual advantages.

Community Participation is active involvement of people in planning, implementation and monitoring of any programme which is for their well-being. Community participation is not just utilization of services and being passive users.

Community Mobilization is the process of bringing together or empowering members of the community from various sectors to raise awareness on a particular development programme. It facilitates change and development taking into account the felt needs of the community and leads to community organization.

Community Organization is the process of organizing the community in such a way that they can identify and prioritize their needs and objectives, develop confidence and will to achieve them by finding resources through cooperative and collaborative attitude, practices and community participation.

Objective of Community Participation

- Assist in smooth functioning of any Govt. Programme
- Reaches the community as a whole and enhance its participation in utilization of programmes & services
- Accountability for success or failure of the programme
- Promotes ownership of the programme
- Increases the sustainability of the programme

Who Can Be Involved In Eliciting Community Participation?

1. Panchayati Raj Members
2. Gram Sabha

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3. Sarpanch
4. Religious & Local Leaders
5. Mahila Mandal
6. Youth Club Members
7. Self Help Groups
8. School Teachers

Role of Community in Any Programme

Community members have an important role to play in Govt. Programmes

Table 25: Role of Community Members

COMMUNITY MEMBER	MAJOR ROLE
Gram Panchayat	• Planning and promotion of delivery of services and advocacy • Monitoring and Implementation
Adolescent Girls	Assist Govt. functionaries in delivery of services, and other advocacy and BCC/IEC material preparation
Mahila Mandal Pradhan	Encourage women to participate in the activities of the programme and utilise services
Primary School Teacher	Encourage community, children and their parents to participate and avail services of the programme
Religious and Local Leaders	Mobilize and organise community to participate in Programme
NGOs	Support services to run the programme effectively

Methods and Techniques of Eliciting Community Participation

How to Elicit Community Participation?

It is very important to know the community and their knowledge, skills and attitude (KSA) towards the government programmes. There are variety of methods to know the KSA of the community members such as group meetings, community meetings, smothers meetings, Mahila Mandal Meetings, meeting with individual, aged persons, influential persons, local leaders, school teachers, traditional birth attendants (Dai), Yuvak Mandals, self-help groups (SHG), panchayat members, Non-governmental organisations, if any, etc.

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- During the process of knowing the community, efforts may be made to know their customs, traditions and practices **(CTP)** through informal discussions among the community members.
- During the process of knowing the CTP, some precautions have to be adopted so that their sentiments should not be affected.
- These precautions include showing respect to their CTP even if it is not good as per the experience/knowledge of the person who is involved in knowing the CTP of the specific area/village.

Techniques to Elicit Community Participation

- Mothers meetings and community meetings
- Advocacy campaign
- Street play, skit or drama
- Use of folk media and folk songs
- Balmela / exhibition / sports meet
- Use of PLA techniques

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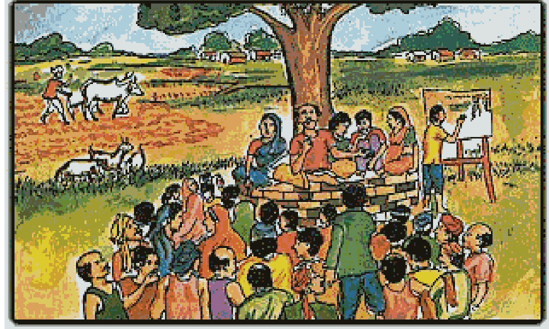
Strategies to Improve the Status of Girl Child

- **Celebrate the Birth of the Girl Child:** This would propagate the message among the community about the importance of the girl child which may help them to create a healthy and safe environment among the society for her.



- **Identification of Community Volunteers & Watch Groups:** The involvement towards various activities among the community will provide the opportunity to them in propagating the message from time to time towards the importance of girl child among the community. Since they are living in the same area/village, their involvement in the same community may yield better results in this direction. For this, adolescent girls or SABLA girls (*Sakhi & Saheli*) can act as volunteers and peer educators.

For example, in projects like Dular, ASAT (Anchal se Aangan Tak) community was mobilised by a band of local women called Local Resource Persons (LRPs), Gram Sampark Samoohs (GSS) or change agents respectively. These women were often assigned households in their neighbourhood to support the target families for behaviour change.

- **Creation of Women & Child Friendly Panchayats:** Gram Panchayats may also be involved in each and every activity carried over in the village so that all the respective volunteers/persons who are involved in propagating the message of the importance of girl child may get sufficient facilities, opportunities and support from the Panchayat to sustain in maintaining the long term effect in this direction. Participation of more number of women in the Gram Panchayat should be encouraged. It may also motivate more women for participation in the meetings organized at village level.
- **Service Delivery Platforms:** Use and identify already existing service delivery platforms like celebration of Girl Child day on January 24, Village Health & Nutrition Day, ECCE day, Annaprashan ceremony, Godbharai ceremony to propagate the messages related to girl child and enable her education. Different stakeholders and committees can be involved in this task like VHSNC, AWLMSC, SHGs, mother's group, mahila samakhya, mahila mandal etc.

Points to Remember for Active Community Participation

1. Know your community well & understand community's problems and their needs
2. Be aware of existing beliefs and practices prevalent in the community
3. Always listen to the community members
4. Do not introduce new interventions that are contradictory to existing practices and beliefs.
5. Try to analyse community dynamics and adjust in that situation
6. Involve community in the programme right from the beginning
7. Give respect/importance to negative experience of the community, if any, and try to minimize the negative feeling not only by sharing but also by doing

Strengthening Community Participation Using PLA Technique

The members of the community may be sensitized towards the reasons for declining Child Sex Ratio (CSR) and their impact in the society. The sensitization of the community may be propagated using Participatory Learning for Action (PLA) Techniques, in which discussions may be initiated among the members of the community about adverse CSR and their impact in the society. During this process, the reasons for

declining CSR and the role of the community in improving the situation through their involvement may be discussed. These messages can also be a part of the Focused Group Discussion (FGD) Method so that community members should be in a position to involve them in improvement of the CSR.

Need of Safe Environment

- Children are more vulnerable than adults particularly to exploitation and abuse. Hence are more affected by the actions and inactions of government and society.
- The opportunity to be born, opportunity to grow in a safe and secure environment, opportunity to develop ones' full potential are some of the major issues concerning the girl child in India.
- Lack of education has lifelong consequences which reduces opportunities for financial independence.
- Provision of adequate knowledge on life skill education to gain confidence and self-reliance, is essential for the girl child.
- Education and empowerment of the girl child regarding Adolescent Reproductive and Sexual Health (ARSH), STD (sexually transmitted diseases) and HIV and their associated risk, would lead to healthy life.

Roles and Responsibilities of Line Ministries

All of the factors ensure a safe, secure and a healthy environment for a girl child who can then become an empowered woman. For this change to sustain, various ministries need to converge and work towards a better future for the girl child. Following are the roles of the various ministries who can help secure a safe future for the girl child.

Role of PRI's In Improving CSR

Panchayat members are an important part of the community, as they have been vested with authority and responsibility to uphold the rights of citizens. They are role models and set norms and are responsible for the well-being and protection of the young.

A child friendly panchayat is one that safeguards children and provides them a violence free and safe environment. As representative of the village they must intervene proactively.

- As the elected representatives, they are responsible for ensuring that the rights of children are protected.
- Understand children's rights as human rights and create awareness amongst others too about the gender sensitivity, laws to stop female foeticide and infanticide and ensure registration of cases against the

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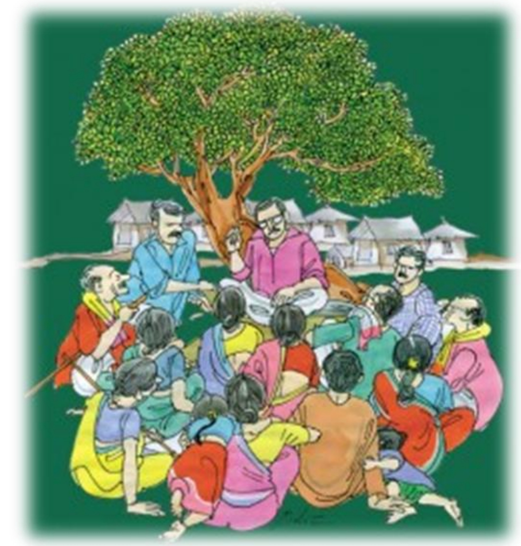
accused, educate them about the violation of rights of children, and the health hazards arising out of early marriage.

- Ensure registration of all births and deaths in the village under the supervision of Panchayat.
- Mobilise the community to act against such crimes against girl child by spreading awareness and gender sensitivity through public education programmes.
- Liaise with ANMs and dais in the village as they can be your informants of any crimes against girl child.
- Campaign against all counterfeits and clinics that misuse the ultra-sound technology to the detriment of the girl child and for their profit.
- Discuss child rights issues with Gram Sabha on a regular basis.
- Set up a child protection monitoring unit or cell in their village, involving children and their parents. The role of this unit should be to maintain records of missing children and children in need of care and protection and report cases of child abuse, gender biased sex selective elimination and child marriage to the police or other concerned authorities.
- Panchayat must identify children and families that require assistance and can be helped through any of the existing government schemes. A list of such children and families can be handed over to the Block/ Taluka/Mandal Panchayat Member or BDPO directly.
- Panchayat must liaise with following to protect children from various issues:
    - The Doctors
    - The Police
    - The Panchayat Secretary
    - School Teachers
    - CDPO, AWWs, ANMs, ASHA
    - Block/*Taluka*/Mandal and Zila Panchayat Members
    - Block Development Officer (BDO) or Block Development and Panchayat Officer (BDPO)
    - District Magistrate/ District Collector

Role of Gram Sabha in Improving CSR

The Gram Sabha is also a village body of elected representatives. They are a council of members taking decisions on issues related to a village's social, cultural and economic life. Following are the ways in which Gram Sabha can contribute to curb CSR:



- Creating / spreading awareness on the issue of gender biased sex selective elimination.
- Organize training programmes on issues concerning girl child and various acts to prevent gender biased sex selective elimination.

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- Involvement of youth as a vigilance group to identified the problem and informed to Gram Sabha.
- Assist the AWW in ICDS services such as registration of pregnancy, birth of child, growth monitoring and use of MCP card, which should be strictly followed to save the girl child.
- Advocate gender equality and educate rural people, using regional language.
- Gram Sabha Members/ local stakeholders should report about hospitals/ nursing homes which indulge in illegal sex determination and abortion.
- Cancellation/ permanent termination of the Doctor's license who are involved in this heinous crime.
- Form a Village Level Supervisory Committee headed by District Level Medical Officer, Family Welfare Officer, Child Specialist, Gynaecologist employed with the State and two persons from local panchayat and three women activist.
- The supervisory committee can conduct raids to check records of nursing homes

Role of *Mahila Sabha* in Improving CSR

- The Ministry of Panchayati Raj had advised the States to have Special Gram Sabha and *Mahila Sabha* meetings to discuss gender issues with special focus on female foeticide and the social impact of having a larger number of men than women.
- It was advised that these meetings should also be organised to discuss the issue of adverse Child Sex Ratio and female foeticide.
- In the areas where *Mahila Sabhas* has not been constituted, they should be constituted and *Mahila Sabhas* should take up the matter of CSR.
- Since the monitoring committee of *Anganwadis* have been put under the control of Panchayat / Ward member and Village Health Sanitation and Nutrition Committee (VHSNC) has been made a sub-committee of GP, Panchayats will have access to information on registration of pregnant mothers, birth of boys and girls and IMR/CMR.
- *Mahila Sabhas* will be able to take up the problem of female foeticide upfront, discover the real reasons behind this mindset (violence against women in public space is a major concern) and how to face this.

Role of Child Friendly Anganwadi Centres

- Identification of villages with issues relating to girl child, using Social Mapping Techniques.
- Need for appropriate building with adequate indoor and outdoor space with space for mothers meeting,
- Space for cooking & storage of food,
- Equipment & utensils for preparation of food,
- Provision for clean drinking water,
- Child friendly toilets with water facility,

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- Records and registers required for running AWCs and providing services,
- Model AWC (MWCD) and provision of Vibrant ECE Centre for the girl child,
- Need and Requirement of a stimulating Indoor space/room with running blackboard on the wall at the eye level of children, space for doll house,
- Cup boards for children to keep their play materials and provision/space for children to take rest/sleep,
- Need and availability of guide book for PSE, time table, PSE kit/materials, work book for children,
- Set of indicators/monitoring tool to assess development of children.

Instructions for Trainers

⇒ For Child Friendly AWCs and Toilets, explain with the Prototype Model or 3-D Images both are available at PHED (Public Health Engineering Department). A Demonstration can be arranged by them.

⇒ Models and 3- D images as examples will have more impact on the Trainees. They will be in a Position to implement or Replicate the same at ground Level.

Role of Schools in Improving Child Sex Ratio

Schools help develop the cognitive, creative and social development in children. Holistic education is considered essential for a protected, sheltered and healthy environment for both girls and boys to learn better and face the challenges of future life. The schools should be oriented towards encouraging the education of the girl child.

- The schools should promote education of the girl child.
- They should keep sessions with the parents to spread awareness.
- The schools should provide the girl child with a good, clean and safe environment to study in.
- The schools should create learning which is girl child oriented so that there is better knowledge transfer.
- Knowledge pertaining to the holistic development of the girl child should be done.
- The teachers should be trained to have child centric and friendly teaching methods.
- Teachers should be trained to be more tolerant and aligned with the needs of the child.
- There should be more number of female teachers in the schools.

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ROLE OF AWW/ASHA/ANM

- Educate, mobilize, and organise the community so that they can participate in Govt. programmes actively for the cause of girl child survival and development.
- Encourage community, children and their parents to participate and avail services of the programme.
- Know the community well & understand community's problems and needs.
- Always listen to community members carefully.
- Based on the needs of the community organise mothers meeting and use various platforms like celebration of girl child day to raise awareness and gain participation of community.
- Identify volunteers in the form of adolescent girls, *mahila mandals,* SHGs and youth groups who can participate in the programme implementation process and mobilise the community.
- Organise street plays, and other folk media's to inform and raise awareness among the community.
- Celebrate important events in the community like celebration of birth of girl child, *annaprashan* day, ECCE day, *godbharai* ceremony and use these platforms to mobilise the community about various issues. AWW must ensure the presence of the PRI Members in the same.
- Organise monthly meetings with the other health functionaries and confirm the presence of PRI members in those meetings.
- Activate and motivate PRI members to take up issues of improving access to schools especially for girl child, provision of water and sanitation facilities in school, child sex ratio, child marriage etc.
- Take the help of Panchayat and Gram Sabha in spreading awareness about low child sex ratio, early child marriage etc.
- Discuss child rights and girl child issues with the Panchayat on a regular basis.

DAY 4

SESSION 1	ADVOCACY FOR SOCIAL AND BEHAVIOUR CHANGE
OBJECTIVE	• To discuss the concept and the process of communication in order to understand how advocacy can bring about social and behavioural change in the community to improve the child sex ratio and target other issues related to the girl child

CONTENT	• Define Advocacy
	• Understanding Effective Communication- definition, process, types and barriers
	• Steps in Planning an advocacy campaign
	    o Selecting an advocacy issue
	    o Setting goals and objectives
	    o Identifying target audience/s
	    o Developing messages
	    o Working with CBOs
	    o Linkages and convergence with line departments for promotion of IEC campaign
	    o Preparation of an action plan for the State/district
	    o Monitoring & Evaluation
	    o Various platforms to promote campaign
	• Role of media in curbing CSR and promoting girl child education along with other gender related issues
	• Role of AWW/ASHA/ANM

DURATION	2 hours 30 minutes (Concept & Understanding of Advocacy) + 3 hours (Group Work & Presentation)
TRAINING METHOD	PowerPoint presentation using examples followed by group discussions, brainstorming exercises, case studies and group work
LEARNING OUTCOME	The trainees will be able to understand the process of advocacy and SBCC to assess the needs of the community. Trainees will be able to promote the value of girl child and highlight the importance of empowering her with education. This will also help trainees find clarity about their roles in the community.
RESOURCES REQUIRED	• Power-point presentation highlighting the key contents • Charts for group work • Felt pens or sketch pens • Stationary for brainstorming sessions
HAND OUT	• Case Study • Media Clip
REFERENCES	• Advocacy Matters: Helping Children Change Their World. Save the Children. • An Advocacy Training Guide: Mobilising Communities on Young People's Health and Rights. Developed by Family Care International. • SBCC for Frontline Health Workers-Facilitator's Guide. Developed by USAID & C-CHANGE.

FACILITATORS NOTES

Methodology

The session may begin by a group discussion on advocacy, IEC and BCC.

Ask

- What do you understand by Advocacy?
- What is the difference between IEC or BCC and Advocacy?

The trainer may then provide accurate definition and make the trainees aware about the concept of advocacy in depth and how it can be utilised to curb CSR. The trainer may then proceed to discuss about the communication skills that will be required by the trainees in order to carry out an effective advocacy campaign.

Ask

- What is the difference between communication and communication for development?
- How can they use communication strategies to spread awareness in the community?

Discuss the above questions and highlight the main differences between the two with the help of answer provided by the trainees and using examples or real life scenarios. Deliberate on the process, types and channels of communication providing relevant examples from the field. The trainers may ask for examples from trainees about their experiences in the field which may result in lack of communication.

Ask

- What are the barriers to communication according to them?

The trainers may utilise a white board to jot down all the suggestions provided by the trainees. The trainer may then take up each suggestion and elaborate on it. Discussion can then proceed to the experiences of trainees to overcome the barriers in their present area/areas of work. Trainers may also show videos related to barrier in communication which can be downloaded from relevant websites if not available.

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The trainer may then elucidate different stages of advocacy explaining the steps with the help of a case study given in the content of the session. The Trainer may get copies of the case study made for the distribution among trainees.

The trainer may proceed to discuss the first step of "Selecting an Advocacy Issue" by giving a simple exercise (refer to contents). Based on the case study, they may ask them to draw a problem tree and identify the issue, causes, and consequences. The trainer may explain the concept of SMART objectives and highlight one example of a SMART objective in order to make the concept more clear to the trainees.

Ask

- The difference between objective and SMART objective?

Moving on to the third step, explain to trainees that before choosing any advocacy activities and materials for the advocacy campaign, they need to identify the target audience.

Ask

- Who can be the target audience?
- Explain the difference between primary and secondary audience?

Trainers may record their comments on a board or piece of paper. Based on the responses, target audience can be identified using stakeholder mapping exercise given in the content.

After the exercise, the trainers may deliberate on the importance of developing messages and general guidance for the same (Refer to contents for sample examples of messages).

The trainer may then proceed to explain the steps to mobilise the community (***refer Day 3 session 4*** for more details).

Ask

- What platforms can be used to promote a Campaign?

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The trainer may talk about the various platforms which can be used to promote advocacy campaign using electronic media, print media, folk and traditional media etc. by providing them with some pointers for using appropriate media.

The trainer may then highlight the importance of linkages and convergence with other departments and how they can be utilized to create safe and secure environment for the girl child.

Ask

- Why it is important to have an implementation or action plan before starting the advocacy activities?

- Record the comments of trainees and refer to the "Action Plan Performa" in contents to plan activities for the case study.
- Explain the importance of monitoring and evaluation for any programme.
- Ask them to incorporate role of ICDS functionaries, Health functionaries, PRIs and others in advocacy campaign.

Activity:

- Trainees in groups may be given an activity to plan an advocacy campaign on a case study (***Annexure-28***) to address the problems of the community and an outline of the communication skills needed to reach their goals. They can prepare some skit, role-play and develop messages based on the case study given to them. A sample case study is given in Hand-out.
- Ask each group to present their action plan on a flip chart and make sure that each group covers the following aspects while preparing the action plan for their case study. Discuss the role of AWW in developing plans of advocacy and community need assessment.

Audiences	Level of change	Risks/ barriers	Themes/ Messages	Media/ Channels	Activities

Media is an integral part of any IEC campaign. The trainer may focus on the role of media in curbing the CSR in the community. A brainstorm session with the trainees can be conducted to seek various strategies that can help involve media in reducing the CSR.

Ask

- What strategies can be employed using media's contribution towards the improvement in CSR in the community thereby improving the status of girl child?

The current contribution of media towards girl child empowerment can be discussed and various newspaper clips and few episodes of "Satyameva Jayate" or "Amma ji kehte hai" may be shared with the trainees. Trainer may also share a media clip related to declining CSR with the trainees (***Annexure-29***). After the videos and clips the trainers may ask the trainees about their thoughts on the same.

Ask

- What more can be done to highlight the issue of girl child or mainstreaming it in media?

The session may conclude by giving a group activity and asking the trainees to prepare an advocacy campaign. The groups may be given the following topics to work on:

- Gender Biased Sex Selective Elimination
- Early Marriage
- School Drop out
- Trafficking
- Safe motherhood

The group work can then be shared with the entire batch for feedback and suggestions.

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CONTENTS FOR TRAINERS

Advocacy

Advocacy is a set of organised activities designed to influence the policies and actions of others (e.g., policy makers, NGOs etc.) to achieve positive changes for girl child (like improved CSR, low SRB, better education) based on the experience and knowledge of working directly with them, their families and communities. Advocacy can help create a safe, secure and healthy environment for the girl child.

Definition

Advocacy is an action directed at changing the policies, perspective, or programmes of any type of institution. It also includes:

- Building support for an issue or cause and influencing others to take action.
- Making sure that the necessary financial resources are provided for programmes and services.
- Persuading government officials to prioritise particular programme approaches or services.
- Informing the general public and opinion leaders about a particular issue or problem and mobilising them to apply pressure to those in the position to take action.
- Creating support among community members and generating demand for the implementation of particular programme approaches or services.

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Essential Points for Discussion

Advocacy, BCC and IEC initiatives are similar because they all are focused on raising awareness about a particular issue. However, BCC or IEC initiatives are aimed at changing behaviour at the individual level, whereas advocacy activities are aimed at mobilising collective action and promoting social or legislative changes at the community, district, national, or global levels. The advocacy initiatives can thus be used to target social evils and crimes against women in order to help provide safe environment for girl child and also create awareness in the community as well.

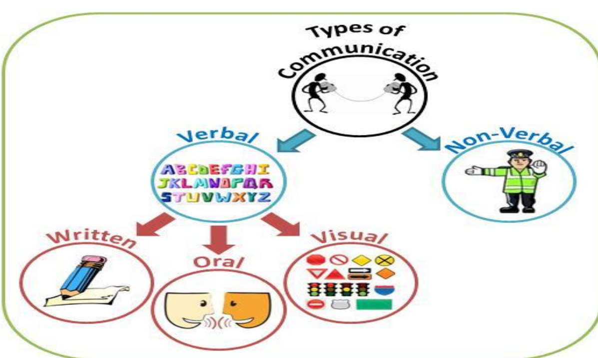
Communication

The process of communication allows us to interact with other people; without it, we would be unable to share knowledge or experience with anything outside of ourselves. Common

forms of communication include speaking, writing, gestures, body language, touch and broadcasting. Communication comprises both verbal and non-verbal language.

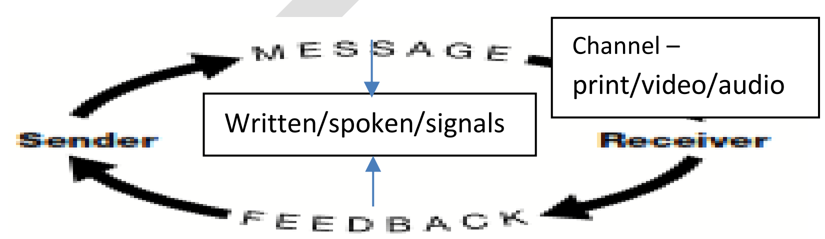
Types of Communication

There are three basic types of communication: verbal, non-verbal, and written.



Process of Communication

Communication Process involves a sender, message, channel through which the receiver will receive the message, and feedback.



Channels of Communication

The channels used in the communication process are the mediums that the sender may use to transmit the message to the receiver.

- Care needs to be exercised in selecting the most effective channel for each message. The channels of communication vary from situation to situation. For example, for a literate population the channels of communication could be power point presentation, brochures, and pamphlets and any type of print media. On the other hand, for illiterate population, channel could be videos like TV or movies, audio like community radio, pictures, skits, plays etc.

Barriers to Communication: The barriers to communication may be described as follows:

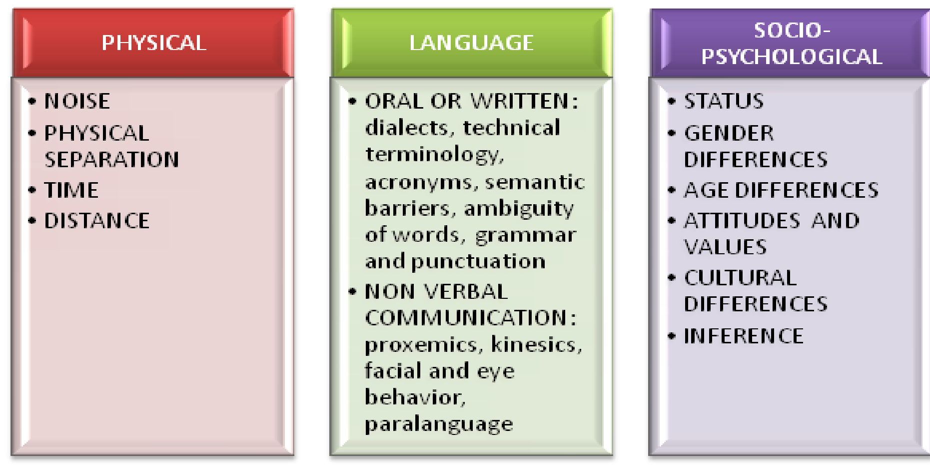


Figure 16: Barriers to Communication

Strengthening Communication

In addition to removal of specific barriers to communication, the following general guidelines may be used:

- A positive attitude about communication. Defensiveness interferes with communication. A negative attitude will be a barrier to effective communication.
- Work at improving inter and intra personal communication skills. It takes both knowledge and work.
- Make communication goal oriented. When the sender and receiver have a good relationship, they are much more likely to accomplish their communication goals.
- Experiment with communication alternatives. What works with one person may not work well with another person. Use different channels, listening techniques, and feedback techniques. Communication should be tailor made for the audience.
- Accept the miscommunication and work to minimize its negative impacts.
- Get the feedback and effectively integrate into the message to make it more efficient and implementable.

Communication Strategies

Several communication strategies have been launched in the last couple of decades to address the problem of gender-biased sex selection and gender discrimination in the country. The components of these campaigns have involved a mix of tools and media channels, radio and TV spots, print and outdoor media as well as community outreach programmes such as rallies, walks, signature campaigns, nukkad natak (street theatre), dramas and folk art.

Below are certain points which highlight and outline the communication strategy:

Basic Tips

1. Address your constituents so that they understand their individual responsibility. Each of us has a role to play – as parents, siblings, family members and friends, and also as professionals, whether teachers, doctors, lawyers, judges, NGO workers, administrators, government officials, law enforcement personnel, elected representatives, journalists, writers, artists, etc.
2. Create awareness about this issue in homes, communities, neighborhoods and the workplace.
3. Let the message incorporate both gender-biased sex selection and gender-based discrimination. Speak up against discrimination. For example, do not tolerate violence and abuse against women and girls, do not give or take dowry, stand up for equal property rights.
4. Find small and big ways to promote equality between boys and girls.
5. Use the law – report the matter to authorities if you know the law is being infringed, Refer to http:// pndt.gov.in or the list of authorities/ medical officers responsible for Act implementation in your areas.
6. Link up and help groups actively involved in mobilizing the community against gender-based discrimination and sex selection.

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Language

7. Avoid use of language that portrays girls as objects of pity and devalues them. Some of the communication says, “Give girls a chance, they too can look after you” or *mujhe maa ke garbh me kyon marte ho, kewal is liye ki main ladki hoon*? Therefore, avoid language that reinforces such stereotypes
8. Similarly avoid use of cliches such as ‘daughters as laxmi’ or beti bojh nahin lathi hai.
9. Refrain from using words such as foeticide, killing, murder, and genocide as this focuses attention on negative emotions of fear and violence thereby turning the audience away from the issue at hand.
10. It is best to avoid using the term ‘sex selective’ abortion as it confuses the issue by linking it to legal and safe abortion per se.
11. Avoid language that holds the mother responsible for sex selection. She has very little control over the decision.
12. Use language, which is simple, direct and appeals to the heart.

Imagery

13. Avoid imagery that is gruesome or gory for instance foetus in a bottle or a dagger piercing a rosebud for the reason that a violent image will have the audience go into a switch-off mode.
14. Avoid imagery that reinforces gender inequality as in the case of some of the popular family based TV serials. Some of them continue to portray women as inferior and men in haloed terms.
15. Respect the female form. A grotesque or provocative portrayal of female anatomy while discussing sex selection could take the issue in a different direction. It also distracts from the message being communicated.

Steps/Stages in Planning an Advocacy Campaign

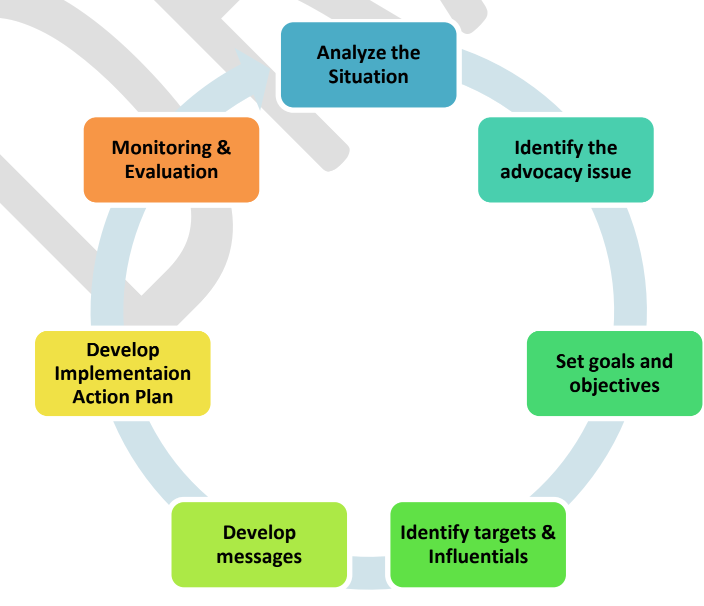

Figure 17: Advocacy Cycle

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Selecting an Advocacy Issue

Advocacy must begin with identification of an issue or problem that the community agrees to support in order to promote a policy change. In this case, the trainer may focus the discussion on curbing CSR in the community. A situation analysis forms the foundation for any programme or advocacy plan. It provides the analysis of the problem that needs to be addressed and seek to bring about change in the community.

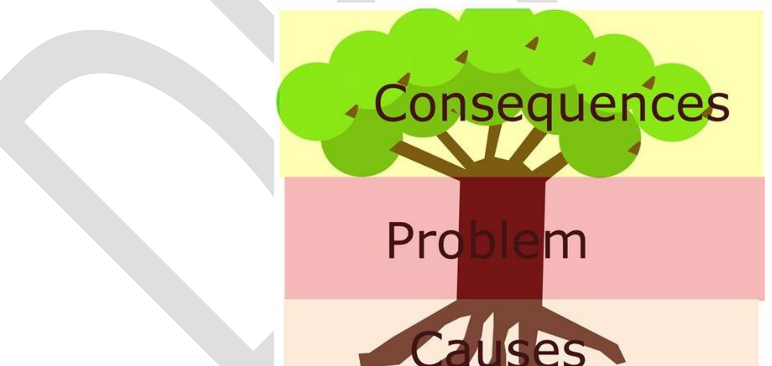
Exercise

Problem Tree Analysis

One way to understand the issue of CSR is to create a visual representation of the problem, its root causes and its consequences in form of a problem tree.

Draw a Problem Tree Showing Causes and Effects of the Problem

- **Identify the central problem** – for example, improving child sex ratio, promoting education of girls, prevention of child marriage, prevention of sex selection and abortion, creating value of girl child etc.
- **Brainstorm** to produce its causes and consequences.
- **Rank** the causes and consequences in terms of importance.
- Identify the **most direct causes** of the problem.
- **Arrange causes and effects** into a problem tree, with causes as the 'roots' and effects as the 'branches'. Discuss the links between them.
- It will become clear that which of the causes can be addressed through advocacy.



Use the Problem Tree to Help Set Your Goals and Objectives

SMART Objectives – Specific, Measurable, Achievable, Realistic, and Time based should be used and should be change-oriented rather than activity-oriented.

The change should be quantified and the objective should state who will do it and when. They should describe the intended change that needs to be brought in the community.

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For example, consider the difference between these two objectives:

Original Objective:

To educate community about child sex ratio.

SMART objective:

By 2015, all women of the North East district of New Delhi will be educated about declining child sex ratio and its ill-effects by AWWs.

The smart objectives provide a specific, targeted, achievable goal within a defined time frame.

Identifying Target Audiences

- ✓ Advise trainees that before choosing an advocacy activity and materials for the advocacy campaign, they need to identify the right target audience to achieve the advocacy objectives.
- ✓ Ask trainees to explain the difference between primary and secondary audiences.
- ✓ Record their comments on the blackboard/paper.
- ✓ Discuss the responses of the trainees.

Decide where to focus the advocacy efforts, and identify targets – people who can make the decisions to bring about the changes desired in the community.

- ✓ The **primary audience** are the individuals and/or institutions with authority to change or ensure the implementation of the policy commitment.
- ✓ The **secondary audience** are the individuals or and/or institutions that can influence the primary audience.

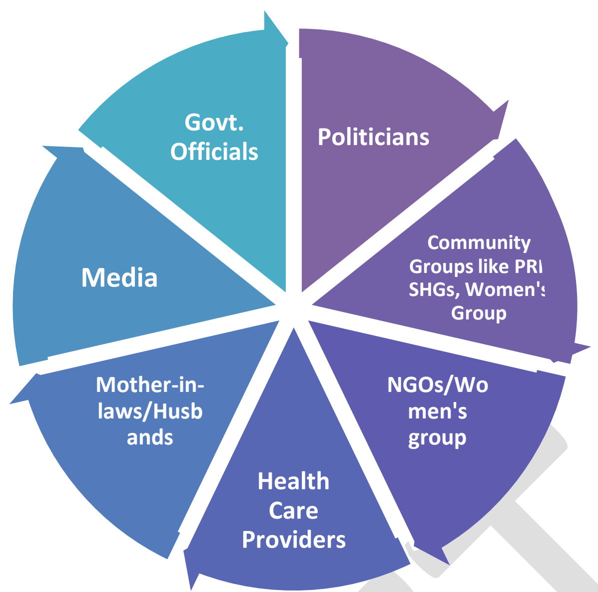

Figure 18: Target Audience for an Advocacy Campaign

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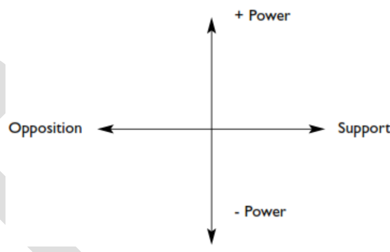
Exercise

Stakeholder Mapping Exercise

This exercise will help map all the relevant stakeholders and the links, power dynamics and relationships between them. Start with identified targets and then include other stakeholders (both allies and opponents).

- On a flip chart draw two axes (see below) showing support/opposition for the change you seek, and their power.
- Brainstorm possible key advocacy targets and place each name on one card/ board (this should be done for each change objective).
- Then place the targets according to perception of their support or opposition to your advocacy objectives, and their power to make a change.



- Those with the most power are the main targets and should be prioritised.
- The hardest targets to influence will be those with the most power who oppose the change.
- Then repeat the same exercise, but use different coloured pens, to identify possible influential allies (those who support the identified advocacy objectives) as well as opponent

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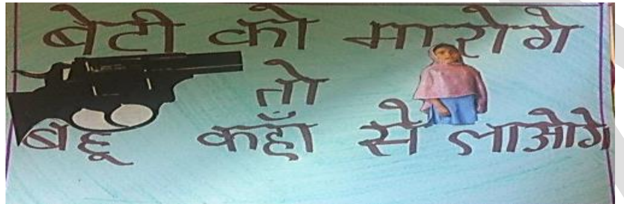
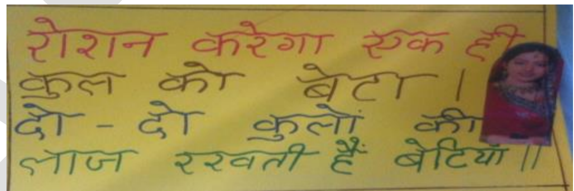
Developing Messages

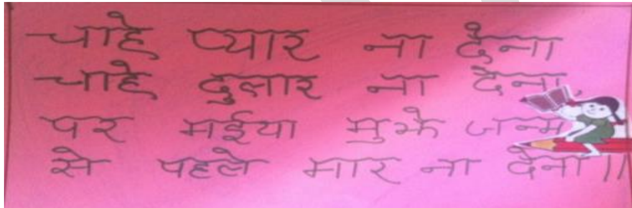
- Messages should be clear, consistent and effective. It is critical to think about what you want to say, and how to say it.

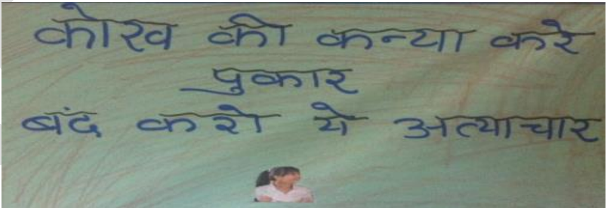
General Guidance on Developing Messages

- ✓ Make messages clear, compelling and engaging. Avoid jargon.
- ✓ Put a 'frame' around the issue – highlight main perspective.
- ✓ Use clear facts and numbers creatively.
- ✓ If possible include information that is local so that it is relevant for people.
- ✓ Allow the audience to reach their own conclusions.
- ✓ Present a solution if possible.
- ✓ Remember: concise and consistent messages are critical for advocacy.
- ✓ Content is only one part of a message. Other factors such as who delivers the message, where a meeting takes place or the timing of the message can be as, or more, important than the content alone. Sometimes what is not said delivers a louder message than what is said.









Mobilising the public/community- will be dealt in detail in community mobilization chapter (Refer Day 3, Session 4)

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Various Platforms to Promote IEC Campaign

***Electronic Media*:** Films, Short movies, documentary, video tapes, Radio, Audio Tapes, TV programme, Mobile messages, SMS, TV advertisements, slides etc.

***Print Media*:** Books, Booklets, Folders and Leaflets, Hand-outs, Flip Book, Flannel Graph, Flash Cards, Charts, Bulletin Board, Letters, Newspapers, Advertisements, Press Release, Posters, Kiosks, Photographs, Hoardings, Magazines, Newsletters, Journals.

Folk & Traditional Media: Song, Dance, Drama, Kirtan/ Bhajan, Puppet Show, Nagada, Wall Writing etc.

Alternate Media: Street Play, Nukkad Natak, Nautanki, etc.

Multi- Media Campaign: Publicity campaigns, Awareness Campaigns, Exhibitions

Group Communication: Group meetings, Demonstrations, Field Camps, Role Play

Points to Remember for Selecting the Print Media

- Educational level of target audience
- Media habits of target audience
- Electronic media can have better reach among a particular section of society and can be used for creating awareness and reinforcement of messages. But may be chosen where it is easily accessible.
- Print media has limited use in areas with low literacy levels
- Folk and traditional media is more popular in rural and tribal areas
- Media-mix approach or use of various media forms at the same time is more effective

Linkages and Convergence with Other Departments for Promotion of IEC Campaign

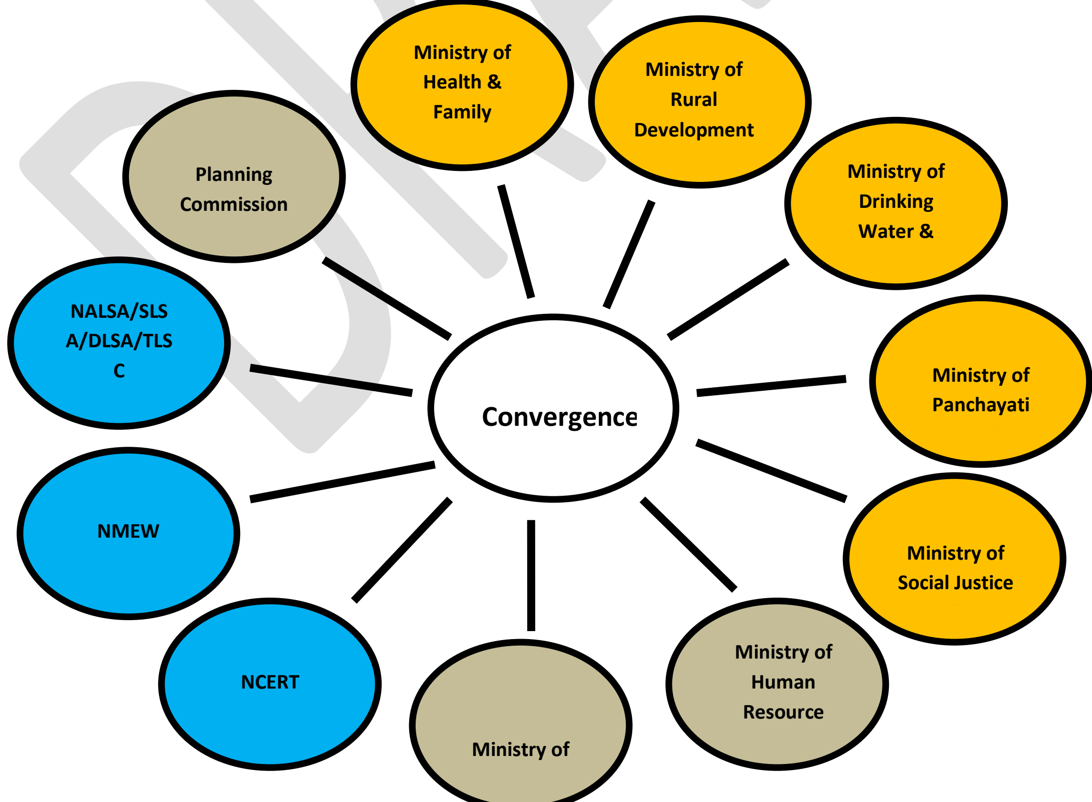

Figure 19: Convergence with Departments

Figure 20: Sample Slogans and Messages

Discuss
Ask the trainees to brainstorm the reasons why it is important to have an implementation or action plan before starting any advocacy activities. Record their comments.

Action Planning

Drawing up An Action Plan

In developing the action plan, there is a need to put together something that directs clear roles of who will do what, and when.

Action Plan Performa				
What do we need to do?		By When?	Who will do it?	What resources are needed?
Output	**Activities**			

Monitoring & Evaluation

Monitoring

The purpose of monitoring is to track activities during every step of the advocacy campaign in order to ensure that activities are being implemented as planned and to compare what has been done against what was planned or expected. The alarming CSR of the nation is a major priority and thus it needs to be monitored carefully.

Evaluation

An evaluation assesses whether the campaign was effective in contributing to progress in meeting the advocacy objectives. Evaluation of advocacy campaign primarily measures outcomes—the achievements or results. In an advocacy campaign, outcomes are measured at two levels—at the level of each advocacy activity, and at the level of the overall advocacy initiative or campaign.

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Role of Media

A significant proliferation of media sources and their deep penetration in the lives of common people over the years has made the media one of the most powerful tools. The role of media thus becomes extremely crucial at a time when the issue related to girl child have become a *'national shame*' in the midst of India's growth story, with serious negative implications for both human growth and national economy.

Numerous print and electronic media can join hands and play a synergistic role for bringing about change in declining child sex ratio, gender biased sex selection & elimination, various forms of discrimination towards girl child after birth in fulfilling her health, nutrition and educational needs.

Over the years, media has played a significant role in bringing about national awakening on numerous issues of broader human and social concerns impacting both human development and the nation such as literacy, mother and child health, hunger, malnutrition and child sex ratio and violence against women.

The media in recent times has played a wide range of roles in:

- Raising issues of social and national concerns
- Generating awareness among the public
- Facilitating policy debates
- Initiating campaigns
- Acting as a watchdog of social development programmes and policy debates on social and economic development
- Engaging the common citizen in reporting
- Motivating people working for social causes both by offering them both media space and honouring them with media awards

Exercise

Ask the trainees about the media's contribution towards improving the status of girl child. Ask them to share their experiences.

Media's Contribution to the Issue of Girl Child

- Selected newspapers and TV channels have also given voice to the voiceless by centre-staging stories of deprivation, discrimination, low-child sex ratio, domestic violence and highlighting other such issues

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Figure 21: Role of Media

- The media can thus successfully impact public view by making them more responsive and accountable for their actions. For e.g., *Satyamev Jayate* episodes on violence and low child sex ratio has forced many family and women to look out for justice and has been an eye opener for many.

What More Can Media Do?

For highlighting the issue of decline in CSR and other girl child related issues by mainstreaming it in media and public discourse:

- Form a '*Media Coalition*' on '*Beti Bachao, Beti Padhao'* and other such media networks for advocating social issues affecting girl child by bringing together TV channels, the print media, audio and video channels and Internet magazines/journals.
- Coverage on BBBP scheme, making the media campaign an integral part of editorial policy, besides sensitising reporters on girl child issues at regular in-house meetings.
- Create a beat (such as a health and pollution beat) for covering girl child related reports and promote a pool of writers, especially those engaged in developmental work among girl children, adolescent girls and women, to report the instances and status of girl child in poorest States and communities.

- Initiate weekly column in the print media,

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TV and radio (especially city-based FM radio) programmes such as '*Beti Bachao, Beti Padhao*' with updates on the status of demand, awareness, availability access, quality of service delivery and community participation in assessing the needs of the girl child and related schemes in the poor and vulnerable blocks.

- Hold regular talk shows and debates on TV channels on different aspects of girl child- such as empowerment, elimination of discrimination, child sex ratio etc. and cost it entails to the nation especially on education related channels like 'Lok Sabha TV', 'Doordarshan', etc., with clear result oriented strategies.
- Handholding with partner organisations for carrying out the girl child education activities and also improving the capacities for the same. There are number of home science, medical, public health, rural development colleges and other educational institutions with child development and women empowerment division whose students will be engaged to dynamically advocate appropriate practices. These colleges can present education seminars/sessions for orientation of the community functionaries and organise outreach events for the community.
- Using brand ambassadors to highlight the importance of girl child.

Group Work:

- Divide trainees into groups and give them a girl child related issue to work on. Ask them to develop some messages on the topic assigned to them.
- Let them create appropriate messages and ask them what type of media they can use to disseminate such messages.

Role of Different Ministries

- ✓ Discuss the role of different line Ministries in development of an Advocacy Plan for girl child related issue/s.
- ✓ Explain the importance of convergence with other ministries (MoWCD, MoHFW, MoHRD, MoRD/MoPR) and DAVP in formulating media and an advocacy plan.

- For example, Field Publicity Units of Ministry of Information & Broadcasting and Local Media may carry the campaign to grassroots.
- The Song and Drama Division may organise field programmes in coordination with the sister media units of the Ministry of Information & Broadcasting, Central/State Government Departments and voluntary organizations.
- Puppet shows, folk dances, plays/ skits, group discussions etc. may be taken up on the related themes of child sex ratio, empowerment of girls through education etc.
- AWWs can involve women and girls of the community to participate in plays, drama etc. to create awareness.

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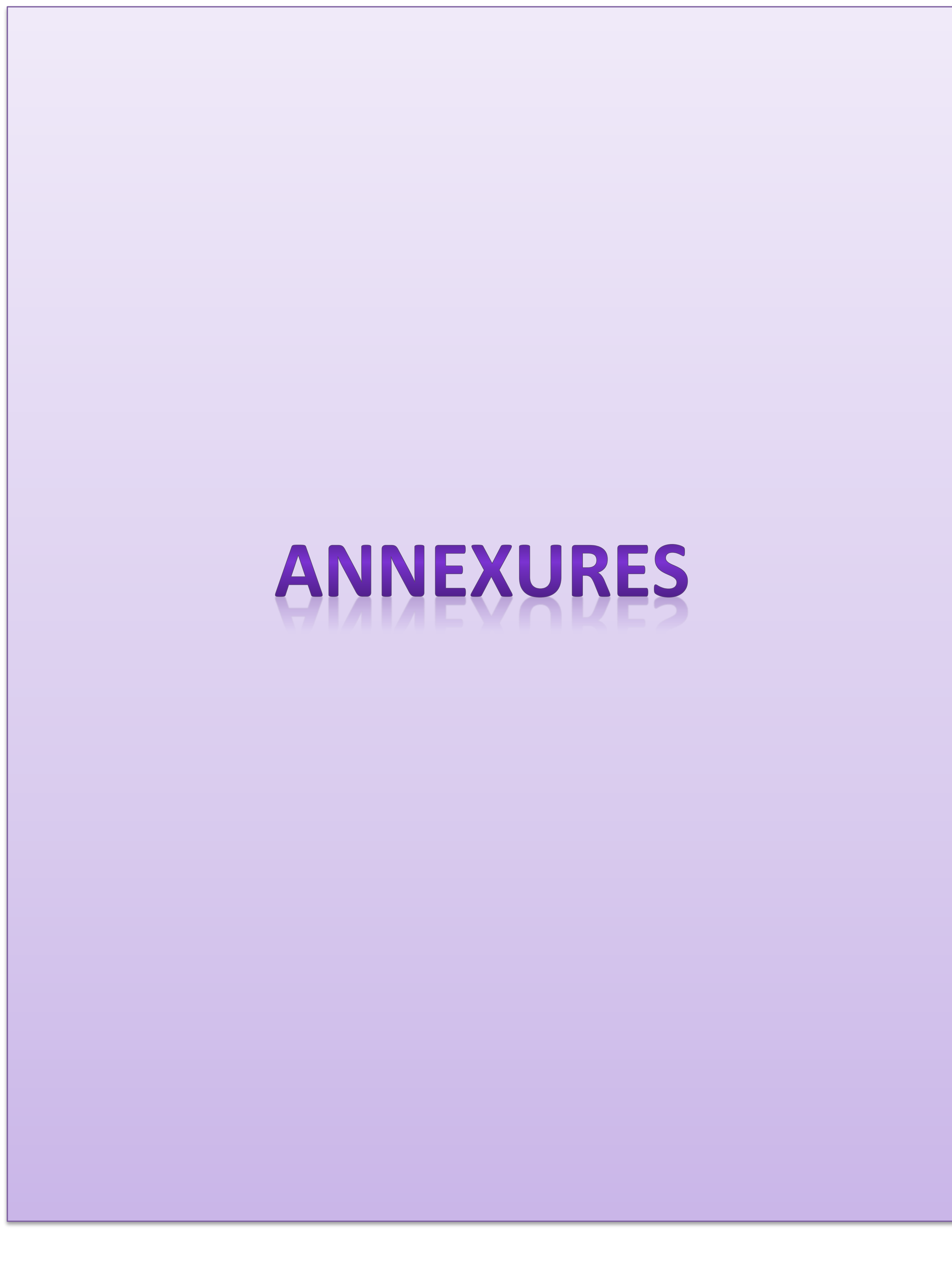
- Theme based articles to be published in regional/local newspapers, magazines, local club monthlies etc.
- Regional FNB Centres will identify issues and forward articles to the printing agencies.
- School magazines, youth circulars may also carry messages, articles, quizzes, writing competitions etc. to spread awareness amongst children and adolescents.
- Schools may keep sessions or workshops for parents to encourage awareness in the community.

Refer Annexure-28, to plan an advocacy campaign.

ROLE OF AWW/ASHA/ANM

- Identify the girl child related problems and challenges that are prevalent in the community.
- Address these issues by planning an advocacy campaign.
- Mobilise the community to get collective action on the issue and reach at common consensus.
- Conduct community survey which will act as a baseline data of your community.
- Focus and use suitable BCC strategies using appropriate communication channels which are apt for your community.
- Raise awareness on Gender Biased Sex Selective Elimination, low child sex ratio, importance of girl child education using SBCC strategies and target to change the beliefs and attitudes of the people.
- Promote social or legislative changes at the community, district levels.
- Involve NGOs or community based organisations in the campaign activities.
- Converge and liaise with the ASHA and ANM for community mobilisation and campaign planning process.
- AWW may involve other members/functionaries e.g. PRIs and Teachers to be involved in campaign of such a vast.
- Use VHND, ECCE day, mothers group meetings as a platform to inform, educate and communicate about the issue of child sex ratio, early child marriage, Gender Biased Sex Selective Elimination etc. with the target audience.
- Identify the media which has a better reach among the community.


ANNEXURES

Annexure-1

List of Gender Critical Districts Covering All States & Uts

SN	Name of State / UT	Districts	Census 2001	Census 2011
1	Andaman& Nicobar	Nicobars	937	945
2	Andhra Pradesh	Y.S.R.	951	918
3	Arunachal Pradesh	Dibang Valley	874	889
4	Assam	Kamrup Metropolitan	943	946
5	Bihar	Vaishali	937	904
6	Chandigarh	Chandigarh	845	880
7	Chhattisgarh	Raigarh	964	947
8	Dadra & Nagar Haveli	Dadra & Nagar Haveli	979	926
9	Daman & Diu	Daman	907	897
10	Goa	North Goa	938	939
11	Gujarat	Surat	859	835
12		Mahesana	801	842
13		Gandhinagar	816	847
14		Ahmadabad	835	857
15		Rajkot	854	862
16	Haryana	Mahendragarh	818	775
17		Jhajjar	801	782
18		Rewari	811	787
19		Sonipat	788	798
20		Ambala	782	810
21		Kurukshetra	771	818
22		Rohtak	799	820
23		Karnal	809	824
24		Yamunanagar	806	826
25		Kaithal	791	828
26		Bhiwani	841	832
27		Panipat	809	837
28	Himachal Pradesh	Una	837	875
29	Jammu & Kashmir	Jammu	819	795
30		Pulwama	1046	829
31		Kathua	847	831
32		Badgam	963	832
33		Anantnag	977	841
34	Jharkhand	Dhanbad	951	916
35	Karnataka	Bijapur	928	931
36	Kerala	Thrissur	958	950
37	Lakshadweep	Lakshadweep	959	911
38	Madhya Pradesh	Morena	837	829
39		Gwalior	853	840

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40		Bhind	832	843
41		Datia	874	856
42	Maharastra	Bid	894	807
43		Jalgaon	880	842
44		Ahmadnagar	884	852
45		Buldana	908	855
46		Aurangabad	890	858
47		Washim	918	863
48		Kolhapur	839	863
49		Osmanabad	894	867
50		Sangli	851	867
51		Jalna	903	870
52	Manipur	Senapati	962	893
53	Meghalaya	Ribhoi	972	953
54	Mizoram	Saiha	950	932
55	Nagaland	Longleng	964	885
56	NCT of Delhi	South West	846	845
57		North West	857	865
58		East	865	871
59		West	859	872
60		North	886	873
61	Odisha	Nayagarh	904	855
62	Puducherry	Yanam	964	921
63	Punjab	Tarn Taran	784	820
64		Gurdaspur	789	821
65		Amritsar	792	826
66		Muktsar	811	831
67		Mansa	782	836
68		Patiala	776	837
69		Sangrur	784	840
70		Sahibzada Ajit Singh Nagar	785	841
71		Fatehgarh Sahib	766	842
72		Barnala	792	843
73		Firozpur	822	847
74	Rajasthan	Jhunjhunun	863	837
75		Sikar	885	848
76		Karauli	873	852
77		Ganganagar	850	854
78		Dhaulpur	860	857
79		Jaipur	899	861
80		Dausa	906	865
81		Alwar	887	865
82		Bharatpur	879	869
83		Sawai Madhopur	902	871

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84	Sikkim	North District	995	929
85	Tamil Nadu	Cuddalore	957	896
86	Telengana	Hyderabad	943	914
87	Tripura	South Tripura	961	951
88	Uttar Pradesh	Baghpat	850	841
89		Gautam Buddha Nagar	854	843
90		Ghaziabad	854	850
91		Meerut	857	852
92		Bulandshahr	867	854
93		Agra	866	861
94		Muzaffarnagar	859	863
95		Mahamaya Nagar	886	865
96		Jhansi	886	866
97		Mathura	872	870
98	Uttarakhand	Pithoragarh	902	816
99		Champawat	934	873
100	West Bengal	Kolkata	927	933

* As per 2011 Census, the national CSR is 918 girls per 1000 boys

Basis for Selection of Districts:

1. 87 Districts in 23 States: CSR below national average of 918
2. 8 Districts in 8 States: CSR above national average of 918 but showing declining trend
3. 5 Districts in 5 States: CSR above national average of 918 and showing improving trend. These are selected so that these CSR levels can be maintained and other districts can emulate and learn from their experiences.

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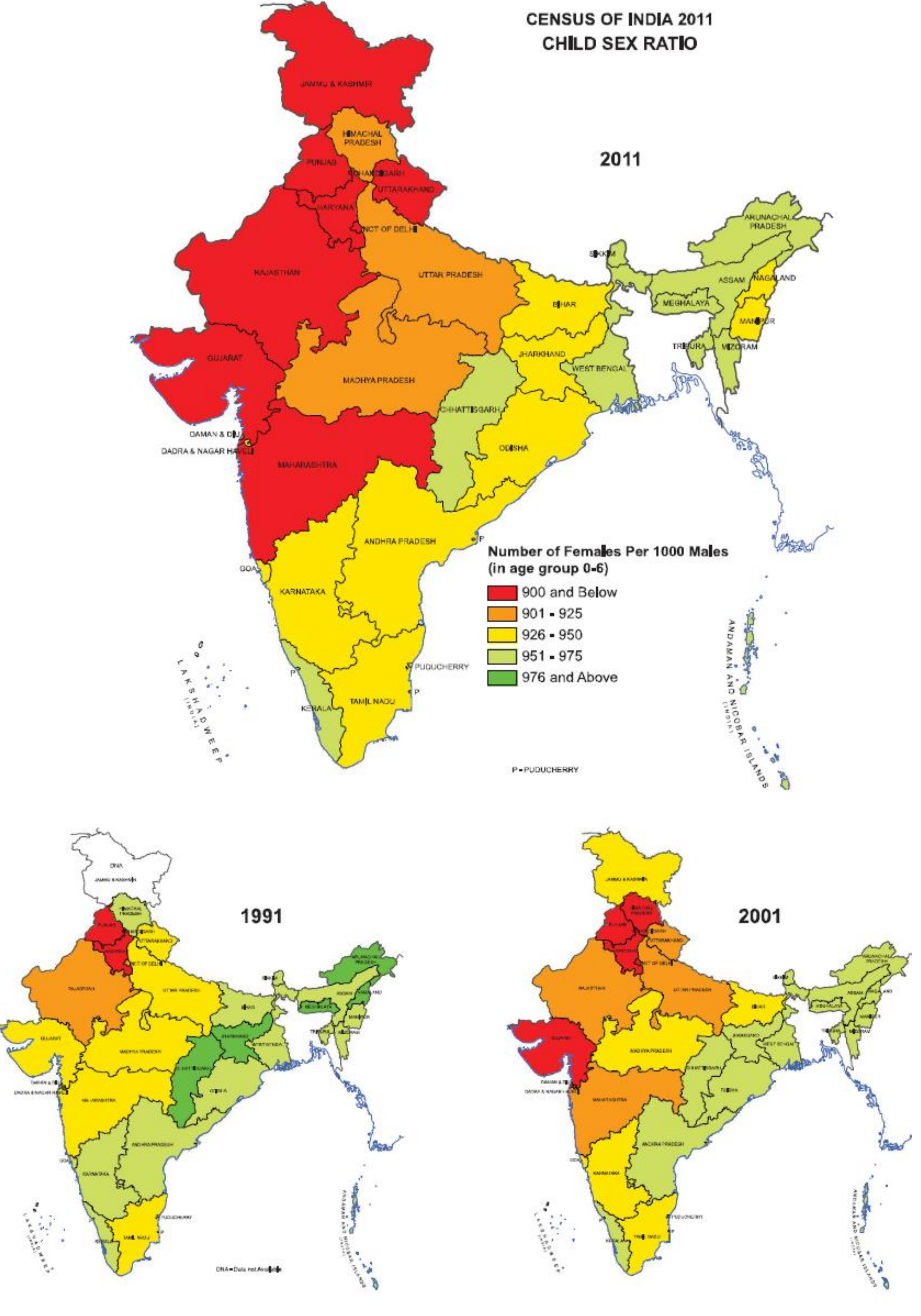
Annexure-2

Child Sex Ratio in India



Annexure-3

Critical Indicators of Health

$$\text{Infant mortality rate (IMR)} = \frac{\text{Number of infant deaths during the year}}{\text{Number of live births during the year}} \times 1000$$

$$\text{Neo-natal mortality rate (NMR)} = \frac{\text{Number of infant deaths of} < \text{than 29 days during the year}}{\text{Number of live births during the year}} \times 1000$$

$$\text{Post neo-natal mortality rate (PNMR)} = \frac{\text{Number of infant deaths of 29 days to} < \text{than one year during the year}}{\text{Number of live births during the year}} \times 1000$$

$$\text{Peri-natal mortality rate (PMR)} = \frac{\text{Number of still births and infant deaths of} < \text{than 7 days during the year}}{\text{Number of live births and still births during the year}} \times 1000$$

$$\text{Still birth rate (SBR)} = \frac{\text{Number of still births during the year}}{\text{Number of live births and still births during the year}} \times 1000$$

$$\textbf{Under Five Mortality Rate} = \frac{\text{Deaths up to five years of age in a year}}{\text{Live births during the same period}} \times 1000$$

$$\textbf{Maternal Mortality Ratio} = \frac{\text{Maternal deaths}}{\text{Live births}} \times 100{,}000$$

$$\textbf{Maternal Mortality Rate} = \frac{\text{Maternal deaths}}{\text{Women in reproductive age group}} \times 100{,}000$$

Annexure-4

Immunization Schedule

S.NO.	VACCINE AND ITS PRESENTATION	PROTECTION	ROUTE	NO. OF DOSES	VACCINATION SCHEDULE
1.	BCG (Baccillus Calmette Guerin)-Lyophilised vaccine	Tuberculosis	Intra dermal	1	At birth (upto 1 year if not given earlier)
2.	OPV (Oral Polio Vaccine)-Liquid vaccine	Poliomyelitis	Oral	5	Birth dose for institutional deliveries, Primary 3 doses at 6, 10 & 14 week and one booster dose at 16-24 month of age. Given orally
3.	Hepatitis B-Liquid Vaccine	Hepatitis B	Intra muscular	4	Birth dose (within 24 hours) for institutional deliveries. Primary 3 doses at 6, 10 & 14 week
4.	DPT (Diphtheria, Pertussis and Tetanus Toxoid)-Liquid vaccine	Diphtheria, Pertussis and Tetanus	Intra-muscular	5	3 doses at 6, 10 & 14 week and 2 booster dose at 16-24 month and 5-6 years of age
5.	Measles-Lyophilised vaccine	Measles	Sub-cutaneous	2	9-12 months of age and 2nd dose at 16-24 months
6.	TT (Tetanus Toxoid)-Liquid Vaccine	Tetanus	Intra-muscular	2	10 years and 16 years of age For pregnant woman, 2 doses given (one dose if previously vaccinated within 3 years)
7.	JE vaccination (in selected high disease burden districts) Lyophilised vaccine	Japanese Encephalitis (Brain fever)	Sub-cutaneous	2	9-12 months of age and 2nd dose at 16-24 months (6 month after vaccination drive)
8.	Hib (given as pentavalent containing Hib+DPT+Hep B) (in 8 states) – Liquid vaccin	Hib, Pneumonia and Hib meningitis	Intra-muscular	3	6, 10 & 14 week of age

Mother and Child Protection Card

Integrated Child Development Services
National Rural Health Mission

Mother and Child Protection Card

Photograph of Mother & Child

Family Identification

Mother's Name ______ Age

Father's Name ______

Address ______

Mother's Education: illiterate/primary/middle/high school/graduate

Pregnancy Record

Mother's ID No. ______

Date of the last menstrual period / /

Expected date of delivery / /

No. of pregnancies/ previous live births /

Last delivery conducted at: Institution ☐ Home ☐

Current delivery: Institution ☐ Home ☐

JSY Registration No. ______

JSY payment Amount ☐ Date / /

Birth Record

Child's Name ______

Date of Birth / / Birth Weight ☐ kgs ☐ gms

Girl ☐ Boy ☐ Birth Registration No: ☐

Institutional Identification

AWW ______ AWC/Block ______

ASHA ______ ANM ______

SHC / Clinic ______

PHC / Town ______ Hospital / FRU ______

Contact Nos. ANM ______ Hospital ______

Transport Arrangement ______

AWC Reg. No ☐ Date ☐ Sub-centre Reg. No ☐ Date ☐

Referral ☐ ☐ ☐ ☐ ☐

Ministry of Women & Child Development, Government of India
Ministry of Health and Family Welfare, Government of India

Regular checkup is essential during pregnancy

Months

Registration — Register with the health centre in the first trimester.

ANC — Have at least 3 antenatal checkups, after registration

BP, Blood & Urine — Have blood pressure (BP) checked and blood and urine examined at each visit.

Weight — Have weight checkup at each visit. Gain at least 10-12 kg. during pregnancy. Gain at least 1kg every mth. during the last 6 mths. of pregnancy.

T.T.Injection — Take two T.T. injections. T.T.1 when pregnancy is confirmed and T.T.2 after 1 month. (Fill in the date)

Iron Tablets — Take one tablet of iron and folic acid a day for at least 3 months. Take at least 100 tablets. (Fill in quantity and date issued)

Care During Pregnancy

- Consume a variety of foods
- Consume more food – around 1/4th times extra than the normal diet
- Consume SNP from the AWC regularly
- Take at least two hours of rest during the day. In addition to 8 hours of rest at night.
- Use only adequately iodised salt

Ensure nutrition counselling at every ANC

ANTENATAL CARE

OBSTETRIC COMPLICATION IN PREVIOUS PREGNANCY
(Please tick (✓) the relevant history)

A. APH ☐ B. Eclampsia ☐ C. PIH ☐
D. Anaemia ☐ E. Obstructed labor ☐ F. PPH ☐
G. LSCS ☐ H. Congenital anomaly in baby ☐ I. Others ☐

PAST HISTORY
(Please tick (✓) the box of the appropriate response/s)

A. Tuberculosis ☐ B. Hypertension ☐ C. Heart Disease ☐
D. Diabetes ☐ E. Asthma ☐ F. Others ☐

EXAMINATION

General Condition	Heart	Lungs	Breasts

ANTENATAL VISITS

	1	2	3	4
Date				
Any complaints				
POG (Weeks)				
Weight (Kg)				
Pulse rate				
Blood pressure				
Pallor				
Oedema				
Jaundice				

ABDOMINAL EXAMINATION

Fundal height Weeks/cm				
Lie/Presentation				
Fetal movements	Normal/Reduced/Absent	Normal/Reduced/Absent	Normal/Reduced/Absent	Normal/Reduced/Absent
Fetal heart rate per minute				
P/V if done				

ESSENTIAL INVESTIGATIONS

Hemoglobin				
Urine albumin				
Urine sugar				
Signature of ANM				

Blood Group & Rh Typing ☐ Date / /

OPTIONAL INVESTIGATIONS

1. Urine pregnancy test ☐ Date / /
2. Hbs Ag ☐ Date / /
3. Blood sugar ☐ Date / /

Participate in monthly fixed village Mother Child Health & Nutrition Day

If you or anyone in your family sees any of these danger signs, take the pregnant woman to the hospital immediately

- Bleeding during pregnancy, excessive bleeding during delivery or after delivery
- Severe Anaemia with or without breathlessness
- High fever during pregnancy or within one month of delivery
- Headache, blurring of vision, fits and swelling all over the body
- Labour pain for more than 12 hours
- Bursting of water bag without labour pains

Ensure Institutional Delivery

- Contact ASHA/ANM/AWW
- Register under Janani Suraksha Yojna (JSY)
- Obtain Benefits under JSY
- Identify Hospital in Advance
- Arrange for Transport in Advance
- Ensure 48 hours of stay after delivery

Preparation in case of Home Delivery

- Ensure safe delivery by ANM
- ✓ Clean hands
- ✓ Clean surface & surroundings
- ✓ Clean blade
- ✓ Clean umbilical cord
- ✓ Clean thread to tie the cord
- ✓ Clean set of clothes for newborn
- Ensure Family Care & Support

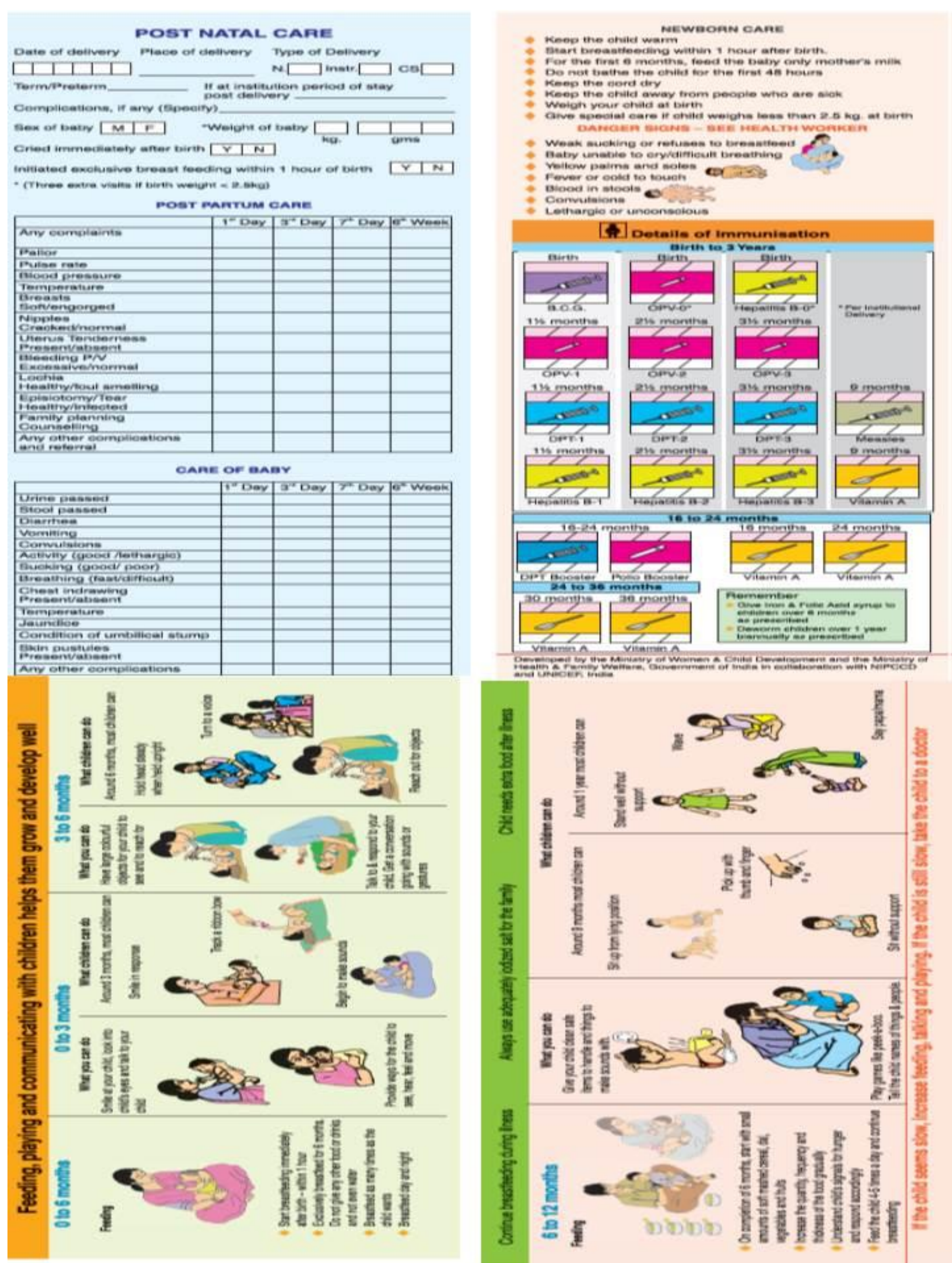
Emergency

- Arrange Transport to Hospital

After Delivery

- Initiated Breastfeeding within 1 Hour of Birth Yes ☐ No ☐
- Family Planning Counselling

Ensure early and exclusive breastfeeding 0-6 months



POST NATAL CARE

Date of delivery | Place of delivery | Type of Delivery: N. [ ] Instr. [ ] CS [ ]

Term/Preterm ________ If at institution period of stay post delivery ________

Complications, if any (Specify) ________

Sex of baby [M | F]   *Weight of baby [ ] kg. [ ] gms

Cried immediately after birth [Y | N]

Initiated exclusive breast feeding within 1 hour of birth [Y | N]

* (Three extra visits if birth weight < 2.5kg)

POST PARTUM CARE

	1st Day	3rd Day	7th Day	6th Week
Any complaints				
Pallor				
Pulse rate				
Blood pressure				
Temperature				
Breasts Soft/engorged				
Nipples Cracked/normal				
Uterus Tenderness Present/absent				
Bleeding P/V Excessive/normal				
Lochia Healthy/foul smelling				
Episiotomy/Tear Healthy/infected				
Family planning Counselling				
Any other complications and referral				

CARE OF BABY

	1st Day	3rd Day	7th Day	6th Week
Urine passed				
Stool passed				
Diarrhea				
Vomiting				
Convulsions				
Activity (good /lethargic)				
Sucking (good/ poor)				
Breathing (fast/difficult)				
Chest indrawing Present/absent				
Temperature				
Jaundice				
Condition of umbilical stump				
Skin pustules Present/absent				
Any other complications				

NEWBORN CARE

- Keep the child warm
- Start breastfeeding within 1 hour after birth.
- For the first 6 months, feed the baby only mother's milk
- Do not bathe the child for the first 48 hours
- Keep the cord dry
- Keep the child away from people who are sick
- Weigh your child at birth
- Give special care if child weighs less than 2.5 kg. at birth

DANGER SIGNS – SEE HEALTH WORKER

- Weak sucking or refuses to breastfeed
- Baby unable to cry/difficult breathing
- Yellow palms and soles
- Fever or cold to touch
- Blood in stools
- Convulsions
- Lethargic or unconscious

Details of Immunisation

Birth to 3 Years

Birth: B.C.G.	Birth: OPV-0*	Birth: Hepatitis B-0*	* For Institutional Delivery
1½ months: OPV-1	2½ months: OPV-2	3½ months: OPV-3	
1½ months: DPT-1	2½ months: DPT-2	3½ months: DPT-3	9 months: Measles
1½ months: Hepatitis B-1	2½ months: Hepatitis B-2	3½ months: Hepatitis B-3	9 months: Vitamin A

16 to 24 months

16-24 months: DPT Booster	16-24 months: Polio Booster	18 months: Vitamin A	24 months: Vitamin A

24 to 36 months

30 months: Vitamin A	36 months: Vitamin A

Remember

- Give Iron & Folic Acid syrup to children over 6 months as prescribed
- Deworm children over 1 year biannually as prescribed

Developed by the Ministry of Women & Child Development and the Ministry of Health & Family Welfare, Government of India in collaboration with NIPCCD and UNICEF, India

Feeding, playing and communicating with children helps them grow and develop well

0 to 6 months

Feeding

- Start breastfeeding immediately after birth – within 1 hour
- Exclusively breastfeed for 6 months. Do not give any other food or drinks and not even water
- Breastfeed as many times as the child wants
- Breastfeed day and night

0 to 3 months

What you can do: Smile at your child, look into child's eyes and talk to your child. Provide ways for the child to see, hear, feel and move

What children can do: Around 3 months, most children can: Smile in response; Track a colour bow; Begin to make sounds

3 to 6 months

What you can do: Have large colourful objects for your child to see and to reach for. Talk to & respond to your child. Get a conversation going with sounds or gestures

What children can do: Around 6 months, most children can: Hold head steady when held upright; Turn to a voice; Reach out for objects

Continue breastfeeding during illness | Always use adequately iodized salt for the family | Child needs extra food after illness

6 to 12 months

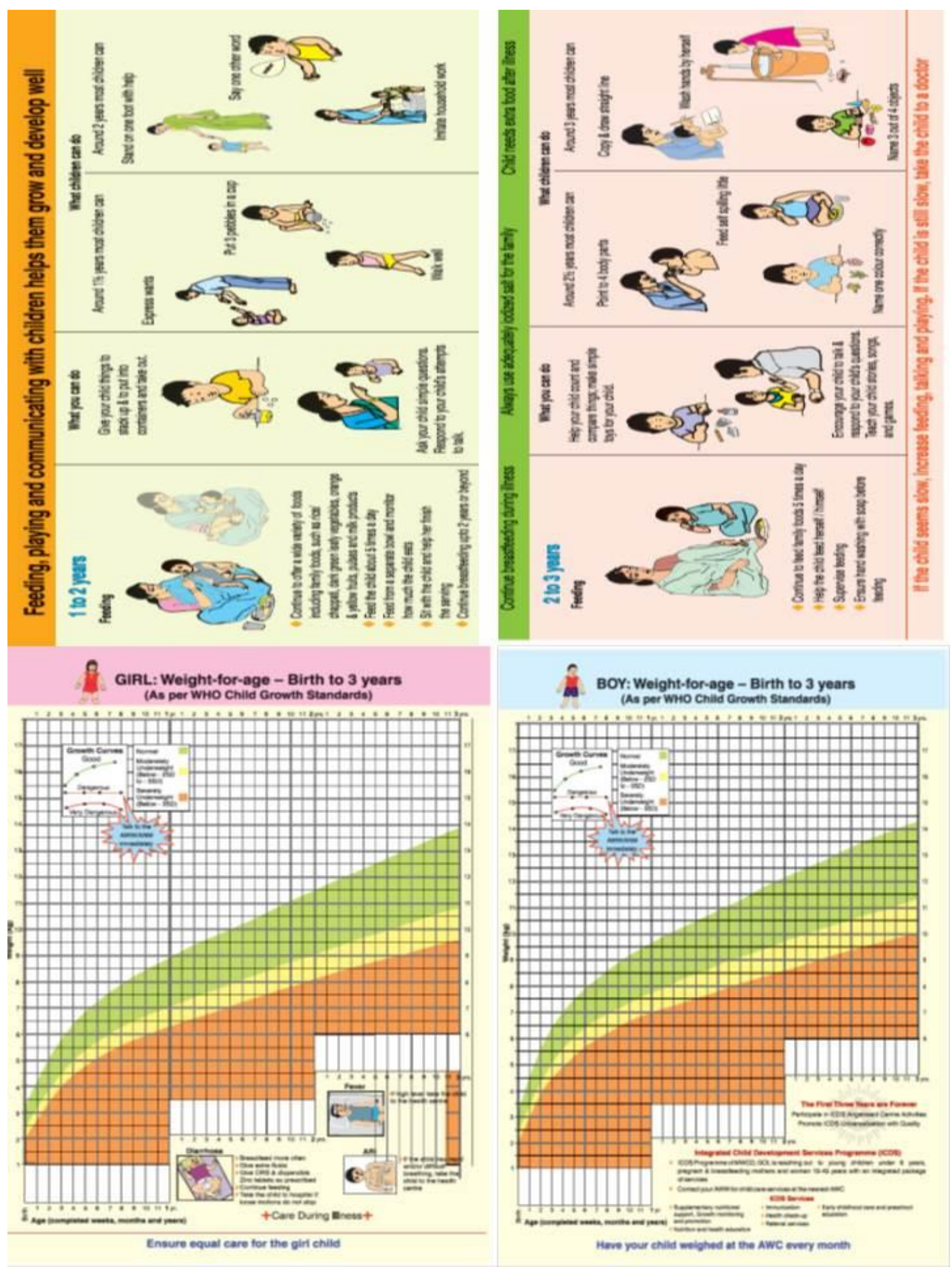
Feeding

- On completion of 6 months, start with small amounts of soft mashed cereal, dal, vegetables and fruits
- Increase the quantity, frequency and thickness of the food gradually
- Understand child's signals for hunger and respond accordingly
- Feed the child 4-5 times a day and continue breastfeeding

What you can do: Give your child clean safe items to handle and things to make sounds with. Play games like peek-a-boo. Tell the child names of things & people

What children can do: Around 9 months most children can: Sit up from lying position; Pick up with thumb and finger; Sit without support. Around 1 year most children can: Stand well without support; Wave; Say papa/mama

If the child seems slow, increase feeding, talking and playing. If the child is still slow, take the child to a doctor


Feeding, playing and communicating with children helps them grow and develop well
1 to 2 years
Feeding
2 to 3 years
If the child seems slow, increase feeding, talking and playing. If the child is still slow, take the child to a doctor
GIRL: Weight-for-age – Birth to 3 years
(As per WHO Child Growth Standards)
Care During Illness
Ensure equal care for the girl child
BOY: Weight-for-age – Birth to 3 years
(As per WHO Child Growth Standards)
Integrated Child Development Services Programme (ICDS)
Have your child weighed at the AWC every month

समेकित बाल विकास सेवाएं
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

मातृ एवं बाल सुरक्षा कार्ड

मां और बच्चे की फोटो

परिवार का परिचय

मां का नाम ____________________ आयु [ ]

पिता का नाम ____________________

पता ____________________

मां की शिक्षा : अनपढ़/प्राथमिक/माध्यमिक/हाईस्कूल/स्नातक

गर्भावस्था का विवरण

मां की पहचान संख्या ____________________

अन्तिम मासिक चक्र की तिथि [/ /]

प्रसव की सम्भावित तिथि [/ /]

कुल गर्भ/पहले जीवित जन्मे बच्चों की संख्या [/]

पिछला प्रसव कहां कराया गया संस्थान [ ] घर [ ]

मौजूदा प्रसव कहां करायेंगे संस्थान [ ] घर [ ]

जे.एस.वाई. पंजीकरण संख्या [ ]

जे.एस.वाई.भुगतान राशि [ ] तिथि [/ /]

जन्म का विवरण

बच्चे का नाम ____________________

जन्म तिथि [/ /] जन्म के समय वजन [ ] कि.ग्राम [ ] ग्राम

लड़की [ ] लड़का [ ] जन्म पंजीकरण संख्या [ ]

संस्थान का परिचय

आंगनवाड़ी कार्यकर्ता __________ आंगनवाड़ी केन्द्र/ब्लॉक __________

आशा __________ ए.एन.एम. __________

उप स्वास्थ्य केन्द्र/क्लिनिक __________

प्राथमिक स्वास्थ्य केन्द्र/शहर __________

अस्पताल/प्रथम सहायता केन्द्र (एफ.आर.यू.) __________

दूरभाष/मो. ए.एन.एम. __________ अस्पताल __________

यातायात की व्यवस्था __________

आंगनवाड़ी केन्द्र पंजीकरण संख्या [ ] तिथि [/ /]

उपकेन्द्र पंजीकरण संख्या [ ] तिथि [/ /]

रेफरल [ ] [ ] [ ] [ ] [ ]

महिला एवं बाल विकास मंत्रालय, भारत सरकार
स्वास्थ्य और परिवार कल्याण मंत्रालय, भारत सरकार

गर्भावस्था के दौरान नियमित जांच अनिवार्य है

पंजीकरण — पहली तिमाही में स्वास्थ्य केन्द्र में पंजीकरण कराएं।

प्रसवपूर्व जांच — पंजीकरण के बाद कम से कम तीन बार प्रसव पूर्व जांच अवश्य कराएं।

रक्तचाप, रक्त, पेशाब — प्रत्येक जांच के समय रक्तचाप और रक्त व पेशाब की जांच करवाएं।

वजन — प्रत्येक जांच के समय अपना वजन अवश्य करवायें। गर्भावस्था में कम से कम 10-12 कि.ग्रा. वजन बढ़ना चाहिये। गर्भावस्था के अन्तिम 6 महीनों में हर महीने कम से कम एक कि.ग्रा. वजन अवश्य बढ़ना चाहिए।

टेटनस टाक्सॉयड के टीके — टेटनस टाक्सॉयड के दो टीके लगवाएं। पहला टीका गर्भावस्था की पुष्टि होने पर और दूसरा टीका एक माह के बाद। (तिथि भरें)

आयरन गोलियां — कम से कम 3 महीने तक प्रतिदिन आयरन व फोलिक एसिड की एक गोली अवश्य खाएं। कुल मिलाकर कम से कम 100 गोलियां खाना आवश्यक है। (दी गई गोलियों की मात्रा एवं तिथि भरें)

गर्भावस्था के दौरान देखभाल

- विभिन्न प्रकार के खाद्य पदार्थों का सेवन करें।
- अधिक मात्रा में भोजन करें– सामान्य आहार से एक चौथाई ज्यादा।
- आंगनवाड़ी केन्द्र से मिले पूरक पोषाहार को नियमित रूप से खाएं।
- दिन में कम से कम 2 घण्टे आराम करें। इसके अलावा रात में 8 घंटे सोयें।
- केवल आयोडीन युक्त नमक का उपयोग करें।

हर प्रसवपूर्व जांच पर पोषण परामर्श सुनिश्चित करें

प्रसव पूर्व देखभाल

पूर्व गर्भावस्था में प्रसूति संबंधी जटिलता

कृपया सही जवाब पर निशान (✓) लगाएं

क. एपीएच [ ] ख. एक्लेम्पसिया [ ] ग. पीआई [ ]

घ. रक्त की कमी [ ] ङ. बाधित प्रसव [ ] च. पीपीएच [ ]

छ. एलएससीएस [ ] ज. शिशु में जन्मजात [ ] झ. अन्य [ ]

पिछला विवरण

कृपया सही जवाब पर निशान (✓) लगाएं

क. तपेदिक [ ] [ ] ख. उच्च रक्तचाप [ ] [ ] ग. ह्रदय रोग [ ] [ ]

जांच

सामान्य अवस्था	दिल	फेफड़े	स्तन

प्रसव पूर्व जांच

	1	2	3	4
तिथि				
कोई समस्या				
पीओजी (सप्ताह)				
वजन (कि.ग्रा)				
नब्ज की गति				
रक्तचाप				
पीलापन				
सूजन				
पीलिया				

उदर जांच

भ्रूण की लंबाई सप्ताह/से.मी.				
बनावट/गर्भस्थिति				
गर्भस्थ शिशु का हिलना-डुलना	[illegible]	[illegible]	[illegible]	[illegible]
गर्भस्थ शिशु की प्रति मिनट ह्रदय गति				
पी/वी यदि किया गया हो				

आवश्यक जांच

हीमोग्लोबिन				
मूत्र एल्ब्यूमिन				
मूत्र शर्करा				
ए.एन.एम. के हस्ताक्षर				

रक्त ग्रुप एवं आरएच प्रकार [ ] तिथि [/ /]

वैकल्पिक जांच

गर्भावस्था में मूत्र की जांच [ ] तिथि [/ /]

एचबीएस एजी [ ] तिथि [/ /]

रक्त शर्करा [ ] तिथि [/ /]

गांव के निर्धारित मासिक ग्राम स्वास्थ्य और पोषण दिवस में शामिल हों

यदि आपको अथवा आपके परिवार में किसी अन्य व्यक्ति को खतरे के ये लक्षण दिखाई दें तो गर्भवती महिला को तुरन्त अस्पताल ले जायें

- गर्भावस्था के दौरान रक्तस्राव, प्रसव के दौरान अथवा प्रसव के पश्चात् अत्यधिक रक्तस्राव
- सांस लेने में कठिनाई के साथ या उसके बिना शरीर में रक्त की गम्भीर कमी
- गर्भावस्था अथवा प्रसव के एक महीने के भीतर तेज बुखार
- दौरे पड़ना, धुंधला दिखाई देना, सिरदर्द, उल्टी, पूरे शरीर में सूजन
- 12 घण्टे से अधिक समय तक प्रसव पीड़ा
- प्रसव पीड़ा के बिना ही पानी की थैली फट जाना

संस्थागत प्रसव सुनिश्चित करें

- आशा/ए.एन.एम./आंगनवाड़ी सेविका से संपर्क करें
- जननी सुरक्षा योजना (जे.एस.वाई.) के अंतर्गत पंजीकरण कराएं
- जे.एस.वाई. के अंतर्गत लाभ उठाएं
- अस्पताल पहले से तय करें
- यातायात की व्यवस्था पहले से करें
- प्रसव के बाद 48 घंटे रहना सुनिश्चित करें

घर में प्रसव की स्थिति के लिए तैयारी

- ए.एन.एम. द्वारा सुरक्षित प्रसव सुनिश्चित करें
- ✓ स्वच्छ हाथ
- ✓ स्वच्छ जगह और स्वच्छ वातावरण
- ✓ स्वच्छ ब्लेड
- ✓ स्वच्छ नाभिनाल
- ✓ नाल बांधने के लिए स्वच्छ धागा
- ✓ नवजात शिशु के लिये स्वच्छ वस्त्र
- पारिवारिक देखभाल और सहायता को सुनिश्चित करें

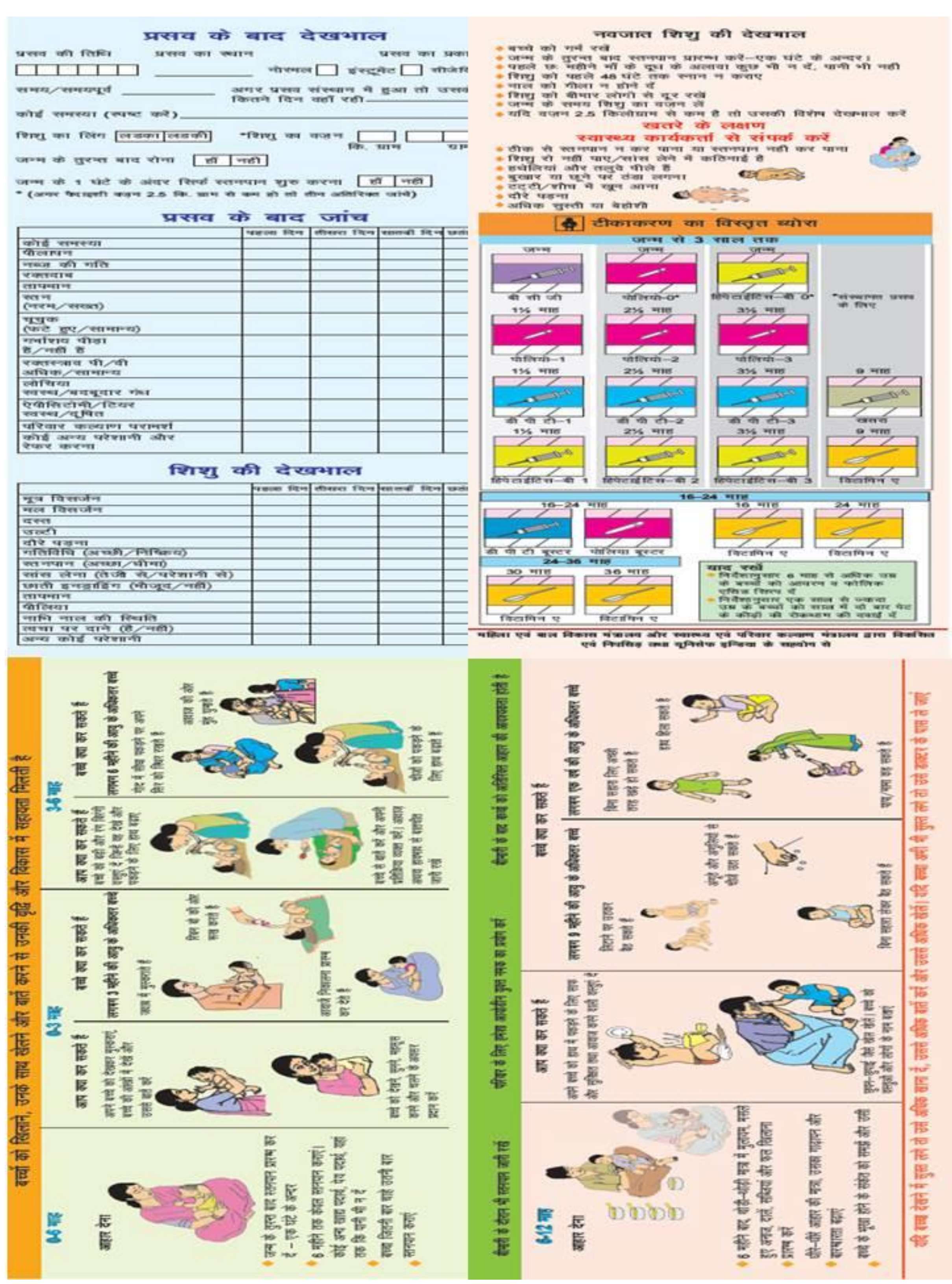
आपात स्थिति

- अस्पताल के लिए यातायात की व्यवस्था करें

प्रसव के बाद

- जन्म के एक घंटे के अन्दर स्तनपान शुरू किया हां [ ] नहीं [ ]
- परिवार कल्याण संबंधी परामर्श

जन्म के तुरन्त बाद स्तनपान शुरू करें
पहले छः महीने मां के दूध के अलावा कुछ भी न दें



प्रसव के बाद देखभाल

प्रसव की तिथि | प्रसव का स्थान | प्रसव का प्रकार: नॉरमल ☐ इंस्ट्रूमेंट ☐ सीजेरियन

समय/समयपूर्व ____ अगर प्रसव संस्थान में हुआ तो उसके कितने दिन वहाँ रही ____

कोई समस्या (स्पष्ट करें) ____

शिशु का लिंग [लड़का | लड़की] *शिशु का वजन [ ] कि. ग्राम [ ] ग्राम

जन्म के तुरन्त बाद रोना [हाँ | नहीं]

जन्म के 1 घंटे के अंदर सिर्फ स्तनपान शुरु करना [हाँ | नहीं]

* (अगर पैदाइशी वजन 2.5 कि. ग्राम से कम हो तो तीन अतिरिक्त जांचें)

प्रसव के बाद जांच

	पहला दिन	तीसरा दिन	सातवाँ दिन
कोई समस्या			
पीलापन			
नब्ज की गति			
रक्तचाप			
तापमान			
स्तन (नरम/सख्त)			
चूचुक (फटे हुए/सामान्य)			
गर्भाशय पीड़ा है/नहीं है			
रक्तस्राव पी/वी अधिक/सामान्य			
लोचिया स्वस्थ/बदबूदार गंध			
एपीसिटोमी/टियर स्वस्थ/दूषित			
परिवार कल्याण परामर्श			
कोई अन्य परेशानी और रेफर करना			

शिशु की देखभाल

	पहला दिन	तीसरा दिन	सातवाँ दिन
मूत्र विसर्जन			
मल विसर्जन			
दस्त			
उल्टी			
दौरे पड़ना			
गतिविधि (अच्छी/निष्क्रिय)			
स्तनपान (अच्छा/धीमा)			
सांस लेना (तेजी से/परेशानी से)			
छाती इनड्राइंग (मौजूद/नहीं)			
तापमान			
पीलिया			
नाभि नाल की स्थिति			
त्वचा पर दाने (हैं/नहीं)			
अन्य कोई परेशानी			

नवजात शिशु की देखभाल

- बच्चे को गर्म रखें
- जन्म के तुरन्त बाद स्तनपान प्रारम्भ करें–एक घंटे के अन्दर।
- पहले छः महीने माँ के दूध के अलावा कुछ भी न दें, पानी भी नहीं
- शिशु को पहले 48 घंटे तक स्नान न कराएं
- नाल को गीला न होने दें
- शिशु को बीमार लोगों से दूर रखें
- जन्म के समय शिशु का वजन लें
- यदि वजन 2.5 किलोग्राम से कम है तो उसकी विशेष देखभाल करें

खतरे के लक्षण
स्वास्थ्य कार्यकर्ता से संपर्क करें

- ठीक से स्तनपान न कर पाना या स्तनपान नहीं कर पाना
- शिशु से नहीं पाए/सांस लेने में कठिनाई है
- हथेलियां और तलुवे पीले हैं
- बुखार या छूने पर ठंडा लगना।
- टट्टी/शौच में खून आना
- दौरे पड़ना
- अधिक सुस्ती या बेहोशी

टीकाकरण का विस्तृत ब्योरा

जन्म से 3 साल तक

जन्म: बी सी जी	जन्म: पोलियो-0*	जन्म: हिपेटाइटिस–बी 0*	*संस्थागत प्रसव के लिए
1½ माह: पोलियो–1	2½ माह: पोलियो–2	3½ माह: पोलियो–3	
1½ माह: डी पी टी–1	2½ माह: डी पी टी–2	3½ माह: डी पी टी–3	9 माह: खसरा
1½ माह: हिपेटाइटिस–बी 1	2½ माह: हिपेटाइटिस–बी 2	3½ माह: हिपेटाइटिस–बी 3	9 माह: विटामिन ए

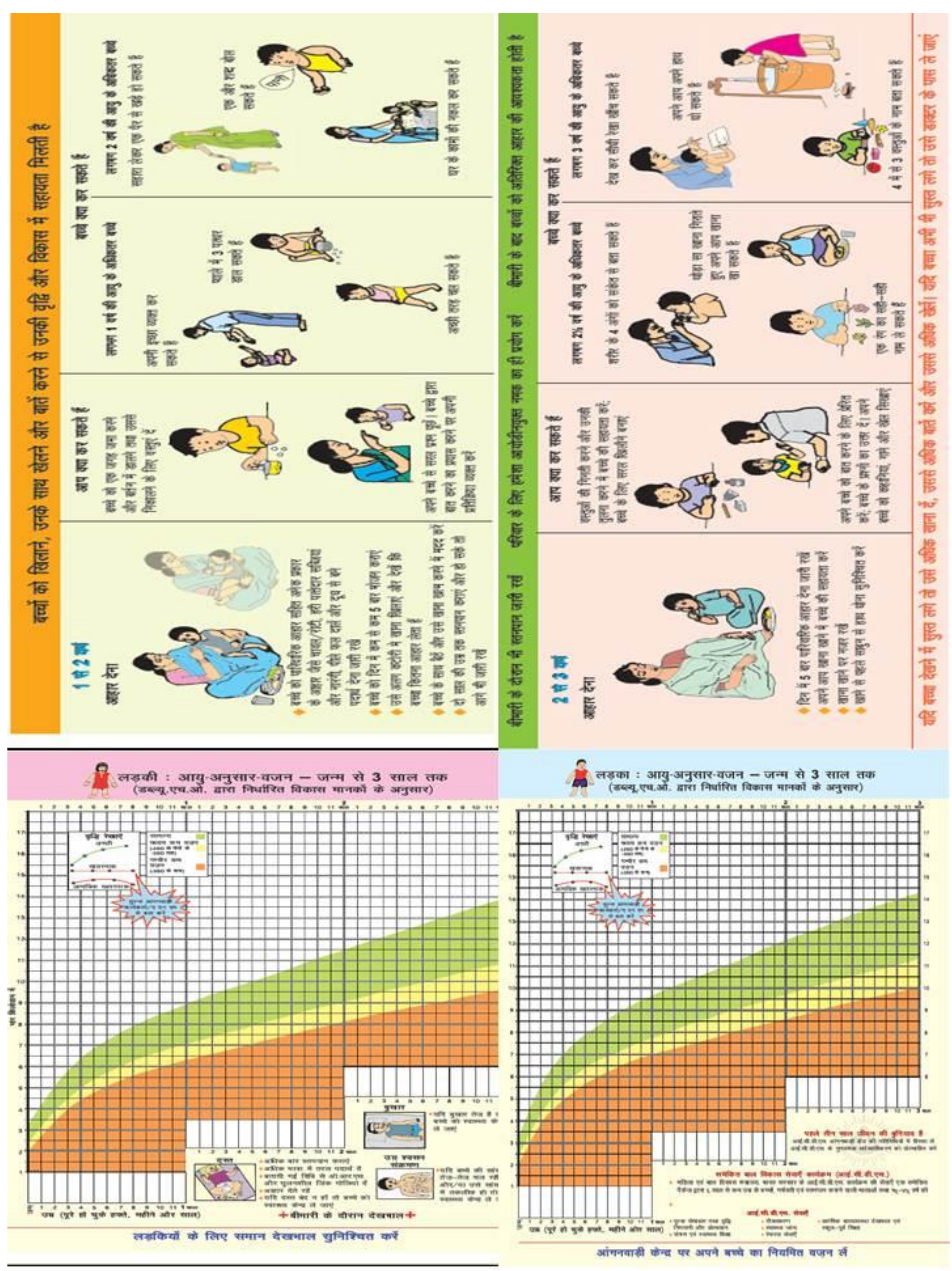
16–24 माह: डी पी टी बूस्टर, पोलियो बूस्टर; 16 माह: विटामिन ए; 24 माह: विटामिन ए

24–36 माह: 30 माह: विटामिन ए; 36 माह: विटामिन ए

याद रखें

- निर्देशानुसार 6 माह से अधिक उम्र के बच्चों को आयरन व फोलिक एसिड सिरप दें
- निर्देशानुसार एक साल से ज्यादा उम्र के बच्चों को साल में दो बार पेट के कीड़ों की दवाई दें

महिला एवं बाल विकास मंत्रालय और स्वास्थ्य एवं परिवार कल्याण मंत्रालय द्वारा विकसित एवं नियमित तथा यूनिसेफ इण्डिया के सहयोग से


बच्चों को खिलाने, उनके साथ खेलने और बातें करने से उनकी वृद्धि और विकास में सहायता मिलती है
लड़की : आयु-अनुसार-वजन — जन्म से 3 साल तक
(डब्ल्यू.एच.ओ. द्वारा निर्धारित विकास मानकों के अनुसार)
बीमारी के दौरान देखभाल
लड़कियों के लिए समान देखभाल सुनिश्चित करें
लड़का : आयु-अनुसार-वजन — जन्म से 3 साल तक
(डब्ल्यू.एच.ओ. द्वारा निर्धारित विकास मानकों के अनुसार)
आंगनवाड़ी केन्द्र पर अपने बच्चे का नियमित वजन लें

Case of Sex Selection: A Case Study

Mrs Ahuja, a 40 year old woman from Delhi, who is pregnant for the 6th time. She already has 2 living female children and 3 spontaneous abortions. She has been married since she was 17 years old and repeatedly conceived soon after delivery. She cannot remember when she last had a menstrual period.

The doctor is forcing her to have a tubal ligation after her delivery, as she tells Mrs. Ahuja, that it is unhealthy and dangerous to be pregnant so many times. She had been offered in vitro fertilization with this pregnancy, to ensure a male fetus, but refused, wanting to have a male child by natural means. Mrs. Ahuja calls to say that she is changing doctors, as she does to want to be forced to stop having children or undergo IVF

Questions:

Q.1: The woman often risk being treated as merely a vehicle for reproduction, what can be done to change this view?

Q.2: How can you change values ascribed to sex and gender roles which dictate that the woman must keep reproducing until she has a son to have any position in the society?

Q.3: Discuss the ethics of using in-vitro fertilization to ensure a male foetus?

Q.4: What advice would you give Mrs. Ahuja?

DRAFT

Annexure-7

Rights of Children: Articles Description

Article 1	Definition of the Child	**Article 16**	Privacy, Honour, Reputation	**Article 31**	Play and Recreation
Article 2	Non-Discrimination	**Article 17**	Access to Information and Media	**Article 32**	Economic Exploitation
Article 3	Best Interests of the Child	**Article 18**	Parental Responsibility	**Article 33**	Narcotic and Psychotic Substances
Article 4	Implementation of Rights	**Article 19**	Abuse and Neglect (while in Family or Care)	**Article 34**	Sexual Exploitation
Article 5	Parents, Family, Community Rights and Responsibilities	**Article 20**	Alternative Care for Children in the Absence of Parents	**Article 35**	Abduction, Sale and Traffic
Article 6	Life, Survival and Development	**Article 21**	Adoption	**Article 36**	Other Forms of Exploitation
Article 7	Name and Nationality	**Article 22**	Refugee Children	**Article 37**	Torture, Capital Punishment, Deprivation of Liberty
Article 8	Preservation of Identity	**Article 23**	Disabled Children	**Article 38**	Armed Conflicts
Article 9	Non-Separation from Parents	**Article 24**	Health Care	**Article 39**	Recovery and Reintegration
Article 10	Family Reunification	**Article 25**	Periodic Review	**Article 40**	Juvenile Justice
Article 11	Illicit Transfer and Non-Return of Children	**Article 26**	Social Security	**Article 41**	Rights of the Child in other Instruments
Article 12	Expression of Opinion	**Article 27**	Standard of Living	**Article 42**	Dissemination of the Convention
Article 13	Freedom of Expression and Information	**Article 28**	Education	**Article 43-54**	Implementation
Article 14	Freedom of Thought, Conscience and Religion	**Article 29**	Aims of Education		
Article 15	Freedom of Association	**Article 30**	Children of Minorities and Indigenous Children		

Annexure-8

Functions and Powers of NCPCR

Function of the commission (NCPCR) the commission shall perform all or any of the following functions, namely:-

1. Examine and review the safeguards provided by or under any law for the time being in force for the protection of child rights and recommend measures for their effective implementation;
2. Present to be central government, annually and at such other intervals, as the commission may deem fit, reports upon working of those safeguards;
3. Inquire into violation of child rights and recommend initiation of proceedings in such cases;
4. Examine all factors that inhibit the enjoyment of rights of children affected by terrorism, communal violence, riots, natural disaster, domestic violence, HIV/AIDS, trafficking, maltreatment, torture and exploitation, pornography and prostitution and recommend appropriate remedial measures;
5. Look into the matters relating to the children in need of special care and protection including children in distress, marginalized and disadvantaged children, children in conflict with law, juveniles children without family and children of prisoners and recommend appropriate remedial measures;
6. Study treaties and other international instruments and undertake periodical review of existing policies, programmes and other activities on child rights and make recommendations for their effective implementation in the best interest of children;
7. Undertake and promote research in the field of child rights;
8. Spread child rights literacy among various section of society and promote awareness of the safeguards available for protection of these rights through publications, the media, seminar and other available means;
9. Inspect or cause to be inspected any juveniles custodial home, or any other place of residence or institution meant for children, under the control of the central government or any other authority, including any institution run by a social organization; reformation or protection and take up with these authorities for remedial action, if found necessary;
10. Inquire into complaints and take suo motu notice of matter relating to
    1. Deprivation and violation of child rights;
    2. Non implementation of laws providing for protection and development of children;
    3. Non-compliance of policy decisions, guidelines or instructions aimed at mitigating hardships to and ensuring welfare of the children and provide relief to such children; Or take up the issues arising out of such matters with appropriate authorities and;

11. Such other functions as it may consider necessary for the promotion a state commission or any other commission duly constituted under any law for the time being in force.

DRAFT

Annexure-9

RTI Act Quiz

1) When did RTI Act come into force in India?

2) Can you ask for reports and records under the Act?

3) Who can seek information under the RTI Act, 2005?

4) Within what time should the information be provided? (In normal case)

5) If information is denied or not provided what can you do?

Answer Key:

1. 12th October, 2005

2. Yes

3. Individual citizen

4. 30 days

5. Appeal to the appellate authority

DRAFT

Annexure-10

APPLICATION FORM UNDER RIGHT TO INFORMATION ACT 2005

To
Name (Designation)
Name of the Unit,
Central Bureau of Investigation
(Complete postal address)

Sub: Information under the Right to Information Act, 2005

Sir,
I am sending herewith an application seeking information under the Right to Information Act, 2005 as per particulars furnished below:

Name:
Postal Address:
Telephone No.:
Mobile phone No.
Date:
*Subject of information
Sought and department concerned:

Application Fee: Rs.10/- (Rs. Ten Only)
Mode of payment: Cash, Demand Draft, Banker's Cheque/IPO

Date
DD/Banker's cheque should be payable to...
New Delhi.
Date of receipt

dd pages if needed　　　　　　　　　　　　　　Signature of applicant

A Model Letter of Application / Request

Date:........

To,
The Public Information Officer
(Name of the Public Authority)
(Address of the Public Authority)

Sir / Madam:

Sub: Request for Information under the Right to Information Act, 2005

[if applicable] Kindly, provide me the following information:............. (Mention the information you want as specifically and clearly as possible and the period of time to which the information pertains)

- ...
- ...

[if applicable] I request for receipt of the information in the following format(s) – true copy / print out / diskette / floppy / tape / video cassettes / certified copies of documents or records – in person / by post / by e-Mail.

[if applicable] I would like to inspect the following works / documents / records / take notes / extracts..... (Mention clearly and specifically what is wanted for inspection). Kindly inform me the date and time for my visit.

[if applicable] Kindly, provide me certified samples of material (Mention specifically and clearly the material). I request for receipt of the certified samples (Describe) ....

The details of fees paid by me are as follows (Specify)......... /I belong to the 'Below Poverty Line Category' [if applicable, attach a photocopy of the proof] and I am not required to pay any fees.

Sincerely,
(Applicant's signature/Thumb Impression)

Applicant's Name:
Applicant's Address:
Applicant's Phone Number/e-Mail Address (optional):
Place:

Annexure-11

Exclusive Breastfeeding

Infant and Young Child Feeding

Update - 1

Exclusive Breastfeeding - the first 6 months

To maximise the benefits of breastfeeding, all infants should be exclusively breastfed for first six months and to ensure that, you could play a significat role. You can make a difference ! With the present knowledge and its application it is now possible to enable women to adopt this most useful practice for optimum development of children and ensure their nutrition rights. In the Infant and Young Child Feeding Update -1, we talk about exclusive breastfeeding, its reasons and how to apply this knowledge. Some common questions asked by mothers are also taken up to provide you with appropriate responses, which would help a mother to be successful in breastfeeding her baby. The following are some practices that help to establish and sustain exclusive breastfeeding for the first six months of the infant's life.

1 Initiate breastfeeding as early as possible preferably within about an hour of birth

Why early initiation?

- The newborn is very active and alert during first hour of life and then goes to sleep. The baby has very strong sucking reflex at this time.
- It helps in better mother-child bonding and development of the baby.
- It stimulates the oxytocin and prolactin reflex and hence breastmilk production.
- It ensures that baby gets colostrum,which serves as the baby's first immunization with a host of antibodies and live cells in it.
- It reduces chances of postpartum haemorrhage in the mother.

2 Establish good breastfeeding skills (proper positioning, attachment and effective feeding)

Why good skills?

- Establishing good breastfeeding skills helps effective milk transfer from mother to the baby.
- This also helps to prevent later breastfeeding problems like nipple pain, sore nipples or mastitis etc. which may lead to discontinuation of breastfeeding.

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3 Breastfeed exclusively for about first six months

Why?

- Breastmilk should be a baby's first taste. There should be no prelacteal feeds such as honey, water, other liquids or ritual foods, as they would delay the start to breastfeeding because babies do not want to suckle if they receive any such foods.

- It fosters mother-infant bonding and optimal growth and development, including brain growth. Many studies have shown this relationship.

- Exclusive breastfeeding for first six months reduces chances of development of asthma and allergy.

- Breastmilk completely satisfies an infant's nutritional and fluid needs for about the first six months. Infants do not need water or other liquids such as herbal teas even in hot climates. The potential dangers of water supplementation are introduction of infection and the reduction in mother's breastmilk supply due to decreased stimulation to produce prolactin.

- Exclusively breastfed children are at a much lower risk of infection from diarrhoea and acute respiratory infections.

4 Practice frequent, on demand breastfeeding, including night feeds

Why?

- Babies should be fed 8-12 times per 24 hours, every 2-3 hours or more frequently if needed, especially in the early months.

- An infant's stomach is small and needs to be refilled often.

- Frequent feeding helps maintain the mother's milk supply, maximizes the contraceptive effect, and provide immune factors at each feeding. It also prevents breastfeeding problems.

Did you know?

Despite the fact that every one knows that breastmilk is the best food for infants, it is unfortunate that;

- *About 50% of babies in first 3 months are not exclusively breastfed (NFHS 1992-93 data).*
- *Use of artificial milk & bottle feeding jumps from 11% during 1st month to 55 % during 4th month (BPNI study).*
- *About 20-30% babies in first year are given supplements of artificial milk under the influence of health care providers.(BPNI Study 1998)*

Tips

While counselling mothers, here are some tips to keep in mind

1. Let mother know that colostrum is enough food and water for the babies during first few days, it is God's gift to save them from diseases and provides security.

2. Offer no bottles or pacifiers (dummies or artificial teats) to babies as it might interfere in lactation performance.

3. If a baby urinates at least six times in 24 hours, this is a sign that breastmilk intake is adequate. This information, you must share with mothers who are worried about their milk supply.

4. While counselling women who have a feeling of "Not enough milk", inform them that adequate weight gain of the baby is the best criteria to assess adequacy of breastmilk supply. So monitoring the growth of babies is a useful strategy in your child health practice.

5. If you like to know why a baby is not getting enough, look for the reasons of not enough milk, most common and imporatnt reasons include the introduction of supplements or incorrect attachment of the baby at the breast.

Applying this Information

Every mother needs help, especially the primigravidas.You can help mothers to position their babies for correct attachment at the breast and it should happen on day one.Though mothers should receive such information during pregnancy it is useful to help a mother to position her baby correctly at the breast immediately after birth. Here are some ideas,

1.Talk to her to find out how she feels.

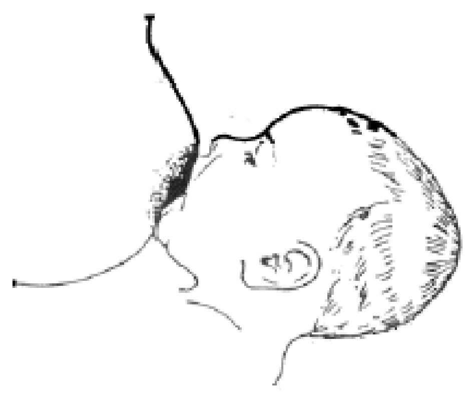

Fig.1:Correctly attached baby

2.Have her baby very near to her. Baby should be held close to the mother, facing the breast with the baby's ear, shoulder and hip in a straight line (Fig.3).

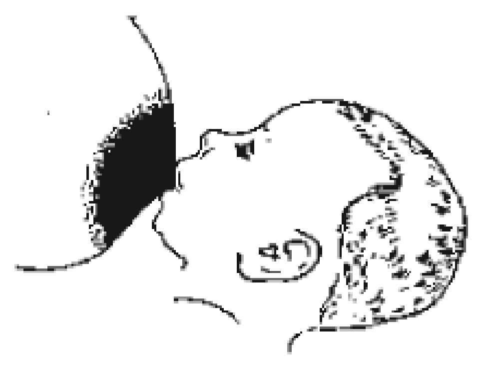

Fig.2:Incorrectly attached baby

3. Baby's mouth should open wide just before attaching so that the nipple and much of the areola are in the mouth. If properly attached, the lips are rolled outward, with the tongue over the lower gum (see *correct & incorrect* position in Figures 1-2).

Fig.3:Positioning a baby in straight line and facing the mother

4. You can observe signs of effective feeding like, visible jaw movement drawing milk out, slow and deep sucks and not the rapid & shallow ones, rhythmical suckling with an audible swallowing and no indrawing of cheeks. Mother should have no pain while feeding.

Commonly asked questions

There are some questions that are commonly asked by the mothers. The following are suggested responses, which you can use while counselling mothers . However , you can individualise your decisions. These are suggestions only.

Q.1.What if I use one bottle-feed/top-feed at night . My friend told me that it will give me rest and my baby would also sleep well.

Response: Good you thought of this question and that you plan to breastfeed your baby mostly. Let me tell you that even one bottle may interfere in breastfeeding process and then the baby would receive less milk and slowly get on to bottles. Regarding sleeping, the artificial milk takes longer to digest and babies donot demand frequently. Exclusively breastfed babies may demand frequently in early weeks but tend to set their own timing over a period of time.

Q.2.If I exclusively breastfeed my baby, he might not get into the habit of other milks later?

Response: You are worried about baby's milk diet when he is older. It may be useful to know that a baby gets about 500 ml of breastmilk per day in 2nd year of life in case a mother continues to breastfeed along with solid food of course. Ideally your baby does not need any other milk for first two years. After two years he would get to habits of milk and other family foods. Milk does not make a priority food when he is grown up after two years of age.

Q.3. As milk does not come in during first three days, is it not right I should give something to my baby?

Response: It is good you are thinking of your baby getting enough food for first few days. It is important to know that during first few days your milk will be thick and yellowish, called *colostrum*. It takes care of baby's food and fluids during these days, after which there is free flow of milk seemingly coming now but milk production starts in pregnancy and as the baby suckles he gets all what he needs.

Resources

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The Law to protect and promote breastfeeding. A book that explains the provisions of the IMS Act in a simple manner.
Rs. 40 each

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Compiled & Edited by : Dr. Arun Gupta, Dr. Mrs. Rita Gupta and Ms. Nirmala Selvam.
Designed by: Mr. Amit Dahiya.
Breastfeeding Promotion Network of India (BPNI), BP-33, Pitampura, Delhi-110 034
Phone: (91) 011-7443445, Fax (91) 011-7219606,
E-mail: ritarun@nda.vsnl.net.in, Website: www.indiasocial.org/bpni

Infant and Young Child Feeding

Update - 2

Complementary Feeding

Breastfeeding alone is sufficient food for all babies till 6 months of age. From 6 months, complementary foods are required to ensure adequate growth and to prevent malnutrition and stunting. In order to help mothers to feed their infants appropriately you need to know the age of introduction of complementary foods, type, texture, frequency, amount of food and method of feeding.

*The 6-11 month period is an especially vulnerable time because infants are just learning to eat and must be fed soft foods frequently and patiently. Care must be taken to ensure that these foods complement rather than replace breastmilk. For older infants and toddlers, breastmilk continues to be an important source of **energy, protein, vitamin A and vitamin C**. Therefore, breastfeeding should continue upto the age of 2 years along with complementary feeding. All health care providers should be able to counsel mothers with regard to complementary feeding and guide them concerning age of introduction, type and texture of food, quantity, and method of feeding.*

Age of introduction of complementary foods

For all infants after six months of age.

Sufficient scientific data is now available to support that exclusive breastfeeding should be continued till six months and complementary foods added to breastmilk after 6 months. Initiating complementary foods **too early** or **too late** can lead to malnutrition. If given **too early** the infant may not be ready to digest the food properly and may also reduce intake of breastmilk thereby losing out on appropriate energy intake for his/her growth. Early introduction of complementary foods replaces breastmilk by food which is usually less nutritious. It also increases the risk of diarrhoea and other infections.

After six months of age, however, the breastmilk cannot supply all the needs of the growing baby. Introduction of complementary feeds **too late** results in an inadequate intake of energy and protein leading to poor growth as well as iron and other nutritional deficiencies.

Why at 6 months

An understanding of the development of suckling and chewing abilities in babies is necessary for the **timing of the introduction** of complementary feeding.

By six months an infant can voluntarily

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control sucking and swallowing, and biting movements begin. The tendency to push solids out of mouth decreases. Teeth begin to erupt and pancreatic enzymes reach adequate levels for digestion of starch. By the age of nine months an infant can use lips to clear a spoon and use the tongue to move food between the teeth. Solids can also be chewed at this age.

This implies that from about 6 months, a child can eat soft and starchy foods such as cereals. By 9 months infants can be given chopped foods.

By one year a child can eat family foods and if trained should be able to use fingers or spoon to feed self.

Taste, consistency and texture and types of complementary foods

A child's first food should be based on cereals like suji or fruit like banana which are soft, thicker than breastmilk, and bland in taste, mashed or strained to homogenize.

The consistency of food should be suitable as per the child's age. For very young infants, liquid supplements should be given and their consistency gradually needs to be changed from liquid to semisolid and then to solid with advancing age of the child. Initially, a baby might spit out the food. That does not mean s/he does not like it. Learning to swallow semisolid food is difficult for a baby who only knows how to suckle at the breast. Husks, bean skin and vegetable fibers may cause indigestion, so everything must be mashed at the beginning.

The first pre-requisite of a good complementary food is to meet the nutritional needs of the child. No single food can meet all the nutrient requirements. Essential nutrients are widely distributed in nature and can be obtained from many foods with ease. Also, most of the foods contain more than one and quite often, many of the essential nutrients in varying proportions. Therefore to achieve a balance of nutrients, foods should be included from all the three food groups (energy giving, body building and protective) in the diet.

Foods	Major Nutrients	Functions
• Milk • Meat • Pulses	Protein	Body Building
• Cereal, starches • Fat • Sugar	Carbohydrates & Fat	Energy Giving
• Vegetables (excluding starchy vegetables) • Fruits	Minerals, Vitamins & Dietary fibres	Protective

Source: Adapted from Text Book of Nutrition and Dietetics, Deptt. of Food & Nutrition, Institute of Home Economics, University of Delhi.

Tips

1. Potatoes, carrots, beans can be easily cooked along with *dal* and rice or *daliya* and mashed to desired softness to feed the young child.
2. Adding oil or butter to cooked and mashed food is a good way to increase energy density.
3. When introducing fresh fruit in the diet mash it for easy feeding.
4. During illness, give small frequent meals along with breastmilk.
5. Avoid spices and chillies.
6. If a food makes the baby sick or he turns pale, it should not be given till the baby is older, as the baby may be allergic to the food.
7. Offer home made family foods as they are more nutritious. Commercially processed foods are seemingly convenient but are not better or even equal to home made foods and they are 6 times costly as well. *(Gupta A, Bhatia S. Commercial Infant Foods-Analysis of Promotion, BPNI 1998)*

Applying this Information

Frequency of complementary foods

When food is first introduced, a small amount should be given 1-2 times a day. From the age of six months to one year adequate serving of complementary foods should be given thrice a day and gradually the amount should be increased. If the child is not breastfed, complementary foods should be given five times a day. It is advisable to continue frequent breastfeeding including night breastfeeds up to two years of age.

Feeding Practice

Children can usually feed themselves by one year of age but they need supervision and help.

- Mothers/care-givers should introduce one food at a time.
- The child should never be fed forcibly. If the child dislikes a particular food, it should be removed from his/her diet for some time and re-introduced at a later stage or mixed with another food that the baby likes. If the child shows a persistent dislike for that food, it should not be forced upon. No food is indispensable and some other substitute can always be given.
- Variety should be introduced in the child's diet to make it more appealing.
- As the child grows older, colour, flavour, texture and shape of the food can be given special consideration so as to attract child's attention.
- To make the child learn to eat all types of foods and to inculcate good eating habits among children, the parents should not show personal prejudices and dislikes towards any foods.
- Use meal times as an opportunity for communicating with the child.
- It is not always necessary to cook seperately for the child, as the family meals can be easily modified in consistency, spicing, etc; for the amount needed to feed the child.

Did you know?

⇨ Recent studies show that the introduction of complementary foods before the age of six months neither enhances growth nor nutritional status of infants and that these foods replace breastmilk in breastfed infants and increase exposure to contaminated weaning foods. *(Ann CH, Maclean WC. Growth of the exclusively breastfed infant. Am J Clin Nutrition 33: 183-192, 1980; Cohen RJ et al. Effects of age of introduction of complementary foods on infant breastmilk intake, total energy intake, and growth: a randomised intervention study in Honduras. The Lancet. 44:288-293, 1994)*

⇨ Early introduction of complementary foods can lead to malnutrition and more importantly decrease mother's milk production due to decreased Prolactin, a hormone, which is responsible for milk production, and depends on suckling stimulation by the baby. *(Malek M A et al. Effects of Training Mothers on Weaning and Supplementary Food in Rural Bangladesh. Journal of Child Health, 10: 134-137, 1986)*

- Feed slowly and patiently and minimize distractions during meals.
- Encourage the child towards self eating.

Hygiene and Care

- When a child starts complementary food, there is increase in risk of diarrhoea. Care should be taken to prepare and handle food hygenically.
- Feed the child fresh food and keep food away from flies, insects and pets. Use cooked food within few hours.

A child of 1-2 years needs half the amount of food that his/her mother eats.

It is preferable to continue breastfeeding until about 2 years. Let the baby decide when to stop breastfeeding. The best time to wean is when the baby wants to stop breastfeeding. Advise mothers to slowly wean off from the breast and not suddenly. Gradually breastmilk supply will decrease and baby will lose interest. The less the baby suckles less breastmilk is made.

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Commonly asked questions

Q 1. My baby is 4 mths old and I am away from home between 8.30 a.m. to 6.30 p.m. How much expressed breastmilk is adequate for each feed and how it should be stored?

Response: It is good that you are keen to give breastmilk to your baby while you are away at work. Here are some useful guidelines.

- ➔ Breastfeed your baby before you leave for work and as soon as you can when you return from work. Baby would need a feed every 3 or 4 hours so you can express enough to last the time that you are away.
- ➔ Your baby would need around 100ml (i.e. about ¾ cup) of expressed breastmilk (EBM) per feed. If you can store for each feed separately then that will be good.
- ➔ Breastmilk can be expressed and stored safely in a clean cup for 8 hours at room temperature even in a hot climate and 24 hours in refrigerator. Use a clean plate to cover the cup.
- ➔ Do not heat expressed milk. If you had stored it in the refrigerator, then ask the care-giver to bring it to room temperature by keeping it out of the refrigerator or keep the cup of milk in a basin of warm water – do not heat the milk.

Q.2. I do not have enough milk so I give some artificial milk in addition to breastfeeds. Is that OK?

Response: Firstly, you need to know, what makes you think that you do not have enough milk. I would like to inform you that if the baby is passing urine 6 or more times a day and is gaining weight appropriately i.e. 500gms per month, then s/he is getting enough milk. If the baby is not getting enough, please don't be anxious or tense as it will affect your oxytocin reflex that is responsible for flow of breastmilk from your breast to your baby. Be confident to keep up your milk supply. Check if your baby is suckling in correct position or not, and you are frequently barestfeeding on demand to the child day and night. It is baby's suckling that controls whole production of breastmilk through a hormone called 'Prolactin'. The other hormone Oxytocin controls the flow of milk from your breast to the baby and is dependant on your confidence, thoughts and feelings; good feelings enhance it, anxiety or doubt depress it.

In our next issue we will cover *Problems in initiating breastfeeding and how breastfeeding works.*

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Rs. 40 each

Under Attack - An Indian Law to Protect Brastfeeding - A report on the monitoring of the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 (The IMS Act)
Rs. 100 each

Commercial Infant Foods - Analysis of Promotion - A report on the ways and means of promotion used by the manufactures
Rs. 100 each

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Compiled & Edited by : **Dr. Arun Gupta, Nirmala Selvam, Ruchika Chugh.**
Designed by: **Amit Dahiya.**
Breastfeeding Promotion Network of India (BPNI), **BP-33, Pitampura, Delhi-110 034**
Phone: (91) 011-7443445, Fax (91) 011-7219606,
E-mail: bpni@bpni.org, Website: http://www.bpni.org

Annexure-13

Situation 1:

Pooja & Rashmi have toady taken their children for weight monitoring at the nearby AWC. Pooja's son Rahul is moderately malnourished while Rashmi's son who is also 2 yrs old is gaining weight as per height.

- AWW now has to counsel Pooja on management of moderate malnutrition
- Enumerate the points that need to be discussed
- Also tell us what all aids could be used by the AWW

Situation 2:

Rani has delivered a baby girl of 2.5 kgs a few days ago in a nearby hospital. The AWW now has to visit Rani and counsel her.

- What all points will you counsel her as an AWW
- Also tell us the aids that you would suggest could be used for Inter-personal communication

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Annexure-14

Sample Story

Rani, at 10 years old, was always full of enthusiasm and indeed was a very intelligent girl. She was the second child of four sisters. Rani's mother has died during birth of her youngest sister. Her father had since then always treated all of his girls as burdens and often came drunk in the night. He had always wished for sons to carry out his legacy, and he made it very clear to all his children that he despised them all. Rani's father was a worker in the mine and hence did not earn a lot; ever since their mother had died it was up to Rani and her elder sister Shanti to take care of her two younger sisters.

As Shanti had turned 12, one of the neighbouring village's Chaudhary who had given a loan to rani's father, demanded that he get Shanti married to his son who was 18 and his load will be forgotten. Since rani's father did not have enough money, he considered the proposal and decided to get Shanti married.

Rani knew that Shanti always wanted to study so that she could help earn for the family but this was a surprise for them all. Reluctantly, though Shanti agreed to the marriage as she did not want to disappoint her father yet again. Out of obligation to her father and thoughts of her sisters, that if she married into a rich family she could help provide for her sisters.

Shanti got married but her family life was not good. Her husband used to beat her and treat her very badly. One of the abuses was so violent that Shanti was left paralysed. Seeing this situation of her sister, Rani decided that she would not get married and would study further. She rebelled against her father and in spite of him decided to study further.

Rani's father also succumbed to her spirit and decided to let his daughter study. Rani finally studied with all her heart and soul and was rewarded equally. After completing her high school with flying colours, she was accepted in a renowned law college on full scholarship. Rani now also got a job working alongside studying. The money she earned, she sent home to take care of her family and also help educate her sisters.

Studying law, rani was able to make her father understand that Child Marriage is an offense. Today rani is successfully practising lawyer who fights for women who do not have a voice for their own. She was able to educate her sisters who became doctor and engineer. Today rani finally made her father proud and her father never stops thanking god for giving him such gifted daughters.

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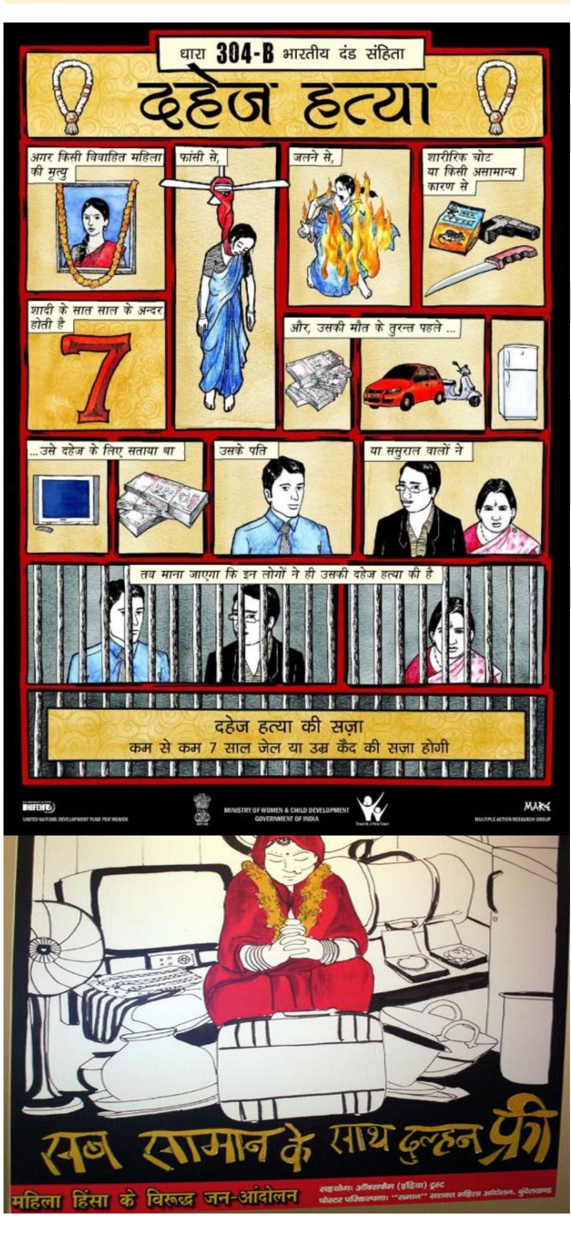
Sample Slogans Annexure-15

1 IN 9 GIRLS IS FORCED INTO MARRIAGE BEFORE HER 15TH BIRTHDAY.

#StealTheseStats



Annexure-16

Frequently Asked Questions on Child Marriage and the Prohibition of Child Marriage Act, 2006

Question No.1: Who is a Child under the "Prohibition of Child Marriage Act, 2006"?

Answer: A girl under 18 years or a boy under 21 years is considered a child under the "Prohibition of Child Marriage Act, 2006".

Question No.2: When is any marriage called Child Marriage?

Answer: Such a marriage, where:

- the girl is less than 18 years and the boy/man is 21 years or above; or else
- the girl/woman is above 18 years and boy is less than 21 years; or else
- the girl is less than 18 years and the boy/man is less than 21 years

Question No.3: Can a Child Marriage be declared void?

Answer: Yes, at the instance of the spouse who was a minor at the time when marriage took place, a Child Marriage may be declared void (no marriage in the eyes of law). Such a spouse who was a minor at the time of performance of marriage should approach the court on turning a major, i.e., 18 years in case of girls and 21years in case of boys.

Question No.4: Who should be approached, to get a Child Marriage declared void?

Answer: District court of the district of residence is to be approached by the spouse who was a minor at the time of performance of marriage for getting the Child Marriage declared void (no marriage in the eyes of law).

Question No.5: Can the petition to get the Child Marriage annulled (dissolved) be filed at any time in life?

Answer: No. Any petition to get Child Marriage annulled (dissolved) has to be filed before completion of two years of being a major. That is to say,

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in case of girl, before she attains the age of 20 years and in case of boy, before he attains the age of 23 years.

Question No.6: On dissolution of Child Marriage, can the parties retain the gifts and valuables exchanged between them at the time of solemnization of Child Marriage?

Answer: No. At the time of dissolution of Child Marriage by the District Court, both parties shall be directed by the Court to return all the ornaments, valuables, gifts and money received by both the parties on the occasion of the Child Marriage, or alternatively pay to the other party money equivalent to the ornaments, valuables, gifts and cash received by it from the other party.

Question No.7: In the case of a Child Marriage, is the married girl entitled to maintenance, during and after the proceedings held to declare the Child Marriage void?

Answer: Yes. A girl who was given in marriage, in the case of a Child Marriage is entitled to maintenance, both during and after the proceedings for getting the Child Marriage dissolved. A decree of dissolution passed to dissolve Child Marriage does not disentitle the girl from continuing to obtain maintenance from her husband (if major) or his parents/guardians (if husband is a minor).

Question No.8: Are children born out of Child Marriage, which has been dissolved, considered legitimate?

Answer: Yes. The children born and/ or even conceived up to the day on which the decree of dissolution of marriage is passed in cases of Child Marriage, are legitimate.

Question No.9: What happens to children in cases of Child Marriage which have been or are being declared void (no marriage in the eyes of law) by the Court?

Answer: The Court passes orders both, during the proceedings to declare the Child Marriage void (no marriage in the eyes of law), and as well as at the stage of passing final order/decree declaring the Child Marriage to have been dissolved, regarding the custody and maintenance of children of such children, in reference to welfare and best interests of such children.

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Question No.10: Where should the petition to get Child Marriage dissolved is filed?

Answer: Any petition to get the Child Marriage dissolved has to be filed in the District Court that has the jurisdiction of the area where:-

- Either party to the Child Marriage resides; or
- Child Marriage was solemnized; or
- Where parties to Child Marriage last resided together; or
- Party to Child Marriage who seeks dissolution of Child Marriage, is residing at the time of presenting the petition.

Question No.11: Can the person who was an adult at the time of Child Marriage be punished for marrying a minor?

Answer: Yes. If an adult man marries a minor girl, he can be made liable to rigorous imprisonment up to 2 years and/or be fined up to Rupees 1 lakh, but not vice-versa.

Question No.12: Is only the male adult entering into Child Marriage liable to penalty in case of a Child Marriage?

Answer: No. Not only the male adult entering into Child Marriage, but also all those persons:-

- who perform;
- who conduct;
- who direct; and
- who abet (support/ encourage)

the Child Marriage are liable for punishment of up to 2 years rigorous imprisonment and/or fine of up to Rupees 1 lakh.

Question No.13: Can we attend and participate in a Child Marriage as a social function when invited as a guest?

Answer :If you attend and participate in a Child Marriage in any capacity, and take no steps to stop it, you are at least abetting (supporting/ encouraging) Child Marriage and thus, liable to be punished with rigorous imprisonment up to 2 years and/or fine of up to Rupees 1 lakh.

Question No.14: Is the age of the minor contracting Child Marriage, the only consideration in declaring the marriage null and void?

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Answer: No. Apart from the age of the minor child, other circumstances are also to be taken into consideration, like:-

- Taking minor child out of the custody (control) and care of parent/guardian; OR
- Forcefully compelling or deceiving the minor child into going from one place to another; OR
- Selling minor child for purpose of marriage and the minor child is married after being sold; OR
- Selling minor child, who is married and thereafter is sold/trafficked/abused for immoral purposes.

Question No.15: Who can file a complaint against performance of Child Marriage?

Answer: The complaint against performance of Child Marriage may be filed by any of the following:-

- Any person having personal knowledge or belief that the marriage being/having been performed is a Child Marriage; OR
- Any Non-Governmental Organisation (NGO) having reasonable information relating to likelihood of taking place of a Child Marriage or mass Child Marriages.
- Child Marriage Prohibition officer (CMPO)

Question No.16: Can a Magistrate do anything if he is in receipt of a reliable report or information about solemnization of Child Marriage?

Answer: The Magistrate may himself take notice of the performance of a Child Marriage as and when any reliable report or information is received and pass necessary orders.

Question No.17: What happens when any person or organisation does not obey the orders of the Magistrate prohibiting Child Marriage?

Answer: When any person or the responsible persons, of any organization, do not obey the orders of the Magistrate prohibiting Child Marriage, such person/persons is liable to pay fine up to Rupees One lakh and/or imprisonment up to two years.

However, no women can be imprisoned for having performed Child Marriage despite the directions of the Magistrate prohibiting that

Child Marriage, even though she is liable to financial punishment, in terms of the fine prescribed under the law prohibiting Child Marriage.

Question No.18: What is the status of a Child Marriage that had been performed in violation of any order passed by the Magistrate prohibiting the performance of that Child Marriage?

Answer: Any Child Marriage, which has been performed in violation of the orders of the Magistrate prohibiting it, is considered to have never been performed and is no marriage at all in the eyes of law.

Question No.19: What is the nature of offence in cases of performance of a Child Marriage?

Answer: Performance of Child Marriage is an offence for which the offenders are not entitled to bail and the police are required to register the case of commission of an offence of Child Marriage, on receipt of such information at the very first instance. Thereafter, the facts related to Child Marriage are confirmed, before filing the challan in the court of the Magistrate. In case a Child Marriage is being solemnized before a police officer, it is his duty to stop such an offence from being committed and register the case against the offenders immediately and proceed with investigation and filing of the challan in court, in cases where the Child Marriage had been performed, despite his best efforts.

Question No. 20: What are the duties of the Child Marriage Prohibition Officer (CMPO)?

Answer: Any person, who is notified by the State Government as the Child Marriage Prohibition Officer (CMPO), for the area specified, shall:-

- Take steps to prevent performance of Child Marriage;
- Collect evidence against the person/persons who violated the law to organize a Child Marriage or else performed a Child Marriage or else participated in the activities relating to Child Marriage, including attending it;
- Advice and counsel persons into not promoting, helping and allowing solemnization of a Child Marriage;
- Generate awareness about the evils associated with Child Marriages.

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Annexure-17

LIST OF ACTS AND LAWS RELATED TO CHILDREN

1. The Child Marriage Restraint Act, 1929.
2. The Prohibition of Child Marriage Act, 2006
3. The Child Labour (Prohibition and Regulation) Act, 1986.
4. The Juvenile Justice (Care and Protection of Children) Act, 2006, Amendment, 2011
5. The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992. Amendment Act, 2003
6. The Pre-Conception and Pre-natal Diagnostic Technique (Prohibition of Sex Selection) Act, 1994. (PNDT) – Amended in 2003 to the Pre-Conception and Pre Natal Diagnostic Techniques (Prohibition of Sex Selection) Act.
7. The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995.
8. The Immoral Traffic (Prevention) Act, 1956.
9. The Guardian and Wards Act, 1890.
10. The Young Persons (Harmful Publications) Act, 1956.
11. The Commissions for Protection of Child Rights Act, 2005 (Amendment Act, 2006)
12. The Right of Children to Free and Compulsory Education Act, 2009
13. The Protection of Children from Sexual Offences Act, 2012

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Annexure-18

LIST OF ACTS AND LAWS RELATED TO WOMEN

- **WOMEN-SPECIFIC LEGISLATIONS**
  1. The Immoral Traffic (Prevention) Act, 1956
  2. The Dowry Prohibition Act, 1961 (28 of 1961) (Amended in 1986)
  3. The Indecent Representation of Women (Prohibition) Act, 1986
  4. The Commission of Sati (Prevention) Act, 1987 (3 of 1988)
  5. Protection of Women from Domestic Violence Act, 2005
  6. The Sexual Harassment of Women at Workplace (PREVENTION, PROHIBITION and REDRESSAL) Act, 2013
  7. The Criminal Law (Amendment) Act, 2013

- **WOMEN-RELATED LEGISLATIONS**
  1. The Indian Penal Code,1860
  2. The Indian Evidence Act, 1872
  3. The Indian Christian Marriage Act, 1872 (15 of 1872)
  4. The Married Womens Property Act, 1874 (3 of 1874)
  5. The Guardians and Wards Act,1890
  6. The Workmens Compensation (Amendment) Act, 2009
  7. The Trade Unions Act 1926
  8. The Child Marriage Restraint Act, 1929 (19 of 1929)
  9. The Payments of Wages (Amendment) Act, 2005
  10. The Payments of Wages (Procedure) Act, 1937
  11. The Muslim Personal Law (Shariat) Application Act, 1937
  12. Employers Liabilities Act 1938
  13. The Minimum Wages Act, 1948
  14. The Employees State Insurance Act,1948
  15. The Factories Act, 1948
  16. The Minimum Wages Act, 1950
  17. The Plantation Labour Act, 1951 (amended by Acts Nos. 42 of 1953, 34 of 1960, 53 of 1961, 58 of 1981 and 61 of 1986)
  18. The Cinematograph Act, 1952
  19. The Mines Act 1952
  20. The Special Marriage Act, 1954
  21. The Protection of Civil Rights Act 1955
  22. The Hindu Marriage Act, 1955 (28 of 1989)
  23. The Hindu Adoptions & Maintenance Act, 1956
  24. The Hindu Minority & Guardianship Act, 1956
  25. The Hindu Succession Act, 1956

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26. The Maternity Benefit Act, 1961 (53 of 1961)
27. The Beedi & Cigar Workers (Conditions of Employment) Act, 1966
28. The Foreign Marriage Act, 1969 (33 of 1969)
29. The Indian Divorce Act, 1969 (4 of 1969)
30. The Contract Labour (Regulation & Abolition) Act, 1970
31. The Medical Termination of Pregnancy Act, 1971 (34 of 1971)
32. Code of Criminal Procedure, 1973
33. The Equal Remuneration Act, 1976
34. The Bonded Labour System (Abolition) Act, 1979
35. The Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979
36. The Family Courts Act, 1984
37. The Muslim women Protection of Rights on Dowry Act 1986
38. Mental Health Act, 1987
39. National Commission for Women Act, 1990 (20 of 1990)
40. The Protection of Human Rights Act, 1993 [As amended by the Protection of Human Rights (Amendment) Act, 2006 No. 43 of 2006]
41. Juvenile Justice Act, 2000
42. The Child Labour (Prohibition & Regulation) Act
43. The Pre-Natal Diagnostic Techniques (Regulation and Prevention of misuse) Act 1994
44. The National Food Security Act, 2013

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Annexure-19

Case Study of a Woman Who Risks her Marriage over Lack of Toilet Facility

For the first time in the country, a woman has been awarded Rs. 7 lakh for refusing to defecate in the open. In a country accounting for 58 per cent open defecation in the world, a tribal woman rejected her in-law's house because there was no toilet in it. Soon after her marriage, she snubbed her newly wedded-husband and told him that she would live as his wife only if he got a latrine constructed. Otherwise, she would continue to live in her father's house.

Anita was pursuing a BA degree when her father decided to marry her away to Shivram Narre of Bhimpur tehsil. Like every obedient daughter, she agreed to marry Shivram even though he was an agricultural labourer belonging to a BPL family and was less educated than her. But all hell broke loose when she was asked to go to the fields the morning after her marriage. The newly wedded bride did not utter a word when she saw the latrine of Jheetudhhana under the open skies. She survived the ordeal in her in-laws' for two days after which, according to tradition, she had to go back to her parents' house for further rituals.

Twenty-three year old Anita Narre, resident of Jheetudhhana village in Betul district of Madhya Pradesh, was felicitated by social service organisation Sulabh International in the presence of foreign media.

After this news was reported in the regional media, Sulabh International decided to help her in-laws construct a toilet and reward the girl for her bold step and for creating awareness about sanitation. By revolting against non-availability of toilet, this rural woman has done a revolutionary act in India where crores of people still defecate in the open, leading to serious diseases.

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Annexure-20

Questionnaire

1. What is the main source of drinking water in your community?

    a. Public Tap
    b. Hand pump/Tube well
    c. Dug well- Protected
    d. Dug well- un- Protected
    e. Lake/Pond
    f. Supplied by tanker
    g. Other (specify)

2. What common measures do you use in your community to make the water safe for drinking?
    a. Boil
    b. Add chlorine
    c. Filter it through a cloth
    d. Use a water filter (ceramic, sand, composite, etc.) RO/electric filter
    e. Solar disinfection
    f. Let it stand and settle
    g. Other (specify)

3. How do you store water in your community and in household?
    a. In a clay pot (matka)
    b. In a filter
    c. In a utensil/container
    d. Other (specify)

4. Do households in your community have toilets within their premises?
    a. Yes
    b. No

5. How do you dispose of faeces of infants in your community?
    a. Throw it out in the dustbin
    b. Throw it in the latrine
    c. Bury it in the dirt

6. Do schools in your community have separate toilets for boys and girls?
    a. Yes
    b. No

7. If yes, what is the type of toilet?
    a. Flush/pour flush

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b. Ventilated pit latrine

8. Do individuals especially children wash their hands after using the toilet and before dealing with food?
    a. Yes- with soap and water
    b. Yes- with water only
    c. Yes- with ash
    d. No

9. Are you aware of the correct hand washing technique?
    a. Yes
    b. No

10. It is important to wash hands and maintain personal cleanliness because
    a. It protects and prevents against infectious diseases like diarrhoea, typhoid.
    b. It ensures maintenance of good personal health
    c. It leads to healthy habits amongst individuals
    d. All of the above

11. Do you feel that it is necessary to maintain hygiene and sanitation in and around your community? If so, then please specify why?
    a. Yes
    b. No

12. How waste is commonly gathered in your community at the household level?
    a. In a dustbin
    b. In plastic bags
    c. In buckets
    d. Any other

13. What methods are used to dispose of the garbage in your area/community?
    a. Burning
    b. Gathering in one place (e.g. dump or landfill)
    c. Don't know

14. Why is it necessary to dispose of the garbage regularly?
    a. It cause diseases
    b. It creates foul smells
    c. It attracts flies and insects
    d. All of the above

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Annexure-21

Child Assessment Card- English

3-4 Years

MY BOOK
(Domains of Development)

Photo of Child

Child's Name.. Name & No. of Anganwadi Centre..

Mother's Name.. Father's Name..

Age.................... Sex.................... Weight.................... Height....................

Assessment Month: First time [ ] Second time [ ] Third time [ ] Forth time [ ]

- The purpose of this profile is to know about the development of the child as per domain so that you may provide them necessary support to develop holistically. You may need to give varied opportunities through methods to learn and grow. Every Child should be assessed every 3 months on given milestones. In case, assessment could not be done in given month then it should be done in the next month.

Opinion of facilitator/teacher on the progress about the child

Signature

Child's Age 3-4 Years — जब बच्चे ने कम से कम 4 आयाम अच्छा किया हो, तब ☺ पर (✓) का निशान लगाएँ।

Aspects of development (☺✓ बच्चे की प्रगति अच्छी है।)	Important points of development	First Assessment		Second Assessment		Third Assessment		Fourth Assessment	
		Needs Help	Performs Well	Needs Help	Performs Well	Needs Help	Performs Well	Needs Help	Performs Well
Physical	1. Throw big ball with both hands								
	2. Jump at one place with both legs								
	3. Get ready at its own								
	4. Tear page according to imagined Picture								
	5. Scribble/ rub with crayons, chalk and other things								
Cognitive	1. Listen, identify and imitate the environmental sound.								
	2. Differentiate concept like between less-more, tall-short, big-small, in-out.								
	3. Identify, match and segregate the vegetables / Fruits / animals./ Colours / Shapes / Parts of body etc								
Language	1. Follow easy instructions								
	2. Repeat Folk Story / folk Song								
	3. Share/express own feelings								
	4. Able to recognise its own name (written)								
Social and Emotional	1. Go to toilet independently								
	2. Comfortable play with other children								
	3. Talk with the teacher								
	4. Wash hands before and after meal and keep themselves clean								
Creativity	1. Do colouring/painting by themselves.								
	2. Construct/develop a shape to / design something with clay/wet mud.								
	3. Sing a Song in the Group.								
	4. Dance on its own.								

4-5 Years

MY BOOK

(Domains of Development)

Photo of Child

Child's Name...Name & No. of Anganwadi Centre..

Mother's Name...Father's Name..

Age...Sex..Weight..Height..

Assessment Month: First time [ ] Second time [ ] Third time [ ] Forth time [ ]

- The purpose of this profile is to know about the development of the child as per domain so that you may provide them necessary support to develop holistically. You may need to give varied opportunities through methods to learn and grow. Every Child should be assessed every 3 months on given milestones. In case, assessment could not be done in given month then it should be done in the next month.

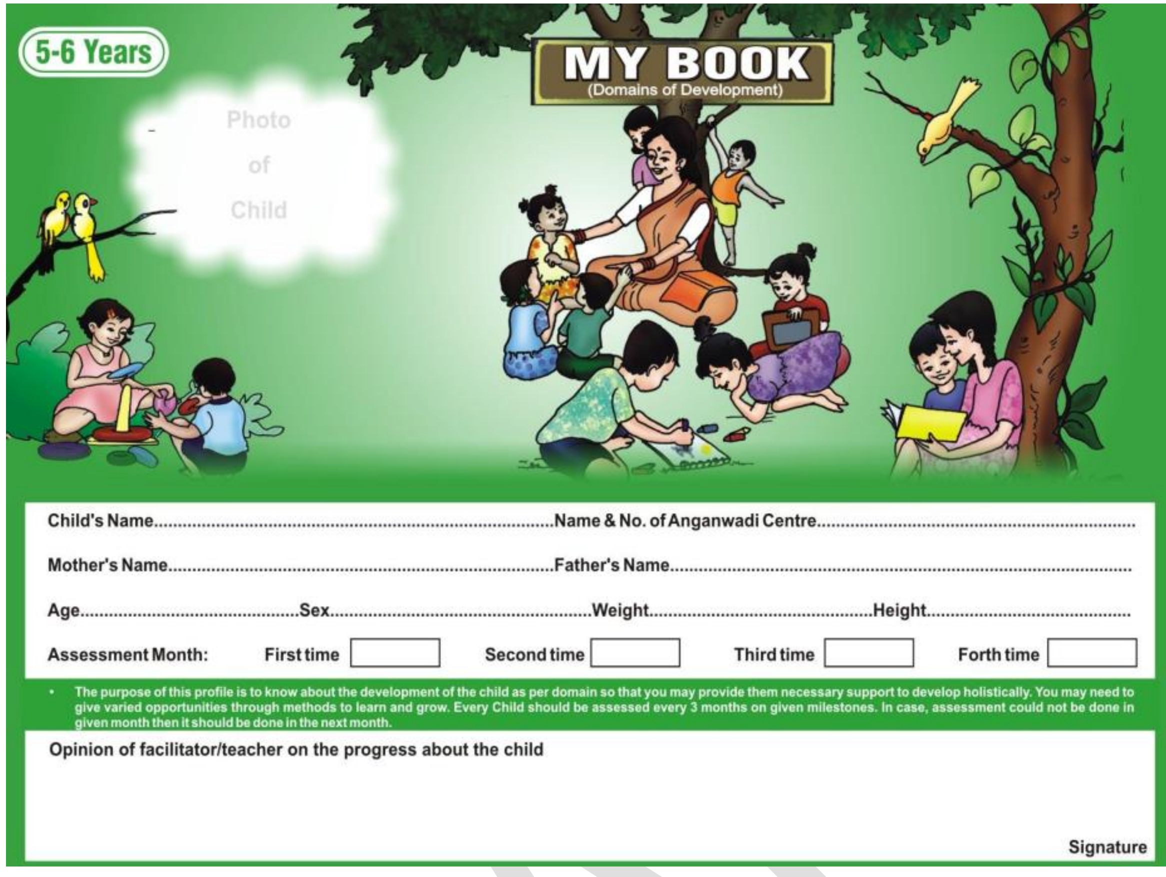
Opinion of facilitator/teacher on the progress about the child

Signature

Child's Age 4-5 Years

जब बच्चे ने कम से कम 4 आयाम अच्छा किया हो, तब ☺ पर (✓) का निशान लगाएें।

Aspects of development ☺ बच्चे की प्रगति अच्छी है।	Important points of development	First Assessment		Second Assessment		Third Assessment		Fourth Assessment	
		Needs Help	Performs Well	Needs Help	Performs Well	Needs Help	Performs Well	Needs Help	Performs Well
Physical	1. Run fast or slow in forward and backward								
	2. String beads in a particular sequence								
	3. Tear the page on a given line								
	4. Throw / catch a ball in the mentioned direction								
	5. Kick the ball in the specified direction								
Cognitive	1. Imitate the heard nearby sounds								
	2. Classify objects on the basis of more than one quality such as divide according to shape and colour								
	3. Identify the left out portion of the picture								
	4. Join the puzzle of 4-6 segments								
	5. Makes one to one correspondence								
	6. Count objects and matches number with things objects								
	7. Identify and the name numbers and arrange in a sequence								
Language	1. Hear the story and rhymes attentively and narrate them in sequence								
	2. Talk on topics like family, birds, plants and animals								
	3. Identify words associated with nearby environments								
	4. Recognise the 'first' and 'last' sound of given words and form new words								
	5. Identify the written alphabet and make words								
	6. Use a book								
Social and Emotional	1. Maintain personal hygiene such as keep nails, hands and clothes clean								
	2. Be comfortable with other children								
	3. Wait for its turn								
	4. Help and cooperate with other children								
	5. Express their feelings openly								
Creativity	1. Create/draw various pictures and shape etc. with different colors								
	2. Make creative/recognizable shape (With mud, sand and other things)								
	3. Sing and dance to the tune								
	4. Form human shapes with the help of colours								



5-6 Years

MY BOOK
(Domains of Development)

Photo of Child

Child's Name...Name & No. of Anganwadi Centre...

Mother's Name...Father's Name...

Age...Sex...Weight..Height...

Assessment Month: First time [ ] Second time [ ] Third time [ ] Forth time [ ]

- The purpose of this profile is to know about the development of the child as per domain so that you may provide them necessary support to develop holistically. You may need to give varied opportunities through methods to learn and grow. Every Child should be assessed every 3 months on given milestones. In case, assessment could not be done in given month then it should be done in the next month.

Opinion of facilitator/teacher on the progress about the child

Signature

Child's Age 5-6 Years

जब बच्चे ने कम से कम 4 आयाम अच्छा किया हो, तब ☺ पर (✓) का निशान लगाएँ।

Aspects of development बच्चे की प्रगति अच्छी है।	Important points of development	First Assessment			Second Assessment			Third Assessment			Fourth Assessment		
		Needs Help	Can Well Performs	Performs Well	Needs Help	Can Well Performs	Performs Well	Needs Help	Can Well Performs	Performs Well	Needs Help	Can Well Performs	Performs Well
Physical	1. String the beads/leaves in a pattern (In a thread)												
	2. Tear a page on the given line												
	3. Throw a ball with one hand in the given direction												
	4. Walk in a backward, forward and sideways direction												
	5. Able to work in workbook												
Cognitive	1. Classify objects and pictures based on multiple qualities (4-6 level)												
	2. Complete a puzzle of five parts												
	3. Recognize the pattern and predict what comes next												
	4. Solve the daily problems (orally)												
	5. Arrange numbers in order												
	6. Recognize big-small number and missing number												
	7. Identify the numbers upto 20 and match with objects												
Language	1. Listen attentively and narrate a story and rhyme/poem sequentially												
	2. Speak clearly to be understood by others												
	3. Ask questions like 'why' and 'how' on topics like people, birds and Animals												
	4. Narrate / develop a story on the given picture												
	5. Form easy sentences using word card												
	6. Begin to read an easy story												
Social and Emotional	1. Keep clean and respect others. Ex- keep nails, hands, clothes and surrounding clean, be organised												
	2. Be comfortable with other children and elders												
	3. Help others and cooperate												
	4. Initiative activities its own												
	5. Work and play after understanding rules/Instruction												
Creativity	1. Draw a recognisable picture on the basis of heard story												
	2. Draw different kinds of shapes Ex-human shapes/figures												
	3. Dance on a tune rhythmically												
	4. Draw a pattern with various materials, ex-matching of dots, shapes, making shapes												

Annexure-22

Child Assessment Card-Hindi

3-4 वर्ष

मेरी पत्रिका

(व्यक्तित्व विकास के आयाम)

बच्चे की फोटो

बच्चे का नाम :..आँगनवाड़ी केन्द्र संख्या व नाम..

माता का नाम :..पिता का नाम :..

आयु :..लिंग :..

आंकलन के महीने : पहला ☐ दूसरा ☐ तीसरा ☐ चौथा ☐

- इस पत्रिका का उद्देश्य बच्चे के विकास को जानना है, ताकि आप उन्हें सीखने व बढ़ने के समुचित अवसर प्रदान कर सकें। प्रत्येक बच्चे का आंकलन हर तीसरे महीने में होना चाहिए। अगर किसी वजह से आंकलन निर्देशित माह में न हो सके तो उसे अगले माह में जरूर कर लें।

सेविका/शिक्षक के बच्चे की प्रगति पर विचार

हस्ताक्षर

बच्चे की आयु : 3 - 4 वर्ष

जब बच्चे ने कम से कम 4 आयाम अच्छा किया हो, तब ☺ पर (✓) का निशान लगाएँ।

विकास के आयाम (☺ ✓ बच्चे की प्रगति अच्छी है।)	विकास के महत्वपूर्ण बिन्दु	पहला आंकलन		दूसरा आंकलन		तीसरा आंकलन		चौथा आंकलन	
		मदद की ज़रूरत है	अच्छा करता है	मदद की ज़रूरत है	अच्छा करता है	मदद की ज़रूरत है	अच्छा करता है	मदद की ज़रूरत है	अच्छा करता है
शारीरिक एवं क्रियात्मक ☺	1. गेंद को दोनों हाथों से फेंक पाना								
	2. एक जगह पर दोनों पैरों से कूद पाना								
	3. अपने कपड़े पहन पाना								
	4. सोची हुई आकृति को पेपर फाड़कर चिपकाना								
	5. मोम रंगो से लिखना/ घसीटना								
मानसिक/बौद्धिक ☺	1. पर्यावरण की आवाज़ों को सुनना, पहचानना व नकल कर पाना								
	2. ज्यादा–कम, लम्बे–छोटे, बड़े–छोटे, अन्दर–बाहर के अन्तर को पहचान पाना								
	3. सब्ज़ियों/फलों/जानवरों/रंगों/विभिन्न आकारों/शरीर के अंगों की पहचान कर पाना मिलान करना व छाँट पाना								
भाषा ☺	1. आसान आदेशों का पालन कर पाना								
	2. लोक कहानी/लोक गीत को दोहरा पाना								
	3. अपनी बात को कह पाना								
	4. अपने लिखे हुए नाम को पहचान पाना								
सामाजिक एवं भावनात्मक ☺	1. अपने आप से शौच जा पाना								
	2. दूसरे बच्चों के साथ आराम से खेल पाना								
	3. शिक्षक/शिक्षका से बातचीत कर पाना								
	4. खाने से पहले एवं बाद में हाथ धोना व स्वयं को साफ रखना								
रचनात्मक ☺	1. स्वयं से तस्वीर बना सकना								
	2. गीली मिट्टी से आकृति बनाना								
	3. समूह में गाना गाना								
	4. खुद से नाचना								

4-5 वर्ष

मेरी पत्रिका

(व्यक्तित्व विकास के आयाम)

बच्चे की फोटो

बच्चे का नाम :..आँगनवाड़ी केन्द्र संख्या व नाम..

माता का नाम :..पिता का नाम :..

आयु :..लिंग :..

आंकलन के महीने : पहला ☐ दूसरा ☐ तीसरा ☐ चौथा ☐

- इस पत्रिका का उद्देश्य बच्चे के विकास को जानना है, ताकि आप उन्हें सीखने व बढ़ने के समुचित अवसर प्रदान कर सकें। प्रत्येक बच्चे का आंकलन हर तीसरे महीने में होना चाहिए। अगर किसी वजह से आंकलन निर्देशित माह में न हो सके तो उसे अगले माह में जरूर कर लें।

सेविका/शिक्षक के बच्चे की प्रगति पर विचार

हस्ताक्षर

बच्चे की आयु : 4 – 5 वर्ष

जब बच्चे ने कम से कम 4 आयाम अच्छा किया हो, तब ☺ पर (✓) का निशान लगाएं।

विकास के आयाम (बच्चे की प्रगति अच्छी है।)	विकास के महत्वपूर्ण बिन्दु	पहला आंकलन		दूसरा आंकलन		तीसरा आंकलन		चौथा आंकलन	
		मदद की ज़रूरत है	अच्छा करता है	मदद की ज़रूरत है	अच्छा करता है	मदद की ज़रूरत है	अच्छा करता है	मदद की ज़रूरत है	अच्छा करता है
शारीरिक एवं क्रियात्मक ☺	1. तेज या धीमी गति से आगे व पीछे की तरफ दौड़ पाना								
	2. मोतीयों को धागे में क्रम से पिरोना								
	3. दी हुई रेखा में कागज़ को फाड़ना								
	4. बताई हुई दिशा में गेंद को फैंकना व पकड़ना								
	5. बताई हुई दिशा में गेंद को लात मारना								
मानसिक / बौद्धिक ☺	1. आसपास की आवाजों को सुनकर नकल कर पाना								
	2. वस्तुओं का एक से ज्यादा गुणों के आधार पर वर्गीकरण कर पाना जैसे: आकार व रंग के अनुसार छाँटना								
	3. तस्वीर में छूटे हुए हिस्से की पहचान कर पाना								
	4. 4–6 टुकड़े वाले पज्जल को जोड़ पाना								
	5. एक से एक मिलान कर पाना								
	6. संख्या को वस्तुओं से मिलान करना व गिन पाना								
	7. संख्याओं का नाम बोल पाना व क्रम में लगा पाना								
भाषा ☺	1. कहानी एवं कविताओं को ध्यान से सुनना व क्रमानुसार सुना पाना								
	2. परिवार, पक्षी, पौधे एवं जानवर जैसे विषयों पर बात कर पाना								
	3. अपने आस–पास के संदर्भ से जुड़े शब्दों की पहचान कर पाना								
	4. शब्दों के पहले व आखिरी अक्षर की ध्वनि की पहचान कर पाना व नये शब्द बनाना								
	5. लिखित अक्षर को पहचानना एवं शब्द बनाना								
	6. किताब को इस्तेमाल कर पाना								
सामाजिक एवं भावनात्मक ☺	1. स्वच्छ रहना जैसे – नाखुन, हाथ एवं कपड़ों को साफ रखना								
	2. दूसरे बच्चों के साथ सहज रहना								
	3. अपनी बारी की प्रतिक्षा करना								
	4. दूसरों बच्चों को सहयोग देना एवं मदद कर पाना								
	5. अपनी भावनाओं को खुल कर व्यक्त करना								
रचनात्मक ☺	1. विविध रंगों से विभिन्न तस्वीरें व आकृति आदि बना पाना								
	2. रचनात्मक आकृति बनाना (मिट्टी, रेत व अन्य चीजों से)								
	3. लय में गीत गाना व नाचना								
	4. मानवीय आकृति को रंगों द्वारा बना पाना								

बच्चे का नाम :.. आँगनवाड़ी केन्द्र संख्या व नाम..

माता का नाम :.. पिता का नाम :..

आयु (जन्मतिथि):.. लिंग :.. जाति :..

आंकलन के महीने : पहला आंकलन ☐ दूसरा आंकलन ☐ तीसरा आंकलन ☐ चौथा आंकलन ☐

- इस पत्रिका का उद्देश्य बच्चे के विकास को जानना है, ताकि आप उन्हें सीखने व बढ़ने के समुचित अवसर प्रदान कर सकें। प्रत्येक बच्चे का आंकलन हर तीसरे महीने में होना चाहिए। अगर किसी वजह से आंकलन निर्देशित माह में न हो सके तो उसे अगले माह में जरूर कर लें।

शिक्षक/सेविका के विचार :

हस्ताक्षर

बच्चे की आयु : 5 - 6 वर्ष

जब बच्चे ने कम से कम 4 आयाम अच्छा किया हो, तब ☺ पर (✓) का निशान लगाएं।

विकास के आयाम (☺✓ बच्चे की प्रगति अच्छी है।)	विकास के महत्वपूर्ण बिन्दु	पहला आंकलन			दूसरा आंकलन			तीसरा आंकलन			चौथा आंकलन		
		मदद की ज़रूरत है	अच्छा कर सकता है	अच्छा है	मदद की ज़रूरत है	अच्छा कर सकता है	अच्छा है	मदद की ज़रूरत है	अच्छा कर सकता है	अच्छा है	मदद की ज़रूरत है	अच्छा कर सकता है	अच्छा है
शारीरिक एवं क्रियात्मक ☺	1. मोतीयों को धागे में किसी पैटर्न (क्रम) से पिरोना												
	2. दी हुई रेखा के साथ कागज़ को फाड़ना												
	3. बताई हुई दिशा में एक हाथ से गेंद को फैंकना व पकड़ना												
	4. बताई हुई दिशा में आगे, पीछे व तिरछा चलना												
	5. किताब/अभ्यास/गतिविधि पुस्तिका में काम कर पाना												
मानसिक/बौद्धिक ☺	1. वस्तुओं व तस्वीरों को गुणों के आधार पर समूह बनाना (4–6 स्तर)												
	2. स्वयं से पाँच हिस्सों की पहेलियों को जमा पाना												
	3. पैटर्न में आसान क्रम को पहचानना व आने वाले क्रम को बता पाना												
	4. दैनिक समस्याओं को सुलझा पाना (मौखिक रूप से)												
	5. अंकों का क्रम से लगाना												
	6. बड़ी–छोटी संख्या एवं गायब संख्या को पहचानना												
	7. 20 तक नम्बरों को पहचानना एवं वस्तुओं से मिलाना												
भाषा ☺	1. कहानी एवं कविताओं को ध्यान से सुनना व उन्हें सुनाना												
	2. सही उच्चारण के साथ सफाई से बोलना												
	3. लोगों, पक्षी, एवं जानवर जैसे विषयों पर "क्यों" व "कैसे" संबंधित प्रश्न पूछना												
	4. दी गई तस्वीर पर अपने आप कहानी बना पाना												
	5. शब्द कार्ड के द्वारा सरल वाक्य बनाना												
	6. सरल कहानी पढ़ने की कोशिश करना												
सामाजिक एवं भावनात्मक ☺	1. स्वच्छ रहना व आदर करना ; जैसे, नाखून, हाथ व कपड़ों को साफ रखना, व्यवस्थित रहना												
	2. दूसरे बच्चों व बड़ों के साथ सहज रहना												
	3. दूसरों को सहयोग देना एवं मदद कर पाना												
	4. स्वयं पहल लेकर काम करना												
	5. नियम/निर्देश समझकर काम करना व खेल पाना												
रचनात्मक ☺	1. सुनी हुई कहानी के आधार पर मुक्त चित्र बना पाना												
	2. नई–नई आकृतियों को बनाना, जैसे मानवीय आकृति												
	3. लय से संगीत पर नाचना												
	4. विभिन्न सामग्री के द्वारा पैटर्न बनाना जैसे बिन्दुओं का मिलान												

Annexure-23

Schemes and Programmes for Girl Child and Women

S. NO	SCHEMES	BENEFICIARIES	SERVICES
		SCHEMES FOR GIRL CHILD	
1	Integrated Child Development Services (ICDS)	• Children belonging to 0- 3 years and 3-6 years • Pregnant and lactating women	• Early Childhood Care , Education and Development • Health services • Nutrition counselling and supplementation • Community Mobilization, Awareness, Advocacy and IEC
2	SABLA – A scheme for Adolescent Girls	• Adolescent girls in the age group of 11-14 & 14-18 years	• Nutrition Provision • IFA supplementation • Health check-up and referral services • Nutrition and Health Education • Counselling and Guidance, ARSH, Child Care Practices • Life Skill Education • Accessing Public Services • Vocational training (16 years and above)
3	Kishori Shakti Yojana (KSY)	• Adolescent Girls (11-18 years)	• IFA supplementation along with deworming interventions • non-formal education through non-formal & functioned literacy pattern • general health check up every six months • treatment for minor ailments • vocational training activities, life education courses • health and nutrition

			education, legal literacy etc.
4	Integrated child protection scheme (ICPS)	• Children in need of care and protection under JJ act • Juvenile in conflict with law • Children in contact with law • Any other vulnerable child	• Shelter and rehabilitation services under Juvenile Justice Act • Integrated Programme for Street Children • Assistance of Home for Children (Shishu Greh) • Institutional Services • Emergency outreach through CHILD LINE • Family based Non institutional Care • General grant in Aid • Child Tracking System • Advocacy , Training and Capacity Building

SCHEMES FOR WOMEN

S. NO	SCHEMES	BENEFICIARIES	SERVICES
1	Indira Gandhi Matritva Sahyog Yojana (IGMSY)	• Pregnant women of 19 years and above up to first two live births	• Cash incentive of Rs.4000 per beneficiary
2	A Scheme for women in difficult circumstances (SWADHAR)	• Deserted Widows • Released women prisoners without family support • Women prisoners released from jail and without family support • Rescued trafficked women/girls • Women/Girls who have been victims of sexual crimes • Women victims of terrorist/extremist violence • Mentally challenged women • Deserted Women with HIV/AIDS • Women in difficult	• Assistance for construction of buildings • Rent for the shelter • Assistance for management of the Centre. • Provision of food, shelter and clothing for women and children • Counselling for the women • Clinical, legal and other support • Training for Economic Rehabilitation • Helpline facility

		circumstances	
3	Scheme for Assistance for the Construction /Expansion of Hostel Building for Working Women with a Day Care	• Working Women • Single Women • Widowed, Separated, Divorced • Women under training for job • Girls up to the age of 18 years and boys upto 5 years of age accompanying their mothers	• Provision of stay in hostel for not more than 3 years
4	Support to Training and Employment Programme (STEP)	• Wage labourers • Unpaid Daily Workers • Female headed households • Migrant Labourers • Tribal and other disposed groups • Marginalised women • SC/ST females	• Skill based training • Employment opportunities
5	UJJAWALA	• Women and children vulnerable to trafficking • Women and children victims of trafficking	• Prevention • Rescue • Rehabilitation • Re-integration • Repatriation
6	DHAN LAKSHMI	• Girl Child family	• Cash transfers to families with Girl Child who are born after 2008 • Cash transfers on immunization • Cash transfers upon enrolment in school and retention thereafter • Having domicile status in selected blocks
6	NATIONAL CRECHE SCHEME FOR CHILDREN OF WORKING MOTHERS	• Working Mothers	• Day care facility to working women • Provision of development services

			• Government grant • Monitoring crèches

Nutrition Resource Platform Brochure

Annexure-24

ABOUT NUTRITION RESOURCE PLATFORM

NRP INITIATIVE

The Nutrition Resource Platform (NRP) is an initiative of the Child Development and Nutrition Bureau of the Ministry of Women and Child Development (MWCD), Government of India, developed with the aim to collect, collate and make available resources and materials on nutrition and child development to diverse stakeholders.

It will have reference materials on nutrition issues relating to policy, programmes, academic and research inputs, materials for capacity building etc. The platform will be web-enabled to maximise outreach at a relatively low cost. It is planned as a knowledge repository of information collected from sectors identified in National Plan of Action on Nutrition such as nutrition, food, health, agriculture, education, water and sanitation to aid knowledge generation, policy formulation and improve adoption of good practices to influence behaviour change around nutrition and child care.

It is an interactive knowledge resource base which facilitates real quick time interaction, exchange of ideas, discussions between Integrated Child Development Services (ICDS) and other stakeholders to promote a better understanding of the existing and the newer researches in the field of nutrition and child care. Besides policy makers and academia, NRP will act as a platform for improved communication among and with stakeholders including front line workers on the issue of nutrition and child care. NRP will impart user friendly services to front line workers through interactive and mobile service networks.

NRP will offer services such as data collection for Management Information System (MIS) besides rendering services such as Voice Blast, SMS Blast, In-Dialling on Interactive Voice Response System (IVRS).

The NRP will function as part of Food and Nutrition Board (FNB) and National Institute of Public Cooperation and Child Development (NIPCCD) with National Informatics Centre (NIC) providing technical, design, developmental, IT logistics and hosting support for its effective and smooth functioning. It would also have linkages with important institutions of repute such National Institute of Nutrition (NIN), Nutrition Foundation of India (NFI) and Breastfeeding Promotion Network of India (BPNI) and others.

NRP is a complete ecosystem developed using Internet, Data Servers, Call Centre, Fixed Line, Mobile Telephony Network, Virtual Classroom and e- Conferencing Technologies.

NRP MANDATE

Nutrition Resource Platform will

- Act as a knowledge/resource platform for nutrition and child care
- Collate and provide evidence based policy advocacy
- Facilitate interactive discussions, knowledge and experience sharing on nutrition and related sectors
- Provide linkages to various national and international institutions and organizations
- Assist in evolving a perspective plan on nutrition at State, District and Sub District Level by MWCD and State Governments
- Be a repository of resource material, researches, Information Education and Communication (IEC) and Inter Personal Communication (IPC) tools, data on nutrition and information from various sources focusing on maternal and child nutrition

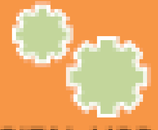
TARGET AUDIENCE

- General population especially mothers, parents and families
- Programme managers and technical personnel's including Panchayati Raj Institutions (PRI)
- Policy Makers and Influencers
- Concerned Line Ministries relating to nutrition
- Civil Society Organizations (CSO) and Community Body Organizations (CBO)
- Academicians and Researchers
- Developmental Partners

KEY TECHNICAL GROUPS

Four key technical groups have been formed as part of NRP. These will cover Information Communication Technology (ICT), Capacity Development, Data Research and IEC/BCC (Behavior Change and Communication) to frame operational guidelines for effective implementation of nutrition and child related promotional materials.

NRP in essence is a people's knowledge facilitation centre related to nutrition focussed on maternal and child care.



DIGITAL LIBRARY DOMAIN

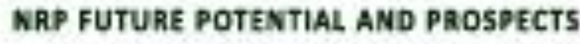
E- Library will function to serve as an electronic library and document management system. It will provide an online repository of nutrition and child care related resource reference materials including video and audio resources accessible to all.

E- FORUM DOMAIN

E- Forum will primarily aim to connect various nutrition and child development sectors through the exchange of ideas and knowledge sharing. The domain offers various different features to stay connected.

TELEPHONY SERVICES DOMAIN

Mobile Telephony is the end-user services for ICDS functionaries. It offers the possibility of services like Interactive Voice Response System (IVRS), Voice Blast, SMS blast including potential for using it as a virtual classroom, information dissemination center and nutrition surveillance to connect with the grass root level workers.



- Support agencies, ministries and departments in dissemination of materials including audio visual spots on nutrition and health education
- Facilitate experience sharing and convergence within various nutrition related sectors
- Help propagate best practices on nutrition and child care
- Promote disintegration of existing nutrition statistics
- Progressively collect and compile information on available training programmes, material and curricula
- Facilitate development of tailor made training courses on maternal nutrition and child care
- Resource directory of institutions and experts working in the field of nutrition
- Provide links for accessing research and studies
- Assist development of interactive games

Technical and Infrastructural Support Provided by CARE, Food & Nutrition Board (FNB), National Institute of Public Cooperation and Child Development (NIPCCD), USAID funded Improving Healthy Behaviors Program (IHBP) and National Informatics Centre (NIC).

We take this opportunity to thank all our development partners, academic institutions who have contributed to the development of NRP. We solicit continued support from "ALL for NUTRITION"!

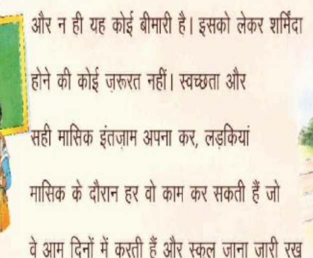
This Portal is hosted and maintained by National Informatics Centre

Annexure-25

Good Practices during Menstruation

मासिक होना है स्वस्थ विकास

मासिक एक सामान्य प्रक्रिया है जो लड़की के सही विकास का चिन्ह है। इसमें कुछ भी गलत नहीं है और न ही यह कोई बीमारी है। इसको लेकर शर्मिंदा होने की कोई ज़रूरत नहीं। स्वच्छता और सही मासिक इंतज़ाम अपना कर, लड़कियां मासिक के दौरान हर वो काम कर सकती हैं जो वे आम दिनों में करती हैं और स्कूल जाना जारी रख सकती हैं।



मासिक के दौरान आहार, आराम व दर्द से राहत

आहार: मासिक के दौरान एक संतुलित भोजन करना चाहिए जिसमें फल, सब्जियां, दालें, दुग्ध पदार्थ इत्यादि काफी मात्रा में हों। भरपूर और पौष्टिक भोजन करने से मासिक के दिनों में भी स्फूर्ति बनी रहती है और कमज़ोरी नहीं होती। जितना हो सके, आयरन से परिपूर्ण भोजन करें। ये शरीर में रक्त की कमी यानी अनीमिया से बचाता है।

आराम व दर्द से राहत : आराम और अच्छी नींद उन दिनों में थकान से राहत दिलाती है और तरोताज़ा रखती है। मासिक के दौरान कुछ लड़कियां दर्द का अनुभव कर सकती हैं। यह दर्द होना सामान्य बात है। इसका कारण है गर्भाशय की पोषण परत यानी एंडोमेट्रियम का टूट कर मासिक के रूप में बहना। कुछ ऐसे व्यायाम हैं जो मासिक के दौरान होने वाले इस दर्द से राहत दिलाते हैं। इन व्यायामों, आराम व अच्छे भोजन से लड़कियाँ मासिक का समय अच्छी तरह बिता सकती हैं।

सही मासिक इंतज़ाम के पाँच तरीके

मासिक के दिनों में स्वच्छ महसूस करने और इंफेक्शन से बचने के लिए बहुत ज़रूरी है कि लड़कियां स्वच्छता बरतें और सही मासिक इंतज़ाम अपनाएं। इसमें शामिल है:

1.

रोज़ स्नान और गुप्तांगों की स्वच्छता: मासिक के दिनों में आम दिनों से भी ज्यादा स्वच्छता बरतने की ज़रूरत होती है, ताकि इंफेक्शन से बचा जा सके। अतः इन दिनों में स्नान करना व गुप्तांगों को कई बार बार स्वच्छ पानी से धोना अत्यावश्यक है।

2. **सैनिटरी नैपकिन या फ्रीडेज़ का इस्तेमाल:** सैनिटरी नैपकिन जैसे कि फ्रीडेज़ मासिक बहाव को बेहतर सोखता है व एक स्वच्छ साधन है। इसे धोने सुखाने का झंझट नहीं होता तथा इसके इस्तेमाल से मासिक के दिनों में लड़कियाँ बेफिक्री से हर काम कर सकती हैं व इंफेक्शन से सुरक्षित रह सकती हैं। सैनिटरी नैपकिन के अलावा साफ कपड़े का इस्तेमाल भी किया जा सकता है।

3. **सैनिटरी नैपकिन या कपड़े को बहाव के मुताबिक बार-बार बदलते रहना :** मासिक के दौरान बहाव के हिसाब से नैपकिन या कपड़े को बदलते रहना चाहिए क्योंकि ज्यादा गंदा होने पर इनके बहाव सोखने की क्षमता समाप्त हो जाती है जिससे गीलेपन का सामना करना पड़ सकता है और कपड़ों में दाग भी लग सकते हैं। अगर इस समय में कपड़े का इस्तेमाल कर रहे है तो वो कपड़ा अच्छी तरह से धुला और धूप में सुखाया हुआ होना चाहिए।

4. **गंदे सैनिटरी नैपकिन को फेंकने का सही तरीका:** सैनिटरी नैपकिन को कागज़ में लपेट कर फेंकना, या जलाना चाहिए। ऐसा करने से हमारा पर्यावरण स्वच्छ रहता है और बीमारी के कीटाणु भी नहीं पनपते।

5.

हाथ हर बार साबुन से धोना

मासिक के दौरान सैनिटरी नैपकिन या कपड़ा बदलने के बाद हाथ साबुन से ज़रूर धोने चाहिए क्योंकि गंदे हाथ कीटाणुओं का घर होते हैं।

Annexure-26

Community Mobilization is….	Community Mobilization isn't….
Fostering collective power	Using power over others
Sustained engagement with the community	One-off activities
Systematic	Ad hoc or done without a plan
Multi-faceted	Done with one strategy
A process	A project
A struggle for social justice	A technical quick-fix
About fostering activism	About implementing activities
Requiring a range of people, groups and institutions	Possible with few individuals or groups
Going beyond individuals to influence people	Focussed only on individuals
Building social networks or capital	Dividing individuals or groups
Fostering alternative values	Providing only information and facts
Stimulating critical thinking	Telling people what to think
Holistic and inclusive	Limited to specific individuals or groups
Positive and supportive	Blaming and shaming
Democratic	Hierarchical
Changing norms	Changing just specific behaviours
Collective: everyone must work together for change	Possible with individuals acting in isolation
Benefits based	Punitive
Focused on root cause	Focused on manifestations of violence

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Annexure-27

Tips for Effective Group Facilitation in PLA Exercises

- Keep your eyes and ears open. Listen to what participants have to say, even when you're not formally conducting an exercise. Pay attention to body language.
- Keep in mind the objectives of the activity. Ask probing questions during and after you have completed the activity. Remember that doing an exercise, such as a map, is only the first step. The discussion that follows is the key opportunity for learning.
- If participants' offer ideas that are connected with PLA exercise's objectives, even if they are not planned or expected, follow them.
- Be careful that your body language does not reveal that you either approve or disapprove of what the participants are saying. Don't be judgmental. Never respond to a participant with astonishment, impatience, or criticism. Remember that there are no right or wrong answers, and a facilitator's role is not to correct what is being said.
- Show interest by using expressions like "I see," or "That's interesting."
- Be aware of people who dominate the process, as well as people who are not participating. Try to bring those who are quiet or shy into the process.
- While some people may be quiet because they are shy, others may be quiet because they are remembering a painful experience (such as violence in their past) and do not want to talk about it. If at any time you sense that someone is uncomfortable with the subject matter, make sure that they are not pressured by your team or other participants to talk about something they don't want to. Remind them that they can choose not to answer any question or not to participate in a particular activity.
- Try to get the opinions of all participants. Do not accept one person's opinion as the opinion of the whole group.
- Encourage participants to speak in whichever language they are most comfortable with, even if it means you need to get a translator.
- Because many issues you are discussing are sensitive, the respondents may often be silent. You may have to try different ways of introducing the same topic. Don't keep repeating the same question; be creative and ask in another way.
- Don't be afraid of silences. The person who was speaking may continue, or another person may decide to talk.
- Diplomatically discourage more than one person from talking at the same time.
- Listen to the discussion and make notes of non-verbal communication such as hesitations, laughter, and silences.
- When using a specific tool, don't limit yourself to the procedures of the tool; the procedures have been provided as a guide to help you. Remember that spontaneous discussion among the participants is good and should be encouraged because it can provide useful insight.

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- Always keep in mind the overall purpose of the project and the broad themes and topics that you want to explore so that you can facilitate an appropriate discussion with the participants when you are doing the exercises.
- Be aware of the personal biases that you might bring to the discussion, and try not to let them limit the conversation.
- Remember that emotion, tension, and conflict are likely to arise in a group setting. This is normal and to be expected, so be ready to handle it appropriately. It is your role to help people find common ground when conflicts arise, and recognize when to agree to disagree. Try to avoid taking criticism or resistance personally.

Annexure-28

Example of Planning of Advocacy Campaign

Based on the following case study, plan an advocacy campaign with the participants.

Selvarani a 20 year old woman and Paulpandi (27 years old) her husband, both natives of Pootchipatti village, Usilampatti taluka, had three daughters. Paulpandi was the only bread-winner of the family. Paulpandi used to do some social work in his village. With the hope of begetting a male child, Selvarani became pregnant for the fourth time. Her husband and her relatives had thought of killing the baby if it was a female child.

At this juncture, the AWW met Selvarani in her house and registered her name for services for pregnant women at the Anganwadi Centre (AWC). She used to meet her regularly to educate her about taking nutritious food and also following the immunization schedule. She was invited to participate in the antenatal training camps organized by AWW in Pootchipatti, her own village. In such camps, the importance of female children was also discussed to sensitize women folk. It was explained that the idea of family members to kill the baby if it happened to be a female child was bad and had to be abandoned as girls are important for a healthy and balanced society. From then onwards, the staff counseled Selvarani's husband and her relatives, but all in vain.

The child was born. It happened to be a female child. As planned earlier, her husband and in-laws had decided to kill the girl child. Selvarani kept the child away throughout the day and night to prevent female infanticide. Fortunately, the next day the AWW visited the mother and the child. She explained to them, the difficulties she faced in her family.

The AWW met her husband and his parents and motivated them to keep the baby. Fortunately, AWW counselled the family intensely, to retain the fourth girl in their family. AWW helped the mother to develop a strong mind and will power to save a girl child from death.

Later after 25 years, her father was proud that his daughters had achieved something that he had always wished his sons would achieve and he realised that they excelled in any field that they chose. One of his daughters was now a Doctor and helped her community by doing charitable practice so that the poor can get treatment.

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Identify Challenge or Problem	Gender Biased Sex Selective Elimination
Identify root-cause/s	▪ Limited knowledge ▪ Poverty
Define problem/effect that is being addressed	1. Negative effects on mother health, with repercussions on many other aspects (education, poverty, etc.) 2. Low child sex ratio
Identify target audiences that have a stake in this area	**Primary Audience** 1. Mothers 2. Husbands 3. Mother-in-laws **Secondary Audience** 4. NGOs in that community 5. PRIs 6. Mahila Mandals 7. Local leaders 8. Adolescent Girls
Viable options/ solutions	• Provide knowledge and support to stop Gender Biased Sex Selective Elimination • Influence the policies and actions of others to achieve positive changes for the community • Involve community for the cause
Turn them into SMART Objective	• 90% of the mothers and mother-in laws of Pootchipatti village will be given knowledge about the importance of girl child, gender sensitivity and dis advantages of low CSR by 2015.
Develop messages	• Develop messages for Rally • Prepare slogans • Skit or puppet show may be prepared and demonstrated by the participants
Action Plan	• Prepare a time-line • Plan and arrange activities that needs to be done in the time-line • Who all will be involved in the campaign and who will do what and when? • What all materials and tools will be used?

Annexure-29

Role of Media-Example

कन्या भ्रूण हत्या और लड़कियों को बराबरी का दर्जा देने की दिशा में आए बदलाव में मीडिया की बहुत बड़ी भूमिका है। समाज में जागरूकता बढ़ने के साथ ही मीडिया का दायरा बढ़ता जा रहा है। जब इंसान को अपने अधिकारों और देश दुनिया के घटनाक्रम में रूचि पैदा होगी तो मीडिया स्वाभाविक तौर पर विस्तार लेगा। किसी अच्छे उद्देश्य के लिए इस विस्तार का फायदा कैसे उठाया जाए , यह हमारे प्रयासों पर निर्भर करता है। आज कोई भी संगठन, कंपनी ऐसी नहीं है जो मीडिया के जरिये लोकप्रियता हासिल करने के लिए रणनीति न बनाती हो।

बेटी बचाओ जैसा विषय तो समाज की आधी आबादी से जुड़ा मामला है। लोकतंत्र में इतनी बड़ी आबादी की उपेक्षा वैसे भी नहीं हो सकती। सामाजिक जड़ता और पुरुष प्रधान समाज की बेड़ियां समय के साथ वैसे भी टूट रही हैं। हिंदी फिल्मों से लेकर जान चेतना का आधुनिक संस्करण ' सोशल मीडिया ' सब इस उद्देश्य में सहायक साबित हो रहे हैं. बस, सवाल है मुद्दा उठाने के सार्थक प्रयास का। आसान शब्दों में यह कि हम अपना सन्देश लोगों तक पहुंचाने के लिए मीडिया के तमाम संस्करणों का कितनी अच्छी तरह इस्तेमाल कर सकते हैं।

इस सिलसिले में सबसे ज़्यादा जरूरी है मीडिया को अपना सहभागी बनाना। सब कुछ हो जाने के बाद अंत में मीडिया को सूचित करके कर्त्तव्य की इतिश्री कर लेने की प्रवृति प्रभावी नहीं रहती। आमतौर पर हमें अपेक्षा के अनुरूप परिणाम नहीं मिलते और हमें निराशा होती है। हमेशा याद रखें मीडिया खुद उन विषयों के प्रति आकर्षित होता है जो मानवीय संवेदनाओं से जुड़े होते हैं। कन्या भ्रूण हत्या तो वैसे भी बेहद संवेदनशील विषय है।

मीडिया की भागीदारी के लिए पहला सूत्र तो यह है कि आप जहां भी काम कर रहे हैं वहां के मीडिया संस्थानों और उनसे जुड़े व्यक्तियों से निरंतर संपर्क। उन्हें अपने प्रयासों से निरंतर अवगत करवाना। परोक्ष रूप से उन्हें यह अहसास करवाते रहना कि मीडिया कि आपके काम में कितनी बड़ी भूमिका है। कर्तव्य बोध का यह अहसास करवाने के साथ ही उनके लिए न्यूज़ प्रोवाइडर की भूमिका भी निभाना। खुद को न्यूज़ मेकर भर मान कर बैठ जाने से अपेक्षित सहयोग कभी नहीं मिल पाता। मिसाल के तौर पर किसी बेटी के उत्कृष्ट काम को मीडिया तक पहुँचाना , किसी बेटी के साथ हुए अन्याय या अमानवीयता की खबर मीडिया तक पहुंचाना , ऐसे किसी चर्चित मामले में ज़्यादा से ज़्यादा तथ्यों को मीडिया तक पहुंचाना , अपने आयोजनों में मीडिया को आमंत्रित करके या फिर उन्हें प्रायोजन में बाकायदा जोड़ना आदि आपको बेहद अच्छे परिणाम देगा। हमने यह किया है इसे आप छाप दीजिए या दिखा दीजिए जैसे औपचारिक संपर्क बदलाव में सहयोगी नहीं बन सकते।

याद रखें हम जो काम कर रहे हैं वो सामाजिक व्यवस्था में परिवर्तन से जुड़ा है। कुरीतियों और सैकडो वर्षों से कायम संकीर्ण नज़रिए को रातों -रात नहीं बदला जा सकता। न ही , इस पावन कार्य को गोष्ठियों और भाषणों जैसी औपचारिकता मात्र से गति दी जा सकती है। लड़कियों के प्रति सोंच में बदलाव तब ही आएगा जब बात दिल पर लगेगी। मीडिया हमारे स्पंदन है। उसमें ताकत है आइना दिखाने की। उसमें ताक़त है घर-घर तक सन्देश पहुंचाने की। मीडिया को अपना बेहद अनिवार्य सहयोगी बनाकर ही आप सफल हो सकते हैं। ज़माना बदल रहा है शिक्षा का प्रचार प्रसार और उसका महत्व लोगों की रहा है। संचार क्रान्ति ने कुछ ही दशकों में सब कुछ बदल के रख दिया है। ऐसे में बेटी बचाओ - बेटी पढ़ाओ जैसे अभियान बहुत तेजी से आगे बढ़ सकते हैं। ज़रुरत है मीडिया में अपना प्रतिनिधित्व हासिल करने के लिए एक बेहतर संवाद की। बस इससे ज़्यादा कुछ नहीं।